

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: February 13, 2026

Inspection Number: 2026-1072-0002

Inspection Type:
Critical Incident

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): February 9-13, 2026

The following Critical Incident (CI) intakes were inspected:

-Intakes #00166574-CI #2460-000026-25 and #00169364-CI #2460-000002-26 were related to resident care and support services.

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

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Staff did not collaborate on a resident's plan of care when the Physiotherapist (PT) made changes to their mobility status and it was not implemented into the resident's daily care.

Sources: A resident's clinical records, interviews with a PT and a Registered Nurse (RN).

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 40

Transferring and positioning techniques

s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A resident required two people to assist with transfers. On a specified date a Personal Support Worker (PSW) completed a transfer without the assistance of an additional staff member.

Sources: A resident's clinical records and interview with a PSW.