Ontario

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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 23, 2015	2015_334565_0023	029884-15	Critical Incident System

Licensee/Titulaire de permis

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

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

EXTENDICARE ROUGE VALLEY
551 Conlins Road TORONTO ON M1B 5S1

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

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 3, 4, 5 and 9, 2015.

The following critical incident intake was inspected concurrently with this Critical Incident System inspection: 001763-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Staff, Personal Support Workers (PSWs), Residents and Family Member.

The inspector conducted observations of staff and resident interactions, provision of care, dining services, record review of resident records, home records and relevant staffing schedules.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone.

A review of the Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessments for residents #001 and #002 revealed the residents were cognitively impaired.

A review of the critical incident report and the progress notes revealed on an identified date, a staff member observed an inappropriate interaction between resident #001 and resident #002. The staff member intervened immediately and separated the two residents.

A review of the critical incident report and the progress notes revealed on another identified date, PSW #100 observed an inappropriate interaction between resident #001 and resident #002. The staff member separated the residents.

Interviews with PSW #100, AADOC and DOC confirmed the above mentioned incidents took place. The home has failed to protect resident #001 from abuse. [s. 19. (1)]

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments and reassessments.

Record review of critical incident reports and progress notes revealed resident #002 demonstrated inappropriate responsive behaviours with resident #001 on two identified dates.

Record review of the progress notes, care plan and staff schedule indicated a specified strategy was implemented for resident #002 after the first identified incident. The specified strategy was discontinued five days later. Staff were expected to monitor the resident for behaviours. A physician order was received for resident #002 to be further assessed by specialized resources. Further review of the resident's health record indicated no assessment was completed for the resident's inappropriate responsive behaviour until an identified date after the second incident.

Interview with the DOC indicated after the referral was sent, the home was told the resident did not qualify for the specified medical consultation due to an identified reason. The home did not pursue another assessment for the resident's inappropriate responsive behaviour until the second incident happened.

Interviews with AADOC and DOC confirmed after resident #002 demonstrated inappropriate responsive behaviour in the first incident, the actions taken to respond to the resident's needs had not included any assessment or reassessment for the resident. [s. 53. (4) (c)]

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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions, to be implemented voluntarily.

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Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.