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

Ottawa District
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Original Public Report

Report Issue Date: September 11, 2023	
Inspection Number: 2023-1571-0006	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Prince Edward	
Long Term Care Home and City: H.J. McFarland Memorial Home, Picton	
Lead Inspector Stephanie Fitzgerald (741726)	**Inspector Digital Signature** Stephanie A Fitzgerald Digitally signed by Stephanie A Fitzgerald Date: 2023.09.18 09:51:52 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 17, 18, 21, 22, 2023

The following intake(s) were inspected:

- Intake: #00090578 - CI# M556-000015-23, Report to the director for a written complaint received by the home.
- Intake: #00090832 - CI# M556-000016-23 Alleged resident to resident sexual abuse.
- Intake: #00093913 - CI# M556-000019-23 Unwitnessed fall of resident with injury.

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Safe and Secure Home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors which led to the non-residential areas of the home were kept closed and locked when they are not being supervised by staff.

Rationale and Summary
While conducting a tour of the home on August 17th, 2023, Inspector observed one door, labelled "Storage Area" on the second floor, Whispering Pines resident area, that was unlocked. The room was left unattended and unsupervised, and led to a non-resident area. Staff could not be found within the immediate vicinity of the room. The Inspector immediately brought the unlocked door to the attention of staff in the area, and the staff member closed the door.

During interviews with staff members, it was confirmed that the door should be locked.

By not ensuring that all doors leading to non-resident areas of the home were kept closed and locked, unsupervised residents may have had an opportunity to wander into the non-resident area posing risk of injury or entrapment.

Sources: Observation occurring on July 17,2023, Interviews with multiple staff [741726]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (2)

The licensee has failed to ensure that that a report to the director was made, in writing, within 10 days of becoming aware of alleged, suspected, or witnessed abuse.

Rationale and Summary

On a day in July, an incident of alleged sexual abuse occurred between two residents.

A review of the Critical Incident System (CIS) Report # M556-000016-23, indicated that the incident occurred on a day in June, and was immediately reported to the After-Hours reporting line. The first written report was submitted to the Ministry of Long-Term Care (MLTC) 17 business days after the incident.

During an interview with the Administrator, it was confirmed that the incident occurred on a day in June, and was not reported in writing until 17 business days after becoming aware of witnessed abuse.

Failure to report incidents of alleged, suspected, or witnessed abuse, in writing, to the Director, puts the residents at risk of additional harm.

Sources: CI # M556-000016-23, Interview with Administrator #100. [741726]