Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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
Jul 23, 2021	2021_882760_0026	003139-21, 003370-21, 010144-21	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

JACK SHI (760)

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): July 13, 14, 15, 16, 19, 20, 21, 22, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to an allegation of improper care;
Two logs were related to a fall.

Inspector #746 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Nurse Managers, Quality Compliance Manager, the Behavioural Support Ontario Registered Practical Nurse (BSO RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and the Director of Care (DOC).

During the course of the inspection, the inspector observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's written plan of care identified all current fall prevention strategies that was in place.

An interview with an RPN indicated that a new fall prevention intervention was implemented for the resident after they sustained a fall. Observations and interviews with another RPN and PSW confirmed that the resident used this fall prevention intervention. A review of the resident's written plan of care did not indicate the use of this fall prevention intervention. The DOC confirmed that this fall prevention intervention was not documented in the resident's written plan of care. Failure to document this fall prevention intervention in the residents written plan of care may result in unclear directions to the staff.

Sources: A resident's progress notes, written care plan; observations in resident room; Two RPNs, a PSW, the DOC and other staff. [s. 6. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a post fall assessment was completed after a resident fell.

A review of the resident's progress notes indicated that the resident sustained a fall. A review of the post fall assessment in risk management indicated that a pain assessment was not completed by an RPN. According to the home's "Falls Prevention and Management" policy, after a fall occurs, staff are responsible to complete a Risk Management Incident Report including conducting a pain assessment. The DOC indicated that the home's expectation is for all sections of the risk management to be completed as per the home's post fall assessment tool. The DOC confirmed that the post fall assessment tool was not completed for the resident, after their fall.

Sources: A resident's progress notes, risk management, Falls Prevention and Management Policy (dated January 17, 2020); Interviews with the DOC and other staff. [s. 49. (2)]

Issued on this 23rd day of July, 2021

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

Original report signed by the inspector.