



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

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

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

**Rapport d'inspection  
prévues le Loi de 2007 les  
foyers de soins de longue**

**Health System Accountability and Performance  
Division  
Performance Improvement and Compliance Branch**  
**Division de la responsabilisation et de la  
performance du système de santé  
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<b>Date(s) of inspection/Date(s) de l'inspection</b>	<b>Inspection No/ No de l'inspection</b>	<b>Type of Inspection/Genre d'inspection</b>
Apr 13, 23, 24, 27, 30, May 2, 2012	2012_102116_0015	Critical Incident

**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**

SARAN DANIEL-DODD (116)

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

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, maintenance service manager, Registered and direct care staff members.

During the course of the inspection, the inspector(s) reviewed the health records of identified residents, reviewed the preventative maintenance policy and observed mechanical lifts used within the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

- The inspector observed a shower room to be open, unlocked and unsupervised.
- Water was observed on the floor and chemicals were contained inside the room.

**Additional Required Actions:**

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. A personal support worker (PSW) failed to ensure that safe transferring techniques were used when assisting a resident.

- An identified resident sustained an injury while being transferred from bed to wheelchair.
- The plan of care for the resident identifies the requirement for all transfers to be provided with two persons and the use of a mechanical aid.
- The resident was transferred without the assistance of another staff member.

**Additional Required Actions:**

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***



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Issued on this 4th day of June, 2012

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