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

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

Public Report

Report Issue Date: February 7, 2025
Inspection Number: 2025-1273-0001
Inspection Type: Critical Incident
Licensee: Shepherd Village Inc.
Long Term Care Home and City: Shepherd Lodge, Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3, to 6, 2025

The following intake(s) were inspected:

- An intake related to infection prevention and control (IPAC)

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with Additional Requirement (9.1b) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September 2023), the licensee has failed to ensure that additional precautions were followed in the IPAC program when an Registered Practical Nurse failed to perform hand hygiene after they doffed their gloves.

Sources: Observation, policy on hand hygiene, interview with the Assistant Director of Care.

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the home's medication management system policies when
1) During an observation a resident had taken two of their prescribed AM medications at lunchtime. The Electronic Medication Administration Record (EMAR) when reviewed, indicated that the resident had already taken all of their AM medications.
2) Residents were observed seated in the dining room with their medications on the

dining table.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the medication management system were complied with. Specifically, the home's policy on medication administration indicated that all medications administered must be signed off electronically as given by the registered staff as soon as the medications have been given based following CNO medication administration rights and home policies, which did not occur.

Sources: Clinical records, observations, medication administration policy, interview with an RPN and the ADOC.

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber when a resident had AM medications at lunchtime.

Sources: Clinical records, observations, medication administration policy, interviews with an RPN and the ADOC.

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