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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 22, 2018	2018_324535_0003	006017-17, 006695-17, 007562-17, 007892-17, 008317-17, 008933-17, 011518-17, 016361-17, 017670-17, 022554-17, 024104-17, 025683-17, 025793-17, 000234-18, 003108-18, 004101-18, 005532-18	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

VERON ASH (535), JOANNE ZAHUR (589)

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): February 13, 14, 15, 16, 20, 21, 22, 23, March 5, 6, 7, 9, 12, 13, 14, 15, 16, 19, April 11, 13, 16, 2018.

The following intakes were completed in this Critical Incident System Inspection: Log #s: 006017-17, 007562-17, 008933-17, 016361-17, 022554-17, 024104-17, 025683-17, 025793-17, 011518-17, 000234-18, 006695-17 and #008933-17 were all related to falls; log #017670-17 and 008317-17 were related to unknown injuries; log #003108-18 was related to alleged abuse; log #004101-18 was related to outbreak notification; and log #005532-18 was related to elopement < 3 hours.

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6; and a Written Notification with a Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6; and Ontario Regulation 79/10; r. 50, identified in this inspection will be issued under report #2018_630589_0003 (Log #s: 024081-16, 029279-16, 000649-17, 014245-17, 016490-17, 019431-17, 022492-17, 027891-17, and 027943-17), concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Quality and Compliance Nurse Manager (QCNM), Nurse Manager (NM), Registered Dietitian (RD), Physiotherapist (PT), Resident Assessment Instrument (RAI) Coordinator, registered staff (RN/ RPN), personal support worker (PSW), Substitute Decision Makers (SDMs), and Residents.

During the course of the inspection, the inspector made observations related to staff and resident interactions and provision of care; conducted reviews of health records, staff education and training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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. 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 offense.

A Critical Incident report was submitted to the MOHLTC on an identified date and time for an alleged incident of abuse which was reported on an identified date.

The CIS revealed that resident #031 had complained of pain in a specific area of the body; and reported to their SDM that someone caused the pain. The SDM was in the home visiting resident #031 and notified NM #119 at a specified time by telephone.

A review of resident #031 documentation notes revealed that the police notification was completed on an identified date and time by the home's DOC; and two police officers attended the home the same day.

During an interview, NM #119 verified that they had not called the police force immediately when the incident was reported as required under the Ontario Regulation. DON #100 stated that when direct care staff contact the police force they encounter a lack of urgency from the police; however, acknowledged that the licensee failed to ensure that the appropriate police force had been notified immediately of resident #031's allegation of abuse as required by the regulation.
[s. 98.]

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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

A Critical Incident (CI) report with an identified date was received by the Ministry of Health (MOH). The CI indicated resident #022 had experienced a fall on an identified date, and was transferred to the hospital with an injury.

On an identified date, the progress notes indicated resident #022 had been sitting in the lounge and experienced a fall to the floor. At an identified time, PSW #193 found the resident lying on the floor in the lounge and alerted registered staff RPN #134. The RPN stated that they completed the initial assessment, documented and verified in an interview that the resident was transferred to hospital for further assessment and treatment; but passed away in the hospital the following day.

During the onsite visit, the inspector requested access to the home's electronic documentation system; specifically the PSW care guide which was used to provide care to the resident at the time of the fall incident. QCNM #104 and DON #100 both verified in separate interviews that the PSW care guides were no longer accessible once the resident had been discharged from the home since the electronic documentation system named Momentum does not make that information accessible.

DON #100 stated that this was identified by the management team as a current issue for the home to resolve; and that they were aware that inspectors were not able to access the PSW care guide for residents' once they were discharged from Momentum. Therefore, the licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home. [s. 233. (1)]

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 the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed, and where the condition or circumstance of the resident requires, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was received by the Ministry of Health (MOH) on an identified date. The report indicated resident #022 experienced a fall on an identified date, and was transferred to hospital with an injury.

On an identified date, the progress notes indicated resident #022 had been sitting in the lounge and experienced a fall to the floor. At a specified time, PSW #193 found the resident lying on the floor in the lounge and alerted RPN #134. The RPN stated that they completed the initial assessment and documented the injury. The staff also verified during the interview that the resident was transferred to hospital for assessment and treatment later that day; and passed away in hospital.

A review of the home's Falls Prevention Policy #NURS IV-73, dated March 2014, revealed that post fall management included the completion of the post fall clinically appropriate assessment instrument known as the Fall Incident Report and a detailed progress note. The Falls Prevention Lead #146, QCM #104, and DON #100 verified during separate interviews that a registered staff was to complete the fall incident report after each fall a resident experience.

Record review revealed that RPN #134 completed the post fall care after resident #022 experienced a fall. During an interview, the RPN verified that the fall incident report should have been completed; however they could not recall completing the electronic fall incident report. The RPN did not have access to the computer to check the documentation at the time of the interview; therefore, Float RN #133 and QCM #104 both accessed their computers and verified that an incident report was opened in the electronic documentation system on that date, but the fall incident report was left blank. Both confirmed that the fall incident report should have been completed after resident #022 experienced the fall. Therefore, the home failed to ensure that a post-fall assessment using a clinically appropriate assessment instrument was completed for resident #022. [s. 49. (2)]

Issued on this 22nd day of June, 2018

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

Original report signed by the inspector.