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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
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419 rue King Ouest bureau 303
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 9, 2018	2018_414110_0009	016489-17, 016491-17, 016734-17, 008323-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

DIANE BROWN (110)

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): May 17, 18, 22, 23, 24, 28, 2018.

This inspection was conducted related to four critical incidents (CI) related to a safe and secure environment.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care, Social Worker, Resident Program Manager, Behavioral Support Ontario (BSO) RPN, Registered Nurse (RN), Registered Practical Nurse (RPN), MDS-RAI Coordinator, Activity Aide, Personal Support Workers (PSW).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **1 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

This inspection was initiated related to four critical incidents (CI) received by the Director pertaining to a safe and secure home environment.

1. A CI was submitted on an identified date and described a safety incident involving an identified resident.

A record review of an identified resident's written plan of care along with interviews with RPN #108, RPN #100, social worker #107 and PSW #107 revealed the identified resident's behaviors were a safety concerns to the resident and to a safe and secure home environment. The resident's written plan of care identified interventions to manage this safety risk.

A record review of progress notes pertaining to the incident identified in the CI and an interview with activity aide #105 and RN #110, who worked this shift and date confirmed the incident as it was reported. A further interview with activity aide #105, who observed and acknowledged the resident on this day confirmed that the interventions as required by the resident's written plan of care were not provided.

At the time of this CI the identified resident was not provided care as identified in their plan of care to provide for a safe and secure environment.

2. A second CI was submitted on an identified date and described a safety incident involving an identified resident.

An interview with PSW #102 who provided care to the identified resident, on the identified date referenced in the CI report, confirmed the incident as it was reported.

At the time of this CI measures were not taken to address an identified resident's behaviors and associated safety risk to a safe and secure environment.

3. A third CI was submitted on an identified date and referenced a safety incident involving an identified resident.

A record review and an interview with activity aide #111 described the incident involving the identified resident. Further interviews with PSW #113, RPN #112 and RN #110 confirmed the incident as it was reported.

At the time of this CI the identified resident was not provided care as identified in their written plan of care to provide for a safe and secure environment and measures were not taken to address the resident's behavior and associated safety risk to a safe and secure

environment.

4. A fourth CI was submitted on an identified date and described a safety incident involving an identified resident.

A record review of the identified resident's written plan of care, progress and consultation notes leading up to the CI was completed. Interviews were conducted with the acting DOC, social worker #107, RAI coordinator #108, RPN #100 and BSO-RPN #109 who confirmed the incident as it was reported.

At the time of this CI the identified resident was not provided care as identified in their written plan of care to provide for a safe and secure environment and measures were not taken to address the resident's behavior and associated safety risk to a safe and secure environment.

The severity of this issue was determined to be a level 2, potential for harm. The scope was a level 1, isolated. The home had a level 3 compliance history with no previous related areas of non-compliance [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

This inspection was initiated related to four critical incidents (CI) received by the Director pertaining to a safe and secure home environment.

1. A CI was submitted on an identified date and described a safety incident involving an identified resident.

A record review of an identified resident's written plan of care along with interviews with RPN #108, RPN #100, social worker #107 and PSW #107 revealed the identified resident's behaviors were a safety concerns to the resident and to a safe and secure home environment. The resident's written plan of care identified interventions to manage this safety risk.

A record review of progress notes pertaining to the incident identified in the CI and an interview with activity aide #105 and RN #110, who worked this identified shift and date confirmed the incident as it was reported. A further interview with activity aide #105, who observed and acknowledged the resident on this day confirmed that the interventions required by the resident's written plan of care were not provided.

At the time of this CI care set out in the plan of care was not provided to the identified resident as specified in the plan.

2. A CI was submitted on an identified date and referenced a safety incident involving an identified resident.

A record review and an interview with activity aide #111 described the incident involving the identified resident. Further interviews with PSW #113, RPN #112 and RN #110 confirmed the incident as it was reported.

At the time of this CI care set out in the plan of care was not provided to the identified resident as specified in the plan.

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 the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours.

A CI was submitted on an identified date and described a safety incident involving an identified resident with responsive behaviors. Another CI was submitted months later and described a similar safety incident involving an identified resident with responsive behaviors.

The written plan of care for the identified resident was reviewed and included interventions to address the residents responsive behaviors and safety risk.

Staff interviews with RPN #108, RPN #100, social worker #107 and PSW #107 confirmed resident's ongoing responsive behaviors and further identified that strategies were not developed and implemented to respond to an identified behavior and safety risk during the time period between the reported CI's submitted to the Director.

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 written strategies include techniques and interventions to prevent, minimize or respond to the responsive behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee has failed to ensure that they had informed the Director immediately, in as much detail as is possible in the circumstances, when an emergency had occurred.

This inspection was initiated related to four critical incidents (CI) received by the Director.

CI #1 was submitted on an identified date for an incident that occurred 30 days prior.
C1 #2 was submitted on an identified date for an incident that occurred 22 days prior.
C1 #3 was submitted on an identified date for an incident that occurred 2 days prior.

An interview with the acting director of care confirmed late reporting to the Director of the above noted incidents. [s. 107. (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 that they had informed the Director immediately, in as much detail as is possible in the circumstances, when an emergency, including fire, unplanned evacuation or intake of evacuees occurred, to be implemented voluntarily.

Issued on this 23rd day of July, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2018_414110_0009
Log No. / No de registre :	016489-17, 016491-17, 016734-17, 008323-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 9, 2018
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Rouge Valley 551 Conlins Road, TORONTO, ON, M1B-5S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Terry Pilgrim-Deane

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall ensure the home is a safe and secure environment for its residents by way of managing the identified resident's responsive behaviors.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

This inspection was initiated related to four critical incidents (CI) received by the Director pertaining to a safe and secure home environment.

1. A CI was submitted on an identified date and described a safety incident involving an identified resident.

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their plan of care to provide for a safe and secure environment.

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At the time of this CI the identified resident was not provided care as identified in their written plan of care to provide for a safe and secure environment and measures were not taken to address the resident's behavior and associated safety risk to a safe and secure environment.

The severity of this issue was determined to be a level 2, potential for harm. The scope was a level 1, isolated. The home had a level 3 compliance history with

no previous related areas of non-compliance [s. 5.] (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of July, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office