

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

Central East Service Area Office  
33 King Street West, 4th Floor  
OSHAWA ON L1H 1A1  
Telephone: (905) 440-4190  
Facsimile: (905) 440-4111

Bureau régional de services de  
Centre-Est  
33, rue King Ouest, étage 4  
OSHAWA ON L1H 1A1  
Téléphone: (905) 440-4190  
Télécopieur: (905) 440-4111

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Jan 7, 2021	2020_832604_0017	024700-20	Complaint

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**Licensee/Titulaire de permis**

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

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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**

SHIHANA RUMZI (604)

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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): December 16, 17, 18, and 21, 2020.**

**During the inspection complaint intake related to fall with injury was inspected.**

**During the course of the inspection, the inspector(s) spoke with the Coroner, Administrator, Registered Nurse (RN), Registered Practical Nurse (RPN), Charge Nurse (CN), Personal Support Worker (PSW), and Interim Program Supervisor (IPS).**

**During the course of the inspection the inspector reviewed resident health records, conducted resident observations, Long-Term Care Home (LTCH). net for CIS amendments, and relevant home policies. and procedures.**

**The following Inspection Protocols were used during this inspection:**  
**Critical Incident Response**  
**Personal Support Services**  
**Prevention of Abuse, Neglect and Retaliation**  
**Responsive Behaviours**

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

**3 WN(s)**

**1 VPC(s)**

**2 CO(s)**

**0 DR(s)**

**0 WAO(s)**

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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 :**

The licensee has failed to ensure the resident was protected from abuse.

The definition of abuse means, under subject to subsection (2) the use of physical force by a resident that cause physical injury to another resident. O. Reg 79/10 s. 2 (1) (c).

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint and a Critical Incident System (CIS) report which indicated a resident was involved in an incident in the home and was transferred to hospital for further assessment.

In an interview Personal Support Worker (PSW) stated they witnessed resident to resident altercation. In separate interviews with PSW's, an Registered Practical Nurse (RPN), and Charge RN (CRN) stated a resident presented with responsive behaviors. A review of the residents documentation revealed the resident had other altercations with another residents.

In separate interviews with PSW's, RPN, CRN, and Interim Program Supervisor (IPS) stated the resident presented with responsive behaviours and the staff identified this incident to be physical.

Source: Initial CIS reports, interviews with the Coroner,, PSW's, RPN, CRN, and IPS.

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**

**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**

**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**

**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint and a Critical Incident System (CIS) report which indicated a resident was involved in an incident in the home and was transferred to hospital for further assessment.

A review of the residents clinical records, it was noted that the resident presented with responsive behaviours and further review of documentation revealed the resident had other altercations with another resident.

In separate interviews with PSW's, RPN , CN, RN, and IPS the staff indicated the resident presented with responsive behaviours. The staff individually reviewed the residents care plan and acknowledged the responsive behaviour care plan did not identify interventions to respond to the responsive behavioural triggers. The staff stated it was a risk to the other residents and staff caring for the resident as the care plan did not identify or implement interventions.

Sources: Documentation review for an identified period of time, assessments, care plans, and interviews with PSW's, RPN, CN, RN, IPS, and Administrator.

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:**

- 3. Actions taken in response to the incident, including,**
- i. what care was given or action taken as a result of the incident, and by whom,**
  - ii. whether a physician or registered nurse in the extended class was contacted,**
  - iii. what other authorities were contacted about the incident, if any,**
  - iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and**
  - v. the outcome or current status of the individual or individuals who were involved in the incident.**

**O. Reg. 79/10, s. 107 (4).**

**Findings/Faits saillants :**

The licensee has failed to ensure the written report included the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted a CIS report indicating a resident had sustained a fall and the resident was transferred to hospital for further assessment. A review of the residents documentation revealed resident had identified diagnosis. In an interview with the Coroner indicated their investigation revealed an identified outcome. In an interview the Administrator reviewed the Long-Term Care Home (LTCH) CIS reporting site and acknowledged the CIS report was not amended.

Sources: Submitted CIS report review , LTCH CIS reporting site, documentation review, and interview with Administrator.

***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 the written report included the outcome or current status of the individual or individuals who were involved in the incident., to be implemented voluntarily.***

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**Issued on this 7th day of January, 2021**

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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 Operations Division  
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée  
Inspection de soins de longue durée

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** SHIHANA RUMZI (604)

**Inspection No. /**

**No de l'inspection :** 2020\_832604\_0017

**Log No. /**

**No de registre :** 024700-20

**Type of Inspection /**

**Genre d'inspection:** Complaint

**Report Date(s) /**

**Date(s) du Rapport :** Jan 7, 2021

**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 :** Sheri Williams

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



**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

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**Order # /**

**No d'ordre :** 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. 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).

**Order / Ordre :**

The Licensee must be compliant with s. 19 (1) of the LTCHA.

Upon receipt of this order the licensee shall ensure that all residents are protected from abuse by an identified resident.

**Grounds / Motifs :**

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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

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

1. The licensee has failed to ensure the resident was protected from abuse.

The definition of abuse means, under subject to subsection (2) the use of physical force by a resident that cause physical injury to another resident. O. Reg 79/10 s. 2 (1) (c).

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint and a Critical Incident System (CIS) report which indicated a resident was involved in an incident in the home and was transferred to hospital for further assessment.

In an interview Personal Support Worker (PSW) stated they witnessed resident to resident altercation. In separate interviews with PSW's, an Registered Practical Nurse (RPN), and Charge RN (CRN) stated a resident presented with responsive behaviors. A review of the residents documentation revealed the resident had other altercations with another residents.

In separate interviews with PSW's, RPN, CRN, and Interim Program Supervisor (IPS) stated the resident presented with responsive behaviours and the staff identified this incident to be physical.

Source: Initial CIS reports, interviews with the Coroner,, PSW's, RPN, CRN, and IPS.

An order was warranted by taking the following factors into account:

Severity: There was actual harm and injury to a resident and another resident was also abused by the same resident.

Scope: This was a pattern as two similar incidents had occurred.

Compliance history indicated in the last 36 months, the licensee was found to have non-compliant with LTCHA 2007, c. 8, s. 19 (1), where a Voluntary Plan of Correction (VPC) were issued to the home. (604)

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

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

Feb 08, 2021

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

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**Order # /**

**No d'ordre :** 002

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

**Order / Ordre :**

The Licensee must be compliant with s. 54 of the O. Reg. 79/10.

The licensee shall upon receipt of this order review the identified resident's plan of care and ensure interventions are identified and developed to respond to the resident's responsive behaviours.

**Grounds / Motifs :**

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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

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

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint and a Critical Incident System (CIS) report which indicated a resident was involved in an incident in the home and was transferred to hospital for further assessment.

A review of the residents clinical records, it was noted that the resident presented with responsive behaviours and further review of documentation revealed the resident had other altercations with another resident.

In separate interviews with PSW's, RPN, CN, RN, and IPS the staff indicated the resident presented with responsive behaviours. The staff individually reviewed the residents care plan and acknowledged the responsive behaviour care plan did not identify interventions to respond to the responsive behavioural triggers. The staff stated it was a risk to the other residents and staff caring for the resident as the care plan did not identify or implement interventions.

Sources: Documentation review for an identified period of time, assessments, care plans, and interviews with PSW's, RPN, CN, RN, IPS, and Administrator.

An order is warranted by taking the following factors into account:

**Severity:** There was actual harm and injury to a resident and another resident as well.

**Scope:** This was isolated as the responsive behaviour care plan did not identify the responsive behaviours observed by staff and potential behavioural triggers for the resident.

Compliance history indicated in the last 36 months, the licensee had no area of non-compliance with s. 54 of the O. Reg. 79/10.  
(604)

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

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

Feb 08, 2021

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

**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 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:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of 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](http://www.hsarb.on.ca).



**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

**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 des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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

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

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)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère 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](http://www.hsarb.on.ca).

**Issued on this 7th day of January, 2021**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Shihana Rumzi

**Service Area Office /**

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