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: June 20, 2025
Inspection Number: 2025-1511-0003
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): June 11, 12, 13, 16, 17, 19, 20, 2025

The following intake(s) were inspected:
Intake #00146789/CI #3016-000012-25 - related to falls prevention and management
Intake #00148395/CI #3016-000014-25 - related to infection prevention and control

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General requirements

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee failed to ensure that staff documented the care intervention tasks for the resident.

On multiple shifts, the Personal Support Worker (PSW) did not document the completion of the resident's evening care interventions. The home's management confirmed that staff are required to document completed interventions and acknowledged that the documentation was missing on the specified dates.

Sources: Home's Fall Prevention and Management Program, Resident Document Survey Reports, interview with the Clinical Quality Coordinator, and the Assistant Director of Care.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the "Infection Prevention and Control Standard for Long-Term Care Homes, September 2023" (IPAC Standard) was implemented. The IPAC Standard under section 9.1, Additional Precautions, section (f), indicated that at minimum, additional precautions shall include additional PPE requirements, including appropriate selection, application, removal, and disposal.

Additional precaution signage outside the resident's room indicated that staff must wear eye protection before entry. On a specified date, the inspector observed a PSW staff member entering and exiting a resident's room without wearing eye protection. PSW staff member admitted that they were required to wear eye protection when they entered the resident's room that day.

Sources: Resident's room observation and interview with the PSW.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the "Infection Prevention and Control Standard for Long-Term Care Homes, September 2023" (IPAC Standard) was implemented. The IPAC Standard under section 10.4 (h) stated that the licensee shall ensure that the hand hygiene program also includes support for residents to perform hand hygiene prior to receiving meals and snacks.

On a specified date, the inspector observed that the home staff did not offer hand

hygiene to two residents seated in the dining area before their lunch meal service. Additionally, a resident reported that staff did not offer or provide assistance with hand hygiene before their lunch meal that day.

Sources: Observations, interview with the resident, and record review of the home's hand hygiene program.

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