



**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  
performance et de la conformité**

Ottawa Service Area Office  
347 Preston St, 4th Floor  
OTTAWA, ON, K1S-3J4  
Telephone: (613) 569-5602  
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Bureau régional de services d'Ottawa  
347, rue Preston, 4<sup>ième</sup> étage  
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**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b>          | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|------------------------------------------------|-----------------------------------------------|-----------------------------------------|----------------------------------------------------|
| Dec 5, 2012; Feb 6,<br>2013                    | 2012_021111_0036                              | 000583,<br>001474,<br>000081,<br>002400 | Critical Incident<br>System                        |

**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**

LYNDA BROWN (111)

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



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 5-7 & 11, 2012

Logs: 002396, 000081, 000583, 001474, 002400

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Social Worker(SW), two Registered Nurses (RN), three Registered Practical Nurses (RPN), and six Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) completed five critical incident inspections, reviewed nine residents health records, observed 9 residents, reviewed the homes policy for resident abuse and the homes investigation into critical incidents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

#### NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| Legend                             | Legendé                               |
|------------------------------------|---------------------------------------|
| 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.

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**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**

- 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
- 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
- 3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
- 4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**

**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**

**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**

**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

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**Findings/Faits saillants :**

**1. Related to log 002396:**

**A critical incident was received for an incident of resident to resident physical abuse resulting in injury.**

**The licensee failed to ensure an identified resident's plan of care related to responsive behaviours provided written strategies, techniques and interventions to prevent or minimize the responsive behaviours and that actions were taken to respond to the responsive behaviours.**



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***Additional Required Actions:***

***CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".***

**WN #2: 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).**

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**Findings/Faits saillants :**

1. Related to log # 00081:

The licensee failed to ensure that the plan of care set out in the plan was provided to an identified resident as specified in the plan related to responsive behaviours and transferring resulting in injury.

***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 the plan of care set out in the plan is provided to residents related to responsive behaviours and transferring as specified in the plan, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**  
**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**

**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

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**Findings/Faits saillants :**



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1. Related to log # 002400:

A critical incident report was received for an incident of resident to resident sexual abuse.

The licensee failed to ensure that the plan of care for an identified resident was based on an assessment of the resident's responsive behaviours in respect to mood and behaviour patterns and any potential triggers.

2. Related to Log # 002396:

A critical incident report was received for an incident of resident to resident physical abuse.

The licensee failed to ensure that the plan of care for an identified resident was based on an assessment of the resident's responsive behaviour of wandering which included the pattern, frequency or intensity and the triggers related to the wandering behaviour.

***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 the plan of care of residents is based on an assessment of the residents mood and behaviour patterns, including wandering and identified responsive behaviours and any potential triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

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**Findings/Faits saillants :**



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1. Related to log # 00081:

A critical incident report was received for an incident of an identified resident that sustained an injury resulting in transfer to hospital.

The licensee failed to ensure that staff used safe transferring devices and techniques when assisting an identified resident resulting in injury.

***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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.***

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**THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/  
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:**

| COMPLIED NON-COMPLIANCE/ORDER(S)<br>REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS: |                                    |                                      |                                       |
|---------------------------------------------------------------------------------------|------------------------------------|--------------------------------------|---------------------------------------|
| REQUIREMENT/<br>EXIGENCE                                                              | TYPE OF ACTION/<br>GENRE DE MESURE | INSPECTION # /<br>NO DE L'INSPECTION | INSPECTOR ID #/<br>NO DE L'INSPECTEUR |
| O.Reg 79/10 s. 53.<br>(4)                                                             | CO #901                            | 2012_021111_0036                     | 111                                   |



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Issued on this 6th day of February, 2013

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

*G. Brown*



Ministry of Health and  
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Order(s) of the Inspector  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur  
Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

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 performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : LYNDA BROWN (111)

Inspection No. /

No de l'inspection : 2012\_021111\_0036

Log No. /

Registre no: 000583, 001474, 000081, 002400

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Dec 5, 2012; Feb 6, 2013

Licensee /

Titulaire de permis : EXTENDICARE (CANADA) INC.  
3000 STEELES AVENUE EAST, SUITE 700,  
MARKHAM, ON, L3R-9W2

LTC Home /

Foyer de SLD : EXTENDICARE ROUGE VALLEY  
551 Conlins Road, TORONTO, ON, M1B-5S1

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : ~~CAROL BALDASTI~~ *JB VANDA COZIER*

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the  
following order(s) by the date(s) set out below:



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

**Order(s) of the Inspector**  
Pursuant to section 153 and/or  
section 154 of the *Long-Term Care  
Homes Act, 2007*, S.O. 2007, c.8

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|                                           |                                                                                  |
|-------------------------------------------|----------------------------------------------------------------------------------|
| <b>Order # /</b><br><b>Ordre no :</b> 901 | <b>Order Type /</b><br><b>Genre d'ordre :</b> Compliance Orders, s. 153. (1) (a) |
|-------------------------------------------|----------------------------------------------------------------------------------|

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,  
(a) the behavioural triggers for the resident are identified, where possible;  
(b) strategies are developed and implemented to respond to these behaviours, where possible; and  
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

**Order / Ordre :**

The licensee will develop and implement strategies for resident #3 who demonstrates responsive behaviours (physical aggression & inappropriate sexual touching) towards other residents.

The licensee will also take appropriate actions to respond to the needs of the resident.

**Grounds / Motifs :**

1. 1. Related to log 002396:

A critical incident was received for an incident of resident to resident physical abuse resulting in injury.

The licensee failed to ensure an identified resident's plan of care related to responsive behaviours provided written strategies, techniques and interventions to prevent or minimize the responsive behaviours and that actions were taken to respond to the responsive behaviours. (111)



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**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

**Immediate**



**Ministry of Health and  
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Pursuant to section 153 and/or  
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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 to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON M5S 2T5

Director  
c/o Appeals Coordinator  
Performance Improvement and Compliance  
Branch  
Ministry of Health and Long-Term Care  
1075 Bay Street, 11th Floor  
TORONTO, ON  
M5S-2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).



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## **RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL**

### **PRENDRE AVIS**

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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**Ministère de la Santé et  
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**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou  
de l'article 154 de la *Loi de 2007 sur les foyers  
de soins de longue durée*, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto (Ontario) M5S 2T5

Directeur  
a/s Coordinateur des appels  
Direction de l'amélioration de la performance et de la  
conformité  
Ministère de la Santé et des Soins de longue durée  
1075, rue Bay, 11e étage  
Ontario, ON  
M5S-2B1  
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 5th day of December, 2012**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :**

LYNDA BROWN

**Service Area Office /**

**Bureau régional de services : Ottawa Service Area Office**