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

Public Report

Report Issue Date: March 4, 2025
Inspection Number: 2025-1511-0001
Inspection Type: Critical Incident Follow up
Licensee: Mennonite Brethren Senior Citizens Home
Long Term Care Home and City: Mennonite Brethren Senior Citizens Home, St Catharines

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 27, 2025 and March 3-4, 2025
The inspection occurred offsite on the following date(s): February 28, 2025

The following intake(s) were inspected:

- Intake: #00131061/Critical Incident (CI) 3016-000024-24 Prevention of abuse and neglect.
- Intake: #00133653/Follow-up #001, Compliance Order (CO) #001/2024-1511-0003 - O. Reg. 246/22 - s. 102 (2) (b), Infection Prevention and Control (IPAC), Compliance Due Date (CDD) February 7, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1511-0003 related to O. Reg. 246/22, s. 102 (2)

(b)

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that a resident's right to be afforded privacy in treatment and in caring for their personal needs was upheld.

A resident was left unattended in the shower room on a specified date, unclothed, with the door and curtain open by staff.

Sources: Resident's clinical records, risk management, home's investigation notes, interview with Director Of Care (DOC).

WRITTEN NOTIFICATION: Accommodation services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that a shower chair was maintained in a safe condition and in a good state of repair.

A staff used a broken shower chair to complete a resident's bath. As per DOC the chair was not working the previous shift, but did not have an out of order sign placed on it. Staff continued with the shower in the broken chair and this resulted in injury to a resident.

Sources: Resident's clinical records, CI #3016-000024-24, home's investigation notes, Interview with DOC.

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