Ontario

**Ministry of Long-Term Care**

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

**Order of the Director**

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

# Order of the Director Public Report Cover Sheet

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| **Date of the Order:** January 16, 2025 |
| **Director Order Number:** DO #001 |
| **Order Type:** Compliance Order s. 155 (1) (a) |
| **Licensee:** Shalom Manor Long Term Care Home |
| **Long Term Care Home and City:** Shalom Manor Long Term Care Home, Grimsby |

## ORDER OF THE DIRECTOR SUMMARY

Director Order #001 was modified to make administrative changes.

The licensee requested the Director to review the inspector's order pursuant to s. 169 of the FLTCA.

As the Director, I found the inspector's order under s. 24 (1) of the FLTCA did not address the fact that two identified residents had committed acts of physical abuse towards other residents and therefore the order is altered and substituted with the following order of the Director.

# Order of the Director Public Report

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| **Date of the Order:** January 16, 2025 |
| **Director Order Number:** DO #001 |
| **Order Type:** Compliance Order s. 155 (1) (a) |
| **Licensee:** Shalom Manor Long Term Care Home |
| **Long Term Care Home and City:** Shalom Manor Long Term Care Home, Grimsby |

## ORDER OF THE DIRECTOR SUMMARY

Director Order #001 was modified to present the information with more generalized language.

The licensee requested the Director to review the inspector's order pursuant to s. 169 of the FLTCA.

As the Director, I found the inspector's order under s. 24 (1) of the FLTCA did not address the fact that two identified residents had committed acts of physical abuse towards other residents and therefore the order is altered and substituted with the following order of the Director.

### Background

An inspection was conducted at Shalom Manor (the Home) on the following dates: October 22, 24, 25, and 28-30, 2024. Inspectors found that the Licensee, Shalom Manor Long-Term Care Home, did not comply with s.24(1) of the Fixing Long-Term Care Act, 2021 (FLTCA). The inspector issued a compliance order for the finding of non-compliance.

The licensee requested the Director to review the inspector's order pursuant to s. 169 of the FLTCA.

As the Director, I found the inspector's order under s. 24 (1) of the FLTCA did not address the fact that the identified residents had committed acts of physical abuse towards other residents and therefore the order is altered and substituted with the following order of the Director.

**Order:** DO #001

To Shalom Manor Long Term Care Home, you are hereby required to comply with the following order by the date(s) set out below:

**Pursuant to**
Order pursuant to FLTCA, 2021,
**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.

**Order**

Shalom Manor Long Term Care Home, ('the licensee') is ordered:
1) Review and revise as needed, identified residents' plans of care to ensure that strategies/interventions are implemented to prevent further physically responsive behaviors and protect fellow residents from abuse.

2) Complete an audit to evaluate the effectiveness of the physical responsive behaviour strategies/interventions for the identified residents.

3) The audit should identify the resident and include, but not be limited to, the dates

of when the audit was completed, the person who conducted the audit, the results of the audit and actions taken as a result of the audit.

4) A written record of steps one through three must be kept in the home.

**Grounds**

A) The licensee failed to protect a resident from physical abuse by another 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".

A resident pushed another resident, causing them to fall and sustain an injury.

The incident of physical abuse resulted in significant impact to the resident's health, safety and quality of life.

**Sources**: Inspector interviews with staff; review of resident's clinical records; the home's investigation notes; CIR #3009-000010-24

B) The licensee failed to protect a resident from physical abuse by another resident.

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

On an identified date, a resident sustained a fall in the lounge area of the home which was caused by another resident resulting in injury.

**Sources:** Resident clinical records, CIR #3009-000007-24; Inspector interview with DOC, review of video footage.

**This order must be complied with by:** January 30, 2025

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**

Pursuant to s. 170 of the Fixing Long-term Care Act, 2021 the licensee has the right to appeal any of the following to Health Service Appeal Review Board (HSARB):

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
email:
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.