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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: September 11, 2023
Original Report Issue Date: August 28, 2023
Inspection Number: 2023-1201-0006 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Marianhill Inc.
Long Term Care Home and City: Marianhill Nursing Home,Pembroke

Amended By	**Inspector who Amended Digital Signature**
Margaret Beamish (000723)	Margaret E Beamish Digitally signed by Margaret E Beamish Date: 2023.09.12 10:31:33 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

This inspection report has been amended to change the numbering of the non-compliance.

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Lead Inspector Margaret Beamish (000723)	**Additional Inspector(s)** Jessica Nguyen (000729) Gurpreet Gill (705004)
Amended By Margaret Beamish (000723)	**Inspector who Amended Digital Signature** Margaret E Beamish Digitally signed by Margaret E Beamish Date: 2023.09.12 10:31:02 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

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INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 27-31, 2023 and August 1-3, 2023.

The following intakes were completed in this complaint inspection:

- Intake #00091375 was related to meal service and staffing; and
- Intake #00091228 was related to concerns regarding palliative care and alleged neglect.

The following intake was completed in this Critical Incident (CI) inspection:

- Intake #00091074 was related to a fall with injury resulting in a significant change in condition.

The following intake was completed in this inspection:

- Intake #00091013 was related to a fall with injury resulting in a significant change in condition.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Staffing, Training and Care Standards
Palliative Care
Falls Prevention and Management

AMENDED 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 (9) 1.

The licensee has failed to ensure that the provision of the care set out in a resident's plan of care was documented.

Rationale and Summary

The point of care (POC) documentation for a resident showed that for a certain month, there was one day, where the resident’s oral care for the evening was not documented, and for another month, there were two days where the resident’s oral care for the morning was not documented.

During an interview, a Unit Manager indicated that residents received their scheduled oral care twice a day, but the staff did not complete their documentation in the POC.

Sources: A resident's health care records and interview with a Unit Manager. [705004]