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: May 22, 2025
Inspection Number: 2025-1511-0002
Inspection Type: Critical Incident
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): May 8, 9, 13-15, 20, 22, 2025

The following intake(s) were inspected:

- Intake: #00138926/Critical Incident (CI) #3016-000004-25 related to Resident Care and Support Services.
- Intake: #00140055/CI #3016-000005-25 ; Intake: #00142853/ CI #3016-000009-25; Intake: #00143764/ CI #3016-000011-25 related Infection Prevention and Control.
- Intake: #00140398/ CI #3016-000006-25 related to Resident Care and Support Services.
- Intake: #00142932/ CI #3016-000010-25 related Falls Prevention and Management.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed, and their plan of care reviewed and revised when the care set out in the plan related to falls was no longer necessary, specifically when the resident no longer required an identified intervention. The resident's plan of care was updated to remove the intervention.

Sources: Resident's clinical record, interview with staff.

Date Remedy Implemented: May 9, 2025

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.

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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect. On a specified date, a staff spoke to a resident in a tone that was not respectful during an activity.

Sources: Interview with staff and investigation notes.

WRITTEN NOTIFICATION: Plan of Care

NC #003 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 plan set out in the plan of care was provided to a resident. The resident's plan of care indicated to ensure an identified intervention was in place. During an observation, the identified intervention for the resident was not in place as required when being tested out by staff.

Sources: Resident's clinical records, observations and interview with staff.

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
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 protect a resident from physical abuse. Section 2 of the Ontario Regulation (O. Reg 246/22) defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury.

During an activity, the resident did not comply with staff 's request and as a result the staff physically abused the resident who fell and hit their head.

Sources: Interview with staff and investigation notes.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their Fall Leaf Program that is part of their falls prevention and management program.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to ensure

that the written policies developed for the falls prevention and management program are complied with.

Specifically, staff did not comply with the "Falls Prevention and Management Program" relating to the Fall Leaf Program, dated February 2014.

Inspector did not observe a leaf logo on the resident's wheelchair nor on their bed, while the resident was on the fall leaf program.

Sources: Observations, Falls Prevention and Management Policy, and interview with staff.

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that a resident's substitute decision-maker was notified within 12 hours upon the licensee becoming aware of alleged, suspected or witnessed incident of abuse. An allegation of abuse was made and the substitute decision-maker was not made aware within 12 hours of the allegation.

Sources: Investigation notes and interview with staff.

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