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: March 24, 2025
Inspection Number: 2025-1368-0002
Inspection Type: Complaint 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): March 18, 19, 20, 24, 2025
The inspection occurred offsite on the following date(s): March 21, 2025

The following intake(s) were inspected:

- Intake: #00142088 - related to an allegation of a resident to resident incident.
- Intake: #00142362 - related to a complaint regarding the discharge of a resident.

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

Infection Prevention and Control
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure strategies were implemented for a resident who exhibited responsive behaviours.

The clinical health record identified that a specific intervention was to be implemented for a resident, as a strategy to prevent responsive behaviours. Video footage and clinical records for the resident indicated that the intervention was not consistently implemented.

Sources: Clinical records, interviews with staff, review of video footage.

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