

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 1, 2026
Inspection Number: 2026-1505-0002
Inspection Type: 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, 2026 and May 1, 2026.

The following intake(s) were inspected:

-Intake #00176304 - Critical Incident (CI) #3009-000006-26 related to falls prevention and management.

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

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) (c)

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,

(c) clear directions to staff and others who provide direct care to the resident; and

A resident's written plan of care did not provide clear directions to staff when it indicated

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that the resident was a specific risk for falls. Another section of the plan of care indicated for staff to refer to the most recent falls risk assessment for their current risk level which identified the resident was a different risk for falls.

Sources: A resident's clinical record, interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Pain management

NC #002 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.

A resident did not have a comprehensive pain assessment completed as required after they received an as needed pain medication that was documented as ineffective.

Sources: A resident's clinical record, the home's policy, interview with the DOC.