Ontario

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 2, 2015	2015_322156_0017	H-003278-15	Resident Quality Inspection

Licensee/Titulaire de permis

SHALOM VILLAGE NURSING HOME
60 MACKLIN STREET NORTH HAMILTON ON L8S 3S1

Long-Term Care Home/Foyer de soins de longue durée

SHALOM VILLAGE NURSING HOME
70 MACKLIN STREET NORTH HAMILTON ON L8S 3S1

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

CAROL POLCZ (156), LESLEY EDWARDS (506), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 21, 24, 25, 28, 29, 30, October 1, 2, 6, 7, 2015

This inspection was in relation to H-003278-15
CIS inspections Log #006734-14 (H-001464-14), 004321-15 (H-002191-15), 006341-15 (H-002317-15), 007132-15 (H-002357-15), 010768-15 (H002598-15), 019730-15 (H-003090-15), and 025132-15 (H-003253-15) were completed simulteously with this inspection.

During the course of the inspection, the inspector(s) spoke with CEO, Executive Coach of Resident Care Shalom Village Original (SVO), Executive Coach Director of Care (DOC) Shalom Village Too (SVToo), Executive Coach Shalom Village Apartments Coach for Hospitality, Maintenance Services Coach, Registered Nursing Staff, Wound Care Coordinator, Personal Support Workers (PSWs), Dietary staff, residents, and families.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **7 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_190159_0030	156
O.Reg 79/10 s. 8. (1)	CO #002	2014_190159_0030	156

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the long term care home was a safe and secure environment for its residents.

A) During the initial tour of the home on September 21, 2015, the hairdressing room in the basement was closed due to renovations being completed. The door was left unlocked and there were wires hanging from the ceilings and several cans of paint. The CEO confirmed that the room should have been locked while the room was closed and that resident's did have access this to area.
B) During the initial tour of the home on September 21, 2015, the art room which was accessible to residents in the basement, was left unlocked. Containers of toxic paint and fabric spray which were labelled as poisonous were found in the unlocked cupboards. The CEO confirmed that the cupboards should have been locked.
C) On September 24, 2015, it was noted that resident #009's pull cord cover plate in the resident's bathroom had wires exposed and the edges of the plate was found to be very sharp and jagged. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.
A) The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Resident #201. On on identified date in 2015 resident #201 touched resident #209 inappropriately without consent. Documentation received through a Critical Incident identified interventions to ensure Resident #209 was not touched inappropriately again by Resident #201. Several interventions were also identified to manage Resident #201 behaviours, however they were not identified in the plan of care to direct staff regarding managing the resident's behaviours. This was confirmed by direct care staff and the Director of Care.
B) The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.
Resident #301 fell and and suffered an injury in August, 2015. Upon return from the hospital, the resident had been unable to weight bear and was a two-person transfer for mobility. The plan of care did not provide clear directions to staff and others who provided direct care to the resident as some areas of the plan of care indicated that staff were to encourage the resident to always use their walker with one person supervision, others indicated that staff were to observe the resident's gait for steadiness and balance and others stated that the resident was dependent in the wheelchair. The DOC confirmed on October 6, 2015 that the plan of care did not provide clear direction to staff regarding the resident's care. [s. 6. (1) (c)]

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

A) The plan of care for resident #009 directed staff to a specified treatment; however the resident was observed without the treatment on September 30, 2015 at approximately 1345 hours. The resident had altered skin integrity. The staff confirmed that the resident was not receiving care according to their plan of care. The licensee failed to ensure that resident #009 received the care set out in the plan of care.
B) The plan of care for resident #401 directed staff to apply a chair alarm to the resident's wheelchair while the resident was up in their wheelchair. An observation of the resident on two consecutive dates in October 2015, confirmed that the resident did not have the chair alarm applied to their wheelchair. Interview conducted with the registered staff, indicated that the resident still needed their chair alarm; however, the battery was not working and needed to be changed. The registered staff confirmed that they did not follow the resident's plan of care. The licensee failed to ensure that the care set out in the plan of care was provided to resident #401 as specified in their plan.
C) The physicians orders dated June, 2015 and the plan of care for resident #007 indicated that the resident was to be provided with a specified amount of a supplement three times a day with medications. The plan of care also indicated that the resident was to be provided with a specified amount of a supplement if there was a meal refused or taken poorly. The Medication Administration Record (MARs) were reviewed for the three months following the order and they did not indicate the supplement order as confirmed with the DOC on September 30, 2015. The resident was not provided the specified amount of the supplement three times a day as per the plan of care as confirmed with the registered staff on September 30, 2015. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
The as needed (PRN) order on the MARs was not signed for once during the period of July – September 2015, however, interview with the registered staff on September 30, 2015 reported that the supplement was provided to the resident on an fairly regular basis as a PRN order but not the specified amount three times a day as per the plan of care. Care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plans of care set out clear directions to staff and others who provided direct care and that residents received the care set out in the plan of care., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to would be kept closed and locked.
During the initial tour of the home on September 21, 2015, it was noted that the door in the basement tunnel in the Shalom Village Too (SVToo) building leading to the kitchen was unlocked. The door was equipped with a door access control system that was on 'by- pass' and therefore accessible. The inspectors walked through the door and down the long hallway where there was an unlocked door that led to very steep stairs to the court yard. Further down the hallway there were double doors that were unlocked that led to the parking lot and delivery drop zone. Beside the double doors was another unlocked door which was also equipped with a door access control system on by-pass and therefore unlocked and open to the outside. The Executive Coach of Shalom Village Apartments reported that this door was on by-pass from 0700-1900 hours daily.
Another door across from the laundry room in the original Shalom Village home area (SVO) had an unlocked door that led to the back parking lot, loading dock and pond area. This door had a sign on it which indicated it was only to be on by-pass during a delivery and must be locked at all other times.
The CEO confirmed that the door leading to the kitchen should be locked at all times or the doors in the hallway should be locked and that any doors leading to the outside should be locked.
The licensee failed to ensure that all doors leading to stairways and outside the home were kept closed and locked. [s. 9. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to would be kept closed and locked., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times. The call bells in specified rooms were checked and when the button were pressed, they did not activate. This was confirmed by the Maintenance Services Coach and the call bells were repaired immediately. The Maintenance Services Coach confirmed the home did not have a preventative maintenance audit program in place to assess if call bells were not functioning and that they rely on nursing staff to report to them when they are not functional. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home was equipped with a resident-staff communication and response system that, could be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels were kept clean and sanitary and were maintained in a good state of repair, free from stains and odours.
On September 30, 2015 it was noted that the cleanable surface of several resident pillows were cracked and in a poor state of repair. An identified room had three pillows that required removal and replacement, another identified room had one, another identified room had two and another identified room had three pillows in need of replacement. These pillows were brought to the attention of the CEO and removed from the resident rooms to be replaced. The CEO confirmed that these pillows should have been removed and replaced as part of the organized laundry service as they were not maintained in a good state of repair. [s. 89. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of laundry services that linen, face cloths and bath towels were kept clean and sanitary and were maintained in a good state of repair, free from stains and odours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure medications were stored in a medication cart that was secure and locked on October 6, 2015 at 1200 hours.

On October 6, 2015, the medication cart was left unattended and unlocked outside of the dining room. The Registered staff was administering medications to residents in the dining room. The inspector was able to open all the drawers including the narcotic drawer of the medication cart. The DOC confirmed that the medication cart was to be locked when left unattended. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that medications were stored in a medication cart that was secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was taking any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.
Resident #009 was receiving a specified medication five times a day for pain management. Resident #009 was unable to move by themselves and limbs were contracted. When the LTC Inspector attempted to move resident #009's foot, the resident yelled out and became very restless and rigid. Documentation in the clinical record revealed the resident was receiving a narcotic pain medication; however there was no documentation to identify pain management monitoring and effectiveness had occurred. Interview with the charge nurse confirmed there was no documentation of the resident's response and the effectiveness of the pain medication. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident was taking any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that resident's privacy was respected during treatments.

A) On October 6, 2015, resident #401 was observed in the dining room receiving their eye drops administered by registered staff, in the presence of other residents.
B) On October 6, 2015, resident #014 was observed in the dining room receiving their insulin administered by the registered staff, in the presence of other residents.
The DOC confirmed that if residents consented to having these treatments in common areas, it would been in their plans of care. The consents to treatments in common areas were not included in the plans of care. The DOC confirmed that staff were to ensure privacy while providing treatments. [s. 3. (1) 8.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the policy entitled "Skin and Wound Care" Reference number 006020.00 was complied with. The policy directed the registered staff to email the
Wound Team when any new alteration in skin integrity was found. Resident #009 was observed with an open area on on September 29, 2015 which was reported to the Registered Nurse. The Wound Care Coordinator confirmed they were not notified of resident #009's altered skin integrity and the policy was not followed. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 13th day of November, 2015

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

Original report signed by the inspector.