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: April 5, 2023	
Original Report Issue Date: March 16, 2023	
Inspection Number: 2023-1266-0002 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Shalom Village Nursing Home	
Long Term Care Home and City: Shalom Village Nursing Home, Hamilton	
Amended By Karlee Zwierschke (740732)	**Inspector who Amended Digital Signature** Karlee Zwierschke Digitally signed by Karlee Zwierschke Date: 2023.04.05 10:43:42 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Non-compliance numbering related to the AMP was corrected.

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Lead Inspector Karlee Zwierschke (740732)	**Additional Inspector(s)** Jonathan Conti (740882) Parminder Ghuman (706988)
Amended By Karlee Zwierschke (740732)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred on the following dates:
February 21-24, 27-8, March 1-3, 6-7, 2023

The following intakes were inspected:

- Intake #00006265 related to falls prevention and management.
- Intake #00017669, Intake #00017694, and Intake #00017789 related to resident abuse.
- Intake #00010977 (complaint) related to resident abuse and transferring techniques.
- Intake #00016599 (complaint) related to IPAC and resident abuse/neglect.
- Intake #00020071 (complaint) related to resident abuse.

- Intake #00004985 (complaint) related to fall of resident and camera being turned off.
- Intake #00019587 (follow-up) related to compliance order #003 from inspection #2022_960695_0001 regarding LTCHA, 2007, s. 76. (4) duty to protect.
- Intake #00017593 (follow-up) related to compliance order #001 from inspection #2022_1266_0001 regarding FLTCA, 2021, s. 24 (1) training.

The following intakes were completed in this inspection:

- Intake #00001603, Intake #00001846, Intake #00001650, Intake #00007096, Intake #00015867, and Intake #00020205 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2022-1266-0001 related to FLTCA, 2021, s. 24 (1) inspected by Karlee Zwierschke (740732)

Order #003 from Inspection #2022-960695-0001 related to LTCHA, 2007, s. 76 (4) inspected by Karlee Zwierschke (740732)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Failure to Comply

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

The licensee has failed to comply with CO #003 from inspection #2022_960695_0001 served on February 28, 2022, with a compliance due date of May 2, 2022.

Rationale and Summary

CO #003 required the home to train all staff on the home's current abuse and neglect policy, and maintain records of the contents of training, person conducting the training, dates that the training was provided, and the staff that attended. Attendance records for training that included the required information as per the order showed that only 80 out of 181 staff completed the training. The Infection Prevention and Control (IPAC) Lead identified that all staff in the home had received the training but acknowledged that not all the attendance records had the information as required by the order.

Sources: CO #003 from inspection #2022_960695_0001, the home's education records, interview with IPAC Lead.
[740732]

WRITTEN NOTIFICATION: Plan of Care- Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that the provision of care was documented as set out in the plan of care.

Rationale and Summary
(a) A resident required checks as per their care plan as a falls prevention intervention due to their history of falls. The resident's checks were not documented in Point of Care (POC) for an identified period of time. Interviews with several staff confirm documentation of plan of care interventions were to be completed by the Personal Support Worker (PSW) and to be documented in POC through tasks. A member of the management team confirmed that there was no documentation for that period of time.

As the resident had several falls, the lack of documentation of care posed a risk of harm to the resident as care may not have been provided as per plan of care.

Sources: clinical records for resident including care plan, progress notes, Kardex, and task report for month of August 2022; interview with staff
[740882]

(b) A Registered Nurse (RN) completed a post-fall assessment and indicated that a falls intervention was in place. The RN confirmed the falls intervention was in place at the time of the incident, however the care plan was not updated with this intervention. The home's falls prevention policy indicated that staff were to update the care plan after the assessment.

When the resident's plan of care was not updated by staff, the falls prevention intervention may not have been utilized by all staff putting the resident at risk for injury.

Sources: homes document titled "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions", reference number 005190.00, interviews with staff, clinical records including care plan, progress notes, Kardex for August 2022.
[740882]

WRITTEN NOTIFICATION: IPAC Lead

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee failed to ensure that the home had an IPAC lead whose primary responsibility was the home's IPAC program.

Rationale and Summary
The home's current IPAC lead started in the role on February 21, 2023. The home was unable to clearly identify who held the primary responsibility of IPAC lead prior to this date. The home did not have one designated IPAC lead that worked the required 26.25 hours per week prior to February 21, 2023.

Sources: interview with IPAC lead, chief executive officer (CEO) and executive director (ED)
[740732]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an allegation of abuse of a resident by anyone that resulted in harm or a risk of harm to the resident was submitted to the Director immediately.

Rationale and Summary
The home did not submit the critical incident (CI) report until 15 days after the incident. The home was aware of the allegation, and the CEO acknowledged that this CI was reported late.

Sources: CI report, interview with staff
[740732]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #005 Written notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 34 (1) 3.

The licensee failed to ensure that the homes required falls prevention and management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The falls prevention and management program, which is an interdisciplinary program required under O. Reg. 246/22 s. 53, has general requirements that the licensee of every long-term care home (LTCH) shall ensure compliance with as per O. Reg. 246/22, s. 34. The home's falls prevention management program annual evaluation was last dated as completed on May 2, 2018. The home's Falls Prevention and Management Program reference number 005190.00 had a last review date of May 26, 2020, as per the Assistant Director of Care (ADOC). Interviews with the ADOC, RN, and the IPAC Lead confirmed that the program had not been evaluated nor updated annually.

Risk of harm to residents if care standards are not in accordance with current evidence-based practices.

Sources: interviews with staff, homes Annual Program Evaluation for falls prevention dated May 2, 2018, homes document titled "Fall Prevention & Management Program - Falls Risk Factors & Related Interventions", reference number 005190.00, last review date per Policy Manager on May 26, 2020. [740882]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes was implemented.

Rational and Summary
(a) The IPAC Standard for Long-Term Care Homes, indicated under section 6.1 that the licensee shall ensure that personal protective equipment (PPE) is available and accessible to staff, appropriate to their role and risk level.

Additional precaution signage was present on five resident rooms. The rooms identified did not have the appropriate PPE accessible to staff as required by the additional precaution signage. The ADOC confirmed that it is the responsibility of all staff to ensure that the PPE bins for the additional precaution rooms were fully stocked with the appropriate PPE.

Failure to provide the appropriate PPE at point of care for staff may have increased the likelihood of staff not wearing the required PPE.

Sources: observations, interview with ADOC
[740732]

(b) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that the licensee shall ensure staff follow additional PPE requirements including appropriate selection, application, removal and disposal of PPE.

A staff member was observed entering a resident's room who was under additional precautions that required specific PPE. The staff member donned the incorrect PPE and did not follow the signage on the resident's door. The staff member and the ADOC confirmed that specific PPE was required when entering additional precaution rooms.

There was an increased risk for spread of infection when the staff member used incorrect PPE during resident care in additional precautions room.

Sources: Observation, Interview with staff and ADOC
[740882]

(c) The IPAC Standard for Long-Term Care Homes, indicated under section 10.1 that the licensee was required to ensure that the hand hygiene program includes access to 70-90% alcohol-based hand rub (ABHR).

It was observed that ABHR in the dining room had an expiration date of June 2022. The second available ABHR in the dining room did not have an identified expiration date. The IPAC lead confirmed that expired ABHR should not be used since it would not meet the efficacy of the required 70-90% alcohol content required.

Sources: ABHR label, interview with IPAC lead
[740732]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (4) (b)

The licensee failed to ensure that a written record was kept relating to each annual IPAC evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
The IPAC program evaluation completed January 2023 did not include the names of the persons who participated in the evaluation, or a summary of the changes made. The ADOC confirmed that the IPAC Observational Checklist was the annual evaluation of the IPAC program and that there was no formal meeting to discuss and evaluate the program.

Lack of completion of the annual IPAC program evaluation increased the risk of gaps in the IPAC program implementation being missed.

Sources: interview with ADOC, IPAC program evaluation dated January 29, 2023
[740732]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that on each shift symptoms of infection were recorded.

Rationale and Summary
Progress notes for three residents indicated that they had an infection and required infection symptom monitoring on each shift for ten days. All three residents did not have symptoms recorded on every shift in Point Click Care (PCC) progress notes. IPAC Lead confirmed that there should be documentation of symptoms on every shift in PCC progress notes.

There was risk that symptoms of infection may have gone unnoticed when documentation of symptoms was not completed on every shift as required.

Sources: interview with IPAC Lead, progress notes for three residents
[740732]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 108 (1) 1.

The licensee failed to ensure that a verbal complaint made to a staff member concerning the care of a resident was dealt with.

Rationale and Summary
A resident's spouse made a verbal complaint to a staff member that was not investigated, resolved and no response was provided to the complainant.

The RPN called the resident's spouse and the spouse raised concerns about the incident that occurred on an identified date. The staff member documented this conversation in resident's electronic chart and also passed this information to ADOC but failed to fill out the complaint form. Interviews with ADOC and the staff member, and review of the progress notes confirmed that staff failed to follow the homes process for dealing with complaints.

Not following the home's complaints process resulted in the resident's spouse not receiving follow-up on their concerns.

Sources: Resident progress notes, the home's Response to Complaint's Policy Reference # 004100.00, and interviews with staff and ADOC.
[706988]

WRITTEN NOTIFICATION: Reporting Critical Incidents

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (4) (b)

The licensee failed to ensure that the Director was informed within three business days after the occurrence of a fall of a that resulted in an injury and hospitalization.

Rationale and Summary
A resident was injured as result of a fall. The CI report was not submitted within three business days from the date of the incident. The IPAC lead acknowledged that the CI was not submitted within three business days after the incident, when they were unable to determine whether the injury resulted in a significant change in the resident's health condition.

Sources: clinical records of a resident, progress notes, physician orders; interviews with staff, CI report
[740882]

WRITTEN NOTIFICATION: Website

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 271 (1) (c) (iv)

The licensee failed to ensure that all infection and prevention control leads for the home were listed on their website.

Rationale and Summary
The homes website did not list any infection and prevention control leads for the home. The ED confirmed that there was no IPAC Lead listed on the website for the home.

Sources: Shalom Village website, interview with ED
[740732]

WRITTEN NOTIFICATION: Failure to Comply

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with CO #001 from inspection #2022_1266_0001 served on October 21, 2022, with a compliance due date of December 1, 2022.

Rationale and Summary
CO# 001 required the Director of Care (DOC) and ADOC to review the home's Mandatory Reporting policy and maintain a signed declaration that included what they reviewed and the date of the review. Records provided by the home related to this order did not include a signed declaration from the ADOC or DOC. The IPAC Lead (who was previously the DOC) confirmed that they had reviewed the homes Mandatory Reporting policy however there was no signed declaration as per the order.

Sources: CO #001 from inspection #2022_1266_0001, the home's compliance order notes, interview with IPAC Lead.
[740732]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #012
Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
This is the first time the licensee has failed to comply with this requirement.
Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

COMPLIANCE ORDER CO #001 Directives by Minister

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
(a) Require visitors to demonstrate proof of a negative test result from an antigen test or PCR test taken on the same day or day prior to the visit
(b) Maintain a record of rapid antigen test results for visitors taken at the home
(c) Document the review of any results of tests taken by visitors outside of the home

Grounds
The licensee failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister's Directive that applied to the long-term care home, the operational Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario was followed.

Rationale and Summary
(a) The COVID-19 Guidance Document for Long-Term Care Homes in Ontario indicated that all general visitors must demonstrate proof of a negative test result from an antigen test or PCR test taken on the same day or the day prior to the visit. A general visitor was observed entering the home without showing proof of a negative antigen test. The visitor confirmed they did not have to show proof of a

negative result to enter. The ADOC confirmed that test results were not documented, and visitors did not have to show proof of a negative antigen test as long as they had a test the day before.

Risk of transmission of COVID-19 by not confirming that general visitors have had a negative antigen test the day prior to entering the home.

Sources: interview with ADOC and general visitor, observations
[740732]

(b) The COVID-19 Guidance Document for Long-Term Care Homes in Ontario indicated that homes must complete IPAC audits every two weeks unless in outbreak where it would be weekly. The IPAC self-assessment audit binder was reviewed for 2023 and there were no audits from January 1 to 25, 2023. The ADOC confirmed that the IPAC self-assessment audits were only being completed once per month when the home was not in outbreak.

Failing to complete the Self-Assessment Audits may have increased the risk of transmission of infectious disease.

Sources: IPAC Self-Assessment Audit Binder, interview with ADOC
[740732]

This order must be complied with by April 13, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.

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