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
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Public Report

Report Issue Date: February 5, 2025
Inspection Number: 2025-1201-0001
Inspection Type: Complaint
Licensee: Marianhill Inc.
Long Term Care Home and City: Marianhill Nursing Home, Pembroke

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 3, 4, 5, 2025

The following intake(s) were inspected:

- intakes #00136063 / 00137955-Complainant with concerns regarding an incident of alleged verbal abuse

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The licensee has failed to ensure that the homes abuse policy is complied with. Specifically, an RPN failed to comply with the homes abuse policy on a specified date in December 2024, when they were verbally abusive towards a resident. The ADOC confirmed that the homes policy is a zero-abuse policy and staff are expected to refrain from being verbally abusive to residents.

Sources: Video recording of incident, homes investigation notes and interview with the ADOC.

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and

neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that all staff at the home have received training as required by this section. Specifically, the home did not provide any orientation training to security guards who were hired by the home to provide one to one sitting for residents.

Sources: Interview with security guards, and interview with the DOC.