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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 6, 2019	2019_598570_0003	026135-17, 005459-18, 006011-18, 008498-18, 012529-18, 014953-18, 019888-18, 030658-18, 032766-18, 002230-19	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

SAMI JAROUR (570), SHIHANA RUMZI (604)

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): January 24, 25, 28, 29, 30, 31, February 01, 04, 05 and 06, 2019.

The following intakes related to complaints were completed:
- Log #026135-17, related to continence care, medical services, nail care, bill of rights, prevention of abuse and neglect.
- Log #005459-18, related to continence care, nutrition and hydration.
- Log #006011-18, related to personal care concerns.
- Log #008498-18, related to care of a resident, continence care and bowel management.
- Log #012529-18, related to an allegation of abuse, infection control concerns, menu planning, maintenance.
- Log #014953-18, related to improper care of a resident.
- Log #019888-18, related to an allegation of neglect.
- Log #030658-18, related to pain management and an allegation of neglect.
- Log #032766-18, related to continence care and bowel management.
- Log #002230-19, related to an allegation of abuse and neglect, improper oral and continence care, and shortage of supplies.

During the course of the inspection, the inspector(s) spoke with Acting Director of Care (Acting DOC), Director of Care (DOC), Dietitian, Dietary Aide (DA), Quality Compliance Manager (QCM), Director of Facility Services (DFS), Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Registered Nurse Manager (RNM), Registered Nurse Float (RNF), Charge Registered Nurse (CRN), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping/Maintenances (HM), Administrative Assistant (AA), and Substitute Decision Maker (SDM).

During the course of the inspection, the inspectors conducted a tour of the home, made observations of staff and resident interactions, provision of care, conducted reviews of health records, and staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Safe and Secure Home

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

- **4 WN(s)**
- **3 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	Légende 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).

Findings/Faits saillants :

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

On specified two dates, the Ministry of Health and Long-Term Care (MOHLTC) received two complaints regarding care concerns in regards to resident #002.

On a specified date, during a telephone interview, the complainant indicated that resident #002 was supposed to receive a specified nutritional intervention using a specified medical equipment. The complainant indicated the specified medical equipment stopped working during an identified period. The complainant indicated the home did not have a spare specified medical equipment.

A review of progress notes of specified dates for resident #002 indicated that registered staff documented that a specified medical equipment utilized for resident was not working properly. The progress notes review indicated that a specified medical equipment was borrowed from another long-term care home on a specified date.

A review of the plan of care for resident #002, revealed the resident will receive a specified intervention for nutrition and hydration.

During interviews with Inspector #570, the Acting Director of Care (ADOC) indicated that registered staff would deal with the specified medical equipment's alerts. The ADOC further indicated that based on progress notes documentation for a specified period, it was unknown if the resident received their specified nutritional intervention when the specified medical equipment was not working properly.

During an interview with Inspector #570, Registered Dietitian (RD) #125 indicated that on an identified date, they had to borrow a specified medical equipment from another LTC home as there was no replacement available at the home. Upon review of the progress notes for resident #002 on identified dates, the RD indicated that the resident did not receive the full identified amount of specified nutritional intervention as the specified medical equipment was not working properly and there was no documentation to indicate how much the resident received of their specified nutritional intervention.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #159 indicated that resident #002's family member was concerned about the specified medical equipment not working properly. The RPN further indicated that on a specified date when the specified medical equipment was not working, they did not document how much the resident received of their specified nutritional intervention.

During an interview with Inspector #570, the Nurse Manager (NM) #104 indicated that on specified dates, there was no documentation to indicate that the resident had their full amount of their specified nutritional intervention.

During an interview with Inspector #570, Registered Nurse (RN) #166 indicated on an identified date, resident #002's was given a specified nutritional intervention due to specified medical equipment was not working properly. Review of progress notes for identified dates for resident #002 with the RN, the RN indicated that the progress notes documentation did not show the amount of nutritional intervention that was given to the resident when the specified medical equipment was not working.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #163 indicated that on an identified date, resident #002's specified medical equipment was not working and that they had to give the resident their nutritional intervention without using the specified medical equipment. Upon review of the progress note for resident #002 on an identified date, the RPN indicated that the resident did not get the full amount of specified nutritional intervention that day as the specified medical equipment was not working properly.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #164 indicated that on an identified date, they had to replace resident #002's specified medical equipment as it was not functioning well for a specified period of time. The RPN further indicated that there was no documentation to indicate that the resident received the full amount of a specified nutritional intervention. The RPN indicated that they just followed the previous shift and gave a specified nutritional intervention to the resident but did not document the amount of nutritional intervention that was given.

The licensee did not ensure that resident #002 received their required amount of nutritional intervention as ordered by the RD and directed in the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to all residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On specified two dates, the Ministry of Health and Long-Term Care (MOHLTC) received two complaints regarding care concerns in regards to resident #002.

On a specified date, during a telephone interview, the complainant indicated that resident #002 was supposed to receive a specified nutritional intervention using a specified medical equipment. The complainant indicated the specified medical equipment stopped working during an identified period. The complainant indicated the home did not have a spare specified medical equipment.

A review of progress notes of specified dates for resident #002 indicated that registered staff documented that a specified medical equipment utilized for resident was not working properly. The progress notes review indicated that the specified medical equipment was

borrowed from another long-term care home on a specified date.

During an interview with Inspector #570, the Acting Director of Care (ADOC) indicated that the home currently had a specified number of residents utilizing a specified medical equipment for nutritional interventions. The ADOC indicated that the home had extra equipment in storage and that one or two of them should be ready to be used.

On an identified date, observation of the specified storage area, by the ADOC and Inspector #570, the ADOC confirmed to the inspector that all specified medical equipments kept in the storage area were not in working order except one that was not ready to be used and required setup. The ADOC indicated no awareness that those specified medical equipment were out of order and that the RN float and or the Nurse Manager were responsible to have those equipment ready to be used.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #159 indicated that resident #002's family member was concerned about the specified medical equipment was not working. The RPN confirmed to the inspector their documentation in a progress note on a specified date that several specified medical equipment tried were found to be not working.

During an interview with Inspector #570, Registered Dietitian (RD) #125 indicated that on an identified date, they had to borrow a specified medical equipment from another LTC home as there was no replacement available at the home.

During an interview with Inspector #570, the Nurse Manager (NM) #104 indicated that a specified medical equipment would give an alert if it was not working properly. If the specified medical equipment was not functioning, a replacement would be used and if needed a new equipment would be ordered.

During an interview with Inspector #570, Registered Nurse (RN) #166 indicated that on an identified date, resident #002's specified medical equipment was not working.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #163 indicated that on specified date, resident #002's specified medical equipment was not working.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #164 indicated that on an identified date, they had to replace resident #002's specified medical

equipment due to not functioning well for a specified period of time.

The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that records of every former resident of the home are kept at the home for at least the first year after the resident is discharged from the home.

On an identified date, Inspectors #604 and #570 requested the clinical records for resident #002, to conduct a complaint inspection.

On an identified date, Administrative Assistant (AA) #119 provided the inspectors a copy of resident #002`s clinical records and indicated the original records could not be found.

During an interview with the ADOC confirmed that resident #002's original clinical records could not be found in the home and indicated that resident #002's family may have had them.

A follow up interview with AA#119 indicated that the family had the original records. AA #119 indicated no awareness when the original records were given to the family and by who. The AA indicated that they had photocopies of the records for the family to pick up but they never did.

During an interview, the Quality Compliance Manager (QCM) indicated that they contacted resident #002's Substitute Decision Maker (SDM) who acknowledged that the records were picked up by a family member. The QCM indicated that they assumed that resident #002's records were kept in the home until inspector #604 requested the records. The QCM further indicated that the original records could not be found at the home and that the assumption was that the family had the original records.

Up to the last date of this inspection, the home was not able to provide resident #002's original records to the inspectors from MOHLTC.

The licensee did not ensure that resident #002's clinical records were kept at the home for at least the first year after the resident was discharged from the home. [s. 233. (2)]

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 records of every former resident of the home are kept at the home for at least the first year after the resident is discharged from the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident-staff communication and response system was easily seen, accessed, and used by the residents, staff and visitors at all times.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint on specified date from resident #001. The resident stated that staff being annoyed when they ring the call bell for assistance.

A telephone interview was conducted with resident #001, and the resident indicated that staff are annoyed when they ring the call bell for assistance.

On specified date and time, Inspector #604 conducted an observation for resident #001. The Inspector observed the resident was asleep in bed and the call bell was not accessible to the resident. During another observation, Inspectors #604 and #747 noted that the resident was awake and was unable to access the call bell as the call bell was observed to be clipped to one side of the bed, not within reach of resident #001.

An interview was conducted with the Resident Assessment Instruments (RAI) – Minimum Data Set (MDS) Coordinator (MDS-RAIC) #142. The RAI-MDSC stated that residents utilized the call bell when they need. The RAI-MDSC and Inspector visited resident #001's room and the RAI-MDSC acknowledged that the call bell was on the floor and not accessible to the resident.

An interview was conducted with Registered Practical Nurse (RPN) #146. The RPN and Inspector carried out an observation with Inspector #747. The RPN acknowledged that resident #001's call bell was tucked under the pillow on one side and the call bell was not accessible to resident #001. [s. 17. (1) (a)]

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

Issued on this 22nd day of March, 2019

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

Original report signed by the inspector.