

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007**

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

**Long-Term Care Operations Division  
Long-Term Care Inspections Branch**

**Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée**

London Service Area Office  
130 Dufferin Avenue 4th floor  
LONDON ON N6A 5R2  
Telephone: (519) 873-1200  
Facsimile: (519) 873-1300

Bureau régional de services de  
London  
130, avenue Dufferin 4ème étage  
LONDON ON N6A 5R2  
Téléphone: (519) 873-1200  
Télécopieur: (519) 873-1300

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 19, 2020	2020_563670_0009	001146-20	Critical Incident System

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**Licensee/Titulaire de permis**

The Corporation of the County of Lambton  
789 Broadway Street WYOMING ON N0N 1T0

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**Long-Term Care Home/Foyer de soins de longue durée**

Marshall Gowland Manor  
749 Devine Street SARNIA ON N7T 1X3

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**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

DEBRA CHURCHER (670)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): February 10 and 11, 2020.**

**The purpose of this inspection was to inspect Log# 001146-20 related to an injury of unknown cause.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse, two Personal Support Workers and one Comfort Clerk.**

**During the course of the inspection the Inspector observed the overall cleanliness and maintenance of the home, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records, reviewed relevant internal documentation and reviewed relevant policies and procedures.**

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

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)**

**0 VPC(s)**

**1 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**  
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**  
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The Ministry of Long-Term Care received a Critical Incident System (CIS) report #M613-000003-20 related to an injury to resident #001.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home's policy titled Falls Prevention and Management, Policy 3-5-6-0, last reviewed February 5, 2020, stated Registered Nursing staff initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy. Refer to policy 3-5-8-1-1 Head Injury.

The home's policy titled Head Injury, Policy 3-5-8-1-1, last reviewed May 10, 2019, stated Registered Staff will assess the resident's neuro-vital signs using the Head Injury record for 72 hours post head injury. Head Injury record stated HIR assessments were to be done as follows;

- every half hour times four
- every hour times four
- every two hours times five
- every four hours times four
- every eight hours times five

Review of resident #001's clinical record showed that resident #001 had a five specific incidents over a three month time period.

Review of resident #001's clinical record showed that resident #001 did not receive a specific clinical assessment related to the five specific incidents on 27 occasions.

During an interview with Director of Care (DOC) #102 the clinical records related to the specific assessments for resident #001 were reviewed. DOC #102 acknowledged that the assessments were not completed and should have been.

B) Review of resident #002's clinical record showed that resident #002 had a specific incident on a specific date.

Review of resident #002's clinical record showed that resident #002 did not receive a specific clinical assessment related to to specific incident on eight occasions.

During an interview with the DOC #102 they acknowledged that the assessments were not completed for resident #002 as per the home's policies and should have been.

C) Review of resident #004's clinical record showed that resident #004 had a specific incident on a specific date.

Review of resident #004's clinical record showed that resident #002 did not receive a specific clinical assessment related to to specific incident on six occasions.

During an interview with the DOC #102 they acknowledged that the assessments were not completed for resident #004 per the home's policies and should have been.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. [s. 8. (1) (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

**Issued on this 19th day of February, 2020**

**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée  
Inspection de soins de longue durée

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** DEBRA CHURCHER (670)

**Inspection No. /**

**No de l'inspection :** 2020\_563670\_0009

**Log No. /**

**No de registre :** 001146-20

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Feb 19, 2020

**Licensee /**

**Titulaire de permis :** The Corporation of the County of Lambton  
789 Broadway Street, WYOMING, ON, N0N-1T0

**LTC Home /**

**Foyer de SLD :** Marshall Gowland Manor  
749 Devine Street, SARNIA, ON, N7T-1X3

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Carla Alway

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To The Corporation of the County of Lambton, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Order # /**

**No d'ordre :** 001

**Order Type /**

**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,  
 (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and  
 (b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with O. Reg. 79/10 s. 8.(1). (a). (b).  
 Specifically;

A) The licensee must ensure that the home's policy #3-5-6-0 Falls Prevention and Management and the home's policy #3-5-8-1-1 Head Injury routine are implemented and complied with.

B) The licensee must ensure that all Registered Nurses and Registered Practical Nurses receive re-training related to the home's policies #3-5-6-0 Falls Prevention and Management and the home's policy #3-5-8-1-1 Head Injury Routine.

C) The licensee must keep a record related to the training that indicates the staff members that received the training and the date the training was completed.

**Grounds / Motifs :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The Ministry of Long-Term Care received a Critical Incident System (CIS) report #M613-000003-20 related to an injury to resident #001.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."



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**Ordre(s) de l'inspecteur**

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The home's policy titled Falls Prevention and Management, Policy 3-5-6-0, last reviewed February 5, 2020, stated Registered Nursing staff initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy. Refer to policy 3-5-8-1-1 Head Injury.

The home's policy titled Head Injury, Policy 3-5-8-1-1, last reviewed May 10, 2019, stated Registered Staff will assess the resident's neuro-vital signs using the Head Injury record for 72 hours post head injury. Head Injury record stated HIR assessments were to be done as follows;

- every half hour times four
- every hour times four
- every two hours times five
- every four hours times four
- every eight hours times five

Review of resident #001's clinical record showed that resident #001 had a five specific incidents over a three month time period.

Review of resident #001's clinical record showed that resident #001 did not receive a specific clinical assessment related to the five specific incidents on 27 occasions.

During an interview with Director of Care (DOC) #102 the clinical records related to the specific assessments for resident #001 were reviewed. DOC #102 acknowledged that the assessments were not completed and should have been.

B) Review of resident #002's clinical record showed that resident #002 had a specific incident on a specific date.

Review of resident #002's clinical record showed that resident #002 did not receive a specific clinical assessment related to to specific incident on eight occasions.

During an interview with the DOC #102 they acknowledged that the assessments were not completed for resident #002 as per the home's policies

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Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

and should have been.

C) Review of resident #004's clinical record showed that resident #004 had a specific incident on a specific date.

Review of resident #004's clinical record showed that resident #002 did not receive a specific clinical assessment related to to specific incident on six occasions.

During an interview with the DOC #102 they acknowledged that the assessments were not completed for resident #004 per the home's policies and should have been.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. (670)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

Mar 09, 2020

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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section 154 of the *Long-Term  
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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
151 Bloor Street West, 9th Floor  
Toronto, ON M5S 1S4

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

**PRENEZ AVIS :**

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 19th day of February, 2020**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Debra Churcher

**Service Area Office /**

**Bureau régional de services :** London Service Area Office