Ontario

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

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

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Original Public Report

Report Issue Date: December 16, 2022

Inspection Number: 2022-1273-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Shepherd Village Inc.

Long Term Care Home and City: Shepherd Lodge, Toronto

Lead Inspector	**Inspector Digital Signature**
Deborah Nazareth (741745)	Deborah A Nazareth Digitally signed by Deborah A Nazareth Date: 2022.12.16 10:53:06 -05'00'

Additional Inspector(s)
Catherine Ochnik (704957)
Reethamol Sebastian (741747)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 16-18, 21-25, and 28-30, 2022

The following intake(s) were inspected:

- Intake: #00004499 - Follow-up to Compliance Order (CO)#001 from inspection #2022_595110_0007 related to menu planning.
- Intake: #00001058 - related to failure/breakdown of major system.
- Intake: #00001365 - related to staff to resident abuse.
- Intake: #00002971 - related to improper care of a resident.
- Intake: #00006786 - related to unexpected death.
- Intake: #00010759 - related to fall and injury of a resident.
- Intake: #00011438 - related to medication incident/adverse reaction.
- Intake: #00003921 - Complaint related to plan of care and discharge.
- Intake: #00001136 - Complaint related to fall prevention and management and plan of care.
- Intake: #00012638 - Complaint related to plan of care/bed rail.

The following intakes were completed in this inspection: Intake #00006257, CI#2782-000032-22, Intake #00006323, CI#2782-000004-22, Intake #00006114, CI#2782-000026-21, Intake #00003941, CI#2782-000021-21, Intake #00005548, CI#2782-000030-22, Intake #00001687, CI#2782-000031-22, Intake #00002968, CI#2782-000016-21, and Intake #00004430, CI#2782-000029-22 were related to falls.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

- Order #001 from Inspection #2022_595110_0007 related to O. Reg. 79/10, s. 71. (1), inspected by Catherine Ochnik (704957).

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

Resident Care and Support Services
Infection Prevention and Control
Medication Management
Housekeeping, Laundry and Maintenance Services
Restraints/Personal Assistance Services Devices (PASD) Management
Prevention of Abuse and Neglect
Food, Nutrition and Hydration
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 9.1 (d)

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the Infection Prevention and Control program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the licensee did not ensure that all staff participated in the implementation of the IPAC program related to proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal as required by Additional Requirement 9.1 Routine Practices (d) under the IPAC Standard.

During this inspection the home was in outbreak. On November 16, 2022, Personal Support Worker (PSW) #123 exited a resident's room who was on isolation precautions but did not doff their gown, face shield or mask. The PSW then walked down the hall to speak with another staff member while wearing their soiled PPE. The IPAC lead confirmed that the staff should have doffed their soiled PPE prior to leaving the resident's room. Additionally, PSW #103 provided care to a resident who was on isolation precautions. The PSW was wearing two masks, an N-95 respirator with a surgical mask underneath. The IPAC lead verified that a surgical mask should not be worn under an N-95 respirator.

During the inspection, multiple staff were observed with their mask below their nose or chin with others present in the surrounding. The IPAC lead and Associate Director of Care (ADOC) #128 confirmed that universal masking was in place and staff were expected to don a mask upon entering the building, and masks must cover the nose and mouth.

Failure to ensure that staff participated in the implementation of the IPAC program related to proper use of PPE may have led to further transmission of disease, which included Covid-19.

Sources: Observations in lobby, administrative area, kitchen, second and third floors. Interviews with IPAC lead, ADOC #128 and others. Home's policies: N-95 Respirator Fit Testing – Use and Care of N95 Respirators. Policy No.: F-20, effective date: May 9, 2022, and Personal Protective Equipment, Policy No.: F-15, effective date May 9, 2022. [741745]

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s. 102 (2) (b), IPAC Standard section 10.1

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and Summary

In accordance with Additional Requirement 10.1 under the IPAC Standard the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

During the inspection, multiple bottles of hand sanitizer were observed in use throughout the home with expiration dates of August and September 2022. These expired ABHRs were observed in nursing stations, medication carts, dining rooms, hallways, and common areas.

The IPAC lead confirmed that expired ABHR should not have been in use in the home as it would not be as effective for hand hygiene. By the home not ensuring that expired ABHR is not used, there was risk of ineffective hand hygiene and potential risk for spreading infectious agents, including Covid-19.

Sources: Observations of resident home areas and common areas, interview with IPAC lead. [741745]