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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Public Report

Report Issue Date: July 15, 2025

Inspection Number: 2025-1309-0004

Inspection Type:
Complaint
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): July 2-4, 7-11, and 13-15, 2025
The inspection occurred offsite on the following date(s): July 8, 2025

The following complaint intake(s) were inspected:
• Intakes #00143242; #00149271 and #00150571/#00135039-24- related to multiple care concerns of residents

The following Critical Incident (CI) intake(s) were inspected:
• Intake #00143382/CI #2824-000037-25 - related to an injury of unknown cause
• Intakes #00145390/CI #2824-000049-25; #00146195/CI #2824-000051-25- related to falls prevention management
• Intakes #00144355/CI #2824-000042-25 and #00148814/CI #2824-000062-25 - related to resident to resident physical abuse
• Intakes #00144703/CI #2824-000045-25/CI #2824-000047-25 and #00147740/CI #2824-000055-25- related to alleged staff to resident physical abuse

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Responsive Behaviours
Prevention of Abuse and Neglect
Recreational and Social Activities
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 a resident's plan of care related to the use of a fall intervention prevention was provided as specified in their plan.

A resident sustained a fall and their fall prevention intervention was not in use at the time of their fall and was found in a specified location as confirmed by staff.

Sources: CI #2824-000051-25, staff interviews, home and residents clinical records.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff use safe positioning techniques when assisting a resident.

A complaint was forwarded to the Ministry of Long-Term Care (MLTC) when a resident sustained an area of altered skin integrity while being repositioned by staff.

Sources: Staff interviews and resident's clinical records.

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically

designed for skin and wound assessment,

The licensee failed to ensure a skin and wound assessment was completed using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment when a resident sustained an area of altered skin integrity.

A review of the skin assessments for a resident showed that there was no initial skin and wound assessment completed on a specified date as per the home's policy as confirmed by staff.

Sources: Staff interviews, home and resident's clinical records.

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) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that a resident was assessed by a Registered Dietitian (RD) when a resident exhibited a skin impairment that would likely require or respond to nutrition intervention.

A RD referral was submitted on a specified date after a resident's altered skin

integrity worsened. Staff confirmed that a RD referral should have been completed at an earlier date when initial signs of altered skin integrity was assessed as per their policy.

Sources: Staff interviews, home and residents clinical records.