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

Toronto District
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Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: May 3, 2023	
Inspection Number: 2023-1466-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Rose of Sharon (Ontario) Retirement Community [Deloitte & Touche Inc., the Court-Appointed Receiver and Manager]	
Long Term Care Home and City: Rose of Sharon Korean Long Term Care, Toronto	
Lead Inspector Slavica Vucko (210)	**Inspector Digital Signature** Slavica Vucko Digitally signed by Slavica Vucko Date: 2023.05.11 14:54:26 -04'00'
Additional Inspector(s) Reji Sivamangalam (739633)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 17, 18, 19, 20, 24, 25, 26, 27, 2023

The following intake(s) were inspected:

- Intake: #00085619 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

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. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for resident #007 set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary

Resident #007 preferred to rest in bed between meals. The resident's written plan of care did not provide direction to staff regarding this rest routine.

Resident #007's written plan of care directed staff to assist the resident with oral care a number of times. The resident was receiving oral care at a different period than their written plan of care.

The resident's written plan of care was revised to clarify the direction to staff related to rest routines and oral care.

Failure to ensure that the written plan of care for the resident set out clear direction to staff related to sleep and rest routine, and personal care could lead to inconsistent care.

Sources: Observation, review of resident #007' written plan of care, interviews with staff. [210]

Date Remedy Implemented: April 26, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 3.

I) The licensee has failed to ensure that a soiled utility room was locked to restrict unsupervised access by the residents.

Rationale and Summary:

On an identified date, the soiled utility room on one unit was found open, and staff #111 verified that the room was expected to be locked when it was not used by staff. The staff locked the door when they were notified.

There were no residents noted to attempt entering the soiled utility room, and it was low risk to residents' safety.

Sources: Observations, and interview with staff.
[739633]
Date Remedy Implemented: April 17, 2023

II) The licensee has failed to ensure that the staff washroom doors were equipped with locks to restrict unsupervised access by the residents.

Rationale and Summary:

On an identified date, the staff washrooms on the units were not locked. The Environmental Service Manager verified that the staff washrooms were open and not kept locked.
On an identified date, the staff washroom doors on all floors were locked. Locks were installed on the staff washroom doors to restrict unsupervised access by residents.

There were no residents noted to attempt entering the staff washroom, and it was low risk to residents' safety.

Sources: Observations and interviews with staff.
[739633]
Date Remedy Implemented: April 26, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 20 (a)

The licensee has failed to ensure that resident #012 could access the resident-staff communication and response system at all times.

Rationale and Summary:

On an identified date, resident #012 was observed lying on the bed in their room, and the call bell cord was on a nearby table, inaccessible to the resident. Staff #110 verified that the call bell was not placed within the resident's reach after providing care. After being notified, the staff placed the call bell within the resident's reach.

There was a low risk to the resident.

Sources: Observation and Interview with staff.
[739633]
Date Remedy Implemented: April 17, 2023

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure that the products used to clean and disinfect the resident care equipment such as whirlpools, tubs, shower chairs and lift chairs, were not expired.

Rationale and Summary:

Disinfectants found in the shower rooms of the third, fourth and fifth floors were observed to be expired. They were used to disinfect the shower chairs and bathtubs. The Nurse Manager acknowledged that the expired products might have reduced effectiveness to disinfect equipment and subsequently replaced the expired products.

Using expired products for cleaning and disinfecting the resident care equipment could lead to an ineffective Infection Prevention and Control (IPAC) program.

Sources: Observations, interviews with staff.
[739633]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the designated Infection Prevention and Control (IPAC) lead worked regularly in the home 17.5 hours per week.

Rationale and Summary:

The home's designated IPAC lead did not work 17.5 hours per week in the role of an IPAC lead in the last three months.

Failure to ensure that the designated IPAC lead worked regularly 17.5 hours per week, could limit the effectiveness of the IPAC program.

Sources: staff schedules, home's policy Infection Prevention and Control Manual (Last Reviewed: 06/22), interviews with staff.
[739633]