Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 15, 2019	2019_577611_0040	011296-19, 013748-19, 018719-19, 019511-19	Critical Incident System

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

KELLY CHUCKRY (611), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 4, 5, 6, and 7, 2019.

Critical Incident inspections were conducted during this inspection. Log 011296-19, pertaining to Responsive Behaviours, 013748-19, pertaining to Medication Management, and Log #018719-19, and 019511-19, both pertaining to Falls Prevention.

Complaint inspection #2019_569508_0031 was conducted concurrently with this inspection.

During the course of the inspection, the inspector toured the facility, observed the provision of care, reviewed resident clinical records, medication incidents, and relevant policies and procedures.

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), Personal Support Workers (PSW)s, registered staff, and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

The home submitted a Critical Incident Report outlining the details of a medication incident involving resident #007. On an identified date in 2019, resident #007 attended an outing arranged by the homes recreation department.

A review of the clinical health records identified that resident #007 had medications prescribed by a physician to be administered at an identified time every day, and therefore required to be administered some medication(s) during the outing on the identified date.

In a phone interview with staff #106, it was identified that the medication(s) were given to a recreation staff member to be administered by a Personal Support Worker (PSW) during the outing. The investigation notes provided by the home, indicated that the PSW administered the medication(s) to resident #007.

The Director of Care and Assistant Direct or Care confirmed in an interview that the PSW administered these medications during the identified outing, and the medication(s) was not administered by a physician, dentist, Registered Nurse (RN), or Registered Practical Nurse (RPN). [s. 131. (3)]

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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The home submitted a Critical Incident Report outlining the details of a medication incident involving resident #007. On an identified date in 2019, resident #007 attended an outing arranged by the homes recreation department.

A review of the clinical health records identified that resident #007 had medications prescribed by a physician to be administered at an identified time every day, and therefore required to be administered some medication(s) during the outing on the identified date.

In a phone interview with staff #106, it was identified that the medication(s) were given to a recreation staff member to be administered by a Personal Support Worker (PSW) during the outing. The investigation notes provided by the home, indicated that the PSW administered the medication(s) to resident #007.

The progress notes entered after resident #007 returned from the outing indicated that resident #007 did not receive one of the prescribed medications.

The Director of Care and Assistant Direct or Care confirmed in an interview that a medication incident report was not completed for this incident, and was not documented together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

Issued on this 20th day of November, 2019

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

Original report signed by the inspector.