

**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:** September 19, 2025

**Inspection Number:** 2025-1072-0004

**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): September 17, 18, 19, 2025

The following Critical Incident System (CIS) intake was inspected:

- Intake: #00155795, related to a resident fall with injury.

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

Falls Prevention and Management

## INSPECTION RESULTS

### WRITTEN NOTIFICATION: STAFF AND OTHERS TO BE KEPT AWARE

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

**Non-compliance with: FLTCA, 2021, s. 6 (8)**

Plan of care

s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and

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immediate access to it, related to falls prevention and management.

The resident had a fall with injury and required an intervention manage their falls as per their progress notes. A Personal Support Worker (PSW) acknowledged that they were not aware of the intervention as it was not in the resident's care plan and kardex. The Director of Care (DOC) indicated that the PSW staff did not have full access to the resident's plan of care which included progress notes.

**Sources:** Review of a resident progress notes and care plan; and interviews with a PSW, DOC and other staff.