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

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Original Public Report

Report Issue Date: May 23, 2024
Inspection Number: 2024-1266-0002
Inspection Type: Proactive Compliance Inspection
Licensee: Shalom Village Nursing Home
Long Term Care Home and City: Shalom Village Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 9, 10, 13, 14 and 15, 2024.

The following intake was inspected:

- Intake: #00115530 - Proactive Compliance Inspection (PCI).

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration

Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
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: 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.

Rationale and Summary
A resident's plan of care specified that when they were in bed it was to be in a specific position. Observation of the resident, in bed, identified that the bed was not in the specified position. Staff acknowledged that the resident was provided care

and the staff did not return the bed to the correct position after the completion of care and they immediately adjusted the bed.

Sources: Record review and observation of a resident and interview with staff. [506]

Date Remedy Implemented: May 13, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 85 (3) (c)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
The home's policy to promote zero tolerance of abuse and neglect of residents was not posted in the home. Staff acknowledged the policy was not posted and then posted the document, the same day, on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: May 9, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (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,

The licensee has failed to ensure that a door, which led to the outside of the home, was kept closed and locked.

Rationale and Summary
A door which led to the outside of the home was not locked and could be opened without a key or code entered into the key pad.
Subsequently, the door was observed to be secured and required a code to be entered into the key pad to release the lock and open the door.

Sources: Multiple tours of the area and interviews with staff. [168]

Date Remedy Implemented: May 10, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict

unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors which led to non-residential areas were kept closed and locked when they were not supervised by staff.

Rationale and Summary
A number of non-residential areas were identified which were not locked or supervised by staff.
Subsequent tours of the home noted that all the required areas were either locked or under constant supervision of staff.

Sources: Tours of the home and interviews with staff. [168]

Date Remedy Implemented: May 10, 2024

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 29 (3) 8.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination.

The licensee has failed to ensure that the plan of care for a resident was based on, at a minimum, an interdisciplinary assessment with respect to the resident's continence, including bladder and bowel elimination.

Rationale and Summary
Records identified that a resident was incontinence of bladder and bowel function.

The resident's care plan did not include interventions related to incontinence.
The plan of care was revised on May 14, 2024, to include the resident's continence status and interventions, based on the assessed needs of the resident.

Sources: Care plan, point of care documentation, progress notes and assessments of a resident and interviews with staff. [168]

Date Remedy Implemented: May 14, 2024

NC #006 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Rationale and Summary
A resident was incontinent.

A continence assessment was initiated; however, the assessment only noted that the resident was incontinent. The assessment was not completed for identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

On May 15, 2024, a full continence assessment was completed.

Sources: Review of assessments and plan of care for a resident and interviews with staff. [168]

Date Remedy Implemented: May 15, 2024

NC #007 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that daily menus were communicated to the residents.

Rationale and Summary
Daily menus were not posted in two resident home areas.
The daily menus were posted on May 10, 2024.

Sources: Observations on the home areas and interviews with staff. [683]

Date Remedy Implemented: May 10, 2024

NC #008 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that their continuous quality improvement report, published on their website included a written record of
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary
The Shalom Village website was reviewed which included their March 2024, Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario and Progress Report. The reports did not include the date the resident and family/caregiver experience survey was taken during the fiscal year, the results of

the survey and how, and the dates when, the results of the survey were communicated to the residents and their families, Residents' Council, Family Council and members of the staff of the home.
Staff confirmed that the information as required was not included in the published continuous quality improvement report, nor was the information located elsewhere on the website.
The required information was posted to the website on May 15, 2024.

Sources: Review of the Shalom Village website including QIP and progress report; interviews with staff. [683]

Date Remedy Implemented: May 15, 2024

NC #009 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee has failed to ensure that the home's current version of their visitor policy was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, the licensee was to ensure that their visitor policy was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements established by the regulations.

The home's visitor policy was not posted in the home. Staff acknowledged the policy was not posted and it was posted the same day on the main information board.

Sources: Observation and interview with staff. [506]

Date Remedy Implemented: May 9, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #010 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 a resident received a nutritional intervention as per their plan of care.

Rationale and Summary
A resident's written plan of care indicated they were on a textured modified diet and required a nutritional intervention. They were served a menu item which was not consistent with their nutritional needs. Staff acknowledged that the menu item should not have been served as per their plan of care.
There was risk of decreased intake and/or difficulties when the item was served to the resident.

Sources: A resident's clinical record; observations; interviews with staff. [683]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that a resident who was at risk of altered skin integrity, received a skin assessment by an authorized person upon any return from the hospital.

Rationale and Summary

A resident had a history of altered skin integrity.
The resident was readmitted from the hospital.
A head to toe skin assessment was not initially completed on return from hospital.
A progress note, recorded two days after readmission, under the heading of readmission included the presence of an area of altered skin integrity.
There was a risk that new or changes to existing areas of altered skin integrity would not be identified/treated, if required, in a timely fashion without a skin assessment.

Sources: Progress notes and assessments of a resident and interview with staff. [168]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #012 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 an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident with an area of altered skin integrity received a skin assessment.

Rationale and Summary

A resident had a surgical procedure.

Post operative instructions included for the surgical dressing to be removed on a specific date.

A documented assessment of the area was completed two days later.

There was a risk that staff would be unaware of potential changes in the resident's care needs, in a timely fashion. without the completion of a skin assessment.

Sources: A resident's progress notes and assessments and interview with staff. [168]

WRITTEN NOTIFICATION: Food production

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

Food production

s. 78 (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and

The licensee has failed to ensure that a menu substitution was communicated to residents and staff.

Rationale and Summary
A specific dessert was on the menu, but residents were served a different flavour of the dessert. The menu substitution was not communicated to residents and staff.

Sources: Observations on a resident home area; interview with staff. [683]

WRITTEN NOTIFICATION: Food production

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (a)
Food production
s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and

The licensee has failed to ensure that all items were prepared, stored, and served by methods to preserve the appearance and food quality.

Rationale and Summary
A menu item served to a resident was observed to be of a specific consistency and appearance.
The home's policy provided direction as to the desired consistency of the food to be served.

Staff was shown a photo of a resident's meal and they acknowledged that the food was not prepared or served with methods to preserve the appearance and food quality.
There was a risk to residents who were served the item as prepared.

Sources: Dining observation and related photo; policy review and interview with staff. [683]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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, with a revised date of September 2023, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection and application.

A resident had a sign on their door which identified they were on additional precautions and required specific PPE for care. Staff were observed in the resident's

room without the required PPE. The staff acknowledged they had provided care to the resident and did not wear the required PPE.
Failure to use PPE posed a risk of spreading infection to other residents.

Sources: Observations of staff, interview with staff. [506]

WRITTEN NOTIFICATION: Medication Management System

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with the procedure Controlled Medication Storage, to sign off controlled substances in the narcotic sign off sheet.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) b the licensee was required to ensure that the procedure, which was part of the medication management system, was complied with.
Specifically, staff did not comply with the Controlled Medication Storage procedure, which identified that each time a controlled substance was accessed and removed from the cart, the nurse who administered the medication must sign off in the narcotic sign off sheet.

A resident was administered a controlled substance.
A review of the Narcotic Sign Off Sheet identified that the medication was not

signed off until the end of the medication pass.
There was a risk of inaccurate records when staff failed to sign off controlled substances when they were removed from the cart.

Sources: Observation of a medication pass, reveiw of procedure Controlled Medication Storage and Narcotic Sign Off Sheet for a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 4.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
4. Every designated lead of the home.

The licensee has failed to ensure that their continuous quality improvement (CQI) committee was composed of every designated lead of the home.

Rationale and Summary:
Meeting minutes for the home's CQI committee were reviewed. The designated leads for three required programs were not listed as members in attendance or regrets.
Staff acknowledged that the leads were not on the CQI committee as required.

Sources: CQI meeting minutes and interviews with staff. [683]

WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all staff who provided direct care to residents received training on skin and wound care in 2023.

Rationale and Summary
Training records for 2023 identified that not all direct care staff completed the mandatory training as required related to skin and wound care.
There was a risk that not all direct care staff were familiar with the home's skin and wound program when they failed to complete the annual training as required.

Sources: Review of Surge Course Completion reports and interviews with staff. [168]