

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: October 22, 2025

Inspection Number: 2025-1266-0006

Inspection Type:

Complaint
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: October 6-10, 14, 16, 17, 21 and 22, 2025.

The following intakes were inspected:

Intake: #00152625 - Critical Incident (CI) related to infection prevention and control (IPAC).

Intake: #00153788 - CI related to prevention of abuse and neglect.

Intake: #00156496 - CI related to prevention of falls.

Intake: #00157303 - Complaint related to care and support services.

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

Resident Care and Support Services

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Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure the care set out in a resident's plan of care was provided when a staff member left the resident on the toilet, without first ensuring their falls interventions were implemented.

Sources: resident's clinical records, Long-term care home's (LTCH's) investigation notes. interviews with staff.

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

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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.

The licensee has failed to ensure that a resident was protected from emotional abuse by a Personal Support Worker (PSW) on one occasion, when the PSW made intimidating remarks to the resident that upset them.

Ontario Regulation 246/22, s. 2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means,

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Sources: LTCH's investigation notes, critical incident report, prevention of abuse and neglect policy, interviews with a resident and staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

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The licensee has failed to ensure that suspected abuse was reported to the Director when a resident alleged that a PSW made intimidating remarks to them and was rough on multiple occasions.

Sources: LTCH's investigation notes, interview with the Director of Care.