Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2017	2017_560632_0010	009659-17	Resident Quality Inspection

Licensee/Titulaire de permis

SHALOM MANOR LONG TERM CARE HOME
12 Bartlett Avenue GRIMSBY ON L3M 4N5

Long-Term Care Home/Foyer de soins de longue durée

SHALOM MANOR LONG TERM CARE HOME
12 BARTLETT AVENUE GRIMSBY ON L3M 4N5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

YULIYA FEDOTOVA (632), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): May 24, 25, 26, 29, 30, 31, June 1, 6, 2017.

The following inspections were completed concurrently with the Resident Quality Inspection.

Critical Incident System Report:
024857-16 related to: Fall with injury
025334-16 related to: Fall with injury
032223-16 related to: Fall with injury
002700-17 related to: Physical Abuse staff to resident

Inquiries:
002068-16 related to Rate Reduction Complaint
031325-16 related to Controlled Substance Missing
023560-16 related to Fall and not Submitting Critical Incident (CI)

During the course of the inspection, the inspector(s) spoke with the Chief Executive Office (CEO), Director of Resident Care (DRC), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Services Manager (DSM), Resident Assessment Instrument (RAI) Co-ordinator, Volunteer Co-ordinator/Interim Recreation Manager, Dietary Aid (DA), residents and their families.

During the course of the inspection, the inspector(s) conducted a tour of the home, including resident rooms and common areas, reviewed infection prevention and control, housekeeping, maintenance, reviewed documentation related to bed rails and relevant clinical records, conducted interviews, reviewed relevant policies, procedures, and practices within the home, reviewed meeting minutes, investigation notes, staff files, observed the provision of care, medication administration, and meal service.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) The plan of care for resident #042, revealed they were at high risk for falls.
On an identified date in August, 2016, the home submitted critical incident system (CI) C558-000008-16, to report that on an identified date in August, 2016, resident #042 had sustained a fall with injury. The CI revealed that a long-term action plan to prevent recurrence, a device was added to the resident's bed.
A Post Fall Assessment completed on an identified date in March, 2017, revealed the resident's need for the device to be placed strategically while they were in bed.
The resident was observed on an identified date in May, 2017, in bed, without a device.
Staff #288 and #365, acknowledged the resident did not have device.
On an identified date in May, 2017, the RAI Co-ordinator confirmed the need for the device was not identified in the written plan of care.
The plan of care for resident #042 was not based on the assessed needs of the resident.

Please note: This non-compliance was issued as a result of the following CI Log #025334-16, which was conducted concurrently with this RQI. [s. 6. (2)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #029 experienced difficulty in swallowing and was observed positioned in a specific manner. A review of the resident's plan of care indicated that their chair was to be positioned in a specific manner for meals. On an identified date in May, 2017, interview with staff #420 confirmed that the resident was not positioned in a specific manner, while eating and care plan indicated that the resident was to be positioned in a specific manner for meals. On an identified date in May, 2017, an interview with the DRC confirmed that the care set out in the plan of care was not provided to the resident as specified in their plan. (632)

B) The plan of care for resident #042, directed staff to raise bed rail when the resident was in bed.
On an identified date in May, 2017, resident #042 was observed in their bed with rails raised. PSW #365, acknowledged that both bed rails were raised when the resident was in bed.

The RAI Co-ordinator acknowledged in an interview on an identified date in May, 2017, that the written plan of care directed staff to raise only one bed rail.
On an identified date in May, 2017, care was not provided to resident #042, as specified in their plan.

Please note: This non compliance was issued as a result of the following CI 025334-16, which was conducted concurrently with this RQI. (130) [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and insuring that the plan of care is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (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. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

A review of resident #045's record identified that a five page report was faxed to the home on an identified date in March, 2017, from a Nurse Practitioner (NP) that included an action/plan of care section. This section described the mathematical equation for the administration of a medication. This document was not signed by the NP. On an identified date in April, 2017, an order was written in the physician orders, and subsequently signed, to administer the "correction dose only for breakfast (supper) as per the NP faxed order".

The action/plan of care was put in the MAR, despite there not being an order for the administration of this medication. The medication was administered from identified dates in April, 2017, without being prescribed for this resident.
In an interview conducted with registered staff #391, it was acknowledged that there was not a signed order in place.
In an interview conducted with the DRC it was acknowledged that the faxed report was transcribed into the MAR for resident #045 without a signed prescription for resident #045. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and insuring that no drug is used by or administered to a resident in the home unless the drug is prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On an identified date in May, 2017, registered staff #409 was observed administering the noon medications. It was observed that staff #409 disposed of the plastic medication pouches in the garbage on the medication cart. An interview conducted with staff #409 acknowledged that the entire plastic medication pouch was disposed of in the regular garbage, and water was added to the garbage.
On an identified date in May, 2017, an interview was conducted with registered staff #397 and this staff member acknowledged that the plastic medication pouches were disposed of in the regular garbage after placing water in the bag. After the noon medication pass, a clear plastic bag was disposed of with the regular garbage in one of residents' home area and placed in a large garbage bin along with other garbage from the home. Upon observation of this garbage, there was a small amount of water in the garbage bag, however most plastic medication pouches were clearly legible with residents' names and medications.
On an identified date in May, 2017, a garbage bag was observed to be disposed of with the regular garbage in the home in one of residents' home area. This garbage bag had a large amount of water evident, however some plastic medication pouches were clearly legible with resident names and medications. In an interview conducted with registered staff #390, it was acknowledged that the personal health information on the medication pouches were not kept confidential.
In a subsequent interview conducted with the DOC and the ADOC it was acknowledged that the current process for disposing of the medication pouches was not effective. It was further acknowledged that the current process did not ensure that every resident had their personal health information kept confidential. [s. 3. (1) 11. iv.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure any plan, policy, protocol, procedure, strategy or system instituted or otherwise put into place was complied with.
LTCHA, S.O. 2007, Chapter 8. s. 8(1)(b) requires the licensee to ensure an organized program of nursing services for the home to meet the assessed needs of the resident.

A) The home's protocol titled: Medical Directives (App-02-12-05a), stated under Treatment: "In and Out catheterization for bladder distention may leave in if (greater than) 500ml (millilitres) and Indwelling foley catheter – change when no longer patent or as ordered by physician".
Resident's #004 and #039 both had urine drainage devices in place. A review of each residents' clinical records revealed that there were no physician orders for either resident's urine drainage device. The Director of Care acknowledged that the Medical Directive pertaining to urine drainage device use was considered a protocol. It was the expectation that when a urine drainage device was required, an individualized physician's order would be obtained, specifying the type, size, frequency of changes of device. The home failed to ensure that resident #004 and #039 had physicians' orders providing direction in regards to their urine drainage devices usage. (536)

B) The home's policy titled Hydration Management (revised in January 25, 2017), indicated that the Registered Dietitian (RD) must receive a referral for all changes in residents` fluid intakes. Review of TASK records related to fluid intake for resident #048, indicated that the resident, who was at risk for dehydration, during two periods in duration of six days each, consumed on average of 30-59% of their target fluid requirement during the month of May, 2017. According to the resident's assessments and progress notes records, there were no records identified about dietary referrals sent to the RD by the registered staff in May, 2017. On an identified date in June, 2017, the staff #414 confirmed that the resident had lower than their target fluid requirement intake during the month of May, 2017, and indicated that no referral was sent to the RD for the hydration assessment, which was confirmed by the DSM. Staff did not ensure that Hydration Management Policy was complied with. (632) [s. 8. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that their restraint policy was complied with.

The home's policy titled: Minimizing Restraints and Use of Personal Assistance Services Device (PASD), OO-02-21-01 (revised February 2, 2017) stated: "Device application must ensure there was a 2-finger space allowance between the resident and the device for resident comfort and safety".
On an identified date in May, 2017, resident #031 was observed in their wheelchair with a device securing the resident applied. The device was observed to be loose enough for the Inspector to place five fingers between it and the resident's abdomen. Staff #318 observed the device and acknowledged the device was too loose.
Resident #031 was observed a second time on an identified date in May, 2017. The device securing the resident was observed to be loose enough for the Inspector to lift it to the resident's chest. Staff #388 acknowledged the space between the device and the resident's abdomen should only allow a two finger space.
On identified dates in May, 2017, the home's policy titled: titled: Minimizing Restraints and Use of Personal Assistance Services Device (PASD), was not complied with. [s. 29. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee failed to ensure that proper techniques to assist residents with eating included safe positioning of residents who required assistance.

Resident #029 had difficulty in swallowing and was observed positioned in a specific manner. A review of the resident's plan of care indicated that their chair was to be positioned in a specific manner for meals. On an identified date in May, 2017, interview with staff #420 confirmed that the resident was not positioned in a specific manner while eating and care plan indicated that the resident was to be positioned in a specific manner for meals. On an identified date in May, 2017, an interview with the DRC confirmed that the proper techniques to assist residents with eating were to be provided. [s. 73. (1) 10.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared.
O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that there was an analysis of the restraining of residents by use of a physical device undertaken on a monthly basis.

A) On an identified date in May, 2017, the DRC acknowledged that although daily rounds included a review of the number of restraints and or new restraints in use, the home did not conduct a formal monthly analysis of the restraining of residents by use of a physical device. [s. 113. (a)]

Issued on this 26th day of June, 2017

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.