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: July 3, 2024	
Inspection Number: 2024-1368-0002	
Inspection Type: Complaint Critical Incident	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Rouge Valley, Toronto	
Lead Inspector Miko Hawken (724)	**Inspector Digital Signature**
Additional Inspector(s) Vernon Abellera (741751)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 21 - 24, 27 - 31, 2024 and June 3 & 4, 2024

The following intake(s) were inspected:

- An intake related to alleged staff to resident abuse.
- Three intakes related to alleged resident to resident abuse.
- A complaint related to neglect, policy, and pain management.
- An intake related to an outbreak.
- A complaint related to consent and continence care.
- An intake related to the improper transfer of a resident.
- An intake related to falls prevention and management

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Continence care and bowel management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to provide care to a resident who required continence care products, to have sufficient changes to remain clean dry and comfortable.

Rationale and Summary

A complaint was received to the Ministry of Long Term Care (MLTC) related to continence care not provided to a resident. The resident was found by the resident's caregiver to be incontinent. The complainant alleged that this had been found on several occasions.

A review of the resident care plan indicated that they required continence care. The resident's progress notes also revealed that there was a concern from the Substitute Decision Maker (SDM) that the resident was found to be incontinent.

The Long Term Care Homes (LTCH) investigation notes found that documentation of care was completed by a Personal Support Worker (PSW) which noted continence care was provided for. The LTCH reviewed camera footage and it was confirmed that the PSW did not complete continence care during the care rounds. The PSW confirmed during the LTCH investigation that they failed to provide continence care for the resident.

The Director of Care (DOC) who completed the investigation confirmed that the PSW failed to complete incontinence care to the resident.

Failure to provide continent care increased the risk of skin breakdown and exposure to infectious disease to the resident.

Sources: Complaint to the MLTC, LTCH investigation notes, resident's medical records and interview with DOC. [724]

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.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality,

regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that the resident was treated with courtesy and respect when staff left a resident sitting exposed and inappropriately left in the resident's room attached to a mechanical lift with a disposal bin underneath to toilet in.

Rationale and Summary

A Critical Incident Report (CIR) was received by the Director related to a complaint from the SDM regarding the unsafe transfer of the resident from their bed to toilet. The SDM had found resident sitting on to toilet still attached to a mechanical lift with no call bell within reach and no staff supervision. The resident was found exposed and facing the doorway with the door left ajar.

The homes internal investigation notes confirmed that two PSW's had transferred the resident using a mechanical lift and left the resident sitting attached to the lift with a disposal bin to toilet into and left without direct supervision.

Resident stated that when this had occurred, it made them feel uncomfortable with a loss of privacy and dignity.

The Director of Care (DOC) stated that home failed to treat the resident with courtesy and respect to protect their dignity and worth, as the two PSWs had not provided privacy and toileted the resident in a unsafe and undignified way.

There was no physical impacts of this incident but it did have a lasting impact to the residents self-worth.

Sources: CIR, LTCH Investigation Notes and interviews with the resident and DOC.[724]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the suspicion and the information upon which it is based to the Director regarding an allegation of abuse by a PSW to a resident.

Rationale and Summary:

A complaint was submitted by a resident's advocate related to allegations of abuse of a PSW staff, towards a resident.

The progress notes of the resident documented a meeting was initiated by the home with the resident's family concerning the reported incident. The family was pleased with the outcome of the meeting.

An RPN who attended the meeting with the family of the resident, confirmed that the resident had reported an allegation of abuse by a staff member in the home. The incident was immediately reported to an ADOC. The results of the investigation were discussed during the family meeting.

The ADOC confirmed the allegation of abuse by a staff towards the resident and also acknowledged that the allegations of neglect were not reported to the Director.

Failing to immediately report the allegations of neglect may delay the investigation, placing residents at risk of harm.

Sources: Complaint Information Report, and interviews with RPN and ADOC. [741751]

WRITTEN NOTIFICATION: Changes in plan of care, consent

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 32
Changes in plan of care, consent
s. 32. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 266 (1) of this Regulation, is reviewed and, if required, revised.

The Licensee failed to ensure that when resident's plan of care was reassessed that consent was obtained from the SDM prior to administration of a treatment.

Treatment as defined in the Health Care Consent Act, 1996 means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

Rationale and Summary

A complaint was received to the MLTC related to the administration of test without prior consent of the SDM for a resident.

The LTCH's investigation notes indicated that a Registered Nurse (RN) had administered a test to the resident. The resident was incapable of consenting to an diagnostic test, the SDM was to be contacted prior to administration.

The resident's progress notes indicated that the RN had not obtained consent from the SDM.

The DOC confirmed the test was administered to the resident without prior consent from the SDM.

As the resident had symptoms and the test is a reliable diagnostic test, there was no risk to the resident from performing the test but it was necessary to complete to protect other residents and staff from exposure and spread of infectious diseases.

Sources: Complaint, LTCH's investigation notes, resident's medical records and interview with the DOC. [724]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

A Critical Incident Report (CIR) was submitted by the Director related to a complaint from the SDM regarding the unsafe transfer of the resident from their bed to chair. The SDM had found the resident sitting and attached to a mechanical lift with no call bell within reach and no staff supervising.

The home's internal investigation notes confirmed that two PSW's had transferred the resident with a mechanical lift and left the resident sitting on a chair attached to the lift without direct supervision.

The DOC stated that both PSWs had used the mechanical lift improperly as the expectation is for care staff, is to release the resident from the lift or directly supervise the resident to ensure the safety of the resident.

There was risk to the resident of falling from or with the lift as they were not directly supervised.

Sources: CIR, LTCH's Investigation Notes and interview with DOC. [724]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (a)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between the resident and other residents, including, identifying factors, based on information provided through observation, that could potentially trigger such altercations.

Rationale and Summary

A CIR was submitted to the Director, related to an altercation between two residents.

A review of the resident's progress notes indicated a Dementia Observation System (DOS) was initiated, related to a physical altercation towards another resident. The DOS tools were implemented to monitor the residents' responsive behaviors and were incomplete for many shifts. The staff interview identified that a DOS monitoring tool should have been initiated and completed by staff members for five days, or as needed, following a resident-to-resident altercation. The staff indicated the Behavioral Supports Ontario (BSO) Lead, and registered staff would evaluate the

DOS upon completion and report the findings to the Physician for possible treatments, interventions, or adjustments.

The ADOC, who was the BSO Lead, acknowledged that DOS monitoring was the appropriate tool used in the home to identify potential triggers and patterns for residents exhibiting responsive behaviors and confirmed that the DOS documentation was incomplete for multiple shifts.

The residents and others were at risk when the triggers and patterns were not identified using the DOS monitoring tool due to incomplete documentation.

Sources: CIR, clinical health records for residents, the Responsive Behavior Policy and interview with BSO lead/ADOC [741751]

WRITTEN NOTIFICATION: Police notification

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police service was immediately notified of a witnessed incident of physical abuse of a resident that the licensee suspects may constitute a criminal offence.

Rationale and Summary

A CIR was reported to the Director concerning alleged Physical witnessed abuse of between two residents.

The incident occurred in the dining room when a resident went to another resident's table. The resident exhibited violent physical behavior towards the other resident. A PSW physically separated the residents to de-escalate the situation. A physical mark was observed on the abused resident, potentially indicating that the other resident had tried to injure them. There were no records indicating that the police services were contacted for this incident.

The ADOC and the DOC confirmed that the police were not called when they became aware of the incident.

Failure to ensure the appropriate police service was notified upon alleged abuse, could potentially increase the risk of recurrence at the home.

Sources: Resident 's electronic medical records, Investigation notes, CIR, and interview with the ADOC and DOC. [741751]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to report to the Director immediately an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary

A CIR was reported to the Director related to a reportable infectious diseases outbreak at the home. According to the CIR the outbreak was declared by Toronto Public Health (TPH) after business hours and no afterhours reporting was made to the MLTC. The outbreak was reported to the Director one day after the outbreak was declared.

The Infection Prevention and Control (IPAC) Lead stated that they thought that the RN who worked the on the day of the outbreak had called in to the MLTC to report the outbreak.

There was no risk to residents.

Sources: CIR, Confirmed respiratory outbreak management Checklist - TPH, interview with IPAC lead.[724]

COMPLIANCE ORDER CO #001 CMOH and MOH

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health

Protection and Promotion Act are followed in the home.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)].

Grounds

The licensee has failed to ensure that Alcohol-Based Hand Rub (ABHR) with a 70-90% alcohol level was accessible a Resident Home Area (RHA) and not expired.

Rationale and Summary

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024, section 3.1 directs the licensee to ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% ABHR and are not expired.

During a tour of a RHA, it was observed that 15 wall mounted units of foam hand sanitizers (Purell 70%) at resident room doorways were expired.

The Housekeeper stated they were unaware of the expired hand sanitizer and that they changed the bottles when they were low.

The Environmental Service Manager (ESM) confirmed that it was the responsibility of the housekeepers on the RHA's to change the wall hand sanitizer when they are low or expired. Further they were aware of the expired hand sanitizers on the specified unit and was waiting for a shipment of more product that day.

The IPAC lead confirmed that the 15 hand sanitizers were expired and that the hand sanitizer was not effective after its expiry date.

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, interviews with Housekeeper, ESM and IPAC Lead. [724]

This order must be complied with by September 17, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.