Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: August 3, 2023
Inspection Number: 2023-1266-0004
Inspection Type: Follow up Critical Incident System
Licensee: Shalom Village Nursing Home
Long Term Care Home and City: Shalom Village Nursing Home, Hamilton

Lead Inspector	**Inspector Digital Signature**
Indiana Dixon (000767)	
Additional Inspector(s) Betty Jean Hendricken (740884) Lillian Akapong (741771)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 24, 25, 26, 27, 2023

The following intake(s) were inspected:
- Intake: #00022344 – [Critical Incident (CI): 2775-000018-23] related to Residents' Rights and Choices.
- Intake: #00022493 – [CI: 2775-000019-23] related to Prevention of Abuse and Neglect.
- Intake: #00090611 - Follow-up #: 1 - FLTCA, 2021 - s. 3 (1) 4. Compliance Due Date (CDD) July 14, 2023.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1266-0003 related to FLTCA, 2021, s. 3 (1) 4. inspected by Betty Jean Hendricken (740884)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that a staff used safe transferring technique when positioning a resident.

A resident required transfer assistance from a staff. During the transfer assistance, the staff did not support the resident appropriately as required, as a result the resident had a fall and sustained an injury.

During an interview, the staff confirmed and the Director of Care (DOC) acknowledged that the staff did not follow the safe transfer technique for the resident using the home's transfer and positioning policy.

Sources: Progress notes, interview with DOC and staff, and Critical Incident Report.

[000767]