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_0006	T-436-14	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

VERON ASH (535), JUDITH HART (513)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 3, 4, 7, 2014.

During the course of the inspection, the inspector(s) spoke with personal support workers (PSWs), registered staff, housekeeper, float nurse (RN), nurse manager, director of nursing, and family member or power of attorney (POA).

During the course of the inspection, the inspector(s) observed residents rooms and common areas on the third floor, conducted interviews, reviewed residents records, policies, and staff training records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services

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 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure to that there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident.

The POA for Resident #001 confirmed the resident had two hearing aids prior to March 11, 2011, one was lost and the second one was taken home. Staff stated the POA took the remaining hearing aid home approximately March 11, 2011. On March 11, 2011 the resident's progress note stated the resident's hearing aid was missing. On March 12, 2011 a search was conducted and the hearing aid was not located.

The Care Planning Report, dated January 1, 2014 to March 21, 2014, under the heading Comm/Hearing, stated that the resident "No longer wears a hearing aid (lost)," while under the heading Outcome/Evaluation Date stated, "Resident's hearing aid is accessible, clean, & available for use." The Care Planning Report was not updated, setting out clear directions to staff and others who provide care to resident #001. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

1. Resident # 001's electronic medication record indicated Sennosides (Senokot) tablet 8.6 mg to be administered one tablet by mouth one time a day for indication not provided and to hold if the patient has diarrhea. The registered staff reported that the resident was having loose stools, therefore on March 7, 2013, the physician wrote an order to hold Senokot if the patient has diarrhea. On March 9 and 13, 2013, the registered staff documented that the resident was having multiple loose stools, however health record review indicated that the registered staff continued to administer Sennosides to the resident daily until March 22, 2013.

2. Resident #001's plan of care included a level four advanced directive indicating that the resident was to be transferred to the acute care hospital in case of a medical emergency, following an assessment by the registered staff in collaboration with the physician. On March 22, 2014, resident # 001 had an unwitnessed fall and was assessed by the registered staff and the nurse manager as having pale lips, both hands were cold to touch, bruised right forearm and right knuckles. The resident started crying as an indication of experiencing pain when the registered staff tried to move the right leg. The resident was also exhibiting signs and symptoms of pneumonia.

Record review revealed that the resident's POA was called at home by the charge nurse to be informed of the resident's transfer to the hospital. The POA asked the charge nurse if it was necessary to transfer the resident to hospital, and the charge nurse responded that the POA was the one who makes the decision whether or not to send the resident to hospital. The charge nurse also informed the POA that he/she will continue to monitor the resident closely in the home, and the POA decided to keep the resident in the home, monitor throughout the night and reassess the situation in the morning. At 9:30 p.m. that evening the resident's blood pressure and oxygen saturation decreased below the normal values.

Health record review and staff interviews confirmed that the resident's transfer to hospital was delayed for over four hours and that the resident's condition deteriorated as indicated by a drop in blood pressure to 83/56 and oxygen saturation 88% on room air, and the resident had a decreased level of consciousness. Emergency services were called at that time, and the resident was transferred and admitted to the hospital with pneumonia and low blood pressure.

Interviews with the float RN and nurse manager confirmed that an advance directive

of level four indicated to staff that the resident was to be transferred to hospital after an assessment which indicated there was a change in the resident's condition beyond the scope of the home, and that the POA was to be notified that the resident was being transferred to the hospital, then let the POA decide whether to make a change to the resident's directive at the hospital instead of asking the POA to make the decision whether to transfer the resident to hospital during an acute incident. [s. 6. (7)]

3. The licensee failed to ensure that the plan of was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The POA stated that resident #001 had an upper and lower denture prior to November 29, 2013. Sometimes the resident would not want to wear the dentures or would take them out. The POA and staff state the resident's lower denture was lost November 29, 2013 and could not be found. The inspector observed Resident #001 to wear the upper denture.

The current Care Guide, to which the PSWs refer, under the heading Oral, stated to "Remove dentures at hs/clean & soak overnight." The current Care Planning Report, to which registered staff refers, stated under the heading Oral Hygiene for resident #001, "has upper and lower denture, provide denture care, will sometimes refuse to wear dentures."
The current plan of care for resident #001 indicates the resident has upper and lower dentures.

The Care Guide and Plan of Care was not revised to reflect the change in the resident's care needs or that the care set out in the plan is no longer necessary. [s. 6. (10) (b)]

WN #2: 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 dated March 2014 is complied with by direct care staff.

A review of the home's falls prevention policy indicated that post fall management included initiating and completing a head injury routine and the completion of an incident report. Health record review and interview with the float RN confirmed that both documents were not completed after resident # 001 had a fall on March 22, 2014. An interview with the director of nursing confirmed that both documents were to be completed after each unwitnessed fall and if a resident sustains a head injury after a witnessed fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The Policy and Procedure NURS III-27, for lost and found items effective January 2011 to March 2014 stated under Procedure #5 "Where money or belongings are reported missing/stolen, Registered Staff will complete Lost or Missing Articles Form and post it at the Nursing Station X 1 week. The nurse manager is to be informed who will inform the laundry and or housekeeping staff. All Staff search for the missing item/s. Then the form is given to the DON for follow up action; staff will communicate to resident or family regarding the outcome of the search."

The POA stated that the resident had two hearing aids, one was taken home and the second one was missing in March 2011. The resident's hearing aid was documented as missing on the progress note of March 11, 2011. On March 12, 2011, a search was conducted and the hearing aid was not located. The POA reported the missing hearing aid to staff. The staff and manager responded to the POA that the hearing aid could not be found. Registered staff stated there was no hearing aid, and the staff and DOC were unable to provide the report of Lost or Missing Articles for the resident's hearing aid. The licensee did not ensure that the Policy and Procedure NURS III-27 was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: 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 when a resident has fallen, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

On March 22, 2014, resident # 001 had a fall and was admitted to hospital. Health record review and staff interview confirmed that a post fall assessment using a clinically appropriate assessment instrument was not completed by the registered staff upon discovering that the resident had an unwitnessed fall. [s. 49. (2)]

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 staff who provide direct care to residents received training in falls prevention and management.

A review of staff training record 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 all direct care staff did not receive training in falls prevention and management in 2013. [s. 221. (1) 1.]

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.