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: July 11, 2025
Inspection Number: 2025-1266-0004
Inspection Type: Critical Incident
Licensee: Shalom Village Nursing Home
Long Term Care Home and City: Shalom Village Nursing Home, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: June 24-26, 30, and July 2-4, 7-11, 2025

The following intakes were inspected:

- Intake 00148450/ Critical Incident (CI) 2775-000034-25 related to prevention of abuse and neglect
- Intake 00149189/ CI 2775-000036-25 related to fall prevention and management

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

Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC # 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.

The licensee failed to ensure that actions taken with respect to a resident under a specified program, including assessments and interventions were documented. Multiple resident assessment attempts, an assessment and interventions were not documented in the resident's plan of care.

Sources: Resident clinical records, interviews with staff.

WRITTEN NOTIFICATION: Air Temperature

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee failed to document the air temperatures which were required to be

measured under subsection (2) at least once every morning, once every afternoon between 1200 hours (hrs) and 1700hrs and once every evening or night on numerous dates in a specified month.

Sources: Air temperature monitoring records, interview with the Environmental Services Manager.

WRITTEN NOTIFICATION: General requirements

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee failed to ensure the fall prevention and management program was implemented for a resident. In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure the home had in place a falls prevention and management program to reduce the incidence of falls and risk of injury, and that it was complied with. Specifically, staff did not comply with the program where it required nursing staff to conduct a specified assessment for a resident.

Sources: Resident clinical records, fall prevention and management policy, interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee failed to ensure the Director was informed no later than one business day after the occurrence of an incident involving a resident, which caused an injury, hospitalization and significant change in their health condition. Nursing management acknowledged the incident should have been reported to the Director one business day prior to the date of their report.

Sources: Resident clinical records, critical incident report, interview with nursing management.