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

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# Public Report

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| Report Issue Date: December 17, 2024 |
| Inspection Number: 2024-1201-0007 |
| Inspection Type:<br>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): December 11, 12, 13, 16, 2024

The following intake(s) were inspected:

- Intake: #00129648 - related to resident to resident physical abuse
- Intake: #00130704 - related to the fall of a resident which resulted in a significant change in condition

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

# 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 ensure abuse of a resident that resulted in harm is reported immediately to the Director. On a specific date, two residents were involved in an incident which resulted in an injury. The licensee did not report the incident until four days after the incident

Source: Resident #002 and #003's health records, CIS report 2702-000035-24, interview with the unit manager.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:

2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed for a resident. A resident elicited responsive behaviours towards a co-resident which resulted in injury. A review of the resident's written plan of care reveals interventions to address responsive behaviours had not been updated and do not include interventions to decrease responsive behaviours towards other residents on the unit.

Source: Resident health record, interviews with personal support workers and the unit manager.

## WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure for a resident who is demonstrating responsive behaviours, the behavioural triggers are identified, strategies are developed and

implemented to respond to these behaviours and actions are taken and that the responses to the interventions are documented.

A resident was involved in a physical altercation with a co-resident. A review of the resident's health record and interviews with staff show that the resident has a history of verbal and physical responsive behaviours towards residents. The review of the resident's written plan of care reveals no assessments have been completed to identify the resident's behavioural triggers or interventions developed to address the responsive behaviours. When interviewed the unit manager confirmed this should be included in the resident's plan of care.

Source: Resident health records, interviews with personal support workers and the unit manager.

## WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) is notified immediately upon the licensee becoming aware of an of incident of abuse that resulted in a physical injury or pain to the resident. The resident was involved in

an incident with a co-resident which resulted in an injury. The licensee did not notify the resident's SDM until the following day.

Source: Resident health record, CIS report and interview with the unit manager.

## WRITTEN NOTIFICATION: Notification re incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (1) (b)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) is notified within 12 hours upon the licensee becoming aware of an incident of abuse or neglect of the resident. The resident was involved in a physical altercation with another resident. The licensee did not notify the resident's SDM until four days after the incident.

Source: Resident health record, CIS report and interview with unit manager.