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

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Public Report

Report Issue Date: January 23, 2026
Inspection Number: 2026-1072-0001
Inspection Type: Complaint 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): January 16, 19-23, 2026.

The following intake was inspected in this Follow-Up Inspection:
- Intake: #00164707 - Compliance Order (CO) #001 from inspection #2025-1072-0006 related to plan of care.

The following intake was inspected in this Complaint Inspection:
- Intake: #00164628 - Complaint regarding concerns with a resident's medication administration.

The following intake was inspected in this Critical incident System (CIS) inspection:
- Intake: #00165287 - CIS #2460-000025-25 - Related to a communicable disease outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2025-1072-0006 related to FLTCA, 2021, s. 6 (4) (a)

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

Resident Care and Support Services
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

The home's outbreak management policy required immediate notification of the infection prevention and control (IPAC) manager upon suspected or confirmed outbreak, and submission of an initial outbreak summary to the local public health authority. At least four residents in a home area developed new infectious symptoms. However, the IPAC manager was not notified on the same day, and the local public health authority was not notified until two days later.

Sources: Home's outbreak management meeting notes, home's outbreak management procedure, residents' progress notes and interview with relevant staff.

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's policy indicated that staff are to clearly document a physician's order. A Registered Nurse (RN) received a telephone order from an on-call physician to modify a resident's medication order, but the order was not transcribed.

Sources: Home's policy, resident clinical records; and interview with relevant staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

A Registered Practical Nurse (RPN) administered a medication prior to administering a different medication in accordance with the prescriber's direction.

Sources: Resident clinical records, and interview with relevant staff.