Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 8, 9, 13, 14, 2012	2012_031194_0037	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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC),Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Physio Therapist Assistant, Physician,three residents and Substitute Decision Maker (SDM) for resident #001,

During the course of the inspection, the inspector(s) observed resident # 001 and #002,reviewed the clinical health records, relevant policies, 24 hour report and documentation of investigation

No Inspection Protocols utilized during this inspection. Inspector used Ad-Hoc notes only.

The following Inspection Protocols were used during this inspection:

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg 79/10 s.6(1)(c) when the written plan of care for resident #001 did not provide clear directions to staff and others who provide direct care, that the SDM was to be notified 24/7 if there was a change of condition.

A meeting was held with SDM stating that SDM was to be called 24/7 with any change in condition for resident # 001.

A change in condition for resident #001 was charted on the night shift and SDM was not notified until the evening shift of the same day.

The SDM was not notified of the change in condition for resident # 001, until 15 hours after it was noted by staff.
2. The licensee failed to comply with O.Reg 79/10 s.6(5) when the resident's substitute decision-maker, was not given an opportunity to participate fully in the development and implementation of the resident's plan of care following a change in condition.

On an identified evening shift it is reported on the manager's report (24 hour report)that resident # 001 had a change in condition. The SDM specified in the resident's clinical health record was not notified. DOC has confirmed that a call was placed to the secondary contact specified in the resident's clinical health record in error.

The SDM was not provided the opportunity to participate in the development of resident #001's plan of care, because SDM was not made aware of the change of condition for five days.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.112 when two commode chairs were noted in the home with restraints attached.

Two rooms were noted by inspector to have commode chairs in the rooms with a restraint belt attached.

RN notified and restraint belts were immediately removed from the commode chairs.

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 by ensuring that no device is used to restrain a resident to a commode or toilet, to be implemented voluntarily.

Issued on this 14th day of August, 2012

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

Chantal Lafreniere (194)