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

Original Public Report

Report Issue Date: April 16, 2024	
Inspection Number: 2024-1201-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Marianhill Inc.	
Long Term Care Home and City: Marianhill Nursing Home, Pembroke	
Lead Inspector Saba Wardak (000732)	**Inspector Digital Signature** Saba Wardak Digitally signed by Saba Wardak Date: 2024.05.06 13:00:08 -04'00'
Additional Inspector(s) Karen Buness (720483)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 20-22, 26-27, 2024 and April 2-3, 8-9, 2024.

The following intake(s) were inspected:

- Intake: #00099534/ CI #2702-000042-23 - related to a fall of a resident resulting in significant change in condition
- Intake: #00105396/ IL-21414-AH/ CI #2702-000001-24 - related to resident to resident alleged physical abuse
- Intake: #00103359/ CI #2702-000044-23, Intake: #00106123/ IL-21751-AH/ CI #2702-000002-24, Intake: #00106465/ CI #2702-000003-24 and Intake: #00108783/ CI #2702-000007-24 - related to resident to resident alleged sexual abuse

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The following complaint intake (s) were inspected:

- Intake: #00101734- related to potential presence of mold in a resident home area

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

Falls Prevention and Management
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to immediately report the abuse of a resident by anyone that resulted in harm or a risk of harm to the resident to the Director.

On a specified date, a resident was observed touching another resident inappropriately. When interviewed, unit manager #111 confirmed that the incident was not reported to the Director until two days after it occurred because it was not reported to the licensee's management team immediately.

Failure to report the incident immediately could have impacted the licensee's investigation and response to the incident.

Sources: Critical Incident Report #2702-000044-23, interview with unit manager #111

[720483]