Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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
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 public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 27, 2019	2019_823653_0030	019283-19	Complaint

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 13, 14, 15, 18, and 19, 2019.

Complaint log #019283-19 related to a fall resulting in an injury, was inspected during this inspection.

During the course of the inspection, the inspector conducted observations of resident care provision, the home's video surveillance, reviewed the staff schedule, clinical health records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with a visitor, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist (PT), and the Assistant Director of Care (ADOC).

The following Inspection Protocols were used during this inspection:
Falls Prevention

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

- **1 WN(s)**
- **0 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	Légende 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. 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 has failed to ensure that the care set out in the written plan of care was provided to resident #004 as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint related to resident#004's recent fall in the home, which resulted in an injury. An interview with the complainant indicated resident #004 was supposed to be monitored because they would always get up from their personal assistive device. The complainant indicated at the time of the incident, the resident must have stood up and fell when no one was watching them.

The home submitted a Critical Incident Report (CIR) for an incident that caused an injury to resident #004, for which they were taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #004 was found on the floor in their bedroom and was sent to hospital for further assessment.

A review of resident #004's written plan of care indicated they were at risk for falls and staff had to ensure that the identified falls prevention intervention was working.

During the on-site inspection, the home provided Inspector #653 with a copy of the video footages from the home's video surveillance from the date of the incident. The interim Director of Care (iDOC) confirmed that resident #004 was identified in the video.

A review of the home's video surveillance revealed at the time of the incident, visitor #114 was observed walking down the hallway, stopped in front of resident #004's bedroom, came close to the door and opened it slightly. The bedroom light was observed to be off. Visitor #114 looked inside the bedroom, and down on the floor, stepped back, closed the door slightly, and ran towards the nursing station.

During an interview, Personal Support Worker (PSW) #109 and Inspector #653 reviewed the home's video surveillance and the PSW confirmed the identity of visitor #114.

During an interview, visitor #114 indicated at the time of the incident, they were sitting on the bench between the dining room and the nursing station, when they heard a low sounding voice. The visitor looked around the dining room and noticed resident #004 was not there. Visitor #114 walked down the hallway and realized the sounds were coming from resident #004's bedroom. Visitor #114 slightly opened resident #004's door, found the resident lying on the floor, and immediately went to the tell the nurse. The visitor further indicated it was resident #004's voice that prompted them to go to their bedroom.

During an interview, PSW #109 confirmed they worked at the time of the incident and was assigned to resident #004's care. The PSW acknowledged the resident was at risk

for falls and had an identified falls prevention intervention. When the inspector asked if they had checked if the falls prevention intervention was working at the beginning of their shift, PSW #109 indicated they did not. Upon review of the home’s video surveillance with Inspector #653, the PSW acknowledged they did not see the falls prevention intervention on the resident and that it was not in place at the time of the incident.

A review of the hospital diagnostic results and an interview with the Physiotherapist (PT) indicated resident #004 sustained an injury as a result of the fall.

During an interview, the Assistant Director of Care (ADOC) acknowledged the above mentioned information obtained from the home's video surveillance and Inspector #653's interviews with PSW #109, the PT, and visitor #114, and that care was not provided to resident #004 as specified in the plan, resulting in actual harm to the resident. [s. 6. (7)]

Additional Required Actions:

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

Issued on this 27th day of November, 2019

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

Original report signed by the inspector.

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) :	ROMELA VILLASPIR (653)
Inspection No. / No de l'inspection :	2019_823653_0030
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Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 27, 2019
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

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. 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).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA).

Specifically, the licensee shall do the following:

1. Review resident #004's current falls prevention interventions as per their plan of care, with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), and Registered Nurses (RNs), who are responsible for the resident's care. Maintain a record of the review, including the content, facilitator, attendees, dates, and times.

2. Develop and implement a process to ensure direct care staff consistently check and ensure resident #004's identified falls prevention intervention is working and in place, when the resident is in their personal assistive device.

3. Ensure all direct care staff that provide care to resident #004, follow the falls prevention interventions as per their plan of care.

The above mentioned documentation shall be made available to the inspector upon request. This order shall be complied no later than January 22, 2020.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the written plan of care was provided to resident #004 as specified in the plan.

The Ministry of Long-Term Care (MLTC) received a complaint related to resident #004's recent fall in the home, which resulted in an injury. An interview with the

complainant indicated resident #004 was supposed to be monitored because they would always get up from their personal assistive device. The complainant indicated at the time of the incident, the resident must have stood up and fell when no one was watching them.

The home submitted a Critical Incident Report (CIR) for an incident that caused an injury to resident #004, for which they were taken to hospital and which resulted in a significant change in the resident's health status. The CIR indicated resident #004 was found on the floor in their bedroom and was sent to hospital for further assessment.

A review of resident #004's written plan of care indicated they were at risk for falls and staff had to ensure that the identified falls prevention intervention was working.

During the on-site inspection, the home provided Inspector #653 with a copy of the video footages from the home's video surveillance from the date of the incident. The interim Director of Care (iDOC) confirmed that resident #004 was identified in the video.

A review of the home's video surveillance revealed at the time of the incident, visitor #114 was observed walking down the hallway, stopped in front of resident #004's bedroom, came close to the door and opened it slightly. The bedroom light was observed to be off. Visitor #114 looked inside the bedroom, and down on the floor, stepped back, closed the door slightly, and ran towards the nursing station.

During an interview, Personal Support Worker (PSW) #109 and Inspector #653 reviewed the home's video surveillance and the PSW confirmed the identity of visitor #114.

During an interview, visitor #114 indicated at the time of the incident, they were sitting on the bench between the dining room and the nursing station, when they heard a low sounding voice. The visitor looked around the dining room and noticed resident #004 was not there. Visitor #114 walked down the hallway and realized the sounds were coming from resident #004's bedroom. Visitor #114 slightly opened resident #004's door, found the resident lying on the floor, and

immediately went to the tell the nurse. The visitor further indicated it was resident #004's voice that prompted them to go to their bedroom.

During an interview, PSW #109 confirmed they worked at the time of the incident and was assigned to resident #004's care. The PSW acknowledged the resident was at risk for falls and had an identified falls prevention intervention. When the inspector asked if they had checked if the falls prevention intervention was working at the beginning of their shift, PSW #109 indicated they did not. Upon review of the home's video surveillance with Inspector #653, the PSW acknowledged they did not see the falls prevention intervention on the resident and that it was not in place at the time of the incident.

A review of the hospital diagnostic results and an interview with the Physiotherapist (PT) indicated resident #004 sustained an injury as a result of the fall.

During an interview, the Assistant Director of Care (ADOC) acknowledged the above mentioned information obtained from the home's video surveillance and Inspector #653's interviews with PSW #109, the PT, and visitor #114, and that care was not provided to resident #004 as specified in the plan, resulting in actual harm to the resident.

The severity of this issue was determined to be a level 3 as there was actual harm to resident #004. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 compliance history as they had a related non-compliance with this section of the LTCHA in the last 36 months, that included:
-A Voluntary Plan of Correction issued July 9, 2018 (2018_414110_0009);
-A Voluntary Plan of Correction issued September 21, 2018 (2018_748723_0007). (653)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2020

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
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 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) Commission d'appel et de revision 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 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 27th day of November, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Romela Villaspir

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