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

Original Public Report

Report Issue Date: February 13, 2024	
Inspection Number: 2024-1505-0001	
Inspection Type: Critical Incident	
Licensee: Shalom Manor Long Term Care Home	
Long Term Care Home and City: Shalom Manor Long Term Care Home, Grimsby	
Lead Inspector Meghan Redfearn (000765)	**Inspector Digital Signature** Meghan Redfearn Digitally signed by Meghan Redfearn Date: 2024.02.23 13:38:21 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 1-2, February 5,-9, 2024.

The following Critical Incident (CI) intake(s) were inspected:

- Intake #00085293/CI#3009-000004-23 - related to the prevention of abuse and neglect.
- Intake #00097592/CI#3009-000008-23/CI#3009-000011-23- related to infection prevention and control.
- Intake #00105099/CI#3009-000016-23 - related to infection prevention and control.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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)
Duty to protect s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by a co-resident.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident".

Rationale and Summary
On a specified date, a resident obtained a tool from a cart, entered a room and hit a co-resident, which resulted in an injury. Staff responded immediately to the situation and separated the residents. Registered staff noted an injury to a specific area on the co-resident with some pain. The home's investigation indicated at the conclusion of the investigation abuse/neglect was found to exist.

The Director of Resident Care acknowledged that the incident could be seen as abuse based on the definition of abuse because the resident did physically strike the co-resident.

Failure to protect the co-resident from physical abuse led to an actual harm to the resident.

Sources: Resident plan of care; home's investigation notes; interviews with staff and the Director of Resident Care.
[000765]