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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St., 4th Floor
Ottawa ON K1S 3J4

Telephone: 613-569-5602
Facsimile: 613-569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
Ottawa ON K1S 3J4

Téléphone: 613-569-5602
Télécopieur: 613-569-9670

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 3, 2011	2011_111_2782_03Mar095702	Critical Incident (Log# O-000477)

Licensee/Titulaire
Shepherd Village Inc.,
3758/3760 Sheppard Avenue East,
Toronto, ON M1T 3K9
Fax:416-609-8329

Long-Term Care Home/Foyer de soins de longue durée
Shepherd Lodge
3760 Sheppard Avenue East,
Toronto, ON
Fax: 416-293-6229

Name of Inspector(s)/Nom de l'inspecteur(s)
Lynda Brown, ID#111

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection for a resident.

During the course of the inspection, the inspector spoke with: 1 Registered Nurse, 1 Registered Practical Nurse, 2 Personal Support Workers, the Director of Care and the Administrator.

During the course of the inspection, the inspector: Observed residents rooms, observed common areas, and reviewed the resident's health record.

The following Inspection Protocol was used during this inspection: Critical Incident Reporting

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN
1 CO: CO # 001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg.79/10, s.16 Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimeters.

Findings:

-An identified residents window was found cranked wide open and with the screen torn.
-On March 3, 2011 the inspector was able to open the crank style windows that were accessible to residents to the following measurements in centimeters (cm) :
-on the second floor (which is the secured unit for wandering residents): resident room 201 (16cm) and the screen was not secured in place, room 206(16cm), room 223 (12 cm) and the screen was not secured in place, room 225(12 cm), room 229(13cm), north wing sun room (left window-16cm and right window over 30 cm), south wing television lounge (left window-18cm)
-on the fifth floor: in the north wing sun room, both the right and left windows opened 15 cm and the screen was not secured; north wing television lounge (left window did not have a screen in place and window opened to 17cm; right window opened to 15cm; south wing television lounge left window opened to 20 cm and the right window opened to 18cm.
-on the sixth floor: in the north wing sun room, the left window opened to 13cm and the right window opened to 16cm. In the north wing television lounge the right window opened to 15cm. In the south wing television lounge, the left window opened to 19cm and the right window opened to 18 cm; resident room 601 opened to 18cm
-on the seventh floor: in the north wing sun room the left window completely opened with no obstruction, in the north wing television lounge the left window opened to 16cm and the right window opened to 19cm; in the south wing television lounge the left window opened to 16cm and the right window opened to 18cm; in resident room: 705(right) opened to 18cm, (left) opened to 21 cm; room 708 opened to 19cm.

Inspector ID #:	111

Additional Required Actions:

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

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Lynda Brown
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 24, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**		
Name of Inspector:	Lynda Brown	**Inspector ID #**	111
Log #:	O-000477		
Inspection Report #:	2011_111_2782_03Mar095702		
Type of Inspection:	Critical Incident		
Date of Inspection:	March 3, 2011		
Licensee:	Shepherd Village Inc., 3758/3760 Sheppard Avenue East, Toronto, ON M1T 3K9 Fax:416-609-8329		
LTC Home:	Shepherd Lodge 3760 Sheppard Avenue East, Toronto, ON Fax:416-293-6229		
Name of Administrator:	Brock Hall		

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O.Reg.79/10, s.16 Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 10 centimetres.

Order: The licensee is to ensure that all windows in the home that open to the outdoors and are accessible to residents have a screen in place and cannot be opened more than 10 centimetres.

Grounds:
-An identified residents window was found cranked wide open and with a torn screen.
-On March 3, 2011 the inspector was able to open the crank style windows that were accessible to residents to the following measurements in centimetres (cm) :

-on the second floor (which is the secured unit for wandering residents): resident room 201 (16cm) and the screen was not secured in place, room 206(16cm), room 223 (12 cm) and the screen was not secured in place, room 225(12 cm), room 229(13cm), north wing sun room (left window-16cm and right window over 30 cm), south wing television lounge (left window-18cm)
-on the fifth floor: in the north wing sun room, both the right and left windows opened 15 cm and the screen was not secured; north wing television lounge (left window did not have a screen in place and window opened to 17cm; right window opened to 15cm; south wing television lounge left window opened to 20 cm and the right window opened to 18cm.
-on the sixth floor: in the north wing sun room, the left window opened to 13cm and the right window opened to 16cm. In the north wing television lounge the right window opened to 15cm. In the south wing television lounge, the left window opened to 19cm and the right window opened to 18 cm; resident room 601 opened to 18cm
-on the seventh floor: in the north wing sun room the left window completely opened with no obstruction, in the north wing television lounge the left window opened to 16cm and the right window opened to 19cm; in the south wing television lounge the left window opened to 16cm and the right window opened to 18cm; in resident room: 705(right) opened to 18cm, (left) opened to 21 cm; room 708 opened to 19cm.

This order must be complied with by:	March 11, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 4th day of March, 2011.	
Signature of Inspector:	Lynda Brown
Name of Inspector:	Lynda Brown
Service Area Office:	OSAO