Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: 2023-06-19	
Inspection Number: 2023-1505-0002	
Inspection Type: Critical Incident System	
Licensee: Shalom Manor Long Term Care Home	
Long Term Care Home and City: Shalom Manor Long Term Care Home, Grimsby	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature**
Additional Inspector(s) Erika Reaman (000764) Tracey Delisle (741863)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15, 17, 19, 23, 24, 25, 2023
The inspection occurred offsite on the following date(s): May 16, 2023

The following intake(s) were inspected:
- Intake: #00087497 - [CI: 3009-000006-23] - Fall of resident.
- Intake: #00003813 - [CI: 3009-000009-22] - Physical abuse between residents.
- Intake: #00012131 - [CI: 3009-000015-22] - Resident sustained an injury of unknown origin.
- Intake: #00016452 - [CI: 3009-000020-22] - Resident sustained an injury, etiology unknown.

The following intake(s) were completed:
- Intake: #00002724 - [CI: 3009-000002-22] - Fall of resident.
- Intake: #00005094 - [CI: 3009-000019-21] - Fall of resident.
- Intake: #00006848 - [CI: 3009-000003-22] - Fall of resident.
- Intake: #00016213 - [CI: 3009-000019-22] - Fall of resident.
- Intake: #00021052 - [CI: 3009-000002-23] - Fall of resident.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect residents from abuse from another resident

Summary and Rationale
A resident had a physical altercation with another resident, which resulted in both residents sustaining injuries. The home's investigation notes on the incident provided by the Director of Care (DOC) stated that the incident took place in the hallway and no staff were present to intervene. When staff arrived, the residents were already separated. The home did not protect the residents from abuse.

Not ensuring residents were protected resulted in injury of the residents.

Sources

Residents progress notes, Investigation notes, Interview with DOC

[741771]