



**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
Facsimile: (905) 433-3008

Bureau régional de services du
Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 21, 2018	2018_748723_0007	018620-18	Follow up

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

ADELFA ROBLES (723)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 29, 30, and 31, 2018.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Assistant Director of Care (ADOC), Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector conducted resident observations, reviewed clinical health records, the home's corrective plan of action, and relevant home policies and procedures.

**The following Inspection Protocols were used during this inspection:
Safe and Secure Home**

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:



REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3.	WN	2018_598570_0006		723
LTCHA, 2007 S.O. 2007, c.8 s. 5.	WN	2018_414110_0009		723
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2018_414110_0009		723

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>Legendé</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. 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 :



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

On an identified date, the home was issued an order under the Long-Term Care Homes Act (LTCHA), 2007, c. 8, s. 5, in report # 2018_414110_0009. The order required the licensee to ensure the home was safe and secure environment for its residents by way of managing resident's #001 behaviours.

A review of resident #001's health records indicated the resident had been discharged from the home on an identified date. As a result of resident #001's discharge, the health care records of resident #006 and #007 were reviewed.

On an identified date, time, and place, Inspector #723 observed resident #006 take out an identified item from their shirt pocket. In an interview, resident #006 stated to the inspector that they do not ask the staff for the identified item and that they were allowed to keep it with them.”

An interview with Registered Practical Nurse (RPN) on an identified date and time, the RPN indicated that resident #006 keeps their identified item with them and were allowed to have the identified item with them. RPN confirmed that as per the resident’s written plan of care, resident’s identified items, should be kept in the medication room after each use. The RPN acknowledged that care had not been provided to resident #006 as specified in the plan.

An interview with the Assistant Director of Care (ADOC) on an identified date and time, the ADOC acknowledged the above mentioned information and indicated that the care had not been provided as specified in the plan as resident #006's identified items should be kept by nursing staff.



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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 is provided
to the resident as specified in the plan, to be implemented voluntarily.***

Issued on this 23rd day of October, 2018

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

Original report signed by the inspector.