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: August 1, 2025
Inspection Number: 2025-1434-0005
Inspection Type: Critical Incident
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): July 29-31, 2025 and August 1, 2025

The following intake(s) were inspected:

- Intake #00146850 - CI (Critical Incident) #2951-000004-25 related to the prevention of abuse and neglect.
- Intake #00148063 - CI #2951-000005-25 related to falls prevention and management.
- Intake #00150369 - CI #2951-000007-25 related to falls prevention and management.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Staff and others to be kept aware

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that staff were kept aware of the contents of a resident's plan of care. A progress note indicated a resident required a certain intervention and their care plan did not indicate this intervention until eight months later. A staff member acknowledged that some staff did not have access to resident progress notes.

Sources: A resident's clinical record, home's investigation notes, interview with staff.

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) 5.
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:
5. Every resident has the right to freedom from neglect by the licensee and staff.

The licensee has failed to respect and promote a resident's right to freedom from

neglect by staff.

O. Reg. 246/22 s. 7 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A staff member reported that other staff members were providing a specific method of care to a resident that did not align with their plan of care. The home's investigation identified that eight staff members were completing this method for a number of months.

Sources: A resident's clinical record, the home's investigation notes, interview with staff, CI report #2951-000004-25.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an allegation of neglect to a resident was immediately reported to the Director when an allegation was received by the home

and it was not reported until the following day.

Sources: CI report #2951-000004-25, interview with staff.

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