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: June 9, 2025
Inspection Number: 2025-1368-0003
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): April 24, 25, 29, 30, 2025, May 1, 2, 5, 29, 30, 2025 and June 2, 3, 4, 5, 6, 2025

The following intake(s) were inspected:

- Intakes related to resident falls that resulted in injury.
- A complaint intake related to staffing and resident care.
- An intake related to improper/incompetent care of a resident.
- An intake related to a disease outbreak.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.
The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Review of a resident's care plan confirmed that they required specific assistance by staff for transferring.

Review of the home's investigation records and an interview with the Director of Care (DOC) confirmed that a Personal Support Worker (PSW) was aware of the resident's transfer status and was non-compliant with the care plan when transferring the resident.

Sources: A Critical Incident Report (CIR), a resident's electronic health records, the home's investigation notes and an interview with staff.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
The licensee has failed to ensure that when a resident was reassessed and their care needs changed, that the plan of care was reviewed and revised.

On a certain date/time, Inspector observed a resident in a home area with a Personal

Assistance Services Device (PASD).

Review of a resident's medication orders confirmed a Physician's order.

Review of a resident's care plan confirmed that a PASD and medication was not indicated.

Interviews with the home's Fall's Lead and Physiotherapist (PT) confirmed that a resident's care plan was not reviewed and revised when a resident's care needs changed.

Sources: Two CIR's, a resident's electronic and paper health records, and interviews with staff.

NC #003 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 has failed to ensure safe transferring and positioning techniques when assisting a resident.

Review of a resident's care plan confirmed their falls risk and indicated an intervention for staff to decrease a resident's risk for falls.

Review of a resident's electronic health records, confirmed that on a specific date/time a PSW was preparing to transfer a resident and did not comply with the intervention which resulted in a resident's fall and injury. This was further confirmed by review of the home's investigation notes and in interviews with the home's Fall's Lead and PT.

Sources: A CIR, a resident's electronic health records, the home's investigation notes, and interviews with staff.

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management

s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).
The licensee has failed to ensure the falls prevention and management program had fall's prevention equipment readily available at the home.

Review of a resident's care plan confirmed that a resident required specific fall's prevention interventions to be in place.

Review of a resident's progress notes confirmed that on a specific date/time, the resident had a fall and did not have a specific falls prevention intervention in place as it was not readily available in the home.

Interviews with the home's Falls Lead and PT, both confirmed that there were incidents when the home did not have falls prevention equipment readily available. Furthermore, the PT confirmed that a resident did not have a specific falls prevention intervention in place for six days as there were none available in the home.

Sources: A resident's electronic health records, and interviews with staff.

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.
An Assistant Director of Care (ADOC) confirmed that the home was aware of multiple verbal complaints received in 2025 related to the care of a resident.

Review of the home's 2025 complaints binder did not indicate any verbal or written complaints

received related to a resident.

Sources: A complaint, the home's complaints policies/procedures, and 2025 complaint records/binder, and an interview with staff.

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The inspector is ordering the licensee to:
1) The Falls/PASD Lead and PT will both review the home's PASD policy and sign off that they have reviewed and understand the home's process prior to and for implementing a PASD for a resident. Sign off must include name, signature, and date.
2) After condition one has been met, the Falls/PASD Lead, and Designate will re-educate Nursing Staff on the home's PASD policy and its direction. A record will be kept of the education provided to Nursing Staff that must include: the date of the education, the name/designation of the staff member providing the education, the education contents and the name/designation of the staff member who was educated.
3) The Falls/PASD Lead and Designate will work collaboratively to determine which residents require the use of a PASD. A record will be kept of all residents that require the use of a PASD, the type/purpose of the PASD, the timeframe for the use of the PASD and confirmation that the resident's use of a PASD was indicated in the care plan.
4) The Falls/PASD Lead will ensure for all residents that require the use of a PASD, that the PASD process, as directed in the home's PASD policy, have been complied with.
5) The home will provide all records to the Inspector upon request..
Grounds
The licensee has failed to ensure that a PASD was used to assist two resident's with a routine activity of daily living only if the use of the PASD was included in the resident's plan of care.

The PASD Lead confirmed that the home's process prior to implementing a PASD for a resident

was that nursing staff were responsible to complete a PASD assessment in Point Click Care (PCC) and then refer the resident to PT for further assessment.

The PASD Lead and PT both confirmed that the after a resident was assessed by PT, the PT would inform Nursing Staff of their recommendations and to update the resident's care plan with the resident's required use of a PASD.

The PASD Lead confirmed that Nursing Staff were then responsible for obtaining written consent from the SDM/POA and a physician's order for the PASD, and that the records were to be kept in the resident's paper chart.

On specific dates/times, Inspector observed two residents in their home areas with a PASD in place.

Review of two resident's care plan's confirmed that the required use of a PASD was not indicated. Additionally, both resident's care plans indicated that they were at risk for skin impairments.

Review of two resident's paper and electronic health records confirmed that the residents did not have a PASD assessment conducted prior to implementing the PASD. Further review confirmed that there was no documented consent or a Physician's order for a PASD.

The PASD Lead confirmed that two residents did not have a PASD assessment conducted prior to implementing a PASD, and that there was no documented consent or a Physician's order for a PASD and there should have been.

Furthermore, review of the home's PASD resident list confirmed all resident's that required the use of a PASD. Review of a PASD Assessment Summary Report in PCC confirmed that the residents indicated on the home's PASD resident list were not indicated as having a PASD assessment conducted.

Failure to ensure for resident's that require the use of a PASD, that the PASD was indicated in the resident's plan of care has placed residents at increased risk of falls and impaired skin integrity.

Sources: Review of two resident's electronic and paper health records, the home's PASD Policy; last reviewed March 2025, and PASD resident list, PCC reports and interviews with staff.

This order must be complied with by September 1, 2025

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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.