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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# Public Report

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| **Report Issue Date:** March 4, 2026 |
| **Inspection Number:** 2026-1571-0001 |
| **Inspection Type:**<br>Critical Incident |
| **Licensee:** The Corporation of the County of Prince Edward |
| **Long Term Care Home and City:** H.J. McFarland Memorial Home, Picton |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 23 - 27, 2026 and March 2 - 4, 2026

The following intake(s) were inspected:
-Intake: #00166600 - M556-000061-25 - Alleged improper/incompetent treatment of a resident
-Intake: #00166785 - M556-000001-26 - Fall of a resident resulting in injury
-Intake: #00167145 - M556-000004-26 - COVID outbreak
-Intake: #00170096 - M556-000006-26 - Fall of a resident resulting in injury
-Intake: #00171557 - M556-000009-26 - Fall of a resident resulting in injury

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

Infection Prevention and Control
Pain Management
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
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.

The care set out in the plan of care for a resident was not provided as specified in the plan.

A resident's plan of care indicated that they were to use a specified device when up in their wheelchair for falls prevention. On a specified date in February 2026, the resident was observed to be in their wheelchair, however, no specified device was in use.

**Sources:** Review of the resident's clinical records, interviews with staff members, and observations made by the Inspector

## WRITTEN NOTIFICATION: Required programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.**
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee's Pain Management policy was not complied with for a resident.

Specifically, the licensee's policy "Pain & Symptom Management " indicated that a specified pain assessment must be completed with any significant change of status, when there are behaviours exhibited by a resident that may be an indicator for the onset of pain or for any new or worsening signs of pain.

An incident occurred on a specified date in December 2025, for a resident which placed them at risk for injury, and they subsequently exhibited indicators of pain on a later specified date in December 2025. The specified assessment was not completed for the resident at this time.

A staff member confirmed that the specified assessment should have been completed for the resident when they began exhibiting indicators of pain.

**Sources:** Review of the resident's clinical records, the licensee's Pain & Symptom Management Policy, and an interview with a staff member

The licensee's Pain Management policy was not complied with for a resident.

Specifically, the licensee's policy "Pain & Symptom Management " indicated that a specified assessment must be completed with any significant change of status, when there are behaviours exhibited by a resident that may be an indicator for the onset of pain or for any new or worsening signs of pain.

A resident sustained a fall on a specified date in February 2026, resulting in the

identification of new pain. The specified assessment was not completed for the resident until a later specified date in February 2026.

A staff member confirmed that the specified assessment should have been completed for the resident at the time the new pain was identified.

**Sources:** Review of the resident clinical records, the licensee's Pain & Symptom Management Policy, and an interview with a staff member

The licensee's Pain Management policy was not complied with for a resident.

Specifically, the licensee's policy "Pain & Symptom Management " indicated that a specified assessment must be completed with any significant change of status, when there are behaviours exhibited by a resident that may be an indicator for the onset of pain or for any new or worsening signs of pain.

A resident sustained a fall on a specified date in February 2026, resulting in the identification of new and worsening pain. The specified assessment was not completed for the resident until a later specified date in February 2026.

A staff member confirmed that the specified assessment should have been completed for the resident at the time the new and worsening pain was identified.

**Sources:** Review of the resident's clinical records, the licensee's Pain & Symptom Management Policy, and an interview with a staff member

## WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 54 (1)**
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee's Head Injury Routine policy was not complied with for a resident.

Specifically, the licensee's policy "Head Injury Routine (HIR)" indicated that HIR is to be completed as per the schedule outlined.

A resident sustained a fall on a specified date in January 2026, resulting in the initiation of HIR. The resident was sent to hospital, and upon their return to the long-term care home, they were required to have HIR completed every four hours, however, on two occasions HIR was not completed as outlined in the policy.

A staff member confirmed that they were unable to locate documentation for the two missing occasions of HIR for the resident's fall.

**Sources:** Review of the resident's clinical records, the licensee's Head Injury Routine Policy, and an interview with a staff member