



**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 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

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| <b>Report Date(s) /<br/>Date(s) du apport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|---|---|--------------------------------|--|
| Jan 23, 2015                                  | 2014_363591_0007                              | T-870-14                       | Complaint  |

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### **Licensee/Titulaire de permis**

EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE ROUGE VALLEY  
551 Conlins Road TORONTO ON M1B 5S1

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

NATASHA JONES (591), TIINA TRALMAN (162)

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## Inspection Summary/Résumé de l'inspection

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**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): October 10, 14, 15, 2014.**

**This complaint inspection occurred concurrently with Resident Quality Inspection #2014\_235507\_0018.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of care (DOC), Social Worker (SW), registered staff, personal support workers(PSW), residents, and family member.**

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

**Contenance Care and Bowel Management  
Dignity, Choice and Privacy  
Personal Support Services  
Prevention of Abuse, Neglect and Retaliation  
Reporting and Complaints  
Responsive Behaviours  
Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)  
0 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)**



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

| Legend  | Legendé  |
|---|--|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order   | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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. 3. Residents' Bill of Rights**



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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**

**11. Every resident has the right to,**

**i. participate fully in the development, implementation, review and revision of his or her plan of care,**

**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**

**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**

**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the resident's right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On October 16, 2014, the inspector observed and heard the staff on an identified unit discussing residents personal health information during shift change report at the nursing station. Other residents, visitors and family members could hear it when passing by.

Interviews with identified registered staff, personal support workers (PSWs), the director of care (DOC) and the administrator confirmed that some units in the home conduct their shift change report, which includes discussion of resident personal health information, at the nursing station. The DOC and administrator confirmed that resident personal health information was not kept confidential. [s. 3. (1) 11. iv.]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**

**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**

**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**

**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**

**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**

**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**

**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**

**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**s. 101. (3) The licensee shall ensure that,**

**(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).**

**(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).**

**(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).**

**Findings/Faits saillants :**

**1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home**



has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

Record review revealed that a complaint was received by the home on an identified date, from resident #1's family member regarding a concern with the provision of medication.

The administrator confirmed that the complaint was not investigated, was not resolved where possible, and no response was provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes:

- (a) the nature of each verbal or written complaint
- (b) the date the complaint was received
- (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
- (d) the final resolution, if any
- (e) every date on which any response was provided to the complainant and a description of the response, and
- (f) any response made by the complainant

Record review revealed that a complaint was received by the home on an identified date from resident #1's family member, concerning the care of another resident. The received complaint was not documented in the home's 2014 complaint record.

Interview with the administrator confirmed that the home did receive the complaint but did not keep a documented record of it. [s. 101. (2)]

3. The licensee has failed to ensure that:

- (a) the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly, (b) the results of the review and analysis are taken into account in determining what improvements are required in the home, and (c) a written record is kept of each review and of the improvements made in response.

Record review and interview with the administrator revealed that the home has not developed a process to ensure that the above mentioned requirements have been implemented. [s. 101. (3)]



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**Issued on this 6th day of February, 2015**

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

**Original report signed by the inspector.**