Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long Term Care Inspections Branch

Central East District
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Original Public Report

Report Issue Date: March 31, 2023

Inspection Number: 2023-1368-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Rouge Valley, Toronto

Lead Inspector	**Inspector Digital Signature**
AngieM King (644)	Angeli M King Digitally signed by Angeli M King Date: 2023.03.31 13:41:41 -04'00'

Additional Inspector(s)
Fatemeh Heydarimoghari (742649)
Joanne Zahur (589)

INSPECTION SUMMARY

The inspection occurred on the following date(s): March 2, 3, 6-10, and 13, 2023.

The following intake(s) were inspected:
- Intake: #00001985 and #00003283 complaints related to residents' rights, skin and wound, plan of care.
- Intake: #00002284 related to alleged sexual abuse.
- Intake: #00004934 and #00007786 related to alleged staff to resident physical abuse.
- Intake: #00017201 related to fall prevention.

The following intakes were completed in the Critical Incidents Systems inspection:
Intake: #00004207 and #00006349 related to falls incidents.

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

Resident Care and Support Services

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for the resident that set out clear directions to staff and others who provide direct care to the resident regarding fall prevention intervention.

Rationale and Summary
A Critical Incident Systems (CIS) report was submitted regarding a fall with transfer to the hospital resulting in multiple fractures for the resident.

A review of the resident's written plan of care indicated they were at medium risk for falls, requiring specific fall interventions and preventions to be used.

Observations indicated that the resident's fall prevention interventions were not in place.

Personal Support Worker (PSW), Physiotherapist (PT), and Registered Practical Nurse (RPN) indicated that the resident required specific fall preventions which also included a safety device while seated. The Assistant Director of Care (ADOC) acknowledged that the care plan did not provide clear direction to the staff for specific fall prevention interventions used for the resident.

Failing to provide clear direction to direct care staff regarding fall prevention intervention was an increased risk to the resident.

Sources: CIS, resident observations, interviews with staff and resident clinical record, home's Falls prevention policy and procedures. [742649]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee failed to ensure that care was provided to resident as per their plan of care.

Rationale and Summary:
A CIS was submitted related to an incident of alleged staff to resident abuse that resulted in a fall.

The resident care plan indicated that two staff were required for personal care and bed mobility related to their diagnosis.

Personal Support Worker (PSW) was not interviewed as they no longer work at the Long-Term Care Home (LTCH); therefore, a review of the LTCH's internal investigation notes was conducted. The home's investigation notes indicated that PSW had provided unassisted personal care to the resident, resulting in a fall.

ADOC and RPN confirmed that PSW had not provided care as per the resident's plan of care.

Failure to provide care to resident as per their plan of care posed an increased risk of falls and potential injury.

Sources: LTCH's investigation notes, record review, and interviews with staffs. [589]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee failed to immediately report an incident of alleged abuse of the resident.

Rationale and Summary
A complaint was received by the Director related to an allegation of staff to resident physical abuse

involving the resident. A CIS report was submitted 102 days after the incident.

ADOC acknowledged the CIS had not been submitted as they had determined after their investigation, that the incident was not abuse.

Failure to submit reports of alleged abuse posed a moderate risk to the residents of the home as this could lead to unreported abuse incidents.

Sources: CIS interview with staff. [589]

WRITTEN NOTIFICATION: Infection Prevention Control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (d).

The licensee failed to ensure that Routine Precautions were followed in the Infection Prevention and Control (IPAC) program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022.

Rationale and Summary
In accordance with the IPAC Standard for LTCH's, revised April 2022, section 9.1 states the licensee shall ensure that additional precautions are followed in the IPAC program that includes: d) Proper use of PPE, including appropriate selection, application, removal, and disposal.

The licensee did not ensure that the process for the application of PPE was followed.

The observation indicated that agency staff was wearing their mask below their nose while in the proximity of less than two meters of the other residents in the homearea. The home was also not in an outbreak during the inspection. Staff acknowledged that the mask should cover their mouth and their nose when worn.

The infection Prevention and Control (IPAC) lead confirmed that universal masking was mandatory for all staff, and their mask should cover their nose and mouth.

Failure to ensure masking requirements were followed could lead to transmission of infection.

Sources: Observations, and interviews with staff. [742649]

WRITTEN NOTIFICATION: Licensees who Report Investigations under s. 27 (2) of Act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.

The licensee failed to ensure that reports made to the Director included the names of any staff members who were present at or discovered the incident involving the resident.

Rationale and Summary
A CIS was submitted to the Director related to an alleged incident of physical abuse towards a resident by a staff member. The CIS did not include the names of the staff members who were present at or discovered the incident.

ADOC confirmed that this report did not include the above-mentioned information.

Failure to include staff names in CIS reports could affect identifying trends with staff members within the home.

S**ources:** CIS interview with staff. [589]

WRITTEN NOTIFICATION: Licensees who Report Investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. iii.

The licensee failed to ensure that reports made to the Director included the names of all staff members who responded to the incident involving the resident.

Rationale and Summary
CIS was submitted to the Director related to an alleged incident of physical abuse towards a resident by a staff member; it did not include all the names of all the staff members who responded to the incident.

ADOC confirmed this report did not include the above-mentioned information.

There was a low risk to the resident when the licensee did not include all of the staff members' names who responded to the incident.

Sources: CIS interview with staff. [589]