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 (A2)

Amended Report Issue Date: January 17, 2025
Original Report Issue Date: November 18, 2024
Inspection Number: 2024-1505-0005 (A2)
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:
Compliance Order (CO) #001 was altered and substituted with a Director Order (DR-001), with a served date of January 16, 2025, with a compliance due date of January 30, 2025.

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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.

(A2) Appeal/DREV #: DREV-0037
The following order(s) has been rescinded: CO #001
The following order(s) has been substituted: DO #001

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.