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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: October 13, 2023

Inspection Number: 2023-1368-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Extendicare (Canada) Inc.

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

Lead Inspector	**Inspector Digital Signature**
Vernon Abellera (741751)	Vernon N Abellera Digitally signed by Vernon N Abellera Date: 2023.11.10 09:40:19 -05'00'

Additional Inspector(s)
Fatemeh Heydarimoghari (742649)
Miko Hawken (724)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18, 20, 21, 22, 28, 29, 2023, with September 25-27, 2023, conducted offsite.

The following intake(s) were inspected:
- Intakes related to fall incidents.
- Intakes related to neglect and abuse.
- Intakes related to responsive behaviors.
- Intakes related to complaint on accommodation charges.
- Intakes related to skin and wound care.
- First follow-up – Compliance Order (CO) #001 from Inspection #2023_1368_0002, O. Reg. 246/22, s. 23 (4) (b), Compliance Due Date (CDD) July 27, 2023
- First follow-up - CO #002 from Inspection #2023_1368_0002, O. Reg. 246/22, s. 23.1 (3) 1, CDD July 27, 2023
- Intakes related to infection prevention and control.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1368-0002 related to O. Reg. 246/22, s. 23 (4) (b) inspected by Vernon Abellera (741751)

Order #002 from Inspection #2023-1368-0002 related to O. Reg. 246/22, s. 23.1 (3) 1. inspected by Vernon Abellera (741751)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management
Resident Charges and Trust Accounts

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 309 (1)

The licensee failed to ensure that the operator of a long-term care home would provide a resident with at least 30 days' written notice regarding the operator's proposal to increase the payable amount and the amount of the proposed increase.

Rationale and Summary:
The Ministry of Long-Term Care (MLTC) received a complaint regarding a lack of communication from

the home regarding accommodation rates increase.

During the inspection, Inspector #741751 conducted an interview with the Operations Manager (OM). The OM explained that the accommodation invoice and communication had been initiated electronically by the corporate office, transitioning from regular mail to email the previous year. The OM confirmed that the Power of Attorney's (POA) email address on file for a resident was incorrect.

The Administrator also confirmed that the corporate office had been sending invoices to the POA via regular mail before transitioning to electronic invoices.

The home failed to provide the resident and the POA with written notice regarding the operator's proposal to increase the payable amount and the amount of the proposed increase due to incorrect email address on file. The Administrator additionally confirmed that the POA's email address had been corrected in the file.

There was no impact on the resident.

Sources: Interviews with the Operations Manager and Administrator. [741751]

Date Remedy Implemented: September 28, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

The licensee failed to ensure resident #007 was treated with courtesy and respect that fully recognized their dignity, worth and individuality.

Rationale and Summary

A complaint was received by the Director related to inappropriate treatment of resident #007 from staff.

The complainant stated when resident #007's was admitted to the Long-Term Care Home (LTCH) the resident had Infection Prevention and Control (IPAC) measures put in place that were not required.

Resident #007 was emotional and felt stigmatized and disrespected by care staff when they had full personal protective equipment in place. The LTCH's staff confirmed the IPAC measures were inappropriate at the time.

The IPAC Lead confirmed that the staff had received IPAC directions inappropriately from another care manager. They also indicated that resident #007 should have been treated the same as any other resident in the LTCH.

The incident had lasting emotional effects on resident #007.

Sources: Resident #007's medical records, Complaint letter, Interviews with complainant, resident, staff, and management. [724]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (2) (a)

The licensee failed to ensure that the IPAC program included evidence-based policies and procedures.

Rationale and Summary

A complaint was received by the Director from a complainant on behalf of resident #007 related to issues at the home related to inappropriate use of Personal Protective Equipment (PPE) while caring for them.

The complainant stated that on the first day of resident #007's admission to the LTCH the resident was not on any additional IPAC measures. Subsequently, resident #007 was placed on additional precautions with staff dressed in full PPE to provide care as they had received direction from the on-call management to do so. The complainant further indicated that resident #007 did not require any additional precautions beyond routine practices.

The Provincial Infectious Diseases Advisory Committee (PIDAC) document on Routine Practices and Additional Precautions, indicated only routine practices were required.

Resident #007 recalled that staff were inappropriately dressed in PPE while providing care.

Personal Support Worker (PSW) #113 confirmed that staff were wearing PPE after resident #007 was admitted to the home, and the additional precautions were inappropriate at the time. PSW #113 also indicated that resident #007 should have been treated like any other resident in the home, using routine practices.
The IPAC Lead confirmed that the staff had received IPAC directions inappropriately from another care manager. The IPAC Lead also indicated that resident #007 should have been treated the same as any other resident in the LTCH as they required only routine practices as per the evidence-based practices.

As the home did not follow evidence based IPAC policies and procedures there could be further risk of exposure or acquiring infectious disease for both residents and staff.

Sources: Complaint letter, Resident #007's medical records, PIDAC - Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, November 2012, Interviews with complainant, resident, staff, and management. [724]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that resident #011 was protected from neglect by staff.

Section 7 of Ontario Regulation 246/22 defines neglect as “the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents”.

Summary And Rationale:

A Critical Incident Report (CIR) was submitted to the Director related to alleged PSW #114 to resident #011 neglect.

The LTCH investigation notes revealed that Registered Nurse (RN) #101 had reported to Assistance Director of care (ADOC) #117 that they had confirmed with PSW #118, that PSW #114 did not get resident #011 up out of bed, did not provide care to them or provided a meal tray.

The LTCH managers reviewed video footage from the entrance of resident #011's room and found the same.

The LTCH's interview with PSW#114, revealed that they did not provide care, did not get them out of bed and did not provide a meal to resident #011. They further stated that resident #011 was asleep and that they delayed their care, so they would be in a better mood.

PSW #114 further indicated that what they did was unintentional neglect to resident #011.

There was a moderate risk to resident #011 as they did not receive food or fluids and care until later in the day.

Sources: CIR, LTCH investigation Notes, Interviews with PSW #114 and ADOC #108. [724]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that resident #005 receives a skin assessment by a member of the registered nursing staff, upon return from the hospital.

Summary And Rationale:

A complaint was submitted to the Director related to resident #005's skin and wound issues.

Resident #005's clinical record indicated multiple wounds and underlying health medical conditions which affected skin integrity.

The resident was transferred to the hospital for treatment, and upon return, there was no documentation of a skin assessment completed for resident #005.

ADOCs #100 and #108 confirmed that no skin assessment was done by a member of the registered nursing staff, upon the return of the resident from the hospital.

There was a risk of delayed treatment and wound healing by not doing a skin assessment for resident #005.

Sources: Resident #005's clinical records and interviews with ADOCs. [742649]

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