

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

Public Report

Report Issue Date: April 7, 2026

Inspection Number: 2026-1608-0002

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 dates: March 25-26, and 30, and April 1-2, and 7, 2026.

The following intakes were inspected:

- Critical Incident (CI) #M613-000004-26 related to allegations of resident neglect; and
- CI #M613-000006-26 related to falls prevention and management.

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

- Prevention of Abuse and Neglect
- Falls Prevention and Management

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.

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Ontario Regulation 246/22 section 7 defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the home alleging that staff in the home neglected to provide a resident with the continence care they required on two dates.

At this time the resident's plan of care outlined that they required specific continence care at particular times of day and were at risk for impaired skin integrity related to their continence status.

The resident was also scheduled to be on hourly purposeful rounds and staff were directed to check on their personal needs, including if they required continence care when completing these purposeful rounds.

On the two dates identified, the resident was not provided with continence care at the particular time of day they required it, despite their Power of Attorney (POA) requesting that they be provided with this care.

The home conducted an investigation related to the allegations of neglect that were reported and found that the resident was neglected by staff when they were not provided with the continence care they required on these two dates. When staff neglected to provide the resident with the continence care they required on these dates, they were placed at risk for further skin breakdown.

Sources: CI report #M613-000004-26; the home's policies; the home's investigation notes related to CI #M613-000004-26; the resident's clinical record, including their care plan and tasks; and staff interviews.

WRITTEN NOTIFICATION: Dining and snack service

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)

Dining and snack service

s. 79 (2) The licensee shall ensure that,

(b) no resident who requires assistance with eating or drinking is served a meal until

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someone is available to provide the assistance required by the resident.

A nutrition assessment completed for a resident assessed them to be at high nutritional risk related to specific risk factors, including requiring assistance with eating.

Their plan of care indicated they required assistance from staff with eating and directed staff to provide them with a specific item at snack time to improve their nutritional status.

Staff reported that Personal Support Workers (PSWs) were responsible for providing residents the assistance they required with eating and drinking and that dietary staff were not adequately trained to do so.

A dietary staff member left the residents specific snack item in their room at which time the resident was not present and they did not communicate to the PSW staff members responsible for providing the resident with assistance that this snack had been left in their room. The snack was later found untouched in the residents room after and disposed of.

The resident was served a snack before someone was available to provide the assistance they required with eating and drinking, which resulted in them not being provided with the nutrition care that they required.

Sources: CI report #M613-000004-26; the home's investigation notes related to CI #M613-000004-26; the resident's clinical record, including their nutrition assessments, care plan, and progress notes; and staff interviews.