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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: January 20, 2026
Inspection Number: 2026-1563-0001
Inspection Type: Critical Incident
Licensee: Regional Municipality of Durham
Long Term Care Home and City: Lakeview Manor, Beaverton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 13, 14, 16, 20, 2026
The inspection occurred offsite on the following date(s): January 15, 19, 2026

The following intake(s) were inspected:
- An intake related to resident to resident sexual abuse.
- An intake related to COVID 19 outbreak.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A resident reported multiple occasions in which a coresident entered the shared washroom and engaged in inappropriate behaviour of a sexual nature.
In an audio recorded interview, a staff confirmed that these inappropriate behaviours occurred several times in the shared bathroom.
Sources: resident clinical documentation, Interview with staff

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).

A COVID 19 outbreak was declared in a resident home area on December 23, 2025. During a review of resident assessments, it was noted that one resident was missing required assessment data for December 22, the date on which symptoms first appeared, as well as missing night shift assessments for December 26. Another resident was missing required assessment data from the night shift of December 25 and was also missing night shift assessments for December 26.
Sources: clinical documentation

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

In accordance with the Minister's Directive: Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings indicates weekly Infection Prevention and Control (IPAC) audits should be conducted for the duration of the outbreak.

A COVID 19 outbreak was declared in a resident home area on December 23, 2025.
Weekly hand hygiene (HH) and Personal Protective Equipment (PPE) audits were not completed for the week of December 21, 2025.
Sources: PPE audits, HH audits, Interview with staff

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