



**Ministry of Health and  
Long-Term Care**

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Ministère de la Santé et des  
Soins de longue durée**

**Rapport d'inspection sous la  
Loi de 2007 sur les foyers de  
soins de longue durée**

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 11, 2013	2013_225126_0030	O- 000563,888, 1034-13	Complaint

**Licensee/Titulaire de permis**

**EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2**

**Long-Term Care Home/Foyer de soins de longue durée**

**EXTENDICARE ROUGE VALLEY  
551 Conlins Road, TORONTO, ON, M1B-5S1**

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

**LINDA HARKINS (126)**

**Inspection Summary/Résumé de l'inspection**



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): on site November 6-7-8, 2013 on site and December 10, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, the Social Workers, one housekeeping staff, family members and residents.

During the course of the inspection, the inspector(s) reviewed two Resident health care records, reviewed the policy on emergency procedures: suctioning of the airway (CLIN-04-03-05), observed care and services provided to residents.

The following Inspection Protocols were used during this inspection: Personal Support Services

Findings of Non-Compliance were found during this inspection.

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<b>Legend</b>	<b>Legendé</b>
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**



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1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8 s. 6. (7) whereby the licensee did not provide care set out in the plan of care as specified in the plan.

The plan of care of Resident #2 required PSW to do daily hygiene. On a specific day in May 2013, in the morning, the resident wife came in and found that Resident #2 did not have morning care. The Registered Practical Nurse documented in the progress notes of that same day in May 2013 that Resident #2 left a note at the nursing station for PSW to read resident care.

The Personal Support Workers are required to observe Resident #2 skin on a daily basis on every shift. It is documented that PSW observed Resident #2 skin on a specific day in June 2013 and the Resident's family reported that same evening that the Resident had a blister in the coccyx area. Resident's family member expressed concerns that care was provided to the resident by the nursing staff on that day and that he/she was the one to report the blister not the nursing staff. No intervention was implemented to monitor the blister until she notified the nursing staff.

Resident #2 was to be repositioned every 2 hours as per care plan. On a specific day in June 2013 Resident #2's family member asked staff to reposition resident at night. The family member came back the next morning around 11:00 and found that no care was provided to the Resident because he/she was still in the same position as the evening before. The personal support Worker flow sheet for that specific day in June 2013, night shift was reviewed and no documentation was found related to turning and repositioning the Resident during the night. The progress note of that specific day in June 2013 does not include any documentation entry for that shift.

Resident #2 was on a daily dose of an anti-epileptic medication and was to have blood work to verify the anti-epileptic level on a regular basis. In July 2013, it was noted in the progress notes of a specific day that a laboratory order error occurred; another type of level was done instead of the anti-epileptic level. In the Medication three months review for July 2013, it is documented by the physician that another type of level was done instead of the anti-epileptic level.

Discussion with the Administrator, indicated that she had several discussions with the informant and whatever she brought to her attention she followed up on with her staff if care was not provided as per care plan.



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The care set out in the plan of care was not provided to Resident #2 as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that care set out in the plan of care is provided in relation to daily hygiene, blood monitoring level are accurately done, daily observation of the skin will occur and report observation to the registered nursing staff if required and that Residents are re positioned on all three shift if needed, to be implemented voluntarily.***

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Issued on this 11th day of December, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

A handwritten signature in cursive script, appearing to read "L. Harkins", is written within a rectangular box.