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: September 25, 2025
Inspection Number: 2025-1368-0006
Inspection Type: Critical Incident Follow up
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): September 18-19, 22, 23-25, 2025.

The following intake(s) were inspected:
-one follow-up intake #1 - FLTCA, 2021 - s. 36 (3) CDD September 1, 2025
-one intake related to resident-to-resident abuse.
-one intake related to resident neglect.
-one intake related to resident neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1368-0003 related to FLTCA, 2021, s. 36 (3)

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

Continence Care
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Responsive Behaviours
Restraints/Personal Assistance Services Devices (PASD) Management

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 that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

The care plan for the resident identified behaviors. Review of the resident's care plan indicated that the resident was receiving behavior interventions. The RPN confirmed that the resident was no longer receiving a behavior intervention. The DOC confirmed the care plan was not reflective of the behavior intervention.

Sources: Review of the resident's care plan and interview with staff.

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 has failed to ensure that the resident was protected from neglect by staff

A. Section 7 of Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Critical Incident Reports (CIRs) were submitted to the Director, concerning neglect of a Resident.

The care plan for the resident requires the night shift staff to check the resident.

However, this was not done on the four incidents reported to the Director. The resident was found by a private caregiver in unacceptable conditions. Additionally, the LTCH investigation notes revealed that resident care was provided only once during the night shift on the days identified.

Sources: CIRs, LTCH investigation notes, the resident's medical records and interview with the ADOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee has failed to ensure that, every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: abuse of a resident by anyone.

During an inspection, the inspector requested the DOC for the home’s investigation notes for the incident which occurred between both resident's. The DOC confirmed to the inspectors on site that they did not have any investigation notes for the incident between both residents.

Sources: Review of the CIR and conversation with DOC.

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

NC #004 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 Zero Tolerance of Abuse and Neglect policy was complied with.

In accordance with Ontario Regulation (O. Reg.) 246/22, section 11(1)(b), the licensee is required to ensure compliance with the home's Zero Tolerance of Abuse and Neglect policy. However, the home failed to place the PSW on administrative leave pending the outcome of the investigation. The ADOC acknowledged that the PSW who was involved in the incident, was not removed from the resident's care due to miscommunication among members of the management team.

Sources: CIRs, LTCH investigation notes, the resident's plan of care and interview with ADOC.

WRITTEN NOTIFICATION: Continence care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to ensure that the resident who required continence care products, received sufficient changes to remain clean, dry, and comfortable, on multiple occasions when found by the resident's personal caregiver.

Sources: Complaint to the MLTC, LTCH investigation notes, the resident's medical records and interview with the ADOC.

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of

the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for cleaning of the home.

The Inspector observed the highland creek behavioral unit during an onsite inspection. The Inspector found sticky floors throughout the home, rooms smelling like urine and walls dirty with food and dirt. The Housekeeper confirmed there is not enough time on their shift to complete the expected work prior to leaving.

The housekeeping manager and staff confirmed they are short staffed on the unit and that staff do not have enough time during their shift to complete their daily duties. Staff have confirmed the unit's uncleanliness has occurred for the past couple years.

Sources: Observations of the unit, and interview with staff.

COMPLIANCE ORDER CO #001 Behaviors and Altercations

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 60 (a)
Behaviors and altercations
s. 60. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviors, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee is to teach staff caring for residents on the Highland Creek House about the different types of behavior interventions including but not limited to pharmacological and non-pharmacological interventions.

a) Please include DOS training and how to interpret the findings.
b) Please include the referral process (pertaining to Highland Creek only) in your teaching
c) Please keep a record of the teaching, who is providing the training, name of employee being trained, date and signature of employee confirming they received the education.
d) Keep a record of the mentioned above to provide to the inspector.

Grounds

The licensee has failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident’s behaviors, including responsive behaviors, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of a resident’s plan of care, identified them to have behaviors. The home implemented a behavior intervention after multiple incidents with other residents. Both resident's sustained injuries from this specific incident.

Sources: Observation of residents, review of the resident's plan of care and interview with staff.

This order must be complied with by November 24, 2025

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.