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: October 30, 2024
Inspection Number: 2024-1266-0004
Inspection Type: Critical Incident
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 date(s): October 8-11, 15-16, 2024

The following Critical Incidents (CI) were inspected:

- Intake #00117834/ CI #2775-000020-24 related to falls prevention and management
- Intake #00118716/ CI #2775-000021-24 related to alleged abuse and neglect
- Intake #00122020/CI #2775-000025-24 related to infection prevention and control
- Intake #00127267/CI #2775-000030-24 and intake #00127426/CI #2775-000031-24 related to medication management

The following Critical Incidents were completed:

- Intake #00115948/CI #2775-000019-24 and intake #00125198/CI #2775-000029-24 related to falls prevention and management

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care for a resident was documented.

Rationale and Summary
A personal support worker (PSW) provided care to a resident. The PSW did not document the provision of the care.

The Director of Care (DOC) acknowledged that the PSW should have documented that care was provided to the resident.

Failure to document the provision of the care set out in the plan of care led to inaccurate information in the resident's plan of care.

Sources: Resident's clinical records and interview with DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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 positioning techniques when assisting a resident.

Rationale and Summary
A PSW provided care to a resident and assisted them back to bed. The PSW positioned the resident on the side of the bed and not in the centre of their bed. The resident then rolled over and fell off of their bed which resulted in a hospital transfer.

The DOC confirmed that the PSW positioned the resident unsafely after providing their care and that the PSW should have positioned the resident in the centre of their bed.

Failure to use safe positioning techniques put the resident at risk of injury.

Sources: Resident's care plan, CI #2775-000021-24 and interview with DOC.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to comply with their drug destruction policy.

In accordance with O Reg. 246/22 s. 11 (1) (b) the licensee is required to have in place a policy to ensure that any controlled substance that is to be destroyed and disposed of shall be stored separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs, and must be complied with.

Specifically, a discontinued narcotic for a resident was stored in the medication cart with medications that were to be administered to residents.

Rationale and Summary
A narcotic was discontinued for a resident on a specified date.

The home's policy, "Drug Destruction - Controlled Substances", indicated that all controlled substances to be destroyed should be stored double locked in a secure designated area within the home and separate from medications which are to be administered to residents.

According to the home's investigation notes and interviews with staff, the discontinued narcotic was not removed from the medication cart for disposal when it was discontinued.

The following day, the discontinued medication was administered to a resident.

As a result, the medication was administered to a resident in error and there was risk of harm to the resident.

Sources: Resident's clinical records, interviews with staff; home's investigation notes, policy Drug Destruction - Controlled Substances, Policy 9.2 [revised September 2023].

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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1) Provide an in-person training session for all personal support workers who work on a specific home area on:

- The definition and meaning of verbal abuse and neglect;
- Specific examples of verbal abuse and neglect;

- Why these incidents met the definition of verbal abuse and neglect;
- Zero tolerance for verbal abuse and neglect;
- The use of personal cellphones on shift, how resident's are impacted by this and how it is linked to neglect.

2) Document the education, include the date and time the education session was held, the length of the session, the staff members who attended the training, the staff signature that had completed the education and who provided the education,

3) Each staff member who attended the education must complete a written assessment that is developed by and deemed appropriate, that reflects the understanding of the training material related to verbal abuse and neglect, and

4) The LTCH must keep a written copy of the education and written assessments for an inspector to review.

Grounds
The licensee has failed to protect a resident from verbal abuse and neglect.

Section 2 of the Ontario Regulation (O. Reg 246/22) defines "verbal abuse" of any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth.

Rationale and Summary
A) A Resident had a camera with audio and visual capabilities at the LTCH. On a specific date, the resident had a fall and was sent to hospital. The resident's substitute decision maker (SDM) reviewed the video footage from the incident. Investigation notes indicated the resident's bed alarm went off and a PSW

responded. Shortly after, the bed alarm went off for a second time and the PSW came into their room while talking on their personal cell phone. The investigation notes indicated that the PSW used derogatory comments about resident #004 to the other person on the phone call and shared information about the care of the resident.

In an interview with the DOC, they confirmed the PSW was making the comments about the resident on their personal device. The DOC also acknowledged that the PSW verbally abused the resident by making derogatory comments.

According to the LTCH's abuse and neglect policy, any behaviour that creates an unsafe environment or is not respectful of an individual's person or values is not acceptable.

Failure to protect the resident from verbal abuse diminished the resident's sense of well-being, dignity and self-worth.

Sources: LTCH'S Investigation Notes, Prevention of Abuse and Neglect Policy, initiated on CI 2775-000021-24 and interview with DOC.

Grounds
The licensee has failed to protect a resident from neglect.

Section 7 of the O. Reg 246/22 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being.

Rationale and Summary

B) On a specific date a resident's bed alarm went off. A PSW went to provide care. Shortly after, the bed alarm went off for the second time and the resident appeared to be agitated and wanted to get up to use the bathroom. The PSW indicated they would not assist the resident and left the room without assisting the resident to the bathroom. Shortly after, the resident's bed alarm went off for the third time as resident had fallen out of the bed.

In an interview with the DOC, they acknowledged that the PSW neglected the resident by not providing care when it was required.

Failure to protect the resident from neglect posed a safety risk to the resident's well-being.

Sources: LTCH'S Investigation Notes, Prevention of Abuse and Neglect Policy, initiated on CI 2775-000021-24 and interview with DOC.

This order must be complied with by
December 11, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order 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 Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, 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 a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

This is the first AMP that has been issued to the licensee for failing 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 #002 Medication management system

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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 Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

-A plan to ensure two registered nursing staff are following the home's medication management policy to ensure the accurate acquisition and administration of drugs for verbal medication orders.

-The type of retraining involved, including who will be responsible for the retraining and when it will be completed;

-The person(s) responsible for monitoring that the policy is being complied with, the frequency of monitoring and how it will be documented;

-The person(s) responsible for implementing an action plan if monitoring demonstrates the policy is not complied with; and

-Actions to address sustainability once the home has been successful in ensuring compliance with this policy.

Please submit the written plan for achieving compliance for inspection #2024-1266-0004 to the LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by November 13, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to comply with their medication management policy developed to ensure the accurate acquisition and administration of drugs for a resident.

In accordance with O Reg. 246/22 s. 11 (1) (b) the licensee is required to have in place policies and protocols to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home and must be complied with.

Specifically, the licensee failed to comply with the home's procedure for "Physician Orders - Transcribing Oral, Written, Telephone [reference 010020.00]".

Rationale and Summary

On specific date, progress notes indicated a resident experienced pain and the on-call physician was contacted. A verbal order was taken by a RPN for additional pain medication. The medication was administered by injection.

The home's procedure "Physician Orders - Transcribing Oral, Written, Telephone" required "two registered staff to process a physician's order: one to transcribe the order and the second to co-sign that the order is transcribed accurately and completely." The process also included that is was the responsibility of the RN/RPN to "repeat the telephone/verbal order in its entirety back - word for word - to the physician to reduce the possibility of error".

In an interview with the inspector, the RPN indicated that they did not follow the home's policy as they did not repeat the order back to the physician when the order was taken.

In an interview with the DOC, they indicated that a second registered staff member did not check that the order was transcribed accurately and completely at the time of taking the order and did not complete the second check until after the medication was administered.

As a result, the resident was administered a medication by route of injection when the physician intended the medication be delivered orally. Consequently, the resident became unresponsive and was sent to the hospital.

Sources: resident's clinical records, policy Physician Orders - Transcribing Oral, Written, Telephone [reference 010020.00], interviews with staff, home's investigation notes for the incident.

This order must be complied with by
December 11, 2024

COMPLIANCE ORDER CO #003 Administration of drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The plan must include but is not limited to:

-A plan to ensure a RPN is following the home's drug administration policy for controlled substances to ensure the accurate administration of medications.
-The type of retraining involved, including who will be responsible for the retraining and when it will be completed;
-The person(s) responsible for monitoring that the policy is being complied with, the frequency of monitoring and how it will be documented;
-The person(s) responsible for implementing an action plan if monitoring demonstrates the policy is not complied with; and
-Actions to address sustainability once the home has been successful in ensuring compliance with this policy.

Please submit the written plan for achieving compliance for inspection #2024-1266-0004 to the LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by November 13, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that a drug administered to a resident was prescribed to them.

Rationale and Summary
According to the resident's clinical records, a narcotic was discontinued on a specific date.

The following day, a RPN administered the discontinued medication to the resident.

The home's policy Drug Administration - Controlled Substances (Policy 8.1) stated to "verify the medication to be administered for accuracy against the eMAR".

The home's investigation notes and interviews with staff indicated that the RPN did not check the resident's electronic medication administration record (eMAR) before administering the medication to the resident.

As a result, the resident was administered a narcotic in error and there was risk of harm to the resident.

Sources: Resident's clinical records, interviews with staff; home's investigation notes, policy Drug Administration - Controlled Substances (Policy 8.1, revised September 2023).

This order must be complied with by
December 11, 2024

COMPLIANCE ORDER CO #004 Infection prevention and control program

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Educate PSW's on a specific resident home area (RHA) of expectations for supporting residents with hand hygiene prior to meal service.

2) Maintain documentation of outline of the education provided, on what date, by whom and the signature of the PSW's who attended this education
3) Audit hand hygiene practices during resident mealtime on the RHA across morning, afternoon, evening until compliance is achieved.
4) Maintain documentation of the audits, names of staff who completed each audit, outcomes and any corrective action taken based on audit results.

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

Rationale and Summary
The IPAC Standard required under section 10.2 that the hand hygiene program was to include hand hygiene support for residents, specifically (c) assistance to residents to perform hand hygiene before meals.

During an observation of meal service on a RHA, residents were seated in the dining room, PSW's served meals to the residents and did not support the residents with cleaning their hands by offering use of alcohol-based hand rub (ABHR).

A RPN and the IPAC Lead confirmed that hand hygiene should be performed in the dining room and residents should be offered hand sanitizer before residents eat their meals.

A PSW confirmed that they did not offer hand sanitizer to the residents seated in the dining room before lunch.

The home's hand hygiene program required that residents are encouraged and/or offered assistance to properly wash or sanitize their hands regularly before meals or

snacks.

Failure of staff to support residents with hand hygiene prior to meal service posed a risk of infectious disease transmission.

Sources: Meal service observation, IPAC Standard (revised September 2023), " Hand Hygiene Program" Publish Date November 2023 Reference no: 005050.00, "Infection Prevention and Control (IPAC) Program" Publish Date: March 2024 Reference No.: 001020.00 and interviews with staff.

This order must be complied with by January 27, 2025

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.