Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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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
Oct 29, 2021	2021_919026_0003	008665-21	Critical Incident System

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

JULIE DUNN (706026)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 20, 21, and 22, 2021

The following intake was completed in this inspection: Log #008665-21 for Critical Incident System (CIS) Report #2883-000010-21, related to falls management.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and Registered Nurses (RNs), a Physiotherapist, the Resident Assessment Instrument (RAI) Coordinator, the Lead of the Infection Prevention and Control (IPAC) Program, the Lead of the Falls Prevention Program, the Assistant Director of Care (ADOC), the Director of Care (DOC), and residents.

During the course of the inspection, the inspector observed care provided for the residents, and reviewed clinical health records, relevant home policies, and other pertinent documents.

Inspector #501 was also present during this inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 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 plan of care was provided to a resident.

A resident fell and sustained an injury and their care plan was revised to include specific instructions for assistance with transfers. During an observation, it was evident that these instructions were not followed. The PSW confirmed they did not follow the instructions as stated in the care plan when assisting the resident with transfers. The RPN and the DOC both confirmed that the expectation is for the PSW to follow the care plan when assisting the resident with transfers.

In failing to follow the care needs as set out in the resident's care plan, there was risk of harm to the resident.

Sources: Critical incident report, resident's clinical record including the care plan, an observation and interviews with PSW, RPN and the DOC. [s. 6. (7)]

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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A resident fell and sustained injury. Interventions to prevent injury were previously initiated in the resident's care plan. These interventions were later noted to have been resolved in the care plan. There was no documentation to provide the rationale or reason for resolving the interventions. During an interview, the ADOC confirmed that there should have been an assessment and documentation to provide the reason for the interventions to be removed, as that is the expectation.

Sources: Critical incident report, resident's clinical record including the care plan, and an interview with the ADOC. [s. 30. (2)]

Issued on this 5th day of November, 2021

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

Original report signed by the inspector.