



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

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

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 11, 2016	2016_324567_0005	31885-15	Critical Incident System

Licensee/Titulaire de permis

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

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

SHEPHERD LODGE
3760 Sheppard Avenue East TORONTO ON M1T 3K9

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

SOFIA DASILVA (567)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 1, 3, 4, 5. March 7, 8, 2016.

This inspection was conducted related to submission of a Critical Incident Report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Charge Nurse and Falls Program Lead, Physiotherapist, Registered Nurses, Personal Support Workers.

During the course of the inspection, the inspector reviewed: resident records in the electronic and hard copy charts of the resident; investigation notes provided by the home; relevant policies and procedures; program evaluation documents and staff training records.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition**

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

2 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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 has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls

Review of a Critical Incident Report(CIR) submitted to the ministry in November, 2015, revealed that resident #001 had an unwitnessed fall which resulted in an injury in November 2015. The resident was assessed by registered staff, and the resident was then transferred to hospital for further assessment and treatment.

Review of the resident's chart and health records did not reveal a completed post fall assessment.

Interview with RPN #001 revealed that resident had an unwitnessed fall and that he/she was then transferred to hospital.

Interview with the DOC revealed that normally, after every fall, staff conduct a post fall huddle, which includes a post fall assessment. The DOC also confirmed that for this particular fall, a post-fall assessment was not completed. [s. 49. (2)]

WN #2: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :



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1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Review of a Critical Incident Report(CIR) submitted to the ministry in November 2015, revealed that resident #001 had an unwitnessed fall which resulted in an injury in November 2015. The resident was assessed by registered staff, and was then transferred to hospital for further assessment and treatment.

Interview with the DOC confirmed that a CIR was not submitted to the ministry within the required timeframe. [s. 107. (3) 4.]

Issued on this 22nd day of March, 2016

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

Original report signed by the inspector.