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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 4, 2013	2013_184124_0018	O-000462-13	Follow up

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 27, 28, 29, 30, 2013

A follow up inspection was conducted related to the two Compliance Orders issued as part of inspection 2013_220111_004.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, Nurse Managers, Social Worker, Registered Nurse, Registered Practical Nurses and Personal Support Workers.

During the course of the inspection, the inspector(s) completed walking tours of the second and third floor, observed staff-resident interactions, made general observations of resident care, reviewed resident health records and the home's "Pain Assessment and Management Policy", "Palliative Care Policy"

The following Inspection Protocols were used during this inspection:
Hospitalization and Death

Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 42 in that the resident did not receive pain management at end-of-life that met the resident's needs as demonstrated by the following findings.

Resident #6 had a palliative diagnosis and was admitted to the home a number of months ago. The Director of Care reported to the inspector that Resident #6 was considered palliative at the time of admission.

As per the physician's orders,Resident #6's pain management regime included three analgesics.

A review of the progress notes for the deceased Resident #6 indicated:

-on a specific day, Resident #6's Power of Attorney (POA) reported that the resident was having severe,generalized pain and that the resident required fast acting medication. One hour and twenty minutes later, Resident #6 was resting quietly. Two hours after the pain medication was administered Resident #6 continued to have pain, so the resident received another dose of medication. One and a half hours after this dose, Resident #6 continued to have pain, no medication was administered and two hours after receiving the medication the resident was sleeping.

- Four days later, Resident #6 complained of severe, generalized pain and the resident received medication that had fair effect. Two and one half hours after the medication, Resident #6 was still complaining of pain. The resident received a different medication, the nurse stayed with the resident and Resident #6 settled and slept. Two and a half hours later, Resident #6 was awake and asking for something for pain.

-Two days after this, Resident #6 was in pain and the resident received medication. One and a half hours later, Resident #6 rang the call bell and complained of pain. The one medication was not yet due, so Resident #6 was given a different medication with fair effect. Resident #6 settled temporarily and was still wide awake. Four hours later, Resident #6 was moaning and asked for fast relief, so the resident was given medication, the resident settled and slept.

-The next day, Resident #6 received four doses of medication. At that point, Resident #6 was described as refusing care. Resident #6's POA was called and came to visit

the resident, Resident #6 then accepted care and slept.

-The following day, Resident #6 requested medication for pain, received the medication and it is documented that the pain eased eventually. Later that afternoon, Resident #6 described the pain as excruciating and all over and the resident received medication again. Two and a half hours later, Resident #6 reported generalized, excruciating pain and medication was given. Less than one hour later, staff was alerted that the resident was in severe pain and the medication was administered again. The third dose of this medication was assessed as having had good effect.

-The next day, Resident #6 was moaning, complaining of severe pain all over, medication was administered. Three and a half hours later, Resident #6 was checked and complained of severe pain, so the medication was again administered. During the day, Resident #6 received two doses of medication and the medication was effective. Three hours later Resident #6 began to have other symptoms and treatment was implemented. Less than an hour later, Resident #6's POA reported that the resident was in severe pain and required medication. The resident received three doses of medication over a four hour period. Fifteen minutes after the last dose of medication, Resident #6's POA rang the call bell to report that the resident was in severe pain.

Staff #111 reported to the inspector that within twenty minutes of the resident receiving the third dose of medication, Resident #6 and the POA were upset and Resident #6 was visibly in pain. Staff #111 contacted the physician who prescribed one additional dose of medication immediately and the medication was administered shortly afterward.

- Two hours and fifteen minutes later, Resident #6 was moaning and medication was administered. Fifty minutes after the medication was administered, the resident was quite comfortable. Less than two hours after the medication, the resident was noted to be moaning, and medication was administered. Three hours and twenty minutes later, Resident #6's POA requested medication for the resident and the medication was administered. Resident #6 died several hours later.

Review of the home's policy "Palliative Care" (NURS V-101) indicated that:

-If the resident is in pain, complete pain assessment and initiate pain flow sheet.

-Follow the pain management guidelines.

The Director of Care stated that the home's Pain Assessment and Management Policy provided the pain management guidelines.

Review of the home's policy "Pain Assessment and Management " (NURS V-102) indicated:

-The inter-disciplinary team will initiate a pain management flow sheet when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions. This initiation is based upon evidence gathered using the Pain Assessment V01 to ensure that those with identified pain are monitored and that pain is brought under control

-The physician will support/guide the development of a plan of care that addresses the identified pain issues and collaborates with the interdisciplinary team members to monitor all intervention outcomes.

There is no documented evidence that Resident #6 was assessed for pain using the Pain Flow Sheets on five occasions when the resident's pain remained regardless of interventions.

On a specified date, the physician documented that the resident was palliative care, no complaints of pain.

Despite Resident #6 repeatedly having excruciating/severe pain on five occasions, there is no clinical documentation to support that the physician was consulted regarding Resident #6's pain or that Resident #6's pain medication was reassessed. The Director of Care confirmed that there was no documented assessment by the physician after the specified date.

(124) [s. 42.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to Resident #6 in accordance with the directions for use specified by the prescriber.

Resident #6 had a palliative diagnosis and a documented history of pain.

On one of the Physician's Order Reviews, Resident #6's physician prescribed medication at a specified time interval.

On a specific date, Resident #6 described the pain as excruciating and all over and the resident received medication. Later, Resident #6 reported generalized, excruciating pain and medication was given. Less than one hour later, staff was alerted that the resident was in severe pain and medication was again administered. The third dose of medication was assessed as having had good effect.

The medication was not administered to Resident #6 in accordance with the directions for use (consistent with the specified time interval. [s. 131. (2)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #002	2013_220111_0004	124

Issued on this 20th day of September, 2013

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

Lynda Hamilton

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2013_184124_0018
Log No. / Registre no:	O-000462-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 4, 2013
Licensee / Titulaire de permis :	SHEPHERD VILLAGE INC. 3758/3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
LTC Home / Foyer de SLD :	SHEPHERD LODGE 3760 Sheppard Avenue East, TORONTO, ON, M1T-3K9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BROCK HALL

To SHEPHERD VILLAGE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_220111_0004, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents who are at end of life/palliative receive pain management that meets their needs and in accordance with the home's Palliative Care and Pain Assessment and Management policies. The plan will identify the strategies:
-to provide education and re-education to all registered staff on the home's policies and procedures related to palliative care and pain management, with an emphasis on pain assessment, monitoring the effectiveness of the residents' pain management, and the steps to take when the residents' pain remains regardless of interventions,
-to ensure that staff demonstrate their ability to competently and consistently follow the policies and procedures of the home.

This plan is to be submitted in writing by September 19, 2013 to LTCH Inspector, Lynda Hamilton at 347 Preston Street, 4th Floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670.

Grounds / Motifs :

1. This non-compliance was previously issued as a Compliance Order on May 13, 2013 as part of inspection 2013_220111_0004 with a compliance date of June 7, 2013. The Compliance Order directed the licensee to ensure that all current residents who are at end of life/palliative receive end of life care provided to them in a manner that meets their needs and in accordance with the home's end of life/palliative care policy.

The licensee failed to comply with O. Reg. 79/10, s. 42 in that the resident did not receive pain management at end-of-life that met the resident's needs as demonstrated by the following findings.

Resident #6 had a palliative diagnosis and was admitted to the home a number of months ago. The Director of Care reported to the inspector that Resident #6 was considered palliative at the time of admission.

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-The next day, Resident #6 received four doses of medication. At that point, Resident #6 was described as refusing care. Resident #6's POA was called and came to visit the resident, Resident #6 then accepted care and slept.

-The following day, Resident #6 requested medication for pain, received the medication and it is documented that the pain eased eventually. Later that afternoon, Resident #6 described the pain as excruciating and all over and the resident received medication again. Two and a half hours later, Resident #6 reported generalized, excruciating pain and medication was given. Less than one hour later, staff was alerted that the resident was in severe pain and the medication was administered again. The third dose of this medication was assessed as having had good effect.

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(124) [s. 42.]

(124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 15, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Lynda Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

Service Area Office / Bureau régional de services : Ottawa Service Area Office