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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: June 28, 2024
Inspection Number: 2024-1608-0003
Inspection Type: Critical Incident
Licensee: The Corporation of the County of Lambton
Long Term Care Home and City: Marshall Gowland Manor, Sarnia

Lead Inspector	**Inspector Digital Signature**
Loma Puckerin (705241)	Loma S Puckerin Digitally signed by Loma S Puckerin Date: 2024.07.02 08:45:51 -04'00'

Additional Inspector(s)
Aby Thomas (000830)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 24, 25, 26, 27, 2024

The following intake(s) were inspected:

- Intake: #00112862 related to the fall of a resident.
- Intake: #00114600 related to the fall of a resident.
- Intake: #00116450 related to resident to resident abuse.

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

Infection Prevention and Control
Responsive Behaviours

Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The home submitted a critical incident report related to the fall of a resident who sustained an injury and required medical treatment.

A review of the resident's care plan indicated a specific safety device was to be in place. The inspector observed the resident's room and did not see the intervention in place.

In an interview with the charge nurse it was revealed that the resident's care plan

was revised, and the safety device was no longer required,

Sources: observation, record review and staff interview

Date Remedy Implemented: June 25, 2024

[000830]