Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 10, 2020	2020_717531_0007	001661-20, 002512-20, 003587-20	Critical Incident System

Licensee/Titulaire de permis

County of Prince Edward
603 Highway 49 R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

H.J. McFarland Memorial Home
603 Highway 49, R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 2, 3, 4, and 5, 2020.

The following logs were inspected concurrently:
Log # 001661-20 Critical Incident #M556-000003-20 related to resident care and services
Log # 002512-20 Critical Incident #M556-000007-20 related to alleged abuse
Log # 003587-20 Critical Incident #M556-000010-20 related to alleged abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Physician, and residents.
During the Course of the inspection the inspector reviewed resident health records, observed resident care and services, reviewed critical incident reports, internal investigation documentation, and the abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, did immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act.

Review of the critical incident report submitted on a specified date, indicated an incident of alleged sexual abuse which alleged resident #003 had inappropriately touched resident #005 and attempted to kiss the resident. The critical incident indicated that the date of the incident occurred the evening of a particular date. There were no untoward effects to resident #005.

During an interview with the DOC and confirmed by the review of the critical incident report and internal investigative documentation, the DOC told inspector #531, that the Director was notified two days after the incident.

The licensee failed to immediately notify the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident shall immediately report the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's SDM was immediately notified upon becoming aware of alleged abuse.

Review of the critical incident report submitted on a specified date, indicated an incident of alleged sexual abuse which alleged resident #003 had inappropriately touched resident #005 and attempted to kiss the resident. The critical incident indicated that the date of the incident occurred the evening of a particular date. There were no untoward effects to resident #005.

During an interview with RN #103, confirmed by the review of the internal documentation the RN told inspector #531, that they had assessed the residents, notified the police, physician and SDM for resident #003, however, was not aware that they had not notified resident #005’s SDM until a particular date.

The licensee failed to ensure that the resident's SDM were immediately notified upon becoming aware of the alleged abuse of the resident. [s. 97. (1) (a)]

Issued on this 10th day of March, 2020

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

Original report signed by the inspector.