

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: March 13, 2026

Inspection Number: 2026-1309-0003

Inspection Type:
Critical Incident

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): March 3-6, 9, 11-13, 2026

The following intake(s) were inspected:

- Intake #00166006/Critical Incident (CI) #2824-000152-25 and Intake #00167085/CI #2824-000003-26 - related to improper care
- Intake #00167013 - CI #2824-000001-26 - related to a resident fall with injury

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

Resident Care and Support Services
Skin and Wound Prevention and Management
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 (4) (a)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

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The staff did not did not collaborate with each other in communicating the transfer of a resident after an injury was identified. A staff completed an assessment but did not inform the other staff not to transfer the resident at that time. The home confirmed that there was a communication breakdown between the staff members at the time of incident.

Sources: Resident's clinical records and staff interviews.

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

A resident sustained altered skin skin integrity when staff used an intervention which was not in their plan of care.

Sources: Resident's clinical records, home's investigation notes an staff interviews.

WRITTEN NOTIFICATION: Falls Prevention and Management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

In accordance with O. Reg. 246/22, s. 11(1) (b), the licensee is required to ensure that written policies developed for the falls prevention and management program were complied with.

Specifically, the home's Falls Prevention and Management policy outlined that following

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a fall, staff are to initiate a Head Injury Routine (HIR) if the resident fall was unwitnessed.

On a specified date, a staff did not document a specific assessment after a resident had an unwitnessed fall. The home confirmed that a specific assessment should have been initiated and documented.

Sources: Resident's clinical records, Apotex Falls Prevention Policy (February 1, 2024) and staff interviews.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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

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,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

A staff reported that a resident had altered skin integrity. There was no treatment provided immediately to the resident's altered skin integrity. The home confirmed that the treatment was implemented three days after it was reported to the staff.

Sources: Resident's clinical records and staff interviews.



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

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