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: September 26, 2025
Inspection Number: 2025-1531-0006
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Bendale Acres, Scarborough

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-26, 2025

The following intakes were inspected on in this Critical Incident (CI) inspection:

- Intake: #00154312/CI #M504-000044-25 -related to injury of unknown cause
- Intake: #00154448/CI #M504-000045-25 - related to improper/incompetent care

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

Resident Care and Support 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 (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

The licensee has failed to ensure that the staff and others involved in the different aspects of a resident's care collaborated with each other when a resident exhibited pain during transfers. A staff member indicated that the resident had pain when transferring but did not report it to the nurse.

Sources: Home's investigation notes and an interview with staff.

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.

The licensee has failed to ensure that a resident wore the appropriate protective device at all times as specified in their plan of care. The resident was observed without said device on a specified date.

Sources: Observation of a resident, a resident's plan of care, and interviews with staff.