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: November 13, 2025

Inspection Number: 2025-1368-0007

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): November 4 - 7, 10, 12, and 13, 2025.

The following intake(s) were inspected:
- Intake: #00158103 - Resident-to-resident altercation
- Intake: #00159512 - Alleged of neglect to a resident.
- Intake: #00159940 - Complaint related to verbal abuse and neglect of a resident.
- Intake: #00157916, Intake: #00158636, Intake: #00159279 - Fall of residents.

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

Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and 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 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Staff did not collaborate each other to provide consistent care a resident.

Source: Interview with Assistant Director of Care (ADOC), the Resident's clinical records, and Home's investigation notes.

WRITTEN NOTIFICATION: Plan of care

NC #002 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.

1- On a specific date, a resident was not wearing a specific fall intervention equipment as per their plan of care.

Sources: The resident's care plan and interview with a Personal Support Worker (PSW).

2- The Licensee did not implement fall interventions as outlined in resident's Care Plan.

Source: Clinical records of the resident and interview with a PSW.

WRITTEN NOTIFICATION: Duty to protect

NC #003 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.

"Neglect" means 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.

The licensee delayed for an extended period of time to attend resident's bed call at night.

Source: Call Bell Log; Interview with staff and resident.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 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 home did not immediately investigate a resident-to-resident abuse incident that occurred on a specific date.

Sources: After hours and interview with Administrator.

WRITTEN NOTIFICATION: Furnishings

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 15 (2) (a)
Furnishings
s. 15 (2) The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care;

Multiple resident room's mattress were not firm, collapsed or slopped at the edge.

Source: Interview with a PSW and Observation.

WRITTEN NOTIFICATION: Transferring and positioning

techniques

NC #006 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.

On a specific date, a PSW provided care to a resident in the bed without using the safe positioning technique, which resulted in a fall.

Source: Clinical records or the resident, and an interview with a PSW.

WRITTEN NOTIFICATION: Responsive behaviours

NC #007 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

On a specific date, a strategy which had been developed to respond to the resident's responsive behaviours was not in place.

Sources: observation and the resident's care plan.

WRITTEN NOTIFICATION: Pest control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 94 (2)
Pest control
s. 94 (2) The licensee shall ensure that immediate action is taken to deal with pests.

On a specific date, a pest concern was brought forward, but was not addressed immediately.

Sources: Orkin logbook, Orkin report, and interview with Maintenance Manager.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (2)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

A resident-to-resident abuse incident occurred on a specific date. The home did not submit the corresponding Critical Incident (CI) within 10 days.

Sources: After hours and the CI.

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