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
Oct 27, 2021	2021_598570_0019	003859-21, 012188-21, 014050-21, 014725-21	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

SAMI JAROUR (570)

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): September 21-24, 27-29, October 1, 4 -6, 13-15, 2021

The following intakes were inspected during this Critical Incident System (CIS) and Follow up Inspection:
- Log # 003859-21 related follow-up to CO#002 from inspection #2021_595110_0001 (A2) regarding s. 8. (1), with CDD July 31, 2021(A2).
- Log # 012188-21, CIS report, related to a fall.
- Log # 014725-21, CIS report, related to a fall.
- Log # 014050-21, CIS report, related to allegation of neglect.

A Complaint inspection #2021_598570_0020 was conducted concurrently with this Critical Incident System inspection.

NOTE: Findings of noncompliance related to section s.6. (7) and s.24. (1) of the LTCHA, 2007, identified in this CIS inspection were issued in Complaint inspection #2021_598570_0020 conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Quality and Compliance Manager (QCM), Nurse Practitioner (NP), Registered Dietician (RD), Facility Department Coordinator, Nurse Manager (NM), IPAC Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Worker (SW), Housekeeper, Physiotherapist (PT), Physiotherapy Assistant (PTA), Dietary Aide, Family members and residents.

During the course of the inspection, the inspector(s) toured residents home areas, conducted observations, reviewed clinical records and reviewed investigation notes and relevant policies.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 8. (1)	CO #002	2021_595110_0001	570

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with.

The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) regarding alleged neglect of residents #006 and #007.

The home's policy with subject "Zero Tolerance of Abuse and Neglect" stated under procedures: Any incident of abuse must be reported immediately to the Director (MOHLTC), a Manager, and the Director of Care and the DCCS.

Interview with PSW #118, indicated that on one occasion, PSW #108 threw away nutritional supplement for residents #006 and #007. PSW #118 indicated they also witnessed PSW #108 being disrespectful when talking to resident #008 and that they felt sorry for the way PSW #108 was treating resident #008. PSW #118 indicated they did not report the two incidents and that they should have immediately reported those incidents.

Interviews with Nurse Manager (NM) #125 and Quality and Compliance Manager (QCM) #102 and the DOC indicated that PSW #118 did not immediately report the allegations of neglect and abuse as directed by the home's policy of "Zero Tolerance of Abuse and Neglect".

Sources: The home's "Zero Tolerance of Abuse and Neglect"; CIS report; investigation notes; and interview with PSW #118, NM #125, Quality and Compliance Manager and the DOC. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

RPN #105 was observed handing a family member a medication to be administered to resident #005 in their room.

Interview with RPN #105 indicated they would observe the family member when giving the medication to the resident as the resident would not take it from them. The RPN acknowledged they made a mistake by not observing the medication being administered to the resident.

Sources: Observation and interview with RPN #105. [s. 131. (3)]

Issued on this 1st day of November, 2021

[redacted]

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

Original report signed by the inspector.