

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: November 26, 2025

Inspection Number: 2025-1228-0006

Inspection Type:
Critical Incident

Licensee: Harold and Grace Baker Centre

Long Term Care Home and City: Harold and Grace Baker Centre, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 21, 24-26, 2025

The following intake(s) were inspected:

Intake: #00162001 - Critical Incident (CI) 2732-000037-25 - Physical abuse of a resident by a staff

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

Prevention of Abuse and Neglect

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.

A staff member provided care to a resident independently. The resident's plan of care indicated they required a specified level of assistance for all tasks related to the care.

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Later that day, the resident was reported to have sustained injuries that were not present prior to the incident.

Sources: Interview with the home's staff and management, a resident's clinical records, the home's investigation notes

WRITTEN NOTIFICATION: Duty to protect

NC #002 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.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain."

A resident resisted and verbalized refusal in another language during the provision of care by a staff member. However, the staff member continued to provide care. Later that day, the resident reported that the staff member provided care despite the resident's refusal and had held the resident to inhibit their movements, which resulted in injury. An assessment was conducted for the resident and found multiple injuries that were not present prior to the incident.

Sources: Interview with the home's staff and management, a resident's clinical records, the home's investigation notes