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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2016	2016_235507_0011	010634-16, 013045-16	Critical Incident System

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

STELLA NG (507)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 27, 28, 29, May 2, 3, 4 and 5, 2016.

This Critical Incident System inspection is related to financial abuse and continence and bowel management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and Substitute Decision Makers (SDMs).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of resident #007 to be properly cared for in a manner consistent with his/ her needs was fully respected and promoted.

Review of the health care record for resident #007 on an identified date revealed that the resident was occasionally incontinent in bowel, frequently incontinent in bladder, and the resident required one-person physical assistance for toileting.

Review of the most current care plan for resident #007 revealed that the resident was independent with minimal assistance for toileting. The resident was prone to a specific bowel condition and the resident used incontinent products.

Interviews with staff #118 and 121 revealed that resident #007 required assistance for toileting. Staff had to check on the resident from time to time because he/she required assistance with peri care.

Interview with resident #007's family member revealed that on an identified date, at an identified time, the family member found resident #007's washroom was dirty with feces upon arrival. The resident was attending an activity program in the TV lounge at the time. The family member approached staff #118 in regards to the dirty washroom, and staff #118 cleaned the washroom. The family member went to the TV lounge locate the resident and found the resident's clothing soiled with feces. The family member approached staff #118 again and requested the resident to be cleaned up. Staff #118 responded that it was time for him/her to go off shift, and the request would be endorsed to the next shift. Resident #007's family member further revealed that he/she needed to clean up the resident.

Interview with staff #118 revealed that on the above mentioned identified date, at the above mentioned identified time, he/she was approached by resident #007's family member to clean up the resident because the resident was wearing soiled clothing. Staff #118 further revealed that he/she responded it was a busy day, it was time for him/her to go off duty, and the request would be endorsed to the next shift. Staff #118 further revealed that he/she did not check on the resident after being approached by the family member. He/she did not remember whether the request was endorsed to the next shift or not.

Interview with staff #121 confirmed that resident #007's right to be properly cared for in a manner consistent with his/ her needs was not fully respected and promoted. [s. 3. (1) 4.]

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Issued on this 28th day of June, 2016

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

Original report signed by the inspector.