Ontario

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 31, 2014	2014_293554_0001	000846	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

KELLY BURNS (554), MARIA FRANCIS-ALLEN (552)

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): January 7, 2014

Follow-Up Inspection was completed for Log #000846-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Nurse Manager, Registered Staff, and Personal Support Worker(PSW)

During the course of the inspection, the inspector(s) Reviewed clinical health records, pain assessment monitoring binders, Pain and Palliative Inter-disciplinary Meeting Minutes, training records of nursing staff relating to 'End of Life Care', discussed the auditing process for monitoring and completion of pain assessments and pain management flow records. Reviewed the home's policies relating to: Pain Assessment and Management, Palliative Care, Hypodermoclysis.

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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:

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).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. Related to log #000846 - Resident #002

The licensee failed to ensure that there was a written plan of care for the resident that sets out,
(a) the planned care for the resident
(b) the goals the care is intended to achieve

The review of progress notes for Resident #002, for the specific time period, indicated the resident's condition had deteriorated during the time period reviewed.

Review of the written plan of care for Resident #002 had no documented evidence related to the resident's change in condition and did not reflect the palliative/end of life care needs of the resident, for the time period reviewed.

Review of the Advanced Directives indicated the level was not changed to a level 1, despite the progress notes indicating the POA requested the level be changed to a level 2, and then to be changed to level 1. [s. 6. (1)]

2. Related to Log #000846 – Resident #001

The Licensee failed to ensure that the care set out in the plan of care was provided to

the Resident #001 as specified in the plan.

A clinical record review, for the period reviewed, identified that the physician had visited the home and changed Resident #001's orders for blood work.

Progress notes demonstrate that registered nursing staff were performing blood testing on Resident #001 outside of the parameters identified by the physicians orders. Blood testing was completed in excess of the planned care for Resident #001.

The written care plan, for the period reviwed, did not reflect changes to Resident #001's plan of care as directed by the physician; interventions in the care plan identified that blood testing/monitoring was to be done monthly during the morning of the 1st and 16th of each month. [s. 6. (7)]

3. Related to Log #000846 - Resident #001

The Licensee failed to ensure that the provision of care was documented.

The written care plan(s) reviewed, for the period reviewed, indicated that Resident #001 could not turn in bed without assistance. The care plan identified that the planned intervention, for this resident, was 'turn and repositioned in bed, every two (2) hours'.

The 'Resident Turning and Position Monitoring' form for the dates above, demonstrated that the Resident #001 was not consistently provided turning or repositioning every 2 hours as directed by the plan of care. Lack of documentation by direct care staff, for the period reviewed, indicates inconsistency in the provision of care afforded to the resident. [s. 6. (9) 1.]

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 there is a written plan of care for each resident that sets out the planned care and the goals the care is intended to achieve. The Licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and that the provision of care, and that the outcomes / effectiveness of the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Related to Log #000846 – Resident #001

The Licensee failed to ensure that when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument, specifically designed for this purpose.

The home does have a Pain Assessment and Management policy in place which directs registered nursing staff to assess and re-evaluate, using a clinically appropriate assessment instrument, when a resident is experiencing pain.

The home's policy 'Pain Assessment and Management' directs registered staff to complete and document pain using the assessment tools:
-on admission, re-admission
-change in condition with onset of pain
-behaviours exhibited by resident that may herald the onset of pain
-change in condition with onset of pain

-receiving pain medication >72 hours
-distress related behaviours or facial grimace
-resident/family/volunteer indicate pain

The policy above, directs the registered staff to initiate a pain management flow record when a scheduled pain medication does not relieve the pain or when pain remains regardless of the intervention.

A clinical record review, identified that the 'Abbey Pain Assessment' tool was completed once in the month prior, indicating Resident #001 to have "mild pain". Registered nursing staff who completed the assessment did not indicate the location of the resident's pain.

A clinical record review, for the dates reviewed, identified that registered nursing staff noted in progress notes for Resident #001, times when the resident was moaning, restless, having facial grimacing, attempting to or removing applied oxygen therapy and verbally expressing discomfort. Progress notes further indicated times when the family communicated to registered nursing staff that resident appeared to be or was in pain.

There is no indication, in the clinical health record, that registered nursing staff utilized the home's Pain Assessment tools or the Pain Management Flow Record to assess or re-assess Resident #001. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument, specifically designed for this purpose, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. Related to Log#000846 – Resident #001

The Licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Physician's orders reviewed indicated, a treatment was ordered for Resident #001, for a specific time period.

The Quarterly Physician Review, signed and reviewed, do not continue the order for the administration of the treatment.

A clinical health record review, for the period reviewed, identified that registered nursing staff were administering the treatment to Resident #001, three times weekly on Monday, Wednesday and Friday's.

Clinical records indicate that registered nursing staff did communicate via phone with the resident's Attending Physician on the above date and that the Comfort Care Measures for End of Life Care orders form was completed and signed as a telephone order. The Comfort Care Measure for End of Life Care form, did not reflect signed physician's orders for the administration of the treatment for this resident.

Treatment Administration Records indicate that registered nursing staff administered the treatment on on various dates without a physician's order.

The homes policy, #NUMM-V-110 directs the following:
Registered staff are to ensure a written physicians order has been obtained for the administration. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

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. 42.	WN	2013_220111_0004	554
O.Reg 79/10 s. 42.	WN	2013_184124_0018	554
O.Reg 79/10 s. 42.	CO #001	2013_184124_0018	554

Issued on this 31st day of January, 2014

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

Kelly Burns (#554)