Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long Term Inspections Branch

Toronto District
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Toronto, ON, M2M 4K5
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Original Public Report

Report Issue Date: November 23, 2022
Inspection Number: 2022-1466-0001
Inspection Type: Critical Incident System
Licensee: Rose of Sharon (Ontario) Retirement Community [Deloitte & Touche Inc., the Court Appointed Receiver and Manager] 165 Vaughan Road Toronto ON M6C 2L9
Long Term Care Home and City: Rose of Sharon Korean Long Term Care 17 Maplewood Avenue Toronto ON M6C 4B3

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2022.12.02 09:31:11 -05'00'

Additional Inspector(s) Nira Khemraj (741716)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 25, 2022
October 26, 2022
October 27, 2022

The following intake(s) were inspected:

- Intake: #00003678-[CI: 3038-000002-22] Unwitnessed fall from resident resulting in a injury

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

Infection Prevention and Control
Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 5

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On October 26, 2022, the inspector observed on an identified unit a wheeled cart in the hallway with multiple tools left unattended. Maintenance staff #114 arrived shortly and immediately moved the wheeled cart containing the tools inside a resident's room and stated they will keep the wheeled cart inside the residents' room when they are working.

The Director of Care (DOC) acknowledged that the tools and equipment should not have been left unattended, and a discussion conducted with the maintenance staff to ensure the safety of the residents.

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Date Remedy Implemented: October 26, 2022

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan.

Rationale and Summary:

The home submitted a Critical Incident System (CIS) report when resident #001 sustained an injury and was transferred to hospital for further treatment.

On an identified date, PSW #106 entered the room and found resident #001 lying on the floor asking for help. Resident #001 was assessed by the registered staff and was later transferred to hospital for assessment. Resident #001 was diagnosed with an injury from the fall.

Resident #001 plan of care requires the staff to apply a fall intervention for the resident. PSW #106 reported that when they entered the room, the resident did not have the fall intervention in place. PSW #106 reported that they informed RPN #107 of the incident. RPN #107 reported that they assessed the resident and confirmed that the fall intervention was not in place.

The Director of Care (DOC) acknowledged that care set out in the plan of care related to the fall intervention was not provided resident #001 as specified in the plan.

Failure to provide the fall intervention placed resident #001 at risk for injury.

Sources: Progress notes, resident #001 care plan, CIS report #3038-000002-22, interviews with PSW # 106, RPN #107, and DOC.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when resident #001 care needs changed.

Rationale and Summary:

The home submitted a Critical Incident System (CIS) report when resident #001 sustained an injury and was transferred to hospital for further treatment.

On an identified date, PSW #106 entered the room and found resident #001 lying on the floor asking for help. Resident #001 was assessed by the registered staff and was later transferred to hospital for assessment. Resident #001 was diagnosed with an injury from the fall.

Between a period of time, the resident's blood pressure was not at their baseline. On an identified date, RPN #102 held their medications and contacted the Physician (MD) for further direction. The MD ordered to a change to their medications, and to continue monitoring the resident's blood pressure.

The resident's BP continued to not be at their baseline, however, no further assessment or follow-up was conducted. RPN #100, #101 and #104 reported they were aware the resident's BP reading was not at their baseline, so they applied an intervention and notified the charge nurse. The Change Nurse #103 reported that they were aware of the abnormal BP, but no further action was taken. On an identified date, RPN #100 reported the abnormal BP, however they proceeded with the previous instructions from the MD. The resident had a change in condition and the Director of Care (DOC) assessed and directed the staff to transfer the resident to the hospital.

The DOC and Charge Nurse #103 acknowledged that the MD should have been contacted again once the resident's BP readings remained abnormal, and that resident #001 was not reassessed nor the plan of care was revised when their care needs changed.

Failure to reassess the blood pressure readings and revise the plan of care placed resident #001 at risk of further changes in their health condition.

Sources: Progress notes, resident #001 care plan, CIS report #3038-000002-22, interviews with RPN #100, Charge Nurse #103, DOC, and other staff.

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