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

Original Public Report

Report Issue Date: April 17, 2024	
Inspection Number: 2024-1266-0001	
Inspection Type: Critical Incident	
Licensee: Shalom Village Nursing Home	
Long Term Care Home and City: Shalom Village Nursing Home, Hamilton	
Lead Inspector Olive Nenzeko (C205)	**Inspector Digital Signature** Olive Mameza Nenzeko Digitally signed by Olive Mameza Nenzeko Date: 2024.04.26 11:37:10 -04'00'
Additional Inspector(s) Jennifer Allen (706480)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 25-28, 2024, and April 2-4, 9-11, 2024.
The inspection occurred offsite on the following date(s): April 5, 8, 2024.

The following intake(s) were inspected:

- Intake #00094624/ CI #2775-000033-23 related to Falls Prevention and management.
- Intake #00096589/ CI #2775-000036-23 related to Prevention of Abuse and Neglect.
- Intake #00105411/ CI #2775-000062-23 related Resident Care and support Services.
- Intake #00105546/ CI #2775-000001-24 related to Resident Care and support Services.

- Intake #00106425/ CI #2775-000004-24 related to Falls Prevention and management.
- Intake #00109475/ CI #2775-000013-24 related to unexpected death of a resident.
- Intake #00110411/ CI #2775-000017-24 related to Disease Outbreak.

The following intakes were completed in this inspection:

- Intake #00109143/ CI #2775-000011-24; Intake #00109675/ CI # 2775-000014-24 related to disease outbreak.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

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: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes section 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

When touring a resident home area (RHA), one bottle of ABHR with an expiry date of August 2021 was observed in the dining room.

The Long-Term care Home Hand Hygiene Policy stated that ABHR should never be used past expiry dates.

The IPAC Lead back-up admitted that expired bottle of ABHR may not have the required 70-90 % alcohol content.

The bottle of ABHR was removed by a staff on March 28, 2024.

Sources: Observations; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (Revised September 2023); interview with IPAC Lead back-up. [C205]

Date Remedy Implemented: March 28, 2024

WRITTEN NOTIFICATION: Required Programs - Falls Prevention

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that the Fall Prevention Program was implemented for two residents.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of resident falls and the risk of injury and must be complied with.

Specifically, staff did not comply with the licensee's post fall documentation in their Fall Prevention & Management Program - Falls Risk Factors & Related Interventions following unwitnessed falls. The home's Fall Prevention & Management Program - Falls Risk Factors & Related Interventions policy, stated for post fall assessments after a resident had fallen, the registered staff were to initiate a post fall pain assessment.

A. Rationale and Summary

A resident sustained a fall with no new physical injury. The resident had been complaining of ongoing pain prior to the fall. Upon review of the resident's health records, a post fall pain assessment on the day of the fall could not be found.

Staff acknowledged that the resident was complaining of pain prior to the fall and that a post fall pain assessment was not found in the resident's chart, that a separate pain assessment in Point Click Care should have been completed for the fall.

The Director of Care (DOC) stated that part of the follow up for the fall would be part of the eTAR documentation, which was why there was not another pain assessment. A review of the eTAR showed that a post fall charting was commenced, but not at the day and time of the fall.

Sources: Resident's health care records; Fall Prevention & Management Program - Falls Risk Factors & Related Interventions (Reference No. 005190.00); Interview with staff.
[706480]

B. Rationale and Summary
The home's Fall Prevention & Management Program - Falls Risk Factors & Related Interventions policy, stated for post fall assessments after a resident had fallen, the registered staff were to initiate a Head Injury Routine (HIR) for all unwitnessed falls, and a post fall pain assessment.

A resident sustained a fall with injuries, began to show signs of changes to their level of conscience and was sent to the hospital for further assessment.
Upon review of the resident 's health records, a head injury routine and pain assessment could not be found.

Staff also reviewed the resident's health records and could not find the required documentation. Staff stated that when a resident was sent to the hospital for assessment following a fall with injury, the staff did not complete the post fall documentation as the resident was in hospital and related information to complete

the documentation was challenging to collect.

The DOC also acknowledged that the missing assessments would be challenging to complete when the resident was sent to hospital so quickly after the incident occurred.

Failure to ensure that post fall assessments were completed put the resident at risk of a delay in treatment and monitoring.

Sources: Resident's health care records; Fall Prevention & Management Program - Falls Risk Factors & Related Interventions (Reference No. 005190.00); Interview with staff.
[706480]

WRITTEN NOTIFICATION: Skin and Wound

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that when a resident exhibited altered skin integrity following a fall, the resident received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary
A resident sustained a fall with injuries on an identified date.

The home's Skin and Wound Care Management Program directed the registered staff to assess the resident's skin and wounds.

Upon review of the resident 's clinical health records, a skin assessment was not completed detailing injuries sustained by the resident.

Staff acknowledged that there was no record of a skin assessment in the resident's clinical record using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Failure to assess the resident's wounds using a clinically appropriate assessment instrument may have compromised the wound monitoring accuracy.

Sources: Resident 's clinical health records; Skin and Wound Care Management Program (Reference No.006020.00)**;** Interview with staff.
[706480]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that, for a resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Rationale and Summary
A resident's plan of care indicated that they had a specific responsive behaviour , and there was an identified intervention that staff should always implement to address the behaviour.

Inspector #C205 observed the resident exhibiting the specific behaviour, however the required intervention was not applied until Inspector approached a staff, who admitted that the resident needed the intervention and applied it. The resident was also observed with no intervention applied the following day.

Failing to implement a responsive behaviour intervention resulted in the resident experiencing the behaviour.

Sources: Resident's observations and clinical record; Interview with staff. [C205]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.
Infection prevention and control program
s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time

per week:
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The Licensee has failed to ensure that the designated infection prevention and control (IPAC) lead worked regularly in that position on site at the home for at least 26.25 hours per week in a home with a licensed bed capacity of more than 69 beds but less than 200 beds.

Rationale and Summary
A review of the designated IPAC lead's weekly hours worked on-site at the home showed that they did not complete the required hours on specific weeks in March 2024 as confirmed by the DOC.

DOC confirmed the home's licensed bed capacity of 125 . DOC indicated that when the IPAC lead was unable to complete the required weekly on-site hours, the remaining hours were covered by the Assistant DOC who was the IPAC lead back-up.

Sources: Designated IPAC lead hours; Interview with IPAC lead back-up and DOC. [C205]

COMPLIANCE ORDER CO #001 Duty to protect

NC #006 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)]:

The licensee shall ensure that no resident in the home is neglected by anyone.

Specifically, the licensee must:
1. Ensure that all PSWs receive re-training on the home's abuse and neglect policy.
2. Ensure the resident is always transferred and toileted by two staff and not left unattended as per their plan of care by completing daily audits during a two-week period to ensure the resident's plan of care is followed.
3. Ensure that there is a written action plan in place if the audits identify any deficiencies. A copy of the audits must be kept in the home.
4. The home shall maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet of all the PSWs who completed the education.

Grounds
The licensee has failed to ensure that a resident was not neglected by staff.

Rationale and Summary
Ontario Regulation 246/22 s.7 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident was found by staff during morning care with multiple injuries. The cause of these injuries was unknown.

The home's internal investigation revealed that a staff transferred the resident

independently from their wheelchair to the toilet using an assistive device. The staff left the resident unsupervised in the bathroom, where they suffered injuries.

The resident 's plan of care identified that the resident required extensive assistance of two staff with toileting and transferring.

The Director of Care (DOC) stated that neglect was substantiated through their internal investigation and that the resident's injuries most likely happened when the resident was left unattended. DOC stated that the resident could not use the call bell and should not be left unsupervised.

Leaving the resident unattended caused injuries to the resident.

Sources: Critical Incident (CI) #2775-000036-23; Resident's clinical records; Investigation notes; Interview with DOC.
[C205]

This order must be complied with by May 21, 2024

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure that staff use safe transferring and positioning techniques when assisting residents.

Specifically, the licensee must:
1. Re-educate staff on the home's safe transferring and positioning policy.
2. Maintain a record of the education content, who provided the education, when it was provided, and a sign-off sheet of staff who completed the education.

Grounds
The licensee has failed to ensure that staff used safe transferring and positioning techniques when transferring residents.

A. Rationale and Summary
A staff transferred a resident independently from their wheelchair to the toilet using an assistive device.

The resident's plan of care identified that they required extensive assistance of two staff for transferring.

The Director of Care (DOC) acknowledged that staff transferring the resident independently was unsafe.

The staff had previous disciplinary actions related to not following safe transferring and positioning of residents and as a result they were terminated.

The home's failure to use safe transferring and positioning techniques placed the resident at risk of injury.

Sources: Resident 's clinical records; Home's investigation notes; Interview with DOC.
[C205]

B. Rationale and Summary
Two staff were repositioning a resident in bed. They attempted to reposition the resident further to the right side of the bed, then pulled and pushed the resident too strongly resulting in the resident sustaining injuries.

The resident 's plan of care indicated that they required extensive assistance assistance of two staff with transfers.

The nurse in charge admitted that both staff did not communicate/coordinate with each other when repositioning the resident in bed and did not use a safe positioning technique.

Failure to use safe transferring and positioning technique caused injuries to the resident.

Sources: Resident's clinical record; Interview with staff.
[C205]

This order must be complied with by May 21, 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.