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: March 24, 2025
Inspection Number: 2025-1201-0002
Inspection Type: Complaint 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): March 18, 19, 20, 24, 2025

The following intake(s) were inspected:

- Intake: #00138668 - Complainant with concerns regarding lack of personal care residents are receiving.
- Intake: #00138752 - Alleged sexual abuse to a resident by another resident.
- Intake: #00140854 - Neglect of a resident by staff.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (1)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve;
(c) clear directions to staff and others who provide direct care to the resident; and
(d) any other requirements provided for in the regulations.

The licensee has failed to ensure that a resident's written plan of care includes a focus and interventions in order to protect them from incidents of sexual assault. Specifically, the home included interventions on the Critical Incident Report that was reported to the Director, but did not add a written plan of care to a resident's written care plan. Staff were not aware of these or unclear of these interventions.

Sources: Homes investigation notes, CIR, Resident's electronic file, interview with a resident, PSW, RPN's and a Unit Manager.

WRITTEN NOTIFICATION: Hydration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (b)

Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

The licensee has failed to ensure that a resident received a between-meal beverage in the morning and afternoon on a specific date in February 2025. The home submitted a Critical Incident report (CIR) to the Director for alleged neglect of a resident which included not being provided with required nourishments.

Sources: Homes investigation notes, CIR, interview with a PSW.

WRITTEN NOTIFICATION: Nourishments

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (4) (c)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(c) a snack in the afternoon and evening. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that a resident received an afternoon snack on a specific date in February 2025. The home submitted a Critical Incident report (CIR) to the Director for alleged neglect of a resident which included not being provided with their required nourishment.

Sources: Homes investigation notes, CIR and an interview with a PSW.

WRITTEN NOTIFICATION: Medication Administration

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that medications prescribed for a resident were administered to the resident on a specified date in February 2025 at specified times. The home submitted a Critical Incident report (CIR) to the Director for alleged neglect of a resident which included not being provided with their required medications on a specific date in February 2025.

Sources: Homes investigation notes, CIR and interview with an RPN.