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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 6, 2023	
Original Report Issue Date: June 21, 2023	
Inspection Number: 2023-1266-0003 (A1)	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Shalom Village Nursing Home	
Long Term Care Home and City: Shalom Village Nursing Home, Hamilton	
Amended By Karlee Zwierschke (740732)	**Inspector who Amended Digital Signature** Karlee Zwierschke (740732)

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct the date of an incident identified in the report.

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Lead Inspector Karlee Zwierschke (740732)	**Additional Inspector(s)** Yvonne Walton (169)
Amended By Karlee Zwierschke (740732)	**Inspector who Amended Digital Signature** Karlee Zwierschke Digitally signed by Karlee Zwierschke Date: 2023.07.06 09:45:26 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Correct the date of an incident identified in the report.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29-31, 2023, and June 1, 5-7, 2023

The following intakes were inspected:

- Intake: #00006348 (critical incident) related to an unexpected death.
- Intake: #00016817 (critical incident) related to falls prevention and management.
- Intake: #00019549 (critical incident) related to reporting of outbreaks.
- Intake: #00022953 (follow-up) related to compliance order #001 from inspection #2023_1266_0002 regarding FLTCA, 2021 s. 184 (3) related to the Minister's Directive.
- Intake: #00084354 (follow-up) related to compliance order #003 from inspection #2022_960695_0001 regarding LTCHA, 2007 s. 76. (4) related to training.

- Intake: #00084357 (follow-up) related to compliance order #001 from inspection #2022_1266_0001 regarding FLTCA, 2021 s. 24 (1) related to duty to protect.
- Intake: #00087493 (complaint) related to abuse/neglect, plan of care, pain management, transferring and positioning techniques.

The following intakes were completed in this inspection:

- Intake: #00087208 (critical incident) and Intake: #00018672 (critical incident) related to falls prevention and management.

Previously Issued Compliance Orders

The following previously issued Compliance Orders were found to be in compliance:

Order #001 from Inspection #2023-1266-0002 related to FLTCA, 2021, s. 184 (3) inspected by Karlee Zwierschke (740732)

Order #003 from Inspection #2023-1266-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 101 (4) inspected by Karlee Zwierschke (740732)

Order #001 from Inspection #2022-1266-0001 related to FLTCA, 2021, s. 24 (1) inspected by Karlee Zwierschke (740732)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
On an identified date, a resident had a procedure done by a staff member at the home. The resident did not receive treatment as directed in the plan of care and staff who assisted identified that the resident responded with a negative outcome. This resulted in hospitalization.

Sources: Resident's clinical record, and interviews with three staff members.
[169]

WRITTEN NOTIFICATION: General Requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

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

Rationale and Summary
On an identified date, a resident had a procedure and there was no documentation in the clinical record of the intervention or the resident's response to the intervention. Two staff members confirmed that they did not document the intervention or the resident's response.

Sources: Resident's clinical record, interviews with two staff members, Director of Care (DOC) and Executive Director (ED).
[169]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that safe positioning techniques were used when assisting a resident.

Rationale and Summary
A staff member did not use safe positioning techniques while providing care to a resident, which resulted in the resident suffering an injury. The Assistant Director of Care (ADOC) confirmed that the staff member did not use safe positioning techniques when assisting the resident with care.

By not using safe positioning techniques while providing care the resident suffered an injury.

Sources: Interview with staff member and ADOC, resident's clinical record
[740732]

WRITTEN NOTIFICATION: Reports: Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 2.

The licensee failed to ensure that the unexpected death of a resident was submitted to the Director immediately.

Rationale and Summary
Critical Incident (CI) report was submitted on August 20, 2022, and the death occurred on a previous identified date. The ADOC confirmed that this was an unexpected death, and that this CI was reported late.

Sources: CI Report, interview with ADOC
[740732]

WRITTEN NOTIFICATION: Reports: Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee failed to ensure that a disease outbreak was reported to the Director immediately.

Rationale and Summary
Critical Incident (CI) report was submitted on January 29, 2023, and the outbreak was declared by Public Health on January 26, 2023. The ADOC confirmed that this CI was reported late.

Sources: CI #2775-000010-23, interview with ADOC
[740732]

COMPLIANCE ORDER CO #001 Residents' Rights

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 4.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must educate two specified staff members on the following:
1. Current identified policy.
2. Completing a procedure on a resident with responsive behaviours.
3. Documentation policy.

Grounds
The licensee failed to ensure that the following rights of residents are fully respected and promoted and that every resident has the right to be free from abuse.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain. (2) For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

Rationale and Summary
On an identified date, a resident had a procedure done by a staff member at the home. The resident did not receive treatment as directed in the plan of care and staff who assisted identified that the resident responded with a negative outcome. This resulted in hospitalization.

Sources: Resident's clinical record, hospital records and interview with nursing staff involved.
[169]

This order must be complied with by July 14, 2023

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NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Intake #00084357- Second follow-up to CO#001 from inspection #2022_1266_0001 regarding FLTCA, 2021 s. 24 (1) related to duty to protect, CDD December 1, 2022, RIF of $500.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.

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.