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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Public Report

Report Issue Date: May 13, 2025

Inspection Number: 2025-1072-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Bayview, North York

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6, 7, 8, 9, 13, 2025

The following intake(s) were inspected:
- Intake: # 00140352 related to Compliance Order #001 under Inspection #2025-1072-0001.
- Intake: #00139562/Critical Incident System (CIS)#2460-000005-25 and intake: #00142461/CIS#2460-000008-25 related infection prevention and control
- Intake: #00144423 /CIS#2460-000009-25 related to falls prevention and management

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1072-0001 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was reviewed and revised, when the resident's care needs changed.

The resident was prescribed a medication to be taken several times a day for a few weeks. Registered Nurse (RN) confirmed that the medication was no longer being administered and the symptoms had resolved. The intervention was removed from the plan of care.

Sources: Resident's clinical records, interview with RN.
Date Remedy Implemented: May 8, 2025

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure that the symptoms for three residents were recorded on each shift while they were demonstrating signs of COVID-19 infection.

The residents' symptoms were not documented on multiple shifts while they were demonstrating signs of COVID-19 infection.

Sources: Clinical records of the residents; interviews with the Registered Practical Nurse, Charge Nurse, and Infection Prevention and Control Lead.