Ontario

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

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Original Public Report

Report Issue Date: November 18, 2022	
Inspection Number: 2022-1571-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: The Corporation of the County of Prince Edward	
Long Term Care Home and City: H.J. McFarland Memorial Home, Picton	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2022.11.18 10:00:07 -05'00'
Additional Inspector(s) Stephanie Fitzgerald (741726)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 20, November 1-3, and 7-9, 2022

The following intake(s) were inspected:

- Log #00004478-22 – regarding a follow-up to compliance order (CO) #001/2022_1571_0001, O. Reg 79/10 s.48 (1) related to falls prevention and management – initiation of head injury routine. Amended Compliance Due Date (CDD) October 30 2022.
- Log #00005861-22 – regarding a follow-up to CO #001/2022_779641_0004 O. Reg 79/10 s. 50 (2)(b)(iv) related to skin and wound care. Amended CDD October 30 2022.
- Log #00006844-22/ CI: M556-000031-22 - regarding a fall with injury and transfer to hospital.
- Log #00007386-22/ CI: M556-000029-22 - regarding a fall with injury and transfer to hospital
- Log #00003856-22/ CI: M556-000026-22 - regarding a fall with injury and transfer to hospital
- Log #00000824-22/ CI: M556-000032-22 - regarding a fall with injury and transfer to hospital.
- Log #00004597-22/ CI: M556-000024-22 - regarding resident to resident physical abuse.
- Log #00006917-22/ CI: M556-000030-22 - regarding alleged resident to resident sexual abuse.
- Log #00008828-22 – complaint regarding alleged resident to resident sexual abuse.
- Log #00006389-22/CI: M556-000025-22 - regarding resident to resident physical abuse.
- **The following intakes were completed in the CI System: Log #00005943-22/CI: M556-000028-22 and #00006844-22/CI: M556-000031-22 and were related to falls with injury and transfer to hospital.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Amended Compliance Order #001/2022_1571_0001, O. Reg 79/10 s.48 (1) related to falls prevention and management - initiation of head injury routine: Complied November 14, 2022

Amended Compliance Order #001/2022_779641_0004 O. Reg 79/10 s. 50 (2)(b)(iv) related to skin & wound care - weekly wound assessments: Complied November 14, 2022.
The following **Inspection Protocols** were used during this inspection:

- Prevention of Abuse and Neglect
- Responsive Behaviours
- Infection Prevention and Control
- Falls Prevention and Management
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
The licensee failed to ensure that a resident's written plan of care set out clear direction to staff and others who provide direct care to the resident.

Rationale & Summary:
A resident had an unwitnessed fall and was transferred to hospital where they required repair of a fractured hip. A review of the care plan in place at the time of inspection indicated the resident transferred using a walker with supervision, cueing/ encouragement and physical assistance; additional transfer documentation indicated the resident was non-weight bearing. Mobility specific information noted the resident required a one person assist with ambulation, while other documentation specified that the resident was wheelchair dependent.

In an interview with a Registered Nurse (RN), the inspector was advised that the resident required a two person transfer. The physiotherapist (PT) indicated the resident required a lift with two person assist to transfer and a wheelchair for mobility. On review of the plan of care, Assistant Director of Care (ADOC) confirmed that it would be difficult for staff to know which transfer and mobility interventions were accurate and current.

Sources:
Critical Incident report, progress notes, care plan, interviews with the RN, PT, ADOC and other staff. [741726]