Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2020	2020_610633_0026	023239-20	Other

Licensee/Titulaire de permis

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/Foyer de soins de longue durée

Rose of Sharon Korean Long Term Care
17 Maplewood Avenue Toronto ON M6C 4B3

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

SHERRI COOK (633), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 23-26, 2020.

This inspection is a Toronto Service Area Office initiated inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), the Program Manager, the Office Manager, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeepers, residents and the Resident Council President.

The inspector(s) observed the general building and maintenance, Infection Prevention and Control (IPAC) practices, meal and snack service and medication administration. The plan of care for the identified residents, and the home's related documentation and policies were reviewed.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure a safe home environment by not implementing the Infection Prevention and Control (IPAC) measure of COVID-19 active screening as required for all staff, essential visitors and other visitors.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, 2020, Directive #3 was issued and revised on October 14, 2020, to all Long-Term Care Homes (LTCHs) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that all residents of LTCHs were at increased risk of COVID-19. A requirement was made for LTCHs to review their IPAC procedures and implement measures. This included active COVID-19 screening and temperature checks twice daily, for all staff, essential visitors and other visitors, prior to their entry to the home as well as best practices for screeners.

The home's policy referenced the Ontario Provincial Directives. All staff would be screened prior to entering the workplace as per the updated MOH COVID-19 screening guidance. All essential visitors and visitors would be actively screened prior to entry. Screening included temperature checks.

A dated Public Health Ontario (PHO) checklist that was completed by the home documented that active screening for COVID-19 had been implemented however, it was not. All staff, essential visitors and visitors were not actively screened upon entrance to the home, prior to going to a residential unit and upon exit of the home. There was no screener present at the entrance 24 hours a day, seven days per week. The screener failed to ask regarding signs and symptoms of COVID-19 and working or visiting at other facilities or homes. Temperatures were not taken at a minimum of twice a day for all staff and essential visitors as required. Safety measures for the screener according to best practices were not implemented. There were no facial masks provided at the entrance for staff to put on. The lack of active screening for COVID-19 failed to provide a safe home. All staff, essential visitors, visitors and residents were at risk for COVID-19 infection and spread.

Sources: Observations, Directive #3 (October 2020), the home's policy (May 2020), PHO checklist (April 2020), screening records, interviews with the Administrator/DOC, Office Manager and other staff.

Additional Required Actions:

CO # - 001 will be 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee failed to submit a written complaint, which alleged neglect/verbal abuse of a resident by a staff member, to the Director immediately as required.

Assistant Deputy Minister (ADM) Memo dated July 17, 2020, stated that the amendments to the Emergency Order O. Reg. 95/20, under the Emergency Management and Civil Protection Act were reverted back to requirements under the LTCHA/Regulation to ensure that the Ministry of Long-Term Care (MLTC) received adequate and necessary information. This included the home's reporting requirements.

A written complaint was received by the Administrator/DOC from the family member of the resident. The family alleged neglect of care and assistance and potential verbal abuse by a staff member towards the resident. The complaint letter and the home's written response was not submitted to the Director as required.

Sources: Written complaint letter (September 2020), the home's complaint policy (March 2019), ADM Memo (July 2020) and interview with the Administrator/DOC.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to ensure that an allegation of neglect/verbal abuse of a resident by a staff member was immediately reported to the Director as required.

A written allegation of abuse was received by the Administrator/DOC from the family member of a resident. A critical incident report (CI) was not submitted to the Director immediately as required.

Sources: Written complaint letter (September 2020), the home's abuse policy (March 2018) and interview with the Administrator/DOC.

Issued on this 15th day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHERRI COOK (633), JANETM EVANS (659)
Inspection No. / No de l'inspection :	2020_610633_0026
Log No. / No de registre :	023239-20
Type of Inspection / Genre d'inspection:	Other
Report Date(s) / Date(s) du Rapport :	Dec 11, 2020
Licensee / Titulaire de permis :	Rose of Sharon (Ontario) Retirement Community [Deloitte & Touche Inc., the Court-Appointed Receiver and Manager] 165 Vaughan Road, Toronto, ON, M6C-2L9
LTC Home / Foyer de SLD :	Rose of Sharon Korean Long Term Care 17 Maplewood Avenue, Toronto, ON, M6C-4B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Helen Jung

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To Rose of Sharon (Ontario) Retirement Community [Deloitte & Touche Inc., the Court-Appointed Receiver and Manager], you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

Specifically, the licensee must ensure that:

1. A screener is present at the entrance of the home to actively screen all persons entering or exiting the home for COVID-19.
2. Safety precautions for the screener must be implemented in accordance with best practices.
3. Facial masks are provided to all staff at the entrance to the home.
4. All staff, managers, essential workers and visitors will be actively screened in accordance with best practices. This must include at a minimum, before entering the home and residential units and upon exit of the home.
5. Screening must include at a minimum, a temperature check as well as asking active COVID-19 screening questions in accordance with current best practices. A record of all screening must be documented.
6. Audits of active screening must be conducted and documented and include at a minimum the date, person responsible, location, results and any actions taken, if required. The audits should continue until such a time that active screening has been achieved throughout the home.

Grounds / Motifs :

1. The licensee has failed to ensure a safe home environment by not implementing the Infection Prevention and Control (IPAC) measure of COVID-19 active screening as required for all staff, essential visitors and other visitors.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and

Civil Protection Act.

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A dated Public Health Ontario (PHO) checklist that was completed by the home documented that active screening for COVID-19 had been implemented however, it was not. All staff, essential visitors and visitors were not actively screened upon entrance to the home, prior to going to a residential unit and upon exit of the home. There was no screener present at the entrance 24 hours a day, seven days per week. The screener failed to ask regarding signs and symptoms of COVID-19 and working or visiting at other facilities or homes. Temperatures were not taken at a minimum of twice a day for all staff and essential visitors as required. Safety measures for the screener according to best practices were not implemented. There were no facial masks provided at the entrance for staff to put on. The lack of active screening for COVID-19 failed to provide a safe home. All staff, essential visitors, visitors and residents were at risk for COVID-19 infection and spread.

Sources: Observations, Directive #3 (October 2020), the home's policy (May 2020), PHO checklist (April 2020), screening records, interviews with the Administrator/DOC, Office Manager and other staff.
An order was made taking the following into account:

Severity: Lack of active COVID-19 screening prior to entrance to the residential

areas and upon exit from the home was a potential risk for all staff, essential workers, visitors and residents for COVID-19 infection and spread throughout the home.

Scope: This issue was widespread as all staff, visitors and residents were impacted.

Compliance History: One written notification (WN) was issued to the home related to a different section of the legislation in the past 36 months.
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 08, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
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
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Cook

Service Area Office /
Bureau régional de services : Toronto Service Area Office