

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: April 17, 2026

Inspection Number: 2026-1595-0003

Inspection Type:
Critical Incident

Licensee: City of Toronto

Long Term Care Home and City: Carefree Lodge, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 9, 13-15, 17, 2026

The following intake(s) were inspected:

- Intake #00168300-related to an allegation of physical abuse
- Intake #00168300- related to allegation of neglect and concerns with medication management

The following **Inspection Protocols** were used during this inspection:

Medication Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 5.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

5. Every resident has the right to freedom from neglect by the licensee and staff.

On a specified date, a resident activated their call bell to request assistance with care.

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However, staff did not respond to the request for an extended period of time.

Sources: Interview with resident and staff, call bell record
[000705]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A resident was observed with an injury on a specified date. On multiple subsequent dates, the resident alleged that the injury was caused by being struck by a staff member. A report to the director for the allegation of abuse was not submitted until several weeks later.

Sources: Critical incident report, resident's clinical records, interview with staff
[000705]

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

On a specified date, a resident was documented to have altered skin integrity. Weekly wound assessments were not completed on multiple occasions.



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Sources: Resident's clinical records, interview with staff
[000705]



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