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

Toronto District
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Toronto, ON, M2M 4K5
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Public Report

Report Issue Date: October 20, 2025
Inspection Number: 2025-1309-0006
Inspection Type:
Critical Incident
Follow up

Licensee: Baycrest Hospital
Long Term Care Home and City: The Jewish Home for the Aged, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 9, 10, 16, 17, 20, 2025
The inspection occurred offsite on the following date(s): October 14, 15, 2025

The following Follow-up intake was inspected:
-Intake: #00154045/Follow-up #1, related to FLTCA, 2021 s. 11 (1) (b), Nursing and personal support services.

The following Critical Incident (CI) intake(s) were inspected:
-Intake: #00155671, related to injury of unknown cause;
-Intake: #00157055, related to an unwitnessed fall with injury;
-Intake: #00158505, related to resident care concerns and plan of care and;
-Intake: #00158808, related to multiple care concerns of a resident and lingering odour.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1309-0005 related to FLTCA, 2021, s. 11 (1) (b)

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care were provided to two residents.

i) A resident's plan of care required an intervention to manage an injury. The resident was observed without the intervention in place which was acknowledged by a Personal Support Worker (PSW).

Sources: Resident observations; review of a resident's clinical records; and interviews with a PSW and other staff.

ii) Another resident had an area of altered skin integrity and required an intervention, which was not provided by a PSW on one shift.

Sources: A resident's clinical records, critical incident (CI) report; and interviews with a PSW and other staff.