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
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Public Report

Report Issue Date: April 8, 2025
Inspection Number: 2025-1128-0003
Inspection Type: Critical Incident
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): March 31, 2025, April 1 to 4, and April 8, 2025

The following intake(s) were inspected:

- One intake related to an Outbreak.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee failed to ensure that with the consideration of the home's outbreak management system, that the home complied with there plan.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the infection prevention and control program. Specifically, the home's outbreak management - respiratory policy indicated that three cases of ARI (laboratory confirmation not necessary) occurring within 48 hours with any common epidemiological link confirmed a respiratory infection outbreak definition. Furthermore, the policy indicated to assess and confirm that there is a suspected or confirmed respiratory outbreak in consultation with Public Health.

Multiple resident's clinical records identified onset of symptoms on a specific date with symptoms continuing to the following day when all resident's were placed on additional precautions. Several additional resident's were placed on additional precautions on the second day. Multiple resident's on the second day were identified to have the same two symptoms. All identified resident's resided on the same floor. The Public Health Nurse (PHN) and the IPAC Lead confirmed that Public Health should have been notified of residents cases sooner than the identified date.

Sources: Clinical health records for several resident's, case definition sheet, monthly surveillance sheet, Outbreak Management - Respiratory policy, and interviews with the PHN and the IPAC Lead.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee failed to ensure that two resident's were monitored on every shift for signs and symptoms when exhibiting the presence of infection.

Clinical health records for both resident's confirmed they were exhibiting signs and symptoms of infection and required additional precautions to be initiated. Both resident's clinical health records indicated that signs and symptoms of infection were not documented for multiple shifts during their respective infectious periods. A Registered Practical Nurse (RPN) and the IPAC Lead confirmed that the home's process was to monitor and document signs and symptoms every shift until the infection was resolved.

Sources: Resident's clinical health records, and interviews with an RPN and the IPAC Lead.

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under

subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that an outbreak of a disease of public health significance was immediately reported to the Director.

The home declared a respiratory outbreak on a specified date. The Critical Incident (CI) report was not submitted to the Director until the following day.

Sources: CI, Outbreak Debriefing and Analysis Report, and interviews with the PHN and the IPAC Lead.

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