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
Sep 30, 2020	2020_664602_0016	013345-20, 015492-20, 016217-20, 016499-20, 016655-20, 017869-20, 018485-20	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

WENDY BROWN (602)

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): September 21- 25, 2020

The following inspections were completed:
Log# 013345-20/CIS# M556-000029-20, log# 0155492/CIS# M556-000031-20 and log# 016499-20/CIS# M556-000034-20 - regarding falls with injury and transfer to hospital.
Log# 016217-20/CIS# M556-000032-20 and log #018485-20/CIS# M556-000041-20 - regarding alleged resident to resident sexual abuse.
Log# 016655-20/CIS# M556-000038-20 and log #017869-20/CIS# M556-000039-20 - regarding missing controlled substance.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Physiotherapist (PT), the Director of Care (DOC), and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care, progress notes , investigation documentation, relevant policies and procedures, and made resident care and service observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to provide clear direction to staff regarding transfers, mobility and skin care for resident #001.

Resident #001's plan of care indicated transfers required one staff and that the resident used a walker for mobility/ambulation; it did not include up to date skin care direction.

Personal Support Workers (PSW) advised that the resident used a wheelchair for mobility and needed two staff to assist with transfers. The Physiotherapist (PT) indicated that the plan of care should note that the resident requires the assistance of two staff and requires a wheelchair. The lack of clear direction could result in skin breakdown as well as unsafe transfers and mobilization.

Sources: Resident observations, interviews with PSWs, the PT and other staff and a review of the resident's health record. [s. 6. (1) (c)]

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Issued on this 1st day of October, 2020

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

Original report signed by the inspector.