Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 21, 2015	2015_378116_0015	T-2783-15	Complaint

Licensee/Titulaire de permis

SHEPHERD VILLAGE INC.
3758/3760 Sheppard Avenue East TORONTO ON M1T 3K9

Long-Term Care Home/Foyer de soins de longue durée

SHEPHERD LODGE
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

SARAN DANIEL-DODD (116)

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): August 12, 13, 14, 17, 19, 2015.

During the course of the inspection, the inspector(s) spoke with the Vice President of Client Care and Services, Director of Care (DOC), Nurse Managers, Resident Assessment Instrument (RAI) coordinator, physiotherapist, registered staff members, personal support workers (PSWs), and the Executor of Estate of resident #001.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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

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

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

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The written plan of care for resident #001 identified that the resident exhibits responsive behaviours and is at risk for falls. The resident requires extensive assistance of two persons for all transfers. The call bell is to be within reach.

On an identified date, the licensee submitted a critical incident to the Director reporting that resident #001 experienced an unwitnessed fall which resulted in injury.

Interviews held with identified staff members revealed that resident #001 was exhibiting responsive behaviours and the interventions in place were not successful in decreasing the behaviours. An identified staff member confirmed that he/she brought resident#001 to his/her room. Interviews held with identified staff members confirmed that the resident's wheelchair was placed in a location of the room where the call bell was not within close proximity and within the resident's reach.

Further interviews held with nurse managers and the DOC confirmed that the care set out in the plan of care for resident #001 was not provided as specified in the plan regarding falls prevention. [s. 6. (7)]

2. The licensee has failed to 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, the resident's care needs change or care set out in the plan is no longer necessary; or care

set out in the plan has not been effective.

The written plan of care for resident #001 documents that the resident is at risk for falls due to cognitive deficit and weakness related to an identified disease process. The written plan of care further documents that the resident exhibits responsive behaviours.

Interviews held with identified staff members and members of the management team revealed that the resident required repositioning while seated in a wheelchair to prevent the resident from falling. On an identified date, resident #001 exhibited heightened responsive behaviours. The interventions in place to manage the responsive behaviours were initiated by staff members but were not effective. An identified staff member brought resident #001 to his/her room and left the resident unattended while leaving the unit for a disclosed period of time. During the disclosed period of time, resident #001 experienced an unwitnessed fall.

Interviews held with identified staff members revealed that they were unaware of the resident's requirement to be repositioned while seated in a wheelchair. Interviews held with identified staff members, a nurse manager and the DOC confirmed that the resident should have been reassessed when the care needs for the management of falls changed and the resident was not responding to current interventions to decrease responsive behaviours.

The care guide and the written plan of care was not revised to reflect the change in the resident's care needs. [s. 6. (10) (c)]

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 following:
- the care set out in the plan of care is provided to the resident as specified in the plan and,
-the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of safety risks for resident #001.

The written plan of care for resident #001 indicates that the resident is at risk of falls. The resident requires frequent re-assurance and monitoring.

Interviews held with identified staff members and members of the management team revealed to the inspector that the resident is kept at the nursing station to monitor for safety and re-assurance. On an identified date, resident #001 exhibited heightened responsive behaviours. Interventions to manage the responsive behaviours were initiated however, not effective to reduce the behaviour. An identified staff member brought resident #001 to his/her room and left the unit for a disclosed period of time. A review of the health record and interviews held with identified staff members revealed that the resident was left unsupervised and not monitored for his/her whereabouts and safety.

The written plan of care does not document the interventions for managing the resident's whereabouts for safety. (3) 19.]

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 plan of care is based on an interdisciplinary assessment of safety risks for resident #001, to be implemented voluntarily.

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Issued on this 22nd day of September, 2015

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

Original report signed by the inspector.