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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 23, 2021	2021_873602_0017	006809-21, 009044-21	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the 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): June 14-16, 2021

The following inspections were conducted:
Log # 006809-21/CIS #M556-000008-21- regarding a fall with injury and transfer to hospital.
Log # 009044-21/CIS #M556-000013-21- regarding alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Infection Prevention & Control (IPAC) management lead/Director of Care (DOC), a Physiotherapy Assistant, housekeeping staff, IPAC screening staff and the Administrator.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was transferred with two staff as per the plan of care.

A resident found they could no longer weight bear and was lowered to the floor by a Personal Support Worker (PSW) who had been assisting the resident to transfer. The resident complained of pain in their leg later that day. A Registered Nurse (RN) and the Director of Care (DOC) indicated that the resident was a two person transfer and should have been assisted by two staff.

Sources: CIS report, resident progress notes & plan of care and interviews with an RN, the DOC and other staff. [s. 6. (7)]

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 to ensure that the care set out in the plan of care is provided to resident(s) as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to follow Infection Prevention and Control (IPAC) evidenced based practices by not assisting residents to perform hand hygiene before and after meals.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals. IPAC lunch hour observations in the main dining area and on the Willow wing revealed resident hands were not cleaned prior to attending or within the dining area(s). This observation was shared with the Administrator who also observed that the hand wipes dispensor placed at the doorway to the main dining room was not being accessed nor were the hand sanitizer pumps. In a subsequent interview with the DOC it was indicated that staff have been asked to ensure resident hand hygiene is conducted pre and post all meals; neglecting hand hygiene at this time increases the risk of virus transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), IPAC Checklist A2, dining area observations and interviews with the Administrator and the DOC. [s. 229. (9)]

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 to ensure all staff participate in the implementation of evidenced based IPAC practices, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature of at least two resident bedrooms was measured and documented and that the measured temperatures were documented at least once every morning, once every afternoon, and once every evening or night.

The inspector reviewed the temperature monitoring log together with the environmental services supervisor (ESS) on June 15, 2021 and found that between June 1 and June 14, 2021 temperatures were recorded once a day from one common area in the home. Interviews with the ESS and Administrator revealed that the temperature of at least two resident bedrooms in different parts of the home was not being measured or documented, nor were temperatures being measured three times a day.

There is a risk to resident comfort and safety when the temperatures are not measured and documented in specified areas of the home during the required time frames.

Sources: Air Temperature log and interview(s) with the ESS and the Administrator. [s. 21. (2) 1.]

Issued on this 24th day of June, 2021

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

Original report signed by the inspector.