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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: December 16, 2024
Original Report Issue Date: November 18, 2024
Inspection Number: 2024-1505-0005 (A1)
Inspection Type: Critical Incident
Licensee: Shalom Manor Long Term Care Home
Long Term Care Home and City: Shalom Manor Long Term Care Home, Grimsby

AMENDED INSPECTION SUMMARY

This report has been amended to:
Written Notification (WN) #002 was amended to correct the risk statement wording. The LR was served to the home November 18, 2024. There is a compliance order listed in the report, however there were no amendments made to the order.

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22, 24, 25, and October 28-30, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00117853/CI #3009-000007-24- related to the prevention of abuse and neglect.
- Intake #00120338/CI #3009-000010-24- related to the prevention of abuse and neglect.

- Intake #00122712/CI #3009-000014-24- related to resident care and support services.
- Intake #00125248/CI #3009-000017-24- related to resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

Rationale and Summary
A resident had recurrent responsive behaviours towards staff, co-residents, and visitors.

The home's policy titled "Responsive Behaviours" indicated that each resident demonstrating responsive behaviours would have written identification of behavioural triggers. A resident's triggers for their responsive behaviours were not documented in their written plan of care.

The Director of Care (DOC) acknowledged that not all direct care staff had access to one area of the resident's plan of care and that the triggers for the resident's responsive behaviors should have been included in their written plan of care to help direct the resident's care.

During the inspection, the written triggers were added to the written plan of care.

Sources: Interview with DOC; resident clinical records; the home's policy titled "Shalom Manors Responsive Behaviours Program", revised March 11, 2024.

Date Remedy Implemented: October 25, 2024

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan related to transferring.

Rationale and Summary
A resident's plan of care indicated that they required assistance from multiple staff to move from one surface to another.

Staff explained that on a date, they transferred the resident independently from one surface to another and then to the bathroom. After the transfer, the resident self-transferred fell, and sustained injury.

Staff stated that other staff had been transferring the resident independently for awhile, even though the plan of care had not changed. This was also confirmed by the DOC.

Not following the plan of care for transferring put the resident at risk for injury.

Sources: Resident clinical records; interview with staff and DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary

On a specified date, a resident was assisted by a staff member using a device without a specific accessory in place. The home's online FLTC Act Part 2 Mandatory Training Course from 2023 indicated while on the home area, any time someone assists a resident, the accessory must be in place on the device.

The home conducted an investigation following the incident. It was concluded that by not using the specific accessory on the device, the staff did not safely assist the resident. The DOC and staff confirmed that the resident did not have the accessory for their device in place at the time of the incident.

Assisting a resident without an accessory in place on their device resulted in injuries to the resident.

Sources: Investigation notes; FLTC Act Part 2 Mandatory Training Course from 2023; resident plan of care; interviews with staff and DOC.

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) Review and revise as needed, a resident's plan of care to ensure there are strategies in place to address responsive behaviors.

2) Complete an audit to evaluate the effectiveness of the responsive behaviour interventions for a resident.
3) The audit should identify the resident and include, but not limited to, the dates of when the audit was completed, the person who conducted the audit, the results of the audit and actions taken. A record of the audit must be kept in the home.

Grounds
A) The licensee failed to ensure that a resident was protected from physical abuse by another resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
On a specified date, a resident pushed another resident, they fell and sustained an injury. The injured resident experienced a significant change to their health status following the incident.

Staff and the DOC acknowledged that physical abuse occurred when a resident used physical force that resulted in injury to another resident.

When the home failed to protect a resident from physical abuse, the resident had a significant change in health status.

Sources: Interviews with staff and DOC; review of resident health records; home's investigative notes; critical incident report.

B) The licensee failed to protect a resident from physical abuse by another resident.

Section 2 of Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
On a specified date, it was documented that a resident pushed another resident resulting in a fall with injury.

The clinical records for both of the resident's confirmed that physical abuse by one resident resulted in an injury to the other resident.

An interview with the DOC and staff, and video footage of the incident, confirmed that a resident pushed another resident to the ground where the resident sustained injury.

Failure to protect a resident from physical abuse by another resident, put the resident at risk for injury.

Sources: Resident clinical records; critical incident report; interviews with DOC and staff.

This order must be complied with by December 23, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.