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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Public Report

Report Issue Date: May 6, 2025

Inspection Number: 2025-1434-0003

Inspection Type:
Critical Incident
Follow up

Licensee: United Mennonite Home for the Aged

Long Term Care Home and City: United Mennonite Home, Vineland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 14-15, 22-25, 2025 and May 5-6, 2025.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intakes #0140402 and #00143688 were related to infection prevention and control
- Intake #00143833 was related to falls prevention and management

The following intakes were completed in this Follow-up inspection:

- Follow-up #01- CO #001 / 2025-1434-0001, O. Reg. 246/22 s. 157 (2) (b), CDD March 21, 2025
- Follow-up #02- CO #002 / 2025-1434-0001, O. Reg. 246/22 s. 161 (2), CDD March 21, 2025

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2025-1434-0001 related to O. Reg. 246/22, s. 157 (2)

(b)
Order #002 from Inspection #2025-1434-0001 related to O. Reg. 246/22, s. 161 (2)

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

Infection Prevention and Control
Falls Prevention and Management
Admission, Absences and Discharge

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 ensure that the falls prevention and management program was implemented.

The home's Head Injury Routine (HIR) policy stated that a HIR must be completed for all unwitnessed falls and listed specific time intervals for neurological vitals to be taken. A resident had unwitnessed falls on three dates in March 2025. For each of these falls, there were two missed HIR checks which were documented as missed or that the resident was sleeping. The Associate Director of Care (ADOC) confirmed it was expected that the resident would be woken up and staff would attempt to

collect vitals at all of the policy indicated time intervals. There is a risk of a head injury going unnoticed and care being delayed when staff do not collect the neurological vitals at the recommended time intervals.

Sources: The resident's clinical records, the HIR Policy dated November 29, 2024, and interviews with staff.

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 any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

A) The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, required that the homes outbreak management team conduct a debrief session at the end of each outbreak to assess the effectiveness of the IPAC practices and to create a summary of recommendations for improvements to outbreak management practices. There were four declared outbreaks during the span of November 2024 to April 2025. The home did not complete the debrief sessions or summary of recommendations for any of these outbreaks.

B) The IPAC Standard for Long-Term Care Homes, revised September 2023, required homes to ensure that personal protective equipment (PPE) was available

and adequately accessible for Routine Practices and Additional Precautions. There was a resident who was on Droplet Contact Precautions that required staff to don eye protection when within two meters of the resident. The inspector observed that there was no eye protection available in the PPE supply bag or bin beside this residents room. To access eye protection, staff had to retrieve goggles from a locked utility closet at the other end of the unit. There was a risk of potentially spreading viruses when staff were not able to adequately access the PPE required to provide direct care to a resident on Additional Precautions.

Sources: The IPAC Standard, the resident's clinical records, observations, and interviews with staff.

WRITTEN NOTIFICATION: CMOH and MOH

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings effective February 2025, stated that all health care workers providing direct care to a suspect or confirmed case of COVID-19 needed to wear eye protection. During the inspection, a staff member was observed to

provide direct care without donning eye protection to a resident who was on Droplet Contact Precautions related to suspect COVID-19. Not wearing the required PPE when providing direct care to a suspect COVID-19 resident, placed the staff member at risk of contracting and potentially spreading COVID-19 to other staff and residents.

Sources: Observations, the resident's clinical records, The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, and interview with staff.