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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2013	2013_214146_0067	H-002012-12, H-000146-13	Complaint

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

BARBARA NAYKALYK-HUNT (146)

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): December 11, 12, 13, 2013.

This inspection was conducted for three complaints H-000146-13, H-000186-13, H-002021-12 and concurrently with a critical incident H-000814-13 inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Directors of Care (DOC), Chief Financial Officer (CFO), registered staff, Personal Support Workers (PSW's), housekeeping staff, residents and family members.

During the course of the inspection, the inspector(s) toured the home areas, reviewed resident health records, observed residents, reviewed policies and procedures related to skin and wound care, falls management and transfer and positioning.

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

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
Room 623 is a non-residential room used as a soiled linen and utility room containing a hopper and a laundry chute. The door to the laundry chute is visible from the open doorway, opens easily and is large enough for a person to fit through. The door to room 623 was found unlocked and ajar the morning of December 11, 2013 as was the adjacent door to the tub room. No staff were in the immediate area. The doors locked when pulled shut. Two PSW's on the floor were notified that the doors should be closed and locked when staff not in the room. Staff stated they did not have keys. The housekeeper had keys. On the morning of December 12, 2013, the door to room 623 with the laundry chute was again unlocked and ajar with paper shoved in the locking mechanism to avoid locking. No staff were in the area. The administrator was notified, the paper removed and the door was closed and locked. On December 13, 2013 at 0915 hours, the door to the room with the laundry chute was again ajar and open with no staff in the area. This information was confirmed by observation. The CEO stated that the home's expectation is that the doors be closed and locked. [s. 9. (1) 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 the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that staff used safe positioning techniques when assisting a resident.
The plan of care for resident #005 indicated that the resident was cognitively impaired and was at high risk for falls. The resident required a seat belt when up in a wheelchair to ensure that when the resident leaned forward, the resident did not fall out of the chair.
In November 2011, a staff member was preparing to bathe and dress the resident in bed as was the routine. The staff person lowered the bed rail and then stepped and turned away from the resident. The resident slid onto the floor mat and suffered a serious injury. The DOC confirmed that the home's expectation is that the bed rail not be lowered until the staff person could maintain full attendance and attention at the bedside. This information was confirmed by the health record, the staff member and the DOC. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 17th day of December, 2013

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

BARB NAYKANYK-HUNT.