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

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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
Jul 11, 2014	2014_274535_0007	T-306-14/T307-14	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

VERON ASH (535)

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): March 28, 31, 2014.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSWs), registered staff, registered nurse float (RN float), nursing manager, director of nursing (DON), and administrator.

During the course of the inspection, the inspector(s) conducted interviews, reviewed policies, health records, and staff training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On September 2, 2013, resident # 001 had an unwitnessed fall and was assessed by the registered staff. The home's falls prevention policy #NURS IV-73 dated March 2014 indicated that staff was to complete a post fall assessment using the designated fall assessment instrument. Health record review and staff interview confirmed that the registered staff did not complete a post fall assessment using the clinically appropriate instrument designed for falls. [s. 49. (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 the completion of a post fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls after witnessed and unwitnessed falls in the home, to be implemented voluntarily.

WN #2: 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is reassessed and the plan of care has not been effective, different approaches are considered in the revision of the plan of care.

Resident # 002 developed a pressure ulcer on the coccyx which was viewed by the registered staff as a possible source of infection when the resident started developing a fever.
Health record review and staff interview confirmed that the resident's temperature was elevated for 2 or more occasions at least 12 hours over a period of four (4) days from January 18 to January 21, 2014 with temperatures ranging from 38.2 to 38.7 degrees Celsius. On February 3, 2014, the resident's body temperature reached 39.1 degrees Celsius. Health record review and an interview with the RN float confirmed that the registered staff continued to treat the resident with Tylenol 325 mg 1-2 tablets every 4 hours and cool compresses even though these strategies were not effectively controlling the resident's increased body temperature. Although the resident's advanced directive listed treatment with antibiotics as an option if warranted, the increased body temperature was not reported to the physician so that a different approach to treatment could be implemented. [s. 6. (11) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the falls prevention and management policy NURS IV-73 was complied with.

On September 2, 2013, resident # 001 had a fall in the home. According to the home's policy, post fall management includes initiating head injury routine, assessing the resident's level of consciousness, investigating any potential injury associated with the fall, notifying the attending physician, completing the fall assessment instrument and a detailed progress note. Health record review and staff interview confirmed that the fall assessment instrument, head injury routine, and notification of the physician and power of attorney were not completed for the fall incident. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff are provided training in falls prevention and management annually.

A review of the staff training records indicated that not all direct care staff completed the training as required for 2013. An interview with the director of nursing confirmed that 19% of direct care staff did not receive the training in falls prevention and management in 2013. [s. 221. (1) 1.]

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Issued on this 11th day of July, 2014

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

Monica Nouri on behalf of Veron Ash.