Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Public Report

Report Issue Date: December 16, 2025
Inspection Number: 2025-1434-0008
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): December 11, 12, 15, 16, 2025.

The following intake(s) were inspected:
-Intake: #00162830 - Critical Incident (CI) #2951-000012-25/2951-000011-25 -related to prevention of abuse and neglect.

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

Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 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.

Section 2 of Ontario Regulation (O. Reg.) 246/22 defines “physical abuse” as the use of

physical force by a resident that causes physical injury to another resident.

A resident used physical force towards a co-resident which resulted in physical injuries to the co-resident.

Sources: critical incident report; home's investigative notes; and an interview with staff #103.

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 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.

A resident used physical force towards a co-resident which resulted in physical injuries to the co-resident. The incident was reported to the Director approximately 15 hours later.

Sources: critical incident report and an interview with staff #103.