Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: December 19, 2023	
Inspection Number: 2023-1273-0004	
Inspection Type: Critical Incident	
Licensee: Shepherd Village Inc.	
Long Term Care Home and City: Shepherd Lodge, Toronto	
Lead Inspector Fatemeh Heydarimoghari (742649)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 14, 15, 2023
The following intake(s) were inspected:

- One Intake related to Improper care
- One Intake related to Fall

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

WRITTEN NOTIFICATION: Safe Transferring and Techniques

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

Non-compliance with O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring techniques when assisting a resident.

Rationale and Summary:

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC), indicating a resident slid from a device by Personal Support Worker (PSW) #104.

The resident's care plan indicated that the resident needs extensive assistance and a transfer device for care.

The home's internal investigation indicated PSW #104 used the device alone as they could not find other staff to help. Also, a resident confirmed they slid down from the device during the transfer and sustained injury.

PSW# 104 acknowledged that they used the device by themselves without another staff during the incident.

Assistant Director of Care (ADOC) #103 confirmed that PSW #104 admitted that they did not follow the home's policy for safe transferring, and they were re-educated on the safe transferring policy.

Failure to use proper techniques to transfer puts residents at risk for injuries.

Sources: The home's investigation notes, CIR, resident clinical record, Policy NURS-14-12-Mechanical lifts, and interviews with staff. [742649]