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: October 28, 2024	
Inspection Number: 2024-1368-0003	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Rouge Valley, Toronto	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7 to 11, 15 to 18, and 21, 2024

The following intake(s) were inspected:

- Follow-up #: 1 - O. Reg. 246/22 - s. 272 CDD September 17, 2024 related to Infection Prevention and Control (IPAC)
- Two intakes related to falls prevention and management
- An intake related to an injury of unknown cause
- A complaint related to resident care
- Two intakes related to prevention of abuse and neglect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1368-0002 related to O. Reg. 246/22, s. 272 inspected by Najat Mahmoud (741773)

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the

review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director related to a resident's fall which resulted in a hip fracture. During an observation, the resident did not have the required falls prevention device. The resident had a 1:1 staff present. ADOC #115, RN #117, RPN #116 and 1:1 PSW #118 confirmed that the resident should have had a falls prevention device and provided this to the resident immediately.

Failure to have the falls prevention device available placed the resident at risk for falling.

Sources: Clinical records, observation, and interviews with staff.

Date Remedy Implemented: October 18, 2024

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 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 to the Director an incident of physical abuse to a resident.

Rationale and Summary
A CIR was submitted to the Director regarding an incident involving two residents. Clinical records indicated they had a previous physical abuse incident.

The ADOC #111 confirmed that a CIR was not submitted related to the physical abuse incident as they had determined that the incident was not abuse.

The ADOC acknowledged that the resident's actions did constitute physical abuse that should have been reported to the Director immediately.

Failure to submit reports of alleged abuse posed a risk to the residents of the home as this may lead to unreported incidents of abuse.

Sources: CIR, Clinical records, interview with ADOC #111.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary
CIR's were submitted regarding two incidents when a resident sustained injuries.

The resident's clinical health records, indicated there were injuries and revealed that weekly skin assessments were not completed for the identified injuries.

RPN #102 and #108 acknowledged they failed to complete the weekly skin assessment on the resident's injuries.

ADOC #111 confirmed that the resident's weekly skin assessments were not completed for the specified time periods.

Failure to complete a weekly skin assessment might have prevented the staff from monitoring the injury, posing a risk for further altered skin integrity and circulation at the site of the injury.

Sources: CIRs, Clinical health records, and interview with staff and management.

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee failed to ensure that a resident's pain was assessed using a clinically appropriate assessment instrument when their pain was not relieved by initial interventions.

Rationale and Summary

A CIR was submitted to the Director after a resident fell and sustained injuries. Clinical records were reviewed and indicated that the resident had a history of pain. The Medication Administration Record (MAR) indicated that the resident had routine and as needed analgesic.

As a result of their injury, the resident experienced worsening pain and had analgesic administered. Progress notes and the MAR indicated that the resident's pain was not relieved by the analgesic. On multiple dates, the Medical Doctor (MD) reviewed and prescribed pharmacological interventions.

No clinically appropriate assessment instrument was used to assess the resident's pain when the initial interventions were ineffective.

PSW #113, RN #114 and the ADOC #115 indicated that due to the residents' cognitive impairment, the resident could not articulate if they were in pain and would display responsive behaviors.

RN #114 and the ADOC #115 indicated that the most appropriate pain assessment for the resident was the ABBEY pain assessment for the cognitively impaired.

RN #114 and the ADOC #115 both indicated that the ABBEY pain assessment should have been completed prior to any new interventions and that failure to complete this could result in unmanaged pain.

Failure to assess the resident's pain using a clinically appropriate tool did not promote overall comfort.

Sources: Clinical records, observations, interview with staff and management

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #005 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 has failed to ensure that the appropriate police service was immediately notified of an alleged physical abuse to resident #006.

Rationale and Summary

A CIR was submitted to the Director regarding an incident involving two residents. Clinical records indicated they had a previous physical abuse incident. There was no record that the police services were contacted.

ADOC #111 acknowledged that the resident's actions did constitute physical abuse and 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: CIR, Clinical records, and an interview with ADOC #111.