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: August 18, 2025
Inspection Number: 2025-1368-0005
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): August 12, 13, 14, 15, 18, 2025

The following intake(s) were inspected:
-Critical Incident (CI) report related to the alleged neglect of a resident.
-CI report related to the alleged physical abuse of a resident by staff.

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

Resident Care and Support Services
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The Licensee has failed to ensure there was a written plan of care that set out clear directions to staff and others who provide direct care to a resident.

A Critical Incident (CI) report was submitted to the Director related to the complaint of alleged neglect of a resident.

The Long Term Care (LTC) homes investigation found that the written care plan for the resident did not provide clear directions to care staff on how to care for the resident.

Sources: CI report, LTC homes investigation notes and interview with the Assistant Director of Care (ADOC).

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 ensure that alleged neglect of resident by a staff member was immediately reported to the Director.

A CI report was submitted to the Director related to the complaint of alleged neglect of resident two days after the incident occured.

Sources: CI Report, LTC homes investigation notes and interview with ADOC.

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to comply with the home's skin and wound care program's policy where a resident who had an alteration in their skin integrity did not receive specified care as set out in their plan of care.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that policies developed for the skin and wound care program were complied with.

A CI report was submitted to the Director related to the complaint of alleged neglect of a resident.

Specifically the home's skin and wound care policy was not complied with when the resident's prescribed intervention was not completed by registered staff.

Sources: CI Report, Resident's medical records, Extendicare Skin and Wound Program: Wound Care Management, and interview with ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 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 has failed to ensure that a resident was reassessed weekly when they exhibited an alteration in their skin integrity.

A CI report was received by the Ministry of Long Term Care (MLTC) related to a complaint of alleged neglect of a resident.

A review of the resident's medical records indicated the resident had an alteration in their skin integrity.

The homes policy on skin and wound program directed the staff to complete a skin and wound assessment and for it to be reassessed at least weekly by registered staff. Weekly assessments were not completed on multiple weeks.

Sources: CI Report, Resident's medical records, Extendicare Skin and Wound Program: Wound Care Management, and interview with ADOC.

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