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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2019	2019_569508_0005	009211-18	Complaint

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 28, 31, February 1 and 4, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed the provision of care, reviewed resident clinical records, reviewed the 2018 complaint log, the 2018 medication incident reports and relevant policies and procedures.

PLEASE NOTE: This Complaint inspection was conducted concurrently with Critical Incident inspection #2019_569508_0006.

During the course of the inspection, the inspector(s) spoke with the Interim Chief Administrator, the Director of Resident Care (DRC), the Associate Director of Care (ADRC), the Administrative Assistant, registered staff, Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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	Légende 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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 had ongoing pain in an identified area and was prescribed a specific assessment to be conducted at certain times and also a specific medication to be administered to manage this pain as required.

During a review of the electronic Medication Administration Record (e-MAR) for an identified month in 2018, it was identified that the resident was administered the medication an identified number of times to manage their pain.

The clinical records for that same identified month revealed that the assessment ordered was not completed as ordered.

It was confirmed during review of the resident's clinical records and during interview with the DRC in February, 2019, that the care set out in the plan of care was not provided to the resident as specified in the plan.

PLEASE NOTE: This area of non-compliance was also identified during a Critical Incident (CI) inspection, log #024778-18, conducted concurrently during this complaint inspection. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain is not relieved by initial interventions, the resident was reassessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A review of the resident's clinical record indicated that resident #001 had an identified diagnosis and a history of pain.

The resident was prescribed routine medications to manage their pain and also was prescribed to have additional doses of these medications as needed (PRN) if their pain was not managed with their routine medication.

A review of the electronic Medication Administration Record (e-MAR) for an identified month in 2018, revealed that in addition to the resident's regularly scheduled medication to manage their pain, the resident was administered the additional pain medication an identified number of times in that month.

Further review of the resident's clinical record indicated that a quarterly pain assessment using a clinically appropriate assessment instrument that was specifically designed for this purpose was completed on one identified date that month, however, no further pain assessments using this instrument had been completed. This information was also confirmed by the DRC during interview in February, 2019. [s. 52. (2)]

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 to ensure that when the resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A review of the resident's clinical record indicated that resident #001 had an identified diagnosis and a history of pain.

The resident was prescribed several pain medications to manage their pain and also was prescribed to have additional doses of these medications as needed (PRN) if their pain was not managed. This included an order for a specific medication as needed for pain.

A review of the 2018 medication incidents and review of the resident's clinical records indicated that on an identified date in 2018, resident #001 was administered 1 dose of this medication for pain. During the routine narcotic count completed at the end of the shift it was identified by registered staff #101 and registered staff #102 that the narcotic count was not accurate.
Once this was identified the registered staff completing the narcotic count discovered that registered staff #101 made an error and administered an additional 1 mg dose of the pain medication to the resident and gave 2 mg instead of 1mg as prescribed.

It was confirmed during review of the medication incident reports, review of the resident's clinical record and during interview with the DRC in February, 2019, that drugs were not administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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. Where the Act or this Regulation required the licensee of a long-term care home to have instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with all applicable requirements under the Act, s. 22(1).

During this inspection, the Long Term Care Homes (LTCH) Inspector requested a copy of the complaint log for 2018 and a copy of the homes current complaint policy.
It was identified that there were several written complaints regarding the care of residents in 2018.

The home had followed up on these complaints and responded to the complainants; however, this information had not been forwarded to the Director.
A review of complaint policy #00-02-19-01, titled Resident/Family Complaints revised February 18, 2018, revealed that the policy did not include the requirement under the Act to ensure that a long-term care home who received written complaints concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

During an interview with the DRC in January, 2019, it was confirmed that the complaint policy was not in compliance with the Long Term Care Homes Act in accordance with s. 22(1) where it did not include the requirement to immediately forward written complaints to the Director. [s. 8. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

During a review of resident #001, 002 and 003's clinical records, documentation had indicated that resident #001 had refused a portion of their scheduled baths during two identified months in 2018.

A review of documentation in a Point Click Care report for resident #001, indicated refusals for bathing were documented an identified number of occasions during the time period reviewed in 2018.

A review of progress notes over this period of time indicated that no documentation had been in place that identified the resident's refusal to have their bath; the reason(s) why they refused; what interventions had been put into place, when they refused, or the resident's response to the interventions.

During an interview with the DRC in February, 2019, it was confirmed that no documentation was available as to the reasons resident #001 refused their baths; what interventions had been put into place to address the reasons for refusal, or the resident's response to any interventions that were tried. The DRC confirmed that any actions taken including assessments, reassessments, interventions and the resident's responses to interventions, had not been documented. [s. 30. (2)]

Issued on this 5th day of March, 2019

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

Original report signed by the inspector.