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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2018	2018_714673_0003	022854-16, 023711-16, 014404-17, 014718-17, 014971-17, 025595-17, 026025-17, 004901-18	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

BABITHA SHANMUGANANDAPALA (673)

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): February 26, 27, 28, 2018 and March 1, 2, 5-9, 12-16, and 20-23

The following intakes were completed in this complaint inspection:
-Log #023711-16 related to plan of care, and Residents' Bill of Rights;
-Log #014404-17 related to alleged abuse, availability of supplies, reporting, and maintenance;

-Log #022854-16 related to alleged abuse, bathing and insufficient staffing;
-Log #026025-17 related to insufficient staffing, complaints process and transferring and positioning techniques;
-Log #025595-17 related to insufficient staffing;
-Log #014718-17, Log #004901-18, and Log #014971-17 related to allegations of abuse

During the course of this inspection, the inspector reviewed health records, staff training records, relevant policies and procedures, investigation records, written correspondence from the home to the resident, and completed observations of staff to resident interactions and the provision of care.

PLEASE NOTE:
A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1), were identified in this inspection and has been issued in Inspection Report 2018_630589_0003, which was conducted concurrently with this inspection.

A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007 S.O. 2007, c. 8, s. 6 (1) (c) was identified in this inspection and has been issued in Inspection Report 2018_630589_0003, which was conducted concurrently with this inspection.

A Written Notification and Compliance Order related to LTCHA, 2007 S.O. 2007, c.8, s. 6 (7) were identified in this inspection and has been issued in Inspection Report 2018_630589_0003, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), Physiotherapy Assistants (PTAs), Director of Nursing (DON), Nurse Managers (NMs), Quality Assurance Manager (QCM), Director of Client Care Services (DCCS), Xray Technician (XT), Vice President of Client Care (VPCC) and Dietary Aide (DA).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **4 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse, neglect, or anything else provided in the regulations, that the licensee knows of, or that is reported is immediately investigated including:
i) Abuse of a resident by anyone

Complaints were submitted to the Ministry of Health and Long Term Care (MOHLTC) on three identified dates by resident #021, related to improper positioning by staff.

1) A Critical Incident Report was submitted to the MOHLTC on an identified date, related to an allegation of abuse of resident #021 by a contracted service provider which occurred on an identified date four days previous to the date that the CIR was submitted to the MOHLTC.

A review of the CIR, completed by QCM #104, indicated that on the identified date of the alleged incident of abuse, an identified contract service provider, came to complete an identified procedure for resident #021. RPN #159 reported that the resident displayed resistance toward the identified service, especially at the identified contract service provider during the process, but they completed the identified process. The CIR further stated resident #021 had written a letter dated two days after the identified date of the incident, and emailed it to the previous Vice President of Client Care (VPCC), and DON #100. The CIR stated that the investigation was in process.

A review of the letter sent to the VPCC and DON #100, dated two days after the identified date of the alleged incident of abuse, from resident #021 revealed that the identified contract service provider had ignored their request to call a nurse, and proceeded to provide the service causing pain.

In an interview, QCM #104 and DON #100 stated that the home did not immediately investigate upon receipt of the abuse allegations dated two days after the identified date of the alleged incident, via email.

A review of the progress notes dated four days after the identified date of the alleged incident of abuse, revealed that resident #021 had reported to an RPN that the identified contract service provider had abused them causing pain.

In an interview, QCM #104 and DON #100 stated that the home had left a message with the contracted service provider's manager four days after the identified date of the alleged incident of abuse.

QCM #104 and DON #100 stated that there was no further investigation of the alleged abuse until the inspector requested for investigation notes during the current inspection which was eight months after the alleged incident of abuse. Following this, a statement by the identified contract service provider was emailed to the home and the inspector on an identified date, by the contracted service provider's manager. QCM #104 stated that the investigation was still ongoing and had not been completed.

QCM #104 and DON #100 acknowledged that the investigation related to this allegation of abuse of resident #021 by the identified contract service provider had not been immediately investigated. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse, neglect, or anything else provided in the regulations, that the licensee knows of, or that is reported is immediately investigated including:
i) Abuse of a resident by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Complaints were submitted to the MOHLTC on three identified dates by resident #021, related to improper positioning by staff.

A review of resident #021's most recent written plan of care, stated that they required total assistance from two or more people for bed mobility, and two person assist for transfers via a total mechanical lift. A review of resident #021's health records indicated multiple identified health conditions.

In an interview, resident #021 stated that on an identified date, PSW #187 prepared resident #021 for a shower but had difficulty applying their sling. Resident #021 stated that PSW #187 continued the process without assistance from another staff member then left the room and brought in a Physiotherapy Assistant (PTA) to assist. The resident told the staff that another caregiver should be assisting instead of the PTA, and asked both staff to leave.

In an interview, PSW #187 stated that two staff are to assist when transferring resident #021 as per the plan of care and that on the identified date of the above mentioned incident, they had prepared resident #021 for their shower with PTA #177. PSW #187 indicated resident #021 voiced concerns of how they had applied the sling for the mechanical lift transfer.

In an interview, PTA #177 stated that on the identified date of the above mentioned incident, PSW #187 had approached them for transferring assistance with resident #021 but when they arrived in resident #021's room, resident #021 immediately asked them to leave. PTA #177 stated that they did not provide any assistance with care, or the transfer of resident #021 at this time.

In an interview, NM #105 stated that resident #021 required two staff to assist with the application of the sling, transferring and positioning. NM #105 acknowledged that by assisting resident #021 with the application of the sling on an identified date without assistance from another staff member, PSW #187 had not used safe transferring and positioning techniques. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Complaints were submitted to the MOHLTC on three identified dates by resident #021, related to improper positioning by staff.

A review of resident #021's most recent written plan of care, indicated that they required total assistance from two or more people for bed mobility, and two person assist for transfers via a total mechanical lift.

On an identified date, at an identified time, the Inspector observed PSW #178 and PSW #174 assist resident #021 with transferring and repositioning resident #021. During this process, a sling manufactured by Waverly Glen was applied; however, the buckle on the waist strap of the sling was noted to be broken. PSW #178 was observed tying the waist strap of the sling by knotting it.

Four days from the time of the above observation, the buckle was observed to have been fixed.

A record review of a progress note by PT #146, dated approximately seven months

previous to the Inspector's observation of the broken buckle, stated that PT #146 had been called by an RPN to check resident #021's broken sling. On inspection, PT #146 observed the buckle clip for safety was missing. Resident #021 stated to PT #146 that it had been like that for one year. PT #146 wrote in the progress note that the plan was to inform the sling company to install the safety buckle for the sling.

A review of Waverly Glen's sling specification for the sling indicated that the strap is to be fastened and tightened to be comfortably firm. A review of Waverly Glen's user instructions for the sling indicated that the wide strap across the chest provided additional upper body support.

In an interview, resident #021 stated that the buckle on the chest strap of their sling had been broken for over a year.

In an interview, PSW #178 stated that they had provided care to resident #021 for three weeks, noticed the buckle on the chest strap was missing. PSW #178 further stated that they had not reported the sling buckle to be missing and had continued to use the sling by tying the chest strap.

In an interview, PT #146 stated that on an identified date last year, they observed the missing buckle on resident #021's sling. PT #146 indicated the sling has a waist band with buckle for extra security as a safety measure and that the manufacturer's recommendations is for it to be buckled. PT #146 stated that they informed NM #105 and requested the vendor, Home Medical Equipment (HME), to replace the buckle, but it was not done, and there was no follow up to the issue. PT #146 acknowledged that resident #021's sling was not being used in accordance with the manufacturer's instructions as staff had been tying the waist band. [s. 23.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following actions taken in response to the incident:
i) what care was given or action taken as a result of the incident and by whom
ii) whether a physician or Registered Nurse in the Extended Class was contacted
iii) what other authorities were contacted about the incident, if any
iv) whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons, and
v) the outcome or current status of the individual or individuals who were involved in the incident

A CIR was submitted to the MOHLTC on an identified date, related to an allegation of abuse of resident #021 by a contracted service provider on an identified date four days previous to the date that the CIR was submitted to the MOHLTC.

Eight days after the above mentioned CIR was submitted,the MOHLTC requested an amendment to the CIR for missing information including a request for more clarity around the incident of abuse, the update and outcome of the investigation, the SDM/family's response to the incident, and long term actions planned to prevent a recurrence.

No subsequent amendment was made to the report by the home.

In an interview DON #100 stated that all amendment requests were being sent to only their email, and that sometimes they are missed. DON #100 acknowledged that the information in relation to the actions taken in response to the incident described in the CIR was not submitted to the MOHLTC. [s. 104. (1) 3.]

Issued on this 24th day of August, 2018

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

Original report signed by the inspector.