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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 15, 2018;	2018_462600_0004 (A3)	010052-17, 018166-17, 004536-18, 004749-18	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

Amended by JOANNE ZAHUR (589) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order #003 in report #2018_462600_0004's compliance date was amended to December 31, 2018.

Issued on this 15 day of August 2018 (A3)

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

Original report signed by the inspector.

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Amended by JOANNE ZAHUR (589) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 6, 7, 8, 9, 12, 13, 15, 16, 21, 22, 23, 26, 2018.

The following intakes were inspected during the inspection:

 # 010052-17, related to concerns about increased number of falls;

 # 018166-17, related to care not provided as required;

 # 004536-18, related to plan of care;

 # 004749-18 related to feeding.

During the course of the inspection, the inspector(s) spoke with Director of Client Care Services (DCCS), Director of Nursing (DON), Quality Compliance Manager (QCM), Nurse Manager (NM), Nurse Practitioner (NP), Registered Nurse (RN), Registered Practical Nurse (RPN), Physiotherapist (PT), Personal Support Worker (PSW), Environmental Supervisor (ES), Maintenance Worker (MW), Housekeeper, Receptionist, Substitute Decision Maker (SDM), and family members.

During the course of the inspection, the inspector conducted a tour of the second and fourth floor of the home, made observations of housekeeping practice of the residents' rooms on an identified floor, observed staff and resident interactions and provision of care, conducted reviews of health records,

and critical incident log, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Critical Incident Response

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

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

- **7 WN(s)**
- **2 VPC(s)**
- **4 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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provided direct care to the resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

A complaint #018166-17, was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date for resident #019 who within less than two months had two falls.

The home submitted a Critical Incident System (CIS) report to the MOHLTC on an identified date related to the incident resident #019 had while in the shower room on a specified date. The incident occurred during PSW #172 assistance to resident #019's care. The resident sustained injury from the incident, was sent to hospital and returned to the home with treatment provided.

A review of the Minimum Data Set (MDS) assessment prior to the incident, indicated the resident was admitted to the home with identified medical condition, cognitive and physical impairment and needed extensive assistance by staff. The resident was identified to have history of responsive behaviour.

A review of resident #019's written plan of care indicated the resident was at risk for falls related to a health condition. The resident required one staff assistance for identified ADL's care and staff were to get help from other staff when the resident exhibited responsive behaviour during the care.

Interviews with PSW #154 and RPN #142 stated the resident was at risk for falls and would exhibit responsive behaviour during care. They further indicated the resident's plan of care had been printed and available in the resident's health record binder at the nursing station, accessible to all regular and casual staff.

An interview with PSW #172 on an identified date, stated the PSW worked casually in the home and had not provided care to resident #019 prior to a specified date. The PSW indicated that they worked on the identified date and they provided care to resident #019. PSW #172 stated resident #019 refused the care but they were able to encourage the resident and provide identified care. During the care, the resident exhibited responsive behaviour and moved from side to side on the chair. The PSW confirmed that they did not know what to do when the resident exhibited the behaviour however, continued to complete the care. The PSW stated they had not called for other staff to assist. Further the PSW stated when they turned around to reach for the resident's belongings, the resident got up from the chair, started walking and fell. The PSW also stated that they had not read resident #019's written plan of care and were not aware of direction of how to intervene when resident #019 expressed a responsive behaviouir. The PSW further confirmed that they are not aware of any resident's plan of care because they do not have time to

read each resident's plan of care that they are assigned to. The PSW stated that they keep themselves aware of the resident's condition and required care by watching the resident when they come to work.

An interview with Nurse Manager (NM) #105 confirmed that all staff are expected to be aware of each resident's plan of care, including their medical condition, their needs and intervention to be applied when providing care to the residents. The casual staff are also expected to attend the shift report, review the resident's written plan of care in the resident's health record and be familiar with the residents.

An interview with the Quality Compliance Manager (QCM) #104 confirmed that the staff is expected to attend the between shift meetings with registered staff and to be kept aware of the content in the resident's plan of care available at the nursing station. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #019 was not neglected by the licensee or staff.

For the purposes of the definition of neglect O. Reg. 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the MOHLTC on an identified date related to resident #019 not receiving the required care.

A review of the Minimum Data Set (MDS) from an identified date, revealed the resident had moderate cognitive impairment, had an unsteady gait and sustained discomfort from recent incidents.

A review of resident #019's health record document from an identified date, indicated the resident had discomfort that was treated. The consultant ordered the home to provide a specified treatment with in an identified number of days. The order was transcribed and placed in the prescribing order sheet within the resident's chart on an identified date and time period required. The order was signed by a registered staff.

A review of the communication calendar for the registered staff at the nursing station revealed a handwritten note stating on the identified date resident #019 was to have a treatment provided by MD only, which was highlighted and crossed out. Few days later, within the same calendar, there appeared a note stating resident #019's specified treatment was to be provided. No other note was found throughout the calendar regarding resident #019's specified treatment.

A review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal any information about the specified treatment.

A review of resident #019's progress notes from May to August, revealed resident #019 had an incident sustained discomfort and was sent to hospital for further assessment and treatment provided. The resident came back and the RN in charge documented the discharge notes and order for the specified treatment to be provided in a number of days and sanctioned the order. On the identified date RN

#153 documented that portion of the specified treatment had been provided. The next day follow up note stated a portion of specified treatment had been completed, and the MD was to assess the area and continue the treatment. The following day MD assessed resident, confirmed the status of the identified area, and recommended monitoring. There was no note to indicate whether further treatment was required. RPN #150 documented that the identified concern required treatment and Nurse Practitioner (NP) will come the next day to provide this treatment. The next day NP documented that the resident was referred regarding the treatment to the identified concern. On an identified date RPN #150 documented a PSW had reported that the resident required further treatment. The RPN assessed the resident and indicated the resident required further treatment, but there was no further documentation if an action was taken. The DON documented that they received a call from an identified person, stating the outside care provider indicated that the resident may need specified care. The DON apologized to the identified caller and ensured that the NP would be notified and the resident assessed.

An interview with RN #153 on an identified date, indicated when a resident is scheduled for a specified treatment, the staff are to check the physician's order to identify the date, location, and the nature of the specified treatment. RN #153 stated that on the identified date, they provided partial treatment and was not able to finish as the resident exhibited a responsive behaviour and was uncomfortable. .

During an interview conducted on an identified date, NP #151 stated they received a referral from the home around a specified date, to provide a specified treatment from resident #019. The NP stated that the practice is when they receive a referral, they will check the physician's order, to identify the concern and nature of the specified treatment. The NP confirmed that they did not review the original physician's order to confirm the specified treatment because the referral was to provide partial treatment. The NP also stated that they were counting on the nurses' assessments so they did not follow up the practice to check the physician's order prior the treatment. The NP acknowledged they should have reviewed and followed the plan of care for the resident and made sure the full treatment was provided.

During an interview RPN #150 stated they were aware that the resident had an incident, sustained discomfort, and came back from the clinic requiring follow up treatment. The RPN also indicated that treatment was to be provided to the resident in an identified number of days. Further interview with RPN #150 revealed

that they did not document the nature of the specified treatment when they had assessed the resident. RPN #150 further indicated that when a PSW reported to them that a part of the specified treatment remained on the resident during care, they did not take any action. RPN #150 stated that in an identified month, when an identified person reported to them that they found a specified treatment on the resident, they still did not take any action.

During an interview with QCM they stated that when a resident returns from the hospital with discharge notes and directions for care, the registered staff is expected to document this information in the resident's chart. The registered staff is expected, to assess the resident upon return from the hospital and to assess the specified treatment if warranted. The process in the home is to have the interventions surrounding the specified treatment documented and it is the RN's responsibility to follow up and provide appropriate treatment.

During an interview with the Director of Nursing (DON) they stated the expectation of the home is for staff to follow up with the plan of care and recommendation from the hospital for each resident coming back from the hospital. The registered staff are to assess the resident and in this case should have assessed the specified treatment. The DON further indicated that the registered staff is expected to check the physician's orders prior to the specified treatment to confirm date and appropriate intervention. The DON confirmed, the staff are expected to communicate the resident's response to the intervention and whether the intervention was completed or not. The DON also confirmed that even when the PSW identified that the resident required further treatment, the RPN did not take any action to intervene and did not communicate to the RN for further action. The DON acknowledged that the staff neglected the resident's care needs by not following the recommendation from the hospital within the recommended number of days as indicated in the plan of care. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A complaint #004749 -18, was submitted to the MOHLTC alleging that the resident was not fed properly. Video footage was provided to the MOHLTC.

An interview with the complainant indicated a video had been taped of the resident being fed by staff. The complainant stated that when they became aware of the video, they called the home and met with management as the resident appeared to have been inappropriately fed by staff. The complainant indicated that the resident was able to demonstrate refusal of treatment by identified means.

A review of resident #019's medical record revealed when the resident had been admitted to the home, needed physical assistance by one staff for some of the Activities of Daily Living (ADL). The resident was to be encouraged by staff for self-feeding and was to be provided cuing. A review of resident #019's progress notes revealed the resident was hospitalized, their condition changed and needed greater assistance by staff.

A review of resident #019's written plan of care from an identified date, revealed that the resident needed physical assistance for eating along with lots of

encouragement. Review of the Medication Administration Record (MAR) revealed that beside the appropriate diet, the resident was to have an intervention provided.

An interview with PSW #166 revealed that on a specified day the PSW fed resident #019 and the resident consumed the foods provided. The PSW stated that when they tried to give more food to the resident, the resident refused and they stopped the feeding. The PSW stated that they were aware that sometimes when the resident did not want to eat they would demonstrate this and provided examples. The PSW also stated that they were aware to leave the resident if they refused.

A review of the video footage revealed that the resident was being fed by staff and continued to do so after the resident refused.

An interview with PSW #154 confirmed they fed resident #019 an identified nourishment on a specified date. The PSW indicated that they were aware that when the resident does not want to eat, the resident would communicate to the staff. The PSW stated that if the resident communicates to them that they do not want to eat, they would normally stop the feeding, leave the resident and come back later. On a specified date the PSW confirmed they were told and given a nourishment by RPN #142 to feed resident #019. The PSW indicated that when they tried to feed the resident, the resident communicated to them that they do not want to eat but identified circumstances encouraged the PSW to continue. The PSW confirmed that the resident did not want or need to be fed at that time.

In an interview with RPN #142 revealed that they were aware not provide care to resident #019 if they refused. The RPN confirmed directing PSW #154 to provide a nourishment to the resident.

An interview with the DON confirmed that for residents who show signs of refusing any treatment, staff are required to discontinue the treatment. After reviewing the video with the DON, the DON stated resident #019 showed signs of refusal and PSW #154 should have stopped feeding the resident. The DON confirmed that PSW #154 and RPN #142 had not fully respected and promoted the residents' right to be properly cared for and fed in a manner consistent with their needs. [s. 3. (1) 4.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist resident #019 with eating, including safe positioning of the resident who required assistance.

A complaint #004749 -18, was submitted to the MOHLTC alleging that the resident was not fed properly at an identified time. The video footage was provided to the MOHLTC.

A review of resident #019's medical record revealed when the resident had been admitted to the home, needed physical assistance by one staff for some of the Activities of Daily Living (ADL). A review of resident #019's progress notes for the noted concern indicated that the resident required full assistance from staff for feeding.

An interview with PSW #166 revealed that on a specified date, they fed resident #019 in the room. The PSW confirmed that when the resident is fed in the room or in the dining room, they must be positioned in an identified position. The PSW confirmed that they had positioned the resident properly when fed.

A review of the video footage revealed details of resident #019's feeding, indicating the resident was not properly positioned when PSW #154 assisted to feed the resident.

An interview with PSW #154 confirmed they fed resident #019 an identified nourishment on a specified date. Further in the interview, the PSW confirmed that resident #019 was not positioned properly during the identified time. The PSW indicated that they fed the resident not in a safe position and not in accordance with the plan of care.

Interview with DON revealed that when feeding residents, the staff is to make sure the residents are properly positioned to prevent any associated risks to the resident. After reviewing the video with the DON, the DON confirmed that resident #019 was not properly positioned for feeding, while being fed on the specified date.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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 any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
- Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

A complaint #004749 -18, was submitted to the MOHLTC alleging that resident #019 was fed inappropriately on an identified date and video footage provided.

An interview with the complainant, stated that the video footage showed the resident being fed inappropriately at an identified time. The complainant stated that they met with the Director of Client Care Services (DCCS), QCM, and Nurse Manager (NM) #103, on an identified date, concerned that resident #019 had not been fed appropriately.

A review of the home investigation notes revealed that the home was to submit a report to the MOHLTC as this concern was identified as Mandatory reporting.

A review of the home's critical incident record revealed no such report had been submitted to the MOHLTC.

An interview with the QCM and DON confirmed that the home did not report the information to the Director regarding the alleged improper care of resident #019. [s. 24. (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 person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm., to be implemented voluntarily.

WN #6: 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 the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint #018166-17, was submitted to the MOHLTC on an identified date, regarding resident #019 who within less than two months had two incidents and two injuries on an identified body part.

The home submitted a Critical Incident report (CIS) to the MOHLTC , related to the incident resident #019 had while provided care. The incident occurred in a common room during an assisted care with PSW #172. The resident sustained injury from the incident, was sent to hospital and returned to the home.

A review of the MDS assessment from recent date revealed that resident #019 was aged person with identified medical diagnosis.

A review of the resident's written plan of care revealed that resident #019 was identified to be at risk for falls related to change in the health condition. Further the resident's written plan of care indicated the resident was at risk for fall, and injury to self, as the resident exhibits an identified behaviour. Interventions were planned and set to prevent falls.

A review of resident #019's progress notes for 2017, revealed the resident had identified number of falls for an identified period in 2017.

A review of the resident's post fall assessment record for 2018, indicated that the post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls was not done for a specified falls.

An interview with RPN #194, confirmed that they found resident #019 had a fall, assessed the resident and later on the resident was sent to the hospital. Further the RPN confirmed that because of the workload on the floor they forget to do the post fall assessment or to endorse to the upcoming shift to complete the assessment.

Further review of the post fall assessment record revealed the assessment tool initiated for the previous two falls were not completed.

An interview with RPN #150, and RPN #142, confirmed that they have not completed an identified section of the requested form but were not able to explain why.

An interview with PT #164 confirmed that the requested form was to be completed after each resident's fall and to identify what intervention the resident had in place before falls and what, if new intervention will be applied.

An interview with DON confirmed that the staff is to investigate what contributed the fall, how the fall happened and what action was to be taken to prevent a future fall. The DON further confirmed that after the fall the staff is expected to complete all sections in the post fall assessment using a clinically appropriate assessment hard copy tool that is specifically designed for falls. [s. 49. (2)]

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 when the resident has fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report submitted to the MOHLTC included a description of the individuals involved in the incident, including name of the resident involved in the incident and name of staff member who was present at the incident.

A CIS report was submitted to the MOHLTC about an incident that caused an injury to a resident for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status. On an identified date resident #019 sustained injury, and was sent to hospital for further assessment and treatment. The resident returned the same evening and treatment provided. The CIS report failed to reveal the name of the resident involved in the incident. The CIS report revealed that the resident had an identified incident witnessed by a staff, however the report failed to reveal the name of the staff member who was present and witnessed the incident. Under the section General Notes in the CIS report, the communication note directed the home to provide a full name of the resident. The information about the resident's and staff's name was not updated and the report was not amended at the time of the inspection.

Interview with DON revealed that at the time when this CIS report was submitted to the MOHLTC, the DON was on a vacation and the DON was the only person who received correspondence from the MOHLTC to amend the CIS. The DON confirmed that they had not amended the CIS report with the resident's and staff's name. [s. 107. (4) 2.]

Issued on this 15 day of August 2018 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JOANNE ZAHUR (589) - (A3)

Inspection No. / No de l'inspection : 2018_462600_0004 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 010052-17, 018166-17, 004536-18, 004749-18 (A3)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Aug 15, 2018;(A3)

Licensee / Titulaire de permis : Shepherd Village Inc.
3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9

LTC Home / Foyer de SLD : Shepherd Lodge
3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Cathy Fiore

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To Shepherd Village Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee must be complaint with LTCHA, 2007, s. 6 (8).

The licensee shall prepare, submit and implement a plan to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The plan must include, but is not limited to the following:

1. Develop a process to ensure all direct care staff, including part time, casual and agency staff know the location, have immediate access to and are made aware of each resident's plan of care prior to providing care to the resident.
2. The plan must also include an auditing process to ensure staff are aware of each resident's plan of care prior to providing care to the resident.

Please submit the written plan, including the person(s) responsible for completing the tasks, quoting inspection #2018_462600_0004 and inspector Gordana Krstevska, LTC Homes inspector, by email to CentralEastSAO.MOH@ontario.ca, by July 20, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others who provided direct care to the resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

A complaint #018166-17, was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date for resident #019 who within less than two months had two falls.

The home submitted a Critical Incident System (CIS) report to the MOHLTC on an identified date related to the incident resident #019 had while in the shower room on a specified date. The incident occurred during PSW #172 assistance to resident #019's care. The resident sustained injury from the incident, was sent to hospital and returned to the home with treatment provided.

A review of the Minimum Data Set (MDS) assessment prior to the incident, indicated the resident was admitted to the home with identified medical condition, cognitive and physical impairment and needed extensive assistance by staff. The resident was identified to have history of responsive behaviour.

A review of resident #019's written plan of care indicated the resident was at risk for falls related to a health condition. The resident required one staff assistance for identified ADL's care and staff were to get help from other staff when the resident exhibited responsive behaviour during the care.

Interviews with PSW #154 and RPN #142 stated the resident was at risk for falls and would exhibit responsive behaviour during care. They further indicated the resident's plan of care had been printed and available in the resident's health record binder at the nursing station, accessible to all regular and casual staff.

An interview with PSW #172 on an identified date, stated the PSW worked casually in the home and had not provided care to resident #019 prior to a specified date. The PSW indicated that they worked on the identified date and they provided care to resident #019. PSW #172 stated resident #019 refused the care but they were able to encourage the resident and provide identified care. During the care, the resident exhibited responsive behaviour and moved from side to side on the chair. The PSW confirmed that they did not know what to do when the resident exhibited the behaviour however, continued to complete the care. The PSW stated they had not called for other staff to assist. Further the PSW stated when they turned around to reach for the resident's belongings, the resident got up from the chair, started walking and fell. The PSW also stated that they had not read resident #019's written plan of care and were not aware of direction of how to intervene when resident #019 expressed a responsive behaviouir. The PSW further confirmed that they are not aware of any resident's plan of care because they do not have time to read each resident's plan of care that they are assigned to. The PSW stated that they keep themselves aware of the resident's condition and required care by watching the resident when they come to work.

An interview with Nurse Manager (NM) #105 confirmed that all staff are expected to be aware of each resident's plan of care, including their medical condition, their needs and intervention to be applied when providing care to the residents. The casual staff are also expected to attend the shift report, review the resident's written

plan of care in the resident's health record and be familiar with the residents.

An interview with the Quality Compliance Manager (QCM) #104 confirmed that the staff is expected to attend the between shift meetings with registered staff and to be kept aware of the content in the resident's plan of care available at the nursing station. [s. 6. (8)]

The severity of this issue was determined to be a level 3 as there was actual harm to resident #019. The scope of the issue was a level 1 as it related to one of three residents reviewed, and the previous compliance history was determined to be a level 4 as there was related non-compliance with an ongoing VPC or order that included:
- Voluntary Plan of Correction (VPC) issued August 12, 2015, (#2015_378116_0015)
- Voluntary Plan of Correction (VPC) issued March 16, 2016, (#2016_377502_0006)
- Voluntary Plan of Correction (VPC) issued February 27, 2017, (#2017_527665_0001)
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 31, 2018(A2)

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be complaint with LTCHA, 2007, c. 8, s .19 (1).

The licensee must prepare, submit and implement a plan to ensure that residents are not neglected by the licensee or staff.
The plan must include, but is not limited to the following:

1. Develop a process to ensure that any resident returning to the home from hospital, discharge records are reviewed, the plan of care documented and provided to the resident.
2. The plan must also include an auditing process to ensure hospital discharge plans and recommendations for resident's care are followed up upon and completed as required.

Please submit the written plan, including the person(s) responsible for completing the tasks, quoting inspection #2018_462600_0004, and inspector Gordana Krstevska, LTC Homes inspector, by email to CentralEastSAO.MOH@ontario.ca, by July 20, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #019 was not neglected by the licensee or staff.

For the purposes of the definition of neglect O. Reg. 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the MOHLTC on an identified date related to resident #019 not receiving the required care.

A review of the Minimum Data Set (MDS) from an identified date, revealed the resident had moderate cognitive impairment, had an unsteady gait and sustained discomfort from recent incidents.

A review of resident #019's health record document from an identified date, indicated the resident had discomfort that was treated. The consultant ordered the home to provide a specified treatment with in an identified number of days. The order was transcribed and placed in the prescribing order sheet within the resident's chart on an identified date and time period required. The order was signed by a registered staff.

A review of the communication calendar for the registered staff at the nursing station revealed a handwritten note stating on the identified date resident #019 was to have a treatment provided by MD only, which was highlighted and crossed out. Few days later, within the same calendar, there appeared a note stating resident #019's specified treatment was to be provided. No other note was found throughout the calendar regarding resident #019's specified treatment.

A review of the resident's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal any information about the specified treatment.

A review of resident #019's progress notes from May to August, revealed resident #019 had an incident sustained discomfort and was sent to hospital for further assessment and treatment provided. The resident came back and the RN in charge documented the discharge notes and order for the specified treatment to be provided in a number of days and sanctioned the order. On the identified date RN #153 documented that portion of the specified treatment had been provided. The next day follow up note stated a portion of specified treatment had been completed, and the MD was to assess the area and continue the treatment. The following day MD assessed resident, confirmed the status of the identified area, and recommended monitoring. There was no note to indicate whether further treatment was required. RPN #150 documented that the identified concern required treatment and Nurse Practitioner (NP) will come the next day to provide this treatment. The next day NP documented that the resident was referred regarding the treatment to the identified concern. On an identified date RPN #150 documented a PSW had reported that the resident required further treatment. The RPN assessed the resident and indicated the resident required further treatment, but there was no further documentation if an

action was taken. The DON documented that they received a call from an identified person, stating the outside care provider indicated that the resident may need specified care. The DON apologized to the identified caller and ensured that the NP would be notified and the resident assessed.

An interview with RN #153 on an identified date, indicated when a resident is scheduled for a specified treatment, the staff are to check the physician's order to identify the date, location, and the nature of the specified treatment. RN #153 stated that on the identified date, they provided partial treatment and was not able to finish as the resident exhibited a responsive behaviour and was uncomfortable. .

During an interview conducted on an identified date, NP #151 stated they received a referral from the home around a specified date, to provide a specified treatment from resident #019. The NP stated that the practice is when they receive a referral, they will check the physician's order, to identify the concern and nature of the specified treatment. The NP confirmed that they did not review the original physician's order to confirm the specified treatment because the referral was to provide partial treatment. The NP also stated that they were counting on the nurses' assessments so they did not follow up the practice to check the physician's order prior the treatment. The NP acknowledged they should have reviewed and followed the plan of care for the resident and made sure the full treatment was provided.

During an interview RPN #150 stated they were aware that the resident had an incident, sustained discomfort, and came back from the clinic requiring follow up treatment. The RPN also indicated that treatment was to be provided to the resident in an identified number of days. Further interview with RPN #150 revealed that they did not document the nature of the specified treatment when they had assessed the resident. RPN #150 further indicated that when a PSW reported to them that a part of the specified treatment remained on the resident during care, they did not take any action. RPN #150 stated that in an identified month, when an identified person reported to them that they found a specified treatment on the resident, they still did not take any action.

During an interview with QCM they stated that when a resident returns from the hospital with discharge notes and directions for care, the registered staff is expected to document this information in the resident's chart. The registered staff is expected, to assess the resident upon return from the hospital and to assess the specified treatment if warranted. The process in the home is to have the interventions

surrounding the specified treatment documented and it is the RN's responsibility to follow up and provide appropriate treatment.

During an interview with the Director of Nursing (DON) they stated the expectation of the home is for staff to follow up with the plan of care and recommendation from the hospital for each resident coming back from the hospital. The registered staff are to assess the resident and in this case should have assessed the specified treatment. The DON further indicated that the registered staff is expected to check the physician's orders prior to the specified treatment to confirm date and appropriate intervention. The DON confirmed, the staff are expected to communicate the resident's response to the intervention and whether the intervention was completed or not. The DON also confirmed that even when the PSW identified that the resident required further treatment, the RPN did not take any action to intervene and did not communicate to the RN for further action. The DON acknowledged that the staff neglected the resident's care needs by not following the recommendation from the hospital within the recommended number of days as indicated in the plan of care. [s. 19. (1)]

The severity of this issue was determined to be a level 2 as there was minimum risk or potential for risk to the resident. The scope of the issue was a level 1 as it related only to resident #019. The home had a level 4 history as they had an ongoing non-compliance with this section of the LTCHA that included:
- Compliance Order (CO) issued March 16, 2016, (#2016_377502_0006) (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 31, 2018(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
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.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in

accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with O.Reg.79/10, s.3. (1).
Specifically, the licensee must re educate all staff on respecting and promoting the Residents' Bill of Rights specifically, the right of every resident to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Grounds / Motifs :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A complaint #004749 -18, was submitted to the MOHLTC alleging that the resident was not fed properly. Video footage was provided to the MOHLTC.

An interview with the complainant indicated a video had been taped of the resident being fed by staff. The complainant stated that when they became aware of the video, they called the home and met with management as the resident appeared to have been inappropriately fed by staff. The complainant indicated that the resident was able to demonstrate refusal of treatment by identified means.

A review of resident #019's medical record revealed when the resident had been admitted to the home, needed physical assistance by one staff for some of the Activities of Daily Living (ADL). The resident was to be encouraged by staff for self-feeding and was to be provided cuing. A review of resident #019's progress notes revealed the resident was hospitalized, their condition changed and needed greater assistance by staff.

A review of resident #019's written plan of care from an identified date, revealed that the resident needed physical assistance for eating along with lots of encouragement. Review of the Medication Administration Record (MAR) revealed that beside the appropriate diet, the resident was to have an intervention provided.

An interview with PSW #166 revealed that on a specified day the PSW fed resident #019 and the resident consumed the foods provided. The PSW stated that when they tried to give more food to the resident, the resident refused and they stopped the feeding. The PSW stated that they were aware that sometimes when the resident did not want to eat they would demonstrate this and provided examples. The PSW also stated that they were aware to leave the resident if they refused.

A review of the video footage revealed that the resident was being fed by staff and continued to do so after the resident refused.

An interview with PSW #154 confirmed they fed resident #019 an identified nourishment on a specified date. The PSW indicated that they were aware that when the resident does not want to eat, the resident would communicate to the staff. The PSW stated that if the resident communicates to them that they do not want to eat, they would normally stop the feeding, leave the resident and come back later. On a specified date the PSW confirmed they were told and given a nourishment by RPN #142 to feed resident #019. The PSW indicated that when they tried to feed the resident, the resident communicated to them that they do not want to eat but identified circumstances encouraged the PSW to continue. The PSW confirmed that the resident did not want or need to be fed at that time.

In an interview with RPN #142 revealed that they were aware not provide care to resident #019 if they refused. The RPN confirmed directing PSW #154 to provide a nourishment to the resident.

An interview with the DON confirmed that for residents who show signs of refusing any treatment, staff are required to discontinue the treatment. After reviewing the video with the DON, the DON stated resident #019 showed signs of refusal and PSW #154 should have stopped feeding the resident. The DON confirmed that PSW #154 and RPN #142 had not fully respected and promoted the residents' right to be properly cared for and fed in a manner consistent with their needs. [s. 3. (1) 4.]

The severity of this issue was determined to be a level 2 with minimal harm/risk or potential for actual harm/risk to resident #019, the scope was determined to be a level 1 as it related only to resident #019, and the previous compliance history was determined to be a level 3 as there was non-compliance in similar areas in the section of the LTCHA that included:
- Written Notification (WN) issued March 16, 2016, (#2016_235507_0011) (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 31, 2018(A3)

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with O.Reg 79/10, r. 73. (1)
Specifically the licensee must:

1. Re educate all direct care staff on proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
2. Maintain attendance records of all staff who participated in the education.
3. All staff must ensure that residents are provided with sufficient time to eat at their own pace.
4. Develop, implement and maintain an auditing process to ensure that staff are using proper techniques and positioning when feeding residents.

Grounds / Motifs :

1. The licensee has failed to ensure that proper techniques were used to assist resident #019 with eating, including safe positioning of the resident who required assistance.

A complaint #004749 -18, was submitted to the MOHLTC alleging that the resident was not fed properly at an identified time. The video footage was provided to the MOHLTC.

A review of resident #019's medical record revealed when the resident had been admitted to the home, needed physical assistance by one staff for some of the Activities of Daily Living (ADL). A review of resident #019's progress notes for the noted concern indicated that the resident required full assistance from staff for feeding.

An interview with PSW #166 revealed that on a specified date, they fed resident #019 in the room. The PSW confirmed that when the resident is fed in the room or in the dining room, they must be positioned in an identified position. The PSW confirmed that they had positioned the resident properly when fed.

A review of the video footage revealed details of resident #019's feeding, indicating the resident was not properly positioned when PSW #154 assisted to feed the resident.

An interview with PSW #154 confirmed they fed resident #019 an identified nourishment on a specified date. Further in the interview, the PSW confirmed that resident #019 was not positioned properly during the identified time. The PSW indicated that they fed the resident not in a safe position and not in accordance with the plan of care.

Interview with DON revealed that when feeding residents, the staff is to make sure the residents are properly positioned to prevent any associated risks to the resident. After reviewing the video with the DON, the DON confirmed that resident #019 was not properly positioned for feeding, while being fed on the specified date.

The severity of this issue was determined to be a level 2 with minimal harm/risk or potential for actual harm/risk to resident #019, the scope was determined to be a

level 1 as it related only to resident #019, and the previous compliance history was determined to be a level 4 as there was related non-compliance with an ongoing VPC or order that included:
- Voluntary Plan of Correction (VPC) issued February 27, 2017, (#2017_527665_0001)
(600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 31, 2018(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15 day of August 2018 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JOANNE ZAHUR - (A3)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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Service Area Office / Bureau régional de services : Central East