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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 10, 2024	
Inspection Number: 2024-1571-0002	
Inspection Type: Complaint 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 Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2024.04.11 15:57:08 -04'00'
Additional Inspector(s) Ashley Bernard-Demers (740787)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 2 - 4, and 8 - 10, 2024

The following intake(s) were inspected:

- Intake: #00105092/CIS #M556-000034-23 - regarding Infection Prevention and Control - ARI Outbreak.
- Intake: #00108100/CIS #M556-000004-24 - regarding a complaint concerning a resident's death.
- Intake: #00108143/CIS #M556-000005-24 - regarding a choking incident.
- Intake: #00109449/CIS #M556-000006-24 - regarding alleged resident to resident sexual abuse.
- Intake: #00109824/CIS #M556-000007-24 - regarding alleged resident to resident sexual abuse.
- Intake: #00110063 - regarding a complaint concerning dental care services performed in the home.
- Intake: #00111617/CIS #M556-000009-24 - regarding a fall with injury requiring transfer to hospital.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to immediately report a complaint regarding alleged improper care provided by an external dental agency on December 12, 2023 to the Director.

Sources: Resident progress notes, email documentation to the Administrator, and interviews with the complainant, Administrator, Assistant Director of Care (ADOC) and other staff.
[602]

WRITTEN NOTIFICATION: Reporting and complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to respond to a complainant regarding concerns specific to the services provided by an external dental agency on December 12, 2023.

Sources: Resident progress notes, email documentation to the Administrator, and interviews with the complainant, Administrator, ADOC and other staff.
[602]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of a resident choking incident that resulted in a significant change to resident's status no later than one business day after the occurrence of the incident.

Sources: A review of critical incident system report, and an interview with the DOC and ADOC/ IPAC Lead.
[740787]

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