

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: November 20, 2025

Inspection Number: 2025-1266-0007

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 date(s): November 13 - 14, & 18 - 20, 2025

The following intake(s) were inspected:

-Intake: #00158152/ Critical Incident (CI) #2775-000071-25 relating to infection prevention and control

-Intake: #00159682/ CI #2775-000078-25 - relating to prevention of abuse and neglect

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 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

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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.

On a specific date in October, a staff made an allegation that they witnessed physical abuse by another staff to a resident during care. The staff who witnessed the incident reported this allegation to a different staff after their shift on that date. That staff reported this allegation to the DOC the following day. The staff who made the allegation did not report the suspicion of physical abuse when they first became aware of it.

Sources: Interview with staff, CI #2775-000078-25 and interview notes.

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

A resident was showing signs of responsive behaviours. Staff continued providing care to the resident. The resident's care plan indicated specific interventions. Strategies responding to the residents responsive behaviours were not implemented when staff was providing care.

Sources: interview notes, resident's care plan and interview with staff.

WRITTEN NOTIFICATION: Food production

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

Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

Food production

s. 78 (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,

(b) prevent adulteration, contamination and food borne illness. O. Reg. 246/22, s. 78

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(3).

Inspector observed staff going behind the servery without a hairnet on when lunch was being served.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the written policies developed for the dining policy are complied with.

Specifically, staff did not comply with the Pleasurable Dining Responsibilities and Dining Room Service Process policy that indicated staff are to have their hair covered with a hair net when behind server.

Sources: observation and interview with administrator.