Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 1, 2020	2020_829757_0024	002931-20, 008262-20, 009232-20, 014100-20, 016570-20	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

DAVID SCHAEFER (757), CHAD CAMPS (609), JULIE KUORIKOSKI (621), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 21-24, 2020

The following intakes were inspected during this Critical Incident System inspection:
-three intakes related to resident falls that resulted in injuries.
-an intake related to an incident of improper care that resulted in an injury.
-an intake related to a resident injury of unknown cause.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Quality Compliance Manager, Resident Assessment Instrument (RAI) Coordinator/Falls Program Lead, Nurse Practitioner, Physiotherapist, Administrative Assistant, Nurse Managers, Registered Practical Nurses (RPNs), Activation Staff, and Personal Support Workers (PSWs).

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, internal investigation notes, as well as specific licensee policies, procedures, and programs.

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.
1 WN(s)
1 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nurse Practitioner (NP), Physiotherapist, and Falls Program Lead collaborated with each other in the assessment of a resident so that their assessments were integrated, consistent with and complemented each other.

The resident was at risk for falls and had a history of multiple recent falls. The NP assessed the resident and recommended a falls prevention intervention be implemented. The NP denied communicating the recommendation to the Physiotherapist or the Falls Program Lead. The Physiotherapist and Falls Program Lead both indicated that they should have been called, emailed or otherwise notified about the recommendation and denied any awareness of the recommendation. The falls prevention intervention was applied after Inspector #609 notified the Falls Program Lead of the NP's assessment.

Sources: Resident's care plan, progress notes, and post fall assessments; NP's assessment; Inspector #609's observations; and interviews with the NP, Physiotherapist, Falls Program Lead and other relevant staff members. [s. 6. (4) (a)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care related to falls prevention was reviewed and revised when the care set out in the plan had not been effective.

The resident was at risk for falls and had a fall in February 2020. The resident’s plan of care indicated that they used a mobility device and that staff were to ensure the resident used this device properly. Inspector #609 observed the resident ambulate to their room without the use of the mobility device. The mobility device was observed in the resident’s bathroom. No staff were observed providing the resident their mobility device, or encouraging them to use it. The resident, Personal Support Worker (PSW) #104 and Registered Practical Nurse (RPN) #105 all verified that the resident did not use the mobility device for short distances, such as coming and going from their room to the dining room. The Falls Program Lead verified that encouraging the resident to use their mobility device for short distances was an ineffective intervention and updated their plan of care at the time of the inspection to include that staff were to offer stand-by assistance when the resident was walking to the dining room.

Sources: Resident's plan of care; Inspector #609’s observations; and interviews with the resident, PSW #104, RPN #105, and the Falls Program Lead. [s. 6. (10) (c)]

3. The licensee has failed to ensure that a resident was reassessed and the plan of care related to falls prevention was reviewed and revised when the care set out in the plan had not been effective.

The resident was at risk for falls and had a history of multiple recent falls. After a recent fall, the resident was transferred to the hospital and diagnosed with an injury. The resident’s plan of care indicated that staff were to encourage the resident to call for staff for assistance with mobility, encourage the use of assistive devices properly and reinforce the need to call for assistance. Inspector #609 observed the resident transfer without assistance from staff. The resident did not call for assistance, nor was there a call bell within reach for them to call for assistance. PSW #117 indicated that the resident would not call for assistance and would self-transfer. RPN #116 described how the resident would self-transfer without calling for assistance. The Falls Program Lead reviewed the resident’s falls history and verified that the interventions were ineffective, that no new interventions had been trialed since July 2020, and that the resident continued to fall.

Sources: Resident's plan of care, progress notes, and post fall assessments; Inspector #609’s observations; and interviews with PSW #117, RPN #116, the Falls Program Lead and other relevant staff. [s. 6. (10) (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 staff and others involved in the different aspects of a resident's care collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and ensure that residents are reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

Issued on this 6th day of October, 2020

[redacted]

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

Original report signed by the inspector.