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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 16, 2015	2015_382596_0012	21993-15	Complaint

Licensee/Titulaire de permis

SHEPHERD VILLAGE INC.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

Long-Term Care Home/Foyer de soins de longue durée

SHEPHERD LODGE
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

THERESA BERDOE-YOUNG (596)

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): September 4, 9, 10, 11, 2015.

During the course of the inspection, the inspector(s) spoke with the director of nursing (DON), director facilities (DF), director of food and nutrition services (DFNS), manager of quality and resident support (MQRS), human resources and marketing coordinator (HRMC), nurse manager (NM), registered practical nurse (RPN), personal support worker (PSW), housekeeper, behavioural support ontario staff (BSO) residents and family members.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
1 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	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. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

Record review of resident #005's clinical record and a Critical Incident revealed that the resident had exhibited responsive behaviours towards co-residents during an identified period of time. Interventions in the resident's care plan included one to one monitoring of the resident by Bevaioural Support Ontario (BSO)staff, behaviour monitoring, redirection and distraction.

Interview with staff #122 revealed that he/she was assigned and doing one-to-one monitoring with resident #005 on a specified date. The staff member was sitting in the lounge with resident #005 and co-resident #004. The staff reported that he/she left to go to the bathroom leaving both residents together and unattended. During this time resident #005 exhibited a responsive behaviour towards co-resident #004. Staff #122 confirmed that he/she should not have left resident #005 who had a history of responsive behaviours towards co-resident #004 unsupervised.

Interview with the Manager of Quality and Resident Support (MQRS) who is the lead for the home's BSO team confirmed that staff #122 should not have left the two above mentioned residents unattended without notifying another staff member to monitor them in his/her absence.
The home did not implement behaviour monitoring of resident #005 when staff #122 left the resident unattended. [s. 54. (b)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

Record review of the home's policy entitled Resident to Resident Abuse/Assault policy #NURS VI-117 dated March 2014, section 7.04 directs staff to complete an incident report and notify the MOHLTC in the event that a resident is assaulted by another resident.
Record review of resident #004 and #005's progress notes, and interviews with staff #122 and #123 revealed that resident #005 exhibited responsive behaviours towards resident #004 several times during an identified time period.

Interviews with the Director of Nursing (DON) and MQRS revealed that Critical Incident reports were not submitted to the MOHLTC, nor the Director notified about the above mentioned incidents of resident to resident abuse, as the home's policy directs them to do. [s. 8. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written hot weather related illness prevention and management plan that meets the needs of the residents is implemented when required to address the adverse effects on residents related to heat.

Interviews with four identified staff, two identified residents, and an identified family member revealed that the temperatures in the home's corridors and residents' rooms were uncomfortably hot on specified dates in September 2015, as the air conditioning system had not been functioning at times. The home did not offer the residents and staff additional fluids, popsicles or jello on all shifts.

Record review and interview with the Director, Facilities (DF) revealed that the home does not record air temperatures daily and has no record of the temperatures taken in the home on a daily basis. DF reported that air temperatures are read by staff at a minimum of once daily.

Interviews with DF, DON, and an identified Nurse Manager(NM) confirmed that they were aware that the air conditioning in the home was not functioning optimally on the specified dates when the outdoor temperatures were excessively hot. The DON and NM revealed that the home did not offer the residents and staff additional fluids, popsicles or jello on those days, as no one asked for it. [s. 20. (1)]

WN #4: 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 :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Record review of the home's investigation notes for an allegation of staff to resident abuse involving resident #001 on a specified date, and the Critical Incident system revealed that there was no Critical Incident for the above mentioned allegation of abuse, and it was not reported to the Director.

Interview with the DON and an identified NM confirmed that the allegation of abuse was not reported to the Director. [s. 24. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training relating to mental health issues, including caring for persons with dementia.

Record review of the home' s training records for 2014 and interview with Human Resources and Marketing Coordinator (HRMC) revealed that 32 out of 254 direct care staff did not receive training on Responsive behaviours in 2014. [s. 76. (7) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Record review of the home's investigation notes regarding an allegation of staff to resident abuse involving resident #001 on a specified date, and review of the resident's clinical record did not include notification of the resident's SDM.

Interview with the DON and an identified NM confirmed resident #001's SDM was not notified about the allegation of abuse by a staff. [s. 97. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Record review of resident #001's clinical record and the home's investigation notes for an allegation of abuse by a staff member on a specified date, did not include notification of the appropriate police force.

Interview with the DON and an identified NM revealed that the home did not notify the appropriate police force about the allegation of abuse by a staff member. [s. 98.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record is created and maintained for each resident of the home.

Record review of resident #005's clinical record revealed that the resident exhibited responsive behaviours towards a co-resident on a specified date. Record review of resident #005's Dementia Observation System (DOS) documentation revealed that there was no DOS documentation completed immediately after the above mentioned incident.

Interview with the MQRS revealed that DOS documentation should be completed for five consecutive days after any resident exhibits a behavioural episode. The MQRS reported that DOS documentation was initiated for a specified five day period of time to monitor resident #005's behaviours after exhibiting responsive behaviours towards a co-resident. The home was unable to locate the documentation. [s. 231. (a)]

Issued on this 3rd day of November, 2015

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

Original report signed by the inspector.