



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 5, 2013	2013_220111_0005	000836 001037	Complaint

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 5 & 6, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), two Registered Nurses(RN), a Personal Support Worker (PSW), a family member and two residents.

During the course of the inspection, the inspector(s) observed two residents, reviewed the health record of two residents, reviewed the homes investigation, and reviewed the homes policies Prevention of Abuse and Complaints.

The following Inspection Protocols were used during this inspection:



Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 23. Licensee must investigate, respond and act



Specifically failed to comply with the following:

- s. 23. (1) Every licensee of a long-term care home shall ensure that,
- (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
 - (i) abuse of a resident by anyone,
 - (ii) neglect of a resident by the licensee or staff, or
 - (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
 - (b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
 - (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).
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Findings/Faits saillants :

1. Related to log 000836-12:

A complaint letter was received by the home to report a witnessed incident of staff to resident verbal abuse. The Director was notified of the complaint via a Critical Incident (CI) report.

Review of the complaint letter, the homes investigation and interview of the DOC confirmed the incident of staff to resident verbal abuse occurred 5 days prior to when the home initiated an investigation and responded.

The licensee failed to ensure that when the long-term care home was notified of a witnessed incident of staff to resident verbal abuse, the incident was immediately investigated and appropriate action was taken.[S.23(1)(a)(i),(b)] [s. 23. (1) (a)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director



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Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

Findings/Faits saillants :

1. Related to log 000836-12:

A critical incident(CI) report was received for an incident of staff to resident verbal abuse. The CI indicated that the allegation was made via a written complaint letter.

Review of the complaint letter indicated the incident occurred 5 days prior to the Director being notified.

The licensee failed to ensure that when a person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident, was immediately reported to the Director.[S.24(1)2.] [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents



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Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to log 000836-12:

Review of the homes investigation indicated that when the home concluded their investigation, a written response was not provided to the complainant for a period of approximately one month.

The licensee failed to ensure that the resident, and the resident's substitute decision-maker, if any, was notified of the results of the investigation immediately upon the completion of the investigation. [s. 97. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :



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1. Related to log 000836-12:

A written complaint letter was received by the home regarding an incident of witnessed staff to resident verbal abuse.

Review of the homes investigation into the allegation of verbal abuse indicated that a written response was not provided to the complainant for a period greater than 10 days.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was provided with a response within 10 business days of the receipt of the complaint. [s. 101. (1) 1.]

Issued on this 5th day of April, 2013

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

A handwritten signature in black ink, appearing to read "J. Brack", written within a rectangular box.