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

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Public Report

Report Issue Date: December 8, 2025
Inspection Number: 2025-1505-0010
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 dates: November 26-28, 2025 and December 1-4, and 8, 2025.

The following intakes were inspected:

-Intake: #00162633 - Complainant with concerns regarding: (1) Responsive Behaviours, (2) Pain Management, and (3) Medication Management.

-Intake: #00162951 [Critical Incident #3009-000017-25] related to Falls Prevention and Management.

-Intake: #00163027 - Complainant with concerns regarding (1) Prevention of Abuse and Neglect.

-Intake: #00163419 - Complainant with concerns regarding: (1) Falls Prevention and Management and (2) Pain Management.

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

Resident Care and Support Services
Continence Care
Medication Management
Responsive Behaviours
Residents’ Rights and Choices
Pain Management

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (b)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(b) the goals the care is intended to achieve;

A resident had a known history of pain that was treated with medication. Their plan of care did not include the goals of care related to pain management.

Sources: Resident's clinical record, Pain Management policy and interviews with staff.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

A resident sustained a significant change in health status. Their Substitute Decision Maker (SDM) was not notified at the time of the incident where they had been consistently involved in making care decisions for the resident in the past.

Sources: Critical incident report, resident’s clinical record and interviews with staff.

WRITTEN NOTIFICATION: General requirements for programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

During an interview with staff, they indicated that at a specified time on a specified date care was provided to a resident as per their plan of care. This care was not documented.

Sources: Resident's clinical record and interview with staff.

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On a specified date, a resident sustained an injury. Registered Nursing staff administered an initial pain intervention from the resident's medical directives. They documented that this intervention was ineffective.

The home had a comprehensive pain assessment in place; however, this had not been conducted when the resident's pain was not relieved by initial intervention.

Sources: Resident's clinical record, the home's Pain Management policy and comprehensive pain assessment and interview with staff.