Ontario

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 16, 2019	2019_530726_0011	023162-19	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

REBECCA LEUNG (726), SLAVICA VUCKO (210)

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): December 10 and 11, 2019

This inspection was initiated by the Toronto Service Area Office.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Nurse Manager, Dietary Supervisor, Dietary Aide, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), President of the Residents' Council, and residents.

During the course of the inspection, the inspectors conducted observations of dining, staff to resident interactions and medication administration, tour of the resident home areas and residents' rooms, reviewed resident's health records, resident complaints report, and home's policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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 O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by resident #002 at all times.

An inspection was initiated by the Toronto Service Area Office and an initial tour of the resident home areas was conducted by the inspector to identify potential/actual issues related to resident safety. Resident #002's room was one of the residents' rooms that were selected for review during the initial tour.

Review of an identified assessment indicated resident #002 had a specified diagnosis with an identified functional impairment.

Review of resident #002's care plan indicated the resident required specified assistance for some identified activities of daily living (ADLs). Under the focus for fall prevention, one of the interventions was the call bell to be secured in a specified way when the resident was in bed and to be within reach at all times.

Review of an identified assessment of resident #002, indicated that resident #002 was at a specified risk level for fall. Review of resident #002's fall history, indicated that the

resident had a specified number of falls in the past 3 months.

Review of the specified nursing notes indicated that the care plan was updated after the fall incident with strategies put in place including but not limited to, remind the resident to use call bell when they need help; and call bell available to allow resident to call for help.

On an identified date and time inside resident #002's room, the inspector observed resident #002 was awake sitting by the window and the call bell was not within reach. The inspector observed that the call bell was hanging from the wall down to the floor below resident's bed.

During the interviews, PSW #101 and RPN #100 acknowledged that the call bell should have been placed within reach of resident #002 when the resident was sitting by the window inside their room.

The home has failed to ensure that they were equipped with a resident-staff communication and response system that could be easily seen, accessed and used by resident #002 at all times. [s. 17. (1) (a)] (726)

Issued on this 16th day of December, 2019

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

Original report signed by the inspector.