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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 14, 2014	2014_159178_0001	T-149-14	Complaint

Licensee/Titulaire de permis

Rose of Sharon (Ontario) Retirement Community
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, 000-000

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

SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 8, 10, 13, 14, 21, February 5, 10, 12, 2014

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), management company representative, nurse manager, registered staff, registered dietitian, business manager, resident's family member/substitute decision maker (SDM).

During the course of the inspection, the inspector(s) reviewed resident and home records.

Ad-hoc notes were used during this inspection.

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (1) Except in the case of a discharge due to a resident's death, every licensee of a long-term care home shall ensure that, before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct,
(a) as far in advance of the discharge as possible; or O. Reg. 79/10, s. 148 (1).
(b) if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge. O. Reg. 79/10, s. 148 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that before resident # 1 was discharged, notice of the discharge was given to the resident's substitute decision-maker (SDM) as far in advance of the discharge as possible.

Family interviews, staff interviews and record review confirm that resident # 1's SDM was not informed of the resident's discharge until after the resident had been discharged on an identified date in 2014.

The resident's SDM had been informed by the home's administration in an email on an identified date in 2013 that if the resident exceeded 21 days of vacation absence then the home would be required under the Long Term Care Homes Act to discharge the resident.
The resident's SDM had been informed by the home's administration via email 32 days after the previous email in 2013 that the resident had only one vacation day remaining for 2013.
According to the home's records, resident # 1 used his/her last vacation absence day for 2013 on an identified date in 2013. The resident did not return to the home after this absence, and as of five days later in 2014, the date of discharge, the resident had not returned to the home. The home considered the resident to be on a weekly casual absence for two identified days in the last week of 2013. When the resident did not return to the home after the two day casual absence, the home considered the resident to have exceeded his/her casual absences for the week and the resident did not have any remaining vacation absence days for 2013. Therefore the home discharged the resident, but did not notify the resident or his/her SDM until after the discharge had been completed.
As a result, the resident's SDM was unable to participate in any discussions or planning to prepare for the resident's discharge. [s. 148. (1) (a)]

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 before a resident is discharged, notice of the discharge is given to the resident, the resident's substitute decision-maker, if any, and to any other person either of them may direct as far in advance of the discharge as possible, to be implemented voluntarily.

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident # 1 or the resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care in regards to swallowing assessment and diet texture.
Staff interviews, family interviews and record review confirm that on an identified date, the home submitted a referral for resident # 1 to Community Care Access Centre (CCAC) for a swallowing assessment, without the knowledge of or input from the resident or the resident's SDM.
The resident's SDM became aware of the referral when the CCAC called the SDM in order to obtain consent to complete an assessment of the resident. [s. 6. (5)]

Issued on this 12th day of March, 2014

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

Susan Li (178)