Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 31, 2019	2019_684604_0016	007442-18, 032781-18, 033387-18, 008972-19, 009805-19, 013387-19, 013521-19	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

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): July 3, 4, 5, 8, 9, 10, 11, and 12, 2019.

During this inspection the following complaints were inspected:
-Log #007442-18, related to not being informed of resident to resident alleged abuse
-Log #032781-18, related to admission refusal/rejection
-Log #033387-18, related to no Social Worker (SW) in the home
-Log #009805-19, related to improper transfer linked to log #008972-19, related to Critical Incident System (CIS) report was concurrently inspected during this complaint inspection.
-Log #013144-19, related to Residents' Bill of Rights

The following logs where related to temperature:
-Log #013387-19
-Log #013521-19

A Voluntary Plan of Correction (VPC) will be issued related to s. 20 (1), of the Long-Term Care Homes Act, S.O. 2007, which will be identified in the concurrent Critical Incident Inspection report #2019_790730_0019, related to log #007442-18, for resident #002.

During the course of the inspection, the inspector(s) spoke with the Administrator, Previous and Current Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Nurse Manager (NM), Float Registered Nurse (FRN), Charge Registered Nurse (CRN), Personal Support Worker (PSW), Private Sitter (PS), Director of Facility (DOF), Quality Compliance Manager, Maintenance, Residents, and Substitute Decision Maker.

During the course of the inspection, the inspector conducted observations of staff to resident interactions, provisions of care, conducted reviews of health records, staff training records, review of the home's complaints binder, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Personal Support Services
Reporting and Complaints
Safe and Secure Home

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	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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the residents' right to give or refuse consent to any treatment, care or services was fully respected and promoted.

An interview was conducted, with resident #001 and an identified person indicating Personal Support Worker (PSW) #106 and #107, came to provide care to them and they did not want PSW #106, in an identified area of the home. PSW #107, had refused for PSW #106 to leave the identified area and provided care.

An interview was conducted with PSW #107, who indicated they worked on an identified date and shift with resident #001. The PSW stated that if a resident refused to have staff in an identified location of the home or refused care the staff is to leave and report it to the nurse. The PSW staff confirmed the above incident had occurred and the staff did not leave the identified area of the home.

An interview was carried out with PSW #106, who indicated they worked on an identified date and shift and they assisted PSW #107 who asked them to come in to supervise the care provided to resident #001 with an identified present. The PSW stated resident #001 did not want them to be in an identified area of the home and stated that did not leave the identified area of the home.

An interview was conducted with Nurse Manager (NM) #109 who indicated that if a resident asked a staff to leave an identified area of the home staff are to leave as it is the resident's right. The NM indicated they worked on an identified date and shift and was unaware of any incident which had occurred that day with resident #001. The Inspector informed NM of the above incident and the NM acknowledged that the PSW staff should have left the identified area because the resident wanted and insisted PSW #106 to not be there and PSW #107 should have found another PSW. The NM further indicated that the PSW staff did not fully respect and promote the residents' right to give or refuse consent to care.

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 rights of the resident was fully respected and promoted and that every resident has the right participate fully in making any decision concerning any aspect of their care, in accordance with that Act, to be implemented voluntarily.

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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of any incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) when an incident which caused an injury to the resident which resulted in a significant change in the resident's health condition for which the resident was taken to a hospital.

The MLTC ACTIONline received a complaint on an identified date, related to resident #001. The complainant had indicated that the resident was not properly cared for which the resident was transferred to hospital and was found to have an identified injury. The complainant alleged that the improper care was not reported to the facility.

The home had submitted a Critical Incident System (CIS) report to the MLTC, Director indicating an incident had occurred causing injury to resident #001 for which the resident was taken to hospital which resulted in a significant change in the resident's heath status. The CIS further indicated that identified diagnostics where taken and were consistent with an identified injury, and the physician was informed, and the resident was transferred to hospital for further assessment.

An interview was conducted with complainant #101 who stated they visited resident #001 and the resident was found in an identified location of the home and the resident complained of pain on an identified area of the body which was found to be abnormal on assessment. The complainant care was not provided appropriately to the resident. The complainant stated that the resident sustained an identified injury and was later transferred to hospital.

An interview was conducted with Nurse Manager (NM) #109, who indicated that they complete CIS reports and submit them to the MLTC as per legislation requirements. The NM indicated on an identified date, they were informed by Registered Practical Nurse (RPN) #108 that resident #001had an incident during care. The NM and Inspector reviewed the CIS report and the NM acknowledged that the CIS report was submitted late.

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 Director was informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4) when an incident which caused an injury to the resident which resulted in a significant change in the resident's health condition for which the resident was taken to a hospital, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 62. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents' needs. O. Reg. 79/10, s. 62.

Findings/Faits saillants :

The licensee has failed to ensure that there was a written description of the social work and social services work provided in the home and that the work meets the residents' needs.

The MLTC received a complaint through the ACTIONline on an identified date from resident #004. The resident stated that they had requested from a staff member of the home that they wanted to speak to a Social Worker (SW). The staff had indicated they would look into it and was informed there was no SW in the home.

An interview was carried out with resident #004 who stated that they wanted to speak to an SW related to their concerns which was private. The resident stated that they were informed there was no SW and stated that they didn't tell anyone about their concerns and does not recall who they nurse was they spoke too.

Interviews were conducted with the home's QCM #121 and NM #109. The QCM and NM stated that the home did have a Social Worker (SW) in the past but does not have a SW in the home anymore. The staff stated if a resident wants to speak to a SW the nurses on the unit will speak to the resident, or the NM or the Director of Care (DOC). The staff stated that the home does not have a written description of the social work and social services work provided in the home which meets the residents as as per legislation.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

The licensee has failed to ensure that documented records were kept in the home which included the date the complaint was received.

The MLTC received a complaint though the ACTIONline on an identified date and the complaint had indicated the resident was in an identified location of the home when another resident was aggressive towards them. The complainant stated that they spoke to the previous Director of Care (DOC)#120 and voiced further concern as the complainant was not contacted and informed as to when the incident had originally occurred and if the resident was assessed, and DOC #120 had indicated that they would contact the complainant which did not occur.

The home's policy "Complaint Procedure-Resident/Family (LTC)", policy #NURS III-17, with an effective date of August 2018, under the "Responsibility" it states that the complaint is to be documented on the "Customer Complaint Form" when the person complaining (visitor, family, and/or resident) has unresolved issues and/or feels that someone at a management level needs to be notified about the issues.

DOC #120 was not able to be reached and is not currently employed at the home.

An interview was conducted with the home's QCM #121. The QCM stated that as per the home's policy "Customer Complaint Form", is to be completed to document further concerns from the resident or family and it is to be resolved within ten days. The QCM further stated that the Previous DOC #120 should have completed the "Customer Complaint Form", as the email was addressed to them. The QCM reviewed the complaints binder for an identified period of time and was unable to find a "Customer Complaint Form", completed for complainant #100, related to when the incident had originally occurred. The QCM acknowledged that the "Customer Complaint Form", was not completed as per home's policy.

Issued on this 3rd day of September, 2019

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

Original report signed by the inspector.