

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

 Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

 Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8^{ème} étage
Toronto, ON M4V 2Y7

**Ministère de la Santé et des Soins de
longue durée**

 Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

 Telephone: 416-325-9297
1-866-311-8002

 Téléphone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Télécopieur: 416-327-4486

<input type="checkbox"/> Licensee Copy/Copie du Titulaire	<input checked="" type="checkbox"/> Public Copy/Copie Public
---	--

Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 16, 17, 18, 24, 25, 26, 2011	2011_195_2460_16May154834	CIS Log # T205-11

Licensee/Titulaire

 Extendicare Canada Inc.
3000 Steeles Avenue East
Markham, ON L3R 9W2
(905) 470-4000

Long-Term Care Home/Foyer de soins de longue durée

 Extendicare Bayview
550 Cummer Avenue
North York, ON M2K 2M2
(416) 226-1331
Fax: (416) 226-2745

Name of Inspectors/Nom de l'inspecteurs

Tiziana Picardo – 195

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: Personal Support Workers (PSW), Registered Staff, Physiotherapist, and Administrator.

During the course of the inspection, the inspector reviewed the care plan, progress notes, assessments, and reviewed policies and procedures.

The following Inspection Protocols were used in part or in whole during this inspection:

 Personal Support Services
Critical Incident Response
Responsive Behaviours

 Findings of Non-Compliance were found during this inspection. The following action was taken:

[1] WN

NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions WN – Written Notifications/Avis écrit VPC – Voluntary Plan of Correction/Plan de redressement volontaire DR – Director Referral/Régisseur envoyé CO – Compliance Order/Ordres de conformité WAO – Work and Activity Order/Ordres: travaux et activités	
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the <i>Long-Term Care Homes Act, 2007</i> (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le <i>Loi de 2007 les foyers de soins de longue durée</i> à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.
WN # 1 - The Licensee has failed to comply with LTCHA, 2007, c. 8, s. 6 (1)(c). Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.	
Findings: 1. Progress notes indicate that an identified resident was physically and verbally aggressive towards residents and staff. 2. Care plan was not revised to reflect documented physical aggression, reassessment, and Minimum Data Set - Resident Assessment Protocol.	
Inspector ID #:	195

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title:	<i>Suzana Picardo</i>
Date:	Date of Report: <i>June 6, 2011</i>