

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: September 2, 2025

Inspection Number: 2025-1511-0005

Inspection Type:

Complaint
Critical Incident
Follow up

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): August 26-29, 2025 and September 2, 2025

The following intake(s) were inspected:

- Intake: #00148950 - Critical Incident (CI): 3016-000017-25 related to resident care and support services.
- Intake: #00151938 - Follow-up #1 - Compliance Order #001/2025-1511-0004 - O. Reg. 246/22 - s. 23.1 (3) 1 Air Conditioning Requirements, Compliance Due Date (CDD) August 01, 2025.
- Intake: #00152541 - complaint related to air temperatures.

Previously Issued Compliance Order(s)

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

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

Order #001 from Inspection #2025-1511-0004 related to O. Reg. 246/22, s. 23.1 (3) 1.

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

Resident Care and Support Services
Safe and Secure Home
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 119 (2) 2.

Requirements relating to restraining by a physical device

s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act:

2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

The licensee failed to ensure that staff applied a resident's restraint in accordance with any instructions specified by the physician.

The resident had orders written by their physician for a restraint to be applied to their mobility device.

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

Record reviews and an interview with a staff member confirmed at the time of their fall, the resident did not have their restraint applied as ordered by their physician.

Sources: Critical incident; resident progress notes; post fall assessment; physician order; Minimum Data Set (MDS)/Resident Assessment Instrument (RAI); care plan; Kardex; 3 Month Physician Medication Review; interview with staff and others.