

# 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

## **Public Report**

Report Issue Date: May 13, 2025

**Inspection Number:** 2025-1608-0003

**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): May 7-9, and 13, 2025.

The following intake was inspected:

• Critical Incident (CI) #M613-000009-25 related to allegations of resident neglect.

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

Prevention of Abuse and Neglect Responsive Behaviours

## **INSPECTION RESULTS**

**WRITTEN NOTIFICATION: Responsive behaviours** 



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NC #001 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 when a resident demonstrated responsive behaviours, strategies to respond to these behaviours were implemented. The resident exhibited a responsive behaviour and personal support staff did not report this behaviour to nursing staff. As it was not reported to them, nursing staff were unaware that the resident had exhibited the responsive behaviour and therefore did not implement strategies to respond to these behaviours as directed in their plan of care.

Sources: The resident's clinical record, including care plan, tasks, progress notes, and orders; the home's investigation notes related to a CI; and staff interviews.