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

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

Public Report

Report Issue Date: April 16, 2026

Inspection Number: 2026-1201-0002

Inspection Type:
Complaint
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): March 31, 2026 and April 1, 2, 7, 8, 9, 13, 14, 15, 16, 2026

The following intake(s) were inspected:

Intake: #00170015 -2702-000005-26 - Resident to resident physical abuse resulting in injury.

- Intake: #00170286 - Fall of resident resulting in injury.
- Intake: #00171002 - Fall of resident resulting in injury.
- Intake: #00171922 - Unexpected death of resident.
- Intake: #00171965 - Resident to resident physical abuse resulting in injury.
- Intake: #00175765 - Complaint related to insufficient transfer supplies.

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

Resident Care and Support Services
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.
On a day in April, 2026 during an interview with a staff member, they confirmed that a toileting sling was used during a transfer from the bed to the wheelchair. They confirmed that this was not the correct sling to use for that transfer. In another interview with a staff member, they confirmed that the two slings within the residents room were toileting slings. During resident record review, it specified that a medium-universal sling with a black spacer is required for transferring of resident.

Sources: Resident record review and interviews with staff

WRITTEN NOTIFICATION: Availability of supplies

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment

and devices are readily available at the home to meet the nursing and personal care needs of residents.

Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.
On a day in April, 2026, a staff member confirmed that supplies are not readily available when providing care to a resident. Specifically, a resident required a medium-universal sling for transfers. During an observation, the specified sling was not available in the resident's room, nor in the tub room on the unit where the staff indicated is where extra slings are kept. In a separate interview with a staff member, they confirmed that on several occasions, the appropriate sling type and size are not available on the unit and this results in delayed care of a resident.

Sources: Resident record review and interviews with staff

COMPLIANCE ORDER CO #001 24-hour admission care plan

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 27 (6)
24-hour admission care plan
s. 27 (6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 246/22, s. 27 (6).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall;

1. Conduct an audit of all residents on two specific units to identify those that are a high risk of falling.

2. Ensure that the fall prevention interventions are updated within the care plan and that the falls prevention measures are in place for the high falls risk residents identified.
3. Conduct an audit one time per week for each shift (total three audits per resident per week) to ensure fall prevention measures are in place in accordance to the residents care plan for a minimum of four weeks or until consistent compliance is achieved.
4. Take immediate corrective action if deviations from the plan of care are identified.
5. Keep written records of one-four until the Ministry of Long Term Care has deemed the home as compliant with this order.

Grounds

The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan.

On a day in February, 2026, a resident sustained a fall resulting in a fracture. During an interview with a staff member, they confirmed that there was one fall mat in place when the resident fell which was located on the opposite side of the fall and a motion sensor alarm was in place however, it was not turned on and therefore, did not sound when the resident had a fall. During a review of resident records, the care plan indicates that two fall mats, as well as a motion sensor alarm in good working order is required when the resident is in bed. In addition, based on resident record review, the main cause of death was due to complications of the fall.

Sources: Resident record review and an interview with staff

A resident sustained a fall on a day in February, 2026 that resulted in a fracture. During a record review, the care plan specified that a chair alarm was supposed to be attached to the resident. During an interviews with staff, they confirmed that it would be expected that the chair alarm be attached to the resident when up in a wheelchair or chair and that on a day in February, 2026, at the time of the fall, the chair alarm was not attached to the resident.

Sources: Resident record review and interviews with staff

This order must be complied with by

May 27, 2026

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.