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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: December 13, 2023	
Inspection Number: 2023-1511-0003	
Inspection Type: Critical Incident	
Licensee: Mennonite Brethren Senior Citizens Home	
Long Term Care Home and City: Mennonite Brethren Senior Citizens Home, St Catherines	
Lead Inspector Mark Molina (000684)	**Inspector Digital Signature** Mark Molina Digitally signed by Mark Molina Date: 2023.12.13 14:12:43 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4-8, 2023

The following intake(s) were inspected:

- Intake: #00096023 - Related to a resident fall
- Intake: #00100492 - Related to a Parainfluenza outbreak

The following intake(s) were completed in this inspection:

- Intake: #00089574 - Related to a resident fall
- Intake: #00094412 - Related to a resident fall

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

NC #001 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 has failed to comply with staff requirement to immediately report to registered staff when a resident had a fall.

In accordance with O. Reg. 246/22 s. 11 (1)(b), the licensee is required to ensure that there is a falls prevention and management program to reduce the incidence of falls and the risk of injury, and must be complied with.

Specifically, staff did not comply with the policy "Falls Prevention & Management Program."

Rationale and Summary

A resident was transferred from the floor to their wheelchair without registered staff being immediately informed.

As per the home's policy titled Falls Prevention & Management Program, a resident should not to be moved after a fall until a registered staff has conducted a full head to toe assessment and appropriate action is determined.

The Clinical Resource Lead stated the resident should not have been transferred off the floor until they were assessed by a registered staff.

By staff not immediately reporting to registered staff about the fall prior to transferring a resident off the floor, the resident was at risk for injury.

Sources: Interview with ADOC #109, Clinical Resource Lead and other staff; Critical Incident; Resident clinical records; Home's fall policy
[000684]