

**Ministry of Long-Term Care**  
Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central East District**  
33 King Street West, 4th Floor  
Oshawa, ON, L1H 1A1  
Telephone: (844) 231-5702

## Amended Public Report Cover Sheet (A1)

<b>Amended Report Issue Date:</b> July 10, 2023	
<b>Original Report Issue Date:</b> June 20, 2023	
<b>Inspection Number:</b> 2023-1273-0003 (A1)	
<b>Inspection Type:</b> Complaint Critical Incident System	
<b>Licensee:</b> Shepherd Village Inc.	
<b>Long Term Care Home and City:</b> Shepherd Lodge, Toronto	
<b>Amended By</b> Deborah Nazareth (741745)	<b>Inspector who Amended Digital Signature</b> Deborah Nazareth (741745)

## AMENDED INSPECTION SUMMARY

This report has been amended to:  
Adjust finding in NC #001.

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<b>Long Term Care Home and City:</b> Shepherd Lodge, Toronto	
<b>Lead Inspector</b> Deborah Nazareth (741745)	<b>Additional Inspector(s)</b> Fatemeh Heydarimoghari (742649) Lisa Salonen Mackay (000761) Manish Patel (740841)
<b>Amended By</b> Deborah Nazareth (741745)	<b>Inspector who Amended Digital Signature</b>

## AMENDED INSPECTION SUMMARY

This report has been amended to:  
Adjust finding in NC #001.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 6-9, 12-15, 2023.

The following intake(s) were completed in this complaint inspection:

- One intake related to fall prevention and responsive behaviours.
- One intake related to alleged abuse and neglect.

The following intakes were completed in this Critical Incident (CI) inspection:

- One intake related to resident to resident abuse

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- Two intakes related to staff to resident abuse.
- Two intakes related to an injury with a significant change in condition.
- One intake related to fall prevention and management.

The following intakes were completed in this inspection: Two intakes related to falls.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services  
Skin and Wound Prevention and Management  
Infection Prevention and Control  
Responsive Behaviours  
Prevention of Abuse and Neglect  
Falls Prevention and Management

## AMENDED INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting certain matters to Director

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) 2.

The licensee has failed to ensure that alleged resident to resident abuse was reported immediately to the Director.

#### Rationale and Summary

The Long-Term Care Home (LTCH) submitted a Critical Incident Report (CIR) regarding alleged abuse between two residents that was not immediately reported to the Director.

The CIR indicated on the day of the incident Registered Practical Nurse (RPN) #103 informed the nurse manager of the incident of alleged abuse. Assistant Director of Care (ADOC) #112 and Director of Care (DOC) confirmed the nurse manager should have reported the incident immediately to the Ministry of Long-Term Care (MLTC).

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**Sources:**

Residents' progress notes, the home's investigation notes, CIR, interviews with RPN #103, ADOC #112 and DOC. [000761]

## WRITTEN NOTIFICATION: Skin and wound care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident's altered skin integrity was reassessed at least weekly by a member of the registered nursing staff.

### Rationale and Summary

A resident was identified with areas of altered skin integrity. Their clinical record indicated weekly assessments were not completed for a period of six weeks between April and June 2022.

RPN #120 confirmed residents with altered skin integrity are to have their wound reassessed at least weekly and acknowledged they did not complete one of the weekly assessments for the resident. ADOC #112 acknowledged weekly reassessments of the resident's altered skin integrity should have been completed between April and June 2022.

When the weekly reassessment of the resident's altered skin integrity was not completed there was risk for delayed treatment and wound healing.

**Sources:**

Resident's progress notes and clinical record. Interviews with RPN #120, ADOC #112 and others. [741745]