

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

Ottawa District

347 Preston Street, Suite 410 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

Public Report

Report Issue Date: August 5, 2025

Inspection Number: 2025-1201-0004

Inspection Type:Critical Incident

Licensee: Marianhill Inc.

Long Term Care Home and City: Marianhill Nursing Home, Pembroke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 30, 31, 2025 and August 1, 5, 2025

The following intake(s) were inspected:

Intake: #00147213 - Unexpected death of a resident

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

Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)



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 **Ottawa District**

347 Preston Street, Suite 410 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's care plan was updated to reflect they required total assistance with feeding of meals from limited assistance of meals.

Sources: a resident's clinical records, interview with PSW's, an RPN and a Unit Manager.

WRITTEN NOTIFICATION: Registered Dietitian Assessments

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 29 (4) (b)

Plan of care

s. 29 (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home.

(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 246/22, s. 29 (4).

The licensee has failed to ensure that the Registered Dietitian (RD) completed an assessment on a resident, on a specified date in February 2025 when an Registered Nurse (RN) expressed that a resident was having difficulty with their present food texture and coughing and drooling a lot when eating.

Sources: A Resident clinical file, interview with an RN and the RD.