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: September 18, 2024
Inspection Number: 2024-1608-0004
Inspection Type: Critical Incident
Licensee: The Corporation of the County of Lambton
Long Term Care Home and City: Marshall Gowland Manor, Sarnia

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 3-6, and 9-10, 2024
The inspection occurred offsite on the following date(s): September 3-6, and 9, 2024
The following intake(s) were inspected:

- Intake: #00120939 related to Prevention of Abuse and Neglect
- Intake: #00122297 related to Infection Prevention and Control
- Intake: #00124073 related to Resident Care and Supportive Services

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident was provided with the care consistent with their needs.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to an injury that a resident sustained during care, which resulted in a significant change in their health.

Two Personal Support Workers (PSWs) reported to a Registered Practical Nurse (RPN) that a resident sustained a suspected injury while they were providing care. The RPN failed to follow-up on the reported concern and assess the resident.

During the following shift, a PSW stated a resident displayed pain indicators when they were providing care and reported their concerns to a Registered Nurse (RN).

Review of the home's investigation noted that there was a significant delay in assessment and treatment for a resident when a RPN did not complete an assessment to determine a resident's medical needs.

Failure to ensure that a resident was provided the care consistent with their needs resulted in a significant delay in meeting the care needs of the resident.

Sources: Review of resident clinical records, the home's investigation, and interviews with staff and management.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that they complied with their written policy to promote zero tolerance of abuse and neglect of a resident.

Rationale/Summary
A Critical Incident (CI) was submitted to the Director related to suspected staff to resident abuse.

On a specific date, a resident exhibited responsive behaviours and a PSW responded in an way that could be seen as potential abuse. An RPN, who was also present during the incident did not intervene or immediately report the incident.

Review of the home's Prevention of Abuse and Neglect policy stated that staff were required to notify their immediate supervisor or designate immediately of any

alleged, suspected or witnessed incidents of abuse.

There was an increased risk to the resident's safety when the suspected incident of abuse was not immediately reported as per the home's policy.

Sources: Review of Critical Incident System (CIS) report, resident clinical records, Prevention of Abuse and Neglect Policy, home's investigation notes, and staff interviews.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee failed to ensure that the strategies and interventions developed to respond to a resident's responsive behaviours were implemented.

Summary/Rationale:
A Critical Incident (CI) was submitted to the Director related to suspected staff to resident abuse.

On a specific date, a resident exhibited responsive behaviours. A Registered Practical Nurse (RPN) and a Personal Support Worker (PSW) did not follow the resident's plan of care in an effort to deescalate the situation.

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During an interview with the Director of Care (DOC), they confirmed that staff members did not implement the interventions set out in the resident's plan of care to support responsive behaviours.

There was a risk to a resident when staff members did not implement the strategies and interventions developed to respond to a resident's responsive behaviours as per their plan of care.

Sources: Review of Critical Incident (CI) report, the home's investigation notes, resident clinical records, and staff interviews.