



**Ministry of Health and  
Long-Term Care**

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

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
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**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Oct 15, 2013	2013_162109_0035	T-505-13	Critical Incident System

**Licensee/Titulaire de permis**

EXTENDICARE SOUTHWESTERN ONTARIO INC  
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE BAYVIEW  
550 CUMMER AVENUE, NORTH YORK, ON, M2K-2M2

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

SUSAN SQUIRES (109)

**Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 19, 2013**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Social Worker, Registered Nurse, Resident**

**During the course of the inspection, the inspector(s) reviewed the health record for resident # 1, conducted a walk through of the unit and bedroom in which resident # 1 resided, reviewed the home's policy for zero tolerance of abuse, reviewed the staff schedules for the identified time period**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**

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**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

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<b>Legend</b>	<b>Legendé</b>
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (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.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**

**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**

**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**

**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**

**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**

**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**



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1. The licensee failed to ensure that a person who has reasonable grounds to suspect that [2] Abuse of a resident by anyone and neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

Resident # 1 was admitted to Extendicare Bayview from another LTCH. On an identified date the licensee was made aware of an investigation of abuse of resident # 1 which was conducted at the other LTCH prior to resident # 1's admission to the home. The licensee reacted by implementing measures to ensure the safety of the resident from the suspected abuser.

The licensee did not report their suspicions of abuse to the Director. [s. 24. (1)]

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**Issued on this 15th day of October, 2013**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

A handwritten signature in black ink, appearing to be "J. Gu" or similar, written over a white background within a rectangular box.