Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2021	2021_882760_0027	003333-21, 003334-21, 008772-21, 008838-21, 009716-21	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

JACK SHI (760)

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): July 13, 14, 15, 16, 19, 20, 21, 22, 2021.

The following intakes were completed in this complaints inspection:

A log was related to an incident of abuse;
A log was related to personal support services and an incident of abuse;
A log was related to air temperatures of the home;

A follow up log was related to CO #001, O. Reg 79/10 s. 8 (1) (b), related to nutritional care, issued under inspection # 2021_784762_0001, on February 16, 2021, with a compliance date of May 14, 2021, was inspected;

A follow up log was related to CO #002, O. Reg 79/10 s. 68 (2), related to nutritional care, issued under inspection # 2021_784762_0001, on February 16, 2021, with a compliance date of May 14, 2021, was inspected.

Inspector #746 was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Facility Services, a Registered Dietitian (RD), Nurse Managers, Quality Compliance Manager, Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Associate Director of Care (ADOC) and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, reviewed home's air temperature monitoring logs, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #001	2021_784762_0001	760
O.Reg 79/10 s. 68. (2)	CO #002	2021_784762_0001	760

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	Légende 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was protected from emotional abuse by resident #008.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as “any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.”

A review of the resident’s progress notes indicated that resident #008 made a threatening action towards resident #001. Resident #001 stated they became afraid of resident #008 after the incident had occurred. Two staff intervened and also heard resident #008 make threatening remarks to resident #001. The DOC confirmed that resident #001 was emotionally abused by resident #008 in this incident. Failure to protect resident #001 from emotional abuse resulted in them being emotionally harmed and frightened by resident #008.

Sources: Resident #001’s progress notes; Interviews with resident #001, the DOC and other staff. [s. 19. (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 to protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that three PSWs and an RPN participated in the home's infection prevention and control (IPAC) program.

The following observations were carried throughout the home:

- A PSW was seen without their mask covering their nose while they were in a resident unit hallway. The QCM stated that the expectation was to have the mask cover the nose when it is worn under the home's universal masking policies.
- A PSW was observed wearing gloves on one of their hands, while their other hand did not have any gloves on. The PSW was observed doing this while in the hallways of a resident unit. The QCM stated the home's IPAC policies indicate that resident unit hallways are a clean area and gloves should not be worn.
- An RPN was seen giving medications to residents and their face shield was worn over their forehead and was not covering their eyes. The RPN was also observed giving medications to a resident and not performing hand hygiene before and afterwards. The QCM stated that the RPN should have had their face shield worn properly, covering their eyes and also perform hand hygiene before and after giving medications to a resident.
- A PSW was observed to have their surgical mask under their chin while they were in a kitchenette area. Two staff members were present beside the PSW. The PSW stated they removed their mask in order to have a drink of water. The DOC stated that staff should be drinking water in an area where there is no other person around.

The observations demonstrated that there were inconsistent IPAC practices performed by the staff of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents.

Sources: Interviews with the QCM, the DOC and other staff; Observations made during the inspection. [s. 229. (4)]

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 all staff participate in the implementation of the program., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperatures were documented in writing on one resident common area on every floor of the home.

Shepherd Lodge is a long-term care home with six floors of resident units. A review of the home's air temperature logs indicated that the air temperatures were being monitored in four different resident unit floors, four times daily. The Director of Facility Services (DFS) stated that the home was not clear with the requirements under the legislation as it pertained to recording the air temperatures in the common areas of resident units. Failure to monitor the air temperatures in the common areas on every resident unit floor may result in uncomfortable temperatures for residents.

Sources: Review of the home's air temperature logs; Interview with DFS #122. [s. 21. (2) 2.]

Issued on this 23rd day of July, 2021

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

Original report signed by the inspector.