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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: February 18, 2025

Inspection Number: 2025-1128-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Mariann Nursing Home and Residence

Long Term Care Home and City: Mariann Home, Richmond Hill

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 10 - 12, 2025.
The inspection occurred offsite on the following date(s): February 13, 2025.

The following intake(s) were inspected:
An intake and a critical incident (CI) were related to an allegation of staff-to-resident abuse.

An intake was related to Compliance Order CO #001 from inspection 2024_1128_0001, O. Reg. 246/22, s. 93(2)(b), with a Compliance Due Date (CDD) of November 15, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1128-0001 related to O. Reg. 246/22, s. 93 (2) (b).

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that the resident was protected from physical and emotional abuse by the Personal Support Worker (PSW).

Ontario Regulation 246/22, s. 2 (1) defines "emotional abuse" as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident. "Physical abuse" is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident was witnessed to have been emotionally and physically abused by the PSW on separate days, and suffered from pain. The Director of Care (DOC) confirmed that the abuse was substantiated.

Sources: Critical Incident (CI), home's investigation notes, the resident's clinical record, the PSW's staff record, interviews with the DOC and others.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 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 suspicion of resident abuse by the PSW to the Director.

On an identified date, a staff had witnessed a suspected physical resident abuse by the PSW. The next day the same staff had witnessed an incident of emotional abuse to the same resident, by the same PSW. The home had only informed the Director days later via the submission of a CI report. The DOC acknowledged that the incidents of abuse should have been reported immediately.

Sources: CI, home's investigation notes, the resident's clinical record, the PSW's staff record, interviews with the DOC and others.

WRITTEN NOTIFICATION: Police notification

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105
Police notification
s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee has failed to ensure that the appropriate police service was immediately notified of the suspected incidents of resident abuse by the PSW that were witnessed by the staff. The DOC confirmed that the police was not notified of the incidents.

Sources: CI, home's investigation notes, the resident's clinical record, the PSW's staff record, interviews with the DOC and others.

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NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
The Compliance Order was initially issued in Workspace 2024-1128-0001 and one of the components was not found to be in compliance in the first Follow-Up Inspection, Workspace 2024-1128-0002.

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.