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

Public Report

Report Issue Date: March 12, 2025

Inspection Number: 2025-1266-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Shalom Village Nursing Home

Long Term Care Home and City: Shalom Village Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred on-site on the following dates: February 26-27, 2025, March 3-7, and 10-11, 2025.
The inspection occurred off-site on the following date: February 28, 2025.

The following intakes were inspected:

- Intake #00130819 was related to follow-up #1 - CO #004 / 2024_1266_0004, O. Reg. 246/22 - s. 102 (2) (b), Infection Prevention and Control (IPAC), CDD January 27, 2025
- Intake #00135356/ CI #2775-000051-24 was related to fall prevention and management
- Intake #00137951/ CI #2775-000006-25 was related to IPAC

The following intakes were completed in this inspection:

- Intake #00134836/ CI #2775-000048-24 was related to fall prevention and management
- Intake #00138693/ CI #2775-000007-25 was related to IPAC

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #004 from Inspection #2024-1266-0004 related to O. Reg. 246/22, s. 102 (2) (b)

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

Infection Prevention and Control
Safe and Secure Home
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 failed to ensure that the IPAC Standard for Long-Term Care Homes, dated September 2023, was implemented. The IPAC Standard indicated under section 11.6 that signage was to be present at entrances to the long-term care home (LTCH) listing the signs and symptoms of infectious diseases for self-

monitoring and steps to be taken if an infectious disease was suspected or confirmed in any individual.

On March 4, 2025, the required signage was not posted at the main entrance to the LTCH, which was confirmed by the IPAC Lead. Later on the same date, the signage was observed to be posted at the main entrance of the LTCH.

Sources: Observations of the main entrance to the LTCH, interview with the IPAC Lead.

Date Remedy Implemented: March 4, 2025

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee failed to ensure a resident was reassessed and their plan of care reviewed and revised at least every six months and at any other time when care set out in the plan was not effective.

The resident had a fall and sustained an injury on a specified date in 2024, and the plan of care was not updated with any new interventions related to mitigating risk of falls and resulting injury since 2023.

Sources: Resident clinical record, critical incident system (CIS) 277-000051-24 and interview with the resident.

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee failed to retrain the required staff on IPAC in 2024, as mandated in Ontario Regulation (O. Reg.) 246/22 s. 259 (2), when 15% of staff did not receive the required training. In accordance with O. Reg. 246/22 s. 260 (1), retraining was to be provided to all staff annually.

Sources: Staff IPAC retraining records, interview with the IPAC Lead.

WRITTEN NOTIFICATION: Care Plans and Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 19.
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:
19. Safety risks.

The licensee failed to ensure that the requirements of the plan of care were based on, at a minimum, interdisciplinary assessment with respect to safety risks for a resident.

The resident had a fall resulting in an injury while ambulating to the smoking area. The plan of care did not set out direction for staff related to smoking and the safety

risks posed to the resident. The smoking policy required staff to update the care plan following the annual smoking assessment. The resident's care plan was not updated as per direction in policy following their most recent smoking assessment.

Sources: Observation of the resident, resident clinical records, smoking policy #005320.00, CIS 2775-000051-24, interviews with nursing management and the resident.

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 (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 failed to ensure that the IPAC Standard for Long-Term Care Homes, dated September 2023, was implemented. The IPAC Standard indicated under section 9.1 that additional precautions were to be followed in the IPAC program which included (f) the proper use of personal protective equipment (PPE) including the appropriate selection, application and removal of PPE.

On a date during the inspection, a staff member did not don a specified article of PPE and was observed providing assistance to the resident. The resident demonstrated symptoms of and had tested positive for an infection at the time of the observation. Signage posted to the resident's room door indicated additional precautions were in place. Upon exiting the resident's room, the staff did not perform hand hygiene after body fluid exposure risk or follow the appropriate order of PPE removal.

Sources: Observation of the resident's room, resident clinical record, IPAC Standard (dated September 2023), policy 005090.00 "Additional Precautions" (dated November 2024), interview with staff.

WRITTEN NOTIFICATION: Orientation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (g)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(g) use of personal protective equipment including appropriate donning and doffing; and

The licensee failed to ensure that the 2024 IPAC education content for staff required under subsection 82 (4) of the Act included use of PPE, including appropriate donning and doffing.

Sources: Staff IPAC education content from 2024, interview with the IPAC Lead.

WRITTEN NOTIFICATION: Orientation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The licensee failed to ensure that the 2024 IPAC education content for staff required under subsection 82 (4) of the Act included handling and disposing of biological and clinical waste, including used PPE.

Sources: Staff IPAC education content from 2024, interview with the IPAC Lead.

WRITTEN NOTIFICATION: CMOH and MOH

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure all applicable recommendations made by the Chief Medical Officer of Health (CMOH) were followed in the home during a confirmed enteric. The IPAC Lead acknowledged that they use the IPAC Self-Assessment Audit for Long-Term Care and Retirement Homes as their IPAC audit and that it was not completed weekly during the above-specified outbreak.

Sources: CIS 2775-000006-25, IPAC Self-Assessment, PPE and hand hygiene audits, Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, Ministry of Health (published April 2024), interview with the IPAC Lead.

COMPLIANCE ORDER CO #001 Windows

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19

Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
1. Audit all windows in the LTCH that open to the outdoors and are accessible to residents to ensure the window opening cannot open more than 15 centimeters (cm), and that each window is equipped with a screen that is in a good state of repair.
2. Document the audit, including the date the audit was completed, location of each window audited, window opening measurement, presence or absence of an intact screen, corrective actions, and who completed the audit.
3. Implement corrective actions to ensure no window opens more than 15cm and each window is equipped with an intact screen.
4. Keep a record of the audit and corrective actions taken with the date completed and whom the work was completed by for Ministry of Long-Term Care (MLTC) Inspector review upon request.

Grounds
The licensee failed to ensure every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened greater than 15cm. Multiple windows, which opened to the outdoors and were accessible to residents, opened more than 15cm in an identified dining room, resident bedrooms and hallways on multiple home areas. Additionally, windows were observed without screens in place in an identified dining room and two hallways.

According to the home's internal audit conducted during the inspection, of 176

windows audited, 43 opened greater than 15cm to the outdoors and 17 had a damaged or missing screen.

Failure to ensure windows could not be opened more than 15cm had the potential for residents to exit or allow undesired access into the home.

Sources: Window observations, LTCH's internal window audit, interviews with the Environmental Service Manager (ESM) and Maintenance Supervisor.

This order must be complied with by March 28, 2025

COMPLIANCE ORDER CO #002 Maintenance Services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
1. Develop and implement a procedure and schedule for routine, preventative and remedial maintenance of windows in the LTCH, including the frequency for conducting preventative audits and who will complete them.
2. Ensure the audits are completed at the required frequency and appropriate corrective actions taken as set out in the maintenance procedure.
3. Keep a record of all audits and corrective actions taken with the date completed and whom the work was completed by for MLTC Inspector review upon request.

Grounds

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure there were schedules and procedures in place for routine, preventive and remedial maintenance. Specifically, windows in the LTCH that opened to the outdoors and were accessible to residents, were not maintained in a good state of repair throughout the home.

During the inspection, multiple window throughout the LTCH were not maintained in good repair. The window frames of hopper windows and sashes of horizontal sliding windows were not correctly installed, screens were ripped and not tight fitting, and screws which were in place to restrict window openings had been removed from the bottom rails of sashes. Specifically, a window observed at the end of an identified home area hallway had screws removed, which enabled the window to open 36cm to the outside of the second floor of the LTCH. Further, multiple windows could not easily be opened, closed or locked properly and maintenance signage was noted on a window in a resident room requesting the window not be opened.

The licensee had not developed written procedures directing the ESM to proactively monitor the condition of the windows in the LTCH on a routine basis or a remedial plan to address any identified issues in a timely manner. There were no maintenance schedules or audits developed to ensure a designated staff member would be prompted to complete the preventative monitoring of the windows. The ESM indicated they were not aware of the poor condition or disrepair of windows throughout the LTCH, and acknowledged that an audit to quantify and detail the window disrepair was not completed until the MLTC Inspectors brought forward their concerns at the time of this inspection.

Failure to proactively monitor the windows led to unidentified and unaddressed disrepair, which increased the risk of residents being able to exit the LTCH or undesired access into the home. Further, when windows were ill-fitting and screens

were damaged or not properly fitted, this posed a risk of pest and temperature management concerns.

Sources: Window observations, LTCH's internal window audit, email records from the Acting Administrator, interviews with the ESM and Maintenance Supervisor.

This order must be complied with by April 22, 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
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.