Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 25, 2020	2020_838760_0004	022454-19, 001518-20	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

JACK SHI (760)

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): January 31, February 3, 4, 5, 6, 7, 10, 11, 12, 2020

The following intakes were completed in this complaint inspection:
Log #022454-19 was related to skin and wound; and
Log #001518-20 was related to falls.
PLEASE NOTE: A Written Notification and Compliance Order related to Ontario Regulation 79/10, s. 8 (1) (b) was identified in this inspection and has been issued in Inspection Report 2020_626501_0003 dated February 25, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Quality Compliance Manager (QCM), Nurse Manager (NM), Associate Director of Care (ADOC), Float Registered Nurse (FRN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Registered Dietitian (RD), Physiotherapist (PT), Residents, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector conducted record reviews, observations and interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 has failed to ensure that a resident exhibiting altered skin integrity received a skin assessment from a registered staff using a clinically appropriate assessment instrument for skin assessment.

In accordance to O. Reg 79/10, r. 50 (3), "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

A review of the home's policy, titled "Skin and Wound Care Program", policy # NURS-13-20, with an effective date of April 1, 2019, indicated that each resident who exhibits skin breakdown shall be assessed by a registered staff member and documented on the electronic wound documentation system.

The Ministry of Long-Term Care (MLTC) received a complaint from resident #001's SDM related to altered skin integrity.

A record review indicated RPN #103 documented there was altered skin integrity related to resident #011. Further review indicated there was no evidence a skin assessment had been conducted.

An interview with RPN #101 indicated that the home's process with discovering a new

altered skin integrity would be to take a picture of the site and conduct a skin and wound assessment on the area of the altered skin condition. They also indicated that this documentation would be completed on an electronic documentation system. An interview with RPN #103 also indicated that this would be the process in the home and stated that they did conduct a skin assessment on resident #011's altered skin integrity when it was first discovered but did not use the home's skin assessment tool.

An interview with NM #105 and QCM #106 confirmed that a skin assessment was not documented using the home's skin assessment tool in resident #011's chart and it would be the home's expectation and policy for the registered staff to document a skin assessment using the home's skin assessment tool when they first discovered resident #011's altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident who exhibits altered skin integrity was assessed by a RD who is a member of the staff of the home.

A review of the home's policy, titled "Skin and Wound Care Program", policy # NURS-13-20, with an effective date of April 1, 2019, indicates that the dietitian is to be notified when a resident exhibits altered skin integrity and the RD will assess each resident who exhibits skin breakdown.

A record review of resident #011's electronic chart did not indicate an assessment was conducted by a RD related to their altered skin integrity.

An interview with RPN #103 and RPN #102 confirmed that a referral to the RD would be made when a resident exhibits altered skin integrity. RPN #103 indicated that they did not make a referral to the RD when they first discovered resident #011's altered skin integrity.

In an interview with RD #104, they stated when they receive a referral from a registered staff related to an altered skin integrity, they will follow up with a nutritional skin assessment. RD #104 indicated they did not receive a referral for resident #011's altered skin integrity or documented an assessment of resident #011's altered skin integrity. RD #104 stated that the home's policy would be to involve the dietitian in an assessment of all residents exhibiting altered skin integrity.

An interview with NM #105 and QCM #106 indicated that a referral to the dietitian was not made and an assessment was not completed by the RD related to resident #011's

altered skin integrity. [s. 50. (2) (b) (iii)]

3. Resident #012 was selected for sample expansion related to non-compliance identified with resident #011.

A record review of resident #012's electronic chart indicated an altered skin integrity. A further review of resident #012's electronic chart did not indicate there was a referral to the RD and an assessment conducted by the RD related to resident #012's altered skin integrity.

An interview with RPN #108 indicated there was no documentation related to a referral being made to the RD and an assessment being completed by the RD related to resident #012's altered skin integrity.

ADOC #107 indicated in their interview that resident #012 was not referred to the RD by the registered staff and an assessment was not completed by the RD related to resident #012's identified skin condition. ADOC #107 stated that the home expects registered staff to immediately make a referral to an RD when they discover a resident with altered skin integrity.

The home has failed to ensure that resident #011 and #012 were assessed by a registered dietitian related to their altered skin integrity. [s. 50. (2) (b) (iii)]

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, (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, (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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The MLTC received a complaint from resident #011's SDM indicating they did not receive information from the home regarding the resident's altered skin integrity until after a physician saw them and there was a diagnosis.

A record review of resident #011's progress notes indicated RPN #103 documented that the resident had altered skin integrity on an identified date but did not specify if the SDM was informed at that time. On a later date, resident #011 was seen by a physician and was diagnosed with an identified medical condition and a treatment was ordered. On that same day, RPN #103 documented they called resident #011's SDM related to the physician's treatment orders.

An interview with RPN #103 indicated that when registered staff identifies new altered skin integrity, the home's expectation was to inform a resident's SDM as soon as possible. RPN #103 stated that they did not notify resident #011's SDM on the date they first identified their altered skin integrity and indicated according to their documentation, this was done after a period of time, when the physician made the diagnosis and treatment of the medical condition.

An interview with NM #105 and QCM #106 indicated the home's expectation was to have the resident's SDM informed as soon as possible, when a resident develops new altered skin integrity. NM #105 and QCM #106 verified that the home did not notify resident #011's SDM right away of their altered skin integrity and confirmed this was done after the physician had diagnosed the condition and ordered a treatment.

The home failed to ensure that resident #011's SDM was given an opportunity to participate fully in the development and implementation of the plan of care related to the resident's identified diagnosis and condition. [s. 6. (5)]

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.