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
Mar 12, 2019	2019_661683_0002	015792-18, 016442-18, 033328-18	Critical Incident System

Licensee/Titulaire de permis

Shalom Village Nursing Home
60 Macklin Street North HAMILTON ON L8S 3S1

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

Shalom Village Nursing Home
70 Macklin Street North HAMILTON ON L8S 3S1

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

LISA BOS (683)

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): February 5, 7, 8, 11, 13 and 20, 2019

This inspection was completed concurrently with follow up inspection #2019_661683_0003. Stacey Guthrie, Inspector #750 was present for this Critical Incident inspection.

The following intakes were completed during this critical incident inspection:
log #016442-18, CIS #2775-000010-18 - related to falls prevention and management
log #015792-18, CIS #2775-000006-18 - related to falls prevention and management
log #033328-18, CIS #2775-000015-18 - related to falls prevention and management

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10 s. 8(1)(b), identified in concurrent inspection #2019_661683_0003 (log #029661-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), registered staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed resident clinical records, reviewed policies and procedures, reviewed training records, reviewed program evaluation records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
4 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A review of Critical Incident (CI) log #033328-18 / 2775-000015-18 indicated that on an identified date, resident #002 sustained an identified number of falls at identified times. On an identified date, the physician assessed the resident and they were transferred to hospital where they received an identified diagnosis.

On an identified date, the resident was observed in an identified position and specific fall prevention interventions were observed to be in place.

A review of the written plan of care in place for resident #002 on an identified date, indicated that they were at risk of falls and they had various interventions in place to prevent falls. The resident's written plan of care did not identify one of the specific falls prevention interventions that were observed to be in place on an identified date.

In interviews with Personal Support Worker (PSW) #100 and Registered Practical Nurse

(RPN) #102 on an identified date, they indicated a specific fall prevention intervention as a strategy used for resident #002.

In an interview with the Director of Care (DOC) on an identified date, they acknowledged that resident #002 had the specific fall prevention intervention in place and it was not identified in their written plan of care.

The home did not ensure that resident #002's written plan of care set out the planned care for the resident related to a specific fall prevention intervention.

B) A review of CI log #015792-18 / 2775-000006-18 indicated that on an identified date, resident #004 sustained a fall which resulted in an identified injury.

A review of the written plan of care in place for resident #004 on an identified date, indicated that they were at risk of falls and had various interventions in place to try and prevent falls.

i) Resident #004 was observed on an identified date, at an identified time, in an identified position. In interviews with PSW #107 and RPN #108 on an identified date, they indicated that an identified intervention was used for positioning and safety.

In an interview with the DOC on an identified date, they indicated that the identified intervention for resident #004 was a personal assistive service device (PASD) and they acknowledged that their written plan of care identified the need for repositioning for the resident, but it did not identify anything related to the identified intervention or a PASD. In an interview with the DOC on an identified date, they acknowledged that the identified intervention for resident #004 was not identified in their written plan of care.

The home did not ensure that there was a written plan of care for resident #004 that set out the planned care for the resident related to an identified intervention.

ii) Resident #004's room was observed on an identified date, at an identified time, and an identified intervention was observed to be in their room. In an interview with PSW #107 and staff #113 on an identified date, they indicated that the resident used the identified intervention for fall prevention.

In an interview with the DOC on an identified date, they acknowledged that resident #004 required the identified intervention and that at the time of the Inspector's clinical record

review, the identified intervention was not identified in their written plan of care.

The home did not ensure that there was a written plan of care for resident #004 that set out the planned care for the resident related to an identified fall prevention intervention. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A review of CI log #016442-18 / 2775-000010-18 identified that on an identified date, resident #003 sustained a fall. At the time of the fall, resident #003 was assessed and transferred to hospital where they received an identified diagnosis.

On an identified date, the written plan of care for resident #003 was reviewed, which identified that they were at risk of falls and their written plan of care identified specific fall prevention interventions.

The fall incident report from an identified date was reviewed on an identified date and it noted that a specific fall prevention intervention was not in place at the time of the fall and it stated that they had an electronic Treatment Administration Record (eTar) for the specific fall prevention intervention. The specific fall prevention intervention was also noted as a current intervention within the post fall report.

On an identified date, a review of the orders and eTars for resident #003 was completed for an identified time period and no order or eTar was found for the identified fall prevention intervention.

In interviews with PSW #107 and RPN #108 on an identified date, both staff were unable to confirm if the identified fall prevention intervention was in place for resident #003 at the time of their fall.

In an interview with the DOC on an identified date they acknowledged that resident #003 refused the identified fall prevention intervention and that it was not a planned intervention for the resident at the time of their fall on an identified date. They acknowledged that this information was not reflected in resident #003's care plan.

The home did not ensure that resident #003's written plan of care was reviewed and

revised when the resident refused the identified fall prevention intervention. [s. 6. (10) (b)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: 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 that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy was complied with.

A) In accordance with O. Reg. 79/10 s. 30 (1), the long term care home was required to ensure that the following was complied with for each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes including protocols for the referral of residents to specialized resources where required. In accordance with O. Reg. 79/10, r. 48(1)1, the home was required to have a Falls Prevention and Management

Program.

Specifically, staff did not comply with the licensee's policy #005190.00, titled "Fall Prevention and Management Program – Falls Risk Factors and Related Interventions," last revised on an identified date, which was part of the licensee's falls prevention and management program. On page one, the policy defined a serious injury to include fractures, laceration-requiring sutures, and any injury requiring assessment in emergency of admission to the hospital. On page two, the policy identified that registered nursing staff were to collaborate with the resident/substitute decision maker (SDM) and family and interdisciplinary team to conduct the fall risk assessment when a change in status put them at increased risk for falling such as falls resulting in serious injury. On page four, the policy identified that when a resident fell, registered nursing staff were to complete the fall huddle with staff present and the at home leader was to review the fall huddle to assess the root cause and interventions required and document these in the fall huddle progress note.

i) A review of CI log #033328-18 / 2775-000015-18 identified that on an identified date, resident #002 sustained an identified number of falls at identified times. On an identified date, the physician assessed the resident and they were transferred to hospital where they received an identified diagnosis. The CI identified that the resident previously had a fall on an identified date, which resulted in an identified injury.

A review of the written plan of care in place for resident #002 on an identified date indicated that they were at risk of falls and had various interventions in place to prevent falls. A review of the clinical record for resident #002 did not identify a fall risk assessment after their fall on an identified date.

In an interview with the DOC on an identified date, they acknowledged that resident #002 did not have a fall risk assessment done after their fall on an identified date, and that as per their policy, one should have been completed.

The home did not ensure that a fall risk assessment was completed after resident #002's fall on an identified date, as per their policy.

ii) A review of CI log #015792-18 / 2775-000006-18 indicated that on an identified date, resident #004 sustained a fall which resulted in an identified injury.

A review of the written plan of care in place for resident #004 on an identified date

indicated that they were at a risk of falls and had specific interventions in place to try and prevent falls. A review of the clinical record for resident #004 did not identify a fall risk assessment after their fall on an identified date.

In an interview with the DOC on an identified date, they acknowledged that resident #004 did not have a fall risk assessment done after their fall on an identified date, and that as per their policy, one should have been completed.

The home did not ensure that a fall risk assessment was completed after resident #004's fall on an identified date, as per their policy.

iii) A review of CI log #033328-18 / 2775-000015-18 indicated that on an identified date, resident #002 sustained an identified number of falls at identified times. On an identified date, the physician assessed the resident and they were transferred to hospital where they received an identified diagnosis. A review of the clinical record identified that the resident sustained further falls on identified dates.

A review of the written plan of care in place for resident #002 on an identified date indicated that they were at risk of falls and had various interventions in place to prevent falls. A review of the clinical record for resident #002 did not identify any progress notes regarding post fall huddles for the resident's falls on two identified dates. In an interview with the DOC on an identified date, they indicated that when a resident fell, the RPN staff were to complete a fall huddle as soon as they had a fall. The fall huddle was documented on paper and the nurse used it to fill out the post fall assessment. On an identified date the DOC acknowledged that there were no fall huddles done, as per their policy, for resident #002's falls on two identified dates.

The home did not ensure that a fall huddle was completed after resident #002's falls on two identified dates, as per their policy.

B) In accordance with O. Reg. 79/10 s. 30 (1), the long term care home was required to ensure that the following was complied with for each of the organized programs required under section 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes including protocols for the referral of residents to specialized resources where required. In accordance with O. Reg. 79/10, r. 48(1)1, the home was required to have a Falls Prevention and Management

Program.

Specifically, staff did not comply with the licensee's policy #005200.00, titled "Head Injury," last revised on an identified date, which was part of the licensee's falls prevention and management program. On page one, the policy identified that "any resident who potentially may have sustained an injury to the head following a fall or impact with an object, will be promptly assessed and have head injury routine initiated," and "as an unwitnessed head injury or neurological insult of unknown origin may cause changes in a resident's level of consciousness or responsiveness, all unwitnessed resident falls will be assessed for a potential head injury unless the resident can state he/she did not hit their head."

A review of CI log #033328-18 / 2775-000015-18 indicated that on an identified date, resident #002 sustained an identified number of falls at identified times. On an identified date, the physician assessed the resident and they were transferred to hospital where they received an identified diagnosis. A review of the clinical record identified that the resident sustained another unwitnessed fall on an identified date.

A review of the written plan of care in place for resident #002 on an identified date indicated that they were at risk of falls and had various interventions in place to prevent falls. In an interview with RPN #102 on an identified date they indicated that a head injury routine was completed for all unwitnessed falls on a paper form and it was stored in resident's hard charts. A review of resident #002's hard chart and electronic record on an identified date did not identify a head injury routine for their unwitnessed fall on an identified date.

In an interview with the DOC on an identified date they acknowledged that there was no head injury routine started for resident #002's fall on an identified date and that one should have been started for the resident's unwitnessed fall, as per their policy.

The home did not ensure that a head injury routine was completed for resident #002 after their unwitnessed fall on an identified date, as per their policy.

C) PLEASE NOTE: The following non-compliance was identified during concurrent inspection #2019_661683_0003 and was issued in this report.

In accordance with O. Reg. 79/10 s. 9(2), the licensee was required to ensure that there was a written policy that deals with when doors leading to secure outside areas must be

unlocked or locked to permit or restrict unsupervised access to those areas by residents.

Specifically, staff did not comply with the licensee's policy #002020.47, titled "Resident Safety and Security," last updated on an identified date, which identified that "doors leading to outdoor secured areas such as courtyards or terraces are equipped with secured locks. Doors will be secured by this means unless they are under the direct supervision of a staff member" and "Shalom Village Original (SVO) second floor balcony and Shalom Village Too (SVToo) sliding door beside the nurses station are unlocked from April to November if not under a heat or cold weather advisory. These doors are locked during heat or cold weather advisories."

On an identified date, the outdoor air temperature throughout the day was between a specific temperature range [as per the Government of Canada's hourly data report].

A tour of the home was completed on an identified date, beginning at an identified time, in order to follow up on compliance order (CO) #003 from inspection #2018_543561_0010. During the tour, a door in an identified home area, which led to an identified outside area, was noted to be unlocked. Residents and an identified staff member were nearby at the time of the observation. At an identified time on an identified date the DOC toured the home at the request of Inspector #683 and acknowledged that the door in the identified home area was not locked and it should have been locked with a key.

In an interview with the DOC on an identified date they acknowledged that as per the home's revised "Resident Safety and Security" policy, the door on the identified home area which led to an identified outside area should have been locked on the identified date.

The home did not ensure that the identified door on the identified home area, which led to an identified outside area, was locked, as per their "Resident Safety and Security" policy, on an identified date. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.

A review of CI log #033328-18 / 2775-000015-18 indicated that on an identified date, resident #002 sustained an identified number of falls at identified times. On an identified

date, the physician assessed the resident and they were transferred to hospital where they received an identified diagnosis.

A review of the written plan of care in place for resident #002 on an identified date indicated that they were at risk of falls and had various interventions in place to prevent falls.

On an identified date, the resident was observed in an identified position in an identified mobility device.

In interviews with PSWs #100 and #103 on an identified date they indicated that sometimes they positioned the resident in an identified manner for an identified reason. In an interview with RPN #102 on an identified date they acknowledged that resident #002 had an identified behaviour and when there was nobody to monitor the resident they placed them in an identified position. RPN #102 reviewed the resident's written plan of care and acknowledged that it did not identify that the resident had the identified device for positioning.

In an interview with the DOC on an identified date, they acknowledged that the home provided resident #002 with an identified device, as they did not have their own. They identified that the identified device had an identified function, but that staff were given strict directions not to use the identified function, for an identified reason. The DOC acknowledged that they were unaware the identified function was being used until the Inspector asked the staff about the resident's mobility device. The DOC identified that they interviewed staff, who indicated that they felt positioning the resident in an identified manner was safer. The DOC confirmed that the identified function of the identified device was being used as a restraint for resident #002 against their knowledge, and acknowledged that the identified mobility device, with the identified function was not identified in their written plan of care.

The home failed to ensure that resident #002 was not restrained by the use of a physical device other than in accordance with section 31. [s. 30. (1) 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 resident of the home is restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A review of CI log #033328-18 / 2775-000015-18 indicated that on an identified date, resident #002 sustained an identified number of falls at identified times. On an identified date, the physician assessed the resident and they were transferred to hospital where they received an identified diagnosis.

A review of the written plan of care in place for resident #002 on an identified date indicated that they were at risk of falls and had various interventions in place to prevent falls.

A review of the clinical record identified that one fall incident report was completed for the identified falls, at identified times, on an identified date. A review of the clinical record identified a fall note that indicated one of the falls was assessed by an identified staff member and another fall was assessed by another identified staff member.

In an interview with the DOC on an identified date, they reviewed resident #002's falls on an identified date and acknowledged that they believed the resident was assessed after the falls, as per the documentation, but acknowledged that a clinically appropriate assessment instrument was not used for all of the falls. The DOC acknowledged that separate fall incident reports should have been completed for the resident's falls at identified times, on an identified date.

The home did not ensure that a post fall assessment was conducted using a clinically appropriate assessment instrument for one of the falls sustained by resident #002 on an identified date. [s. 49. (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 a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.