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

Public Report

Report Issue Date: May 8, 2025
Inspection Number: 2025-1505-0006
Inspection Type: Complaint Critical Incident
Licensee: Shalom Manor Long Term Care Home
Long Term Care Home and City: Shalom Manor Long Term Care Home, Grimsby

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29, 30 & May 5-8, 2025.
The inspection occurred offsite on the following date(s): May 1, 2025.

The following intake(s) were inspected:

- Intake: #00139968 - complaint related to resident care and support services.
- Intake: #00143215 - critical incident (CI) related to prevention of abuse and neglect.
- Intake: #00144381 - CI related to prevention of abuse and neglect.
- Intake: #00146069 - CI related to prevention of abuse and neglect.

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

Resident Care and Support Services
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.

A. The licensee failed to ensure that a resident was protected 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".

On an identified date, a resident was injured as a result of an altercation with a co-resident.

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

On an identified date, a resident received an injury as a result of an altercation with a co-resident.

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

On an identified date, a resident received an injury as a result of an altercation with a co- resident.

Failure to protect the residents from physical abuse put them at risk of harm.

Sources: Critical Incident Report, resident's clinical records, staff interviews, interviews with management.

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