Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Public Report

Report Issue Date: October 9, 2025
Inspection Number: 2025-1595-0005
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): October 2-3, 6-7, 2025

The following intakes were inspected on in this Critical Incident (CI) inspection:

- Intake: #00158007/ CI#M596-000018-25 -related to infection prevention and control
- Intake: #00158198 /CI#M596-000019-25 -related to infection prevention and control

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes issued by the Director was complied with. In accordance with Additional Requirement 9.1 (f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), a staff member did not wear the required Personal Protective Equipment (PPE) according to additional precautions including the appropriate selection and application of PPE.

A resident was on droplet and contact precautions. On a specified date, a staff member was not wearing a face shield while assisting the resident. The IPAC Lead confirmed that the staff member should have worn a face shield.

Sources: An observation and interviews with a staff member and the IPAC Lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that symptoms for multiple residents were recorded on each shift when they were diagnosed with an infectious disease.

Symptoms for multiple residents were not documented in their clinical records on specific shifts while the residents were actively exhibiting symptoms and on isolation precautions. The IPAC Lead confirmed that symptoms were not recorded on each shift for multiple residents.

Sources: Review of a residents' clinical records, interview with IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed of an outbreak that was declared on specified date. The licensee did not report it to the Director until the next day.

Sources: Ontario LTC Homes Portal; and interview with the IPAC Lead.