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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: October 30, 2025
Inspection Number: 2025-1128-0005
Inspection Type: Critical Incident
Licensee: Mariann Nursing Home and Residence
Long Term Care Home and City: Mariann Home, Richmond Hill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 28, 29, 2025

The following intake(s) were inspected:
- One intake related to an outbreak, and
- One intake related to an allegation of verbal abuse from staff to resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident was treated with courtesy and respect.

A verbal altercation occurred between a resident and a Personal Support Worker (PSW). The incident report indicated that the resident had been mobilizing past the snack cart when the PSW informed the resident that they had a cookie for them. The resident declined the cookie at this time and the PSW then threw the cookies in the garbage. The resident found this wasteful and disrespectful and called the PSW some inappropriate words. The PSW had responded by repeating the inappropriate words back to the resident in a higher volume.

During an interview, the resident indicated that they felt bad for declining the snack at the time and also after the verbal altercation, however; when the staff member threw the cookies into the garbage, it left the resident feeling disrespected.

Sources: CIR, resident's progress notes, Point of Care (POC) documentation, plan of care, and interviews with the resident, the Administrator, and other staff.

WRITTEN NOTIFICATION: Maintenance services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that procedures were developed and implemented to ensure that, all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.
On an identified date, four resident fall mats in rooms were observed to be ripped or torn.

Sources: Observations, and interviews with the Administrator and the Infection Prevention and Control (IPAC) lead.

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