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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

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_0010	031885-15	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

STELLA NG (507)

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): April 27, 28, 29, May 2, 3, 4 and 5, 2016.

This Complaint Inspection is related to a complaint regarding the administration of medication, continence and bowel management, Residents' Bill of Rights and resident charges.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Nursing Rehabilitation, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Manager of Finance, Hair Stylist, Salon Owner, residents and Substitute Decision Makers (SDMs).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressures ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Review of the progress notes and discharge summary record from the hospital on an identified date for resident #001 revealed that an alteration in skin integrity was found on one of his/her limbs. The resident was sent to the hospital for treatment.

Review of the home's "Skin and Wound Care" policy (policy #NURS V-94, revised March 2014) revealed that residents who exhibited skin breakdown and/ or wounds are assessed weekly or more frequently if required, by a registered staff member and documented on the Skin Status Questionnaire.

Review of the health record for resident #001 and interview with staff #102 revealed that a Skin Status Questionnaire was not completed for resident #001's altered skin integrity.

Interview with staff #111 revealed the home was using two types of Skin Status Questionnaires depending on the type of altered skin integrity exhibited by the resident. The questionnaire for assessment of resident's #001's alteration was not implemented at

the time of inspection. Staff #111 confirmed that the skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for an altered skin integrity was not completed for resident #001's above mentioned altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressures ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Review of the progress notes and discharge summary record from the hospital on an identified date for resident #001 revealed that an alteration in skin integrity was found on one of his/her limbs. The resident was sent to the hospital for treatment.

Review of the home's "Skin and Wound Care" policy (policy #NURS V-94, revised March 2014) revealed that residents who exhibited skin breakdown and/ or wounds are assessed by the dietitian.

Review of the health record for resident #001 and interview with staff #111 revealed that there was no referral made to the registered dietitian (RD) for the above mentioned alteration in skin integrity.

Interview with staff #112 revealed that he/she did not receive a referral for resident #001 in relation to the above mentioned altered skin integrity and staff #112 confirmed that a nutritional assessment was not completed for the resident. [s. 50. (2) (b) (iii)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for anything other than accommodation, a resident should be charged only if it was provided under an agreement.

Interview with resident #001's family member and record review of Statement for the Account of resident #001 on an identified date revealed that the family received the above mentioned statement which included non-funded services provided to the resident on two identified dates.

Record review of the progress notes for resident #001 and the invoice/ receipt of the identified service provider for the resident on an identified date, revealed that services were provided to the resident on the above mentioned identified dates. Review of the service record for the identified month of the identified service provider revealed that the resident did not receive services on the above mentioned identified dates.

Interview with staff #104 revealed that a mistake was made in regards to the service charges for resident #001 when the information from the service record was transferred onto the computer. Therefore incorrect information was provided to the accounting department of the home for billing. Staff #104 further revealed a refund of one service was made to the family four months prior. An interview with staff #109 confirmed that resident #001 was charged for services that were not provided. [s. 91. (1) 3.]

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.