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 4, 2024	
Inspection Number: 2024-1368-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Rouge Valley, Toronto	
Lead Inspector Deborah Nazareth (741745)	**Inspector Digital Signature**
Additional Inspector(s) Miko Hawken (724)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12-16, 20, 22, 23, 2024.

The following intake was inspected:

- An intake related to a Proactive Compliance Inspection (PCI).

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Windows

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The licensee failed to ensure that the window in a resident's room, that opened to the outdoors and was accessible to them, had a screen in place.

Rationale Summary

During the initial tour of the home, an Inspector observed on a Resident Home Area (RHA) that the window in one resident room was opened ten centimeters and the

screen was missing. The resident was not in the room.

The Registered Practical Nurse (RPN) stated that they were unaware of the missing screen and that all staff are to report maintenance requests to the RHA's registered staff so it could have been reported to maintenance for repair or replacement.

The Maintenance Supervisor was aware of the missing window screen in this room and reported that the screen was replaced. They further confirmed that the screen reduced the risk of the resident from falling out of the window.

The missing window screen increased the risk of residents falling out the window.

Sources: Observations, interviews with RPN and Maintenance Supervisor. [724]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 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 program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee has failed to ensure that Additional Screening Requirements, specifically signage is posted at the entrance of the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual, was followed in accordance with the Infection Prevention and Control (IPAC) Standard

for Long-Term Care Homes (LTCH) issued by the Director.

Rationale and Summary

In accordance with the IPAC Standard for LTCHs, revised September 2023, section 11.6 directs the licensee to ensure that signage is posted at entrances and throughout the home that lists the signs and symptoms of infectious diseases for self-monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

Upon entry to the LTCH, it was observed that there was no signage at the front entryway of the home that listed the signs and symptoms of infectious diseases for self monitoring as well as steps that must be taken if an infectious disease is suspected or confirmed in any individual.

The IPAC lead confirmed that signage related to the signs and symptoms of infectious diseases for self-monitoring was missing at the front entrance.

There was an increased risk to residents for exposure and spread of infectious diseases.

Sources: Observations, interview with IPAC lead. [724]

2) The licensee has failed to ensure that Alcohol-Based Hand Rub (ABHR) including 70-90% alcohol level was accessible in a Resident Home Area (RHA).

Rationale & Summary

In accordance with the IPAC Standard for LTCHs, revised September 2023, section

10.1 directs the licensee to ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% ABHR.

During the initial tour of the home, it was observed on a RHA that all bottles of foam hand sanitizers were past their posted expiry date or had no date of expiry.

The IPAC Lead confirmed that there were multiple bottles of expired hand sanitizer on the RHA. They acknowledged there was a risk to residents as the expired hand sanitizer would not be effective in destroying infectious diseases.

There was a risk to residents due to exposure to infectious diseases as the hand sanitizer would not be effective after the expiry date.

Sources: Observations, interview with IPAC Lead. [724]