Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 7, 8, 14, 15, 16, 17, 18, 2011	2011_048175_0018	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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Personal Support Worker(PSW).

During the course of the inspection, the inspector(s) reviewed identified resident's Health Care Record specific to the complaint, Policies & Procedures including NURS IV-73, Pain Assessment & Management #NURS V-102, documentation between resident's family member and DOC

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dignity, Choice and Privacy

Falls Prevention

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Resident Care Plan reviewed Nov. 8, 2011 and indicated: Pain and Safety assessments and interventions did not reflect the resident's current health and functional status.

2. A review of the resident's health care record November 8, 2011, indicated the resident fell and after the fall, changes to the resident's health status occurred. The resident's care plan was not reviewed and revised to include a re-assessment of changes in health status and interventions to manage the changes, including the potential impact on the risk for falls.

3.The resident sustained a second fall 2 days later, with progressive changes documented in functional status and development of related pain varying from mild to severe.The resident's plan of care was again not revised to include a re-assessment of changes to functional status and pain and interventions to manage the potential impact to falls risk, comfort, and activities of daily living, at a minimum.

4.Resident Care Planning Report identified "Safety" risk for falls was outdated and did not include current falls risks and safety requirements.

5.The licensee did not ensure the resident was re-assessed, and the plan of care was reviewed and revised after two falls.

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 all residents are re-assessed and their plans of care reviewed and revised...when the residents care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Ont Reg 79/10 s. 48 (1)1 4: Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
A falls prevention and management program to reduce the incidence of falls and the risk of injury.
A pain management program to identify pain in residents and manage pain.

2.The Home's Falls Prevention and Management Policy #NURS IV-73 indicates the Registered Nurse and Registered Practical Nurse
completes fall-risk assessments on transfer, following a change in status, following a fall, and quarterly,...Evaluates the Plan of Care.

3.A review of the resident's health record November 8, 2011, indicated the Registered Nurses or the Registered Practical Nurses did not complete a fall risk assessment following specific changes to the resident's health status post fall.The resident then sustained a second fall, with progressive changes.

4.The home's pain Assessment and Management Policy #NURS V-102 indicates that the interdisciplinary team will conduct and document a pain assessment with a change of condition with onset of pain. A review of the resident's plan of care November 8, 2011, indicated that the resident did not receive an interdisciplinary assessment of noted changes.

5.The licensee did not ensure the home complied with their policies for Falls Prevention and Management and Pain Assessment and Management.

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 the home's Falls Prevention and Management Policy #NURS IV-73 and Pain Assessment and Management Policy #NURS V-102 are complied with., to be implemented voluntarily.

Issued on this 18th day of November, 2011

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