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

Public Report

Report Issue Date: January 29, 2025

Inspection Number: 2025-1368-0001

Inspection Type:
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Rouge Valley, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16, 17, 27, to 29, 2025
The inspection occurred offsite on the following date(s): January 22, 2025

The following intake(s) were inspected:

- An intake related to responsive behaviours
- An intake related to infection prevention and control (IPAC)
- A intake related to resident to resident sexual abuse

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

Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

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. 97
Hazardous substances
s. 97. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times when disinfectant supplies were not locked on the housekeeping cart. A Housekeeper indicated that the disinfectant supplies could be harmful to residents if ingested and should be locked on the housekeepers cart.
The Housekeeper then immediately closed the compartment where the disinfectant supplies were kept.
Sources: Observation, safety data sheet, interview with a Housekeeper.
[741773]

Date Remedy Implemented: January 17, 2025

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse

by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from sexual abuse when a co-resident was found touching them. “Sexual abuse” means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. Clinical records and camera footage indicated that a Personal Support Worker (PSW) discovered the resident touching another resident. Interviews with the Associate Director of Care (ADOC) and the Administrator indicated that consent was unable to be provided due to the residents medical diagnosis.

Sources: Critical incident report (CIR), clinical records, camera footage, interviews with the ADOC and the Administrator. [741773]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented.

The licensee failed to document the reassessment of interventions taken to respond to a residents responsive behaviours. Clinical records indicated that an intervention was implemented to deter wandering residents from entering a residents room. The ADOC indicated that the intervention was ineffective and thus no longer in place. There was no documented record to indicate that the intervention was ineffective and discontinued.

Sources: Observations, clinical records, interviews with a PSW and the ADOC [741773]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that medications were stored inside the locked medication cart when a resident's medications were found on top of the medication cart. A Registered Practical Nurse (RPN) indicated that the medications were prepared for a resident and were not administered. The RPN further indicated that the medications were easily accessible by others, and should have been kept inside the locked medication cart.

Sources: Observations, clinical records, interview with an RPN.
[741773]

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