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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: October 15, 2025

Inspection Number: 2025-1526-0003

Inspection Type:
Complaint
Critical Incident

Licensee: The Leamington United Mennonite Home and Apartments

Long Term Care Home and City: Leamington Mennonite Home Long Term Care Residence, Leamington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 6, 7, 8, 15, 2025
The inspection occurred offsite on the following date(s): October 10, 2025

The following intake(s) were inspected:

- Intake: #00156895 - Critical Incident System report #3035-000005-25 related to a fall with injury.
- Intake: #00157331 - Related to a complaint alleging improper care.

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

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Records

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 274 (b)
Resident records
s. 274. Every licensee of a long-term care home shall ensure that,
(b) the resident's written record is kept up to date at all times.

The licensee failed to ensure that a resident's written record was kept up to date at all times.

During an interview a Registered Practical Nurse (RPN) they shared that they had spoken with Substitute Decision Makers (SDM's) and the Director of Care (DOC) regarding a resident on at least two occasions but did not document these conversations in the resident's record. The DOC acknowledged that they had notified the Physician on at least two occasions related to the residents condition but had not documented the Physician notifications.

Sources: A resident's clinical record, interview with an RPN and the DOC.