Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2014	2014_348143_0019	O-000923-14	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49, R R 2, PICTON, ON, K0K-2T0

Long-Term Care Home/Foyer de soins de longue durée

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAUL MILLER (143)

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): October 23rd, 2014.

During the course of the inspection, the inspector(s) spoke with The Administrator.

During the course of the inspection, the inspector(s) reviewed Critical Incident Reports as well as resident health care records completed as part of the Resident Quality Inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Findings of Non-Compliance were found during this inspection.

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	Legendé 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a report was made to the Director within 10 days of becoming aware of a resident who is missing less than three hours and returns to the home.
On a specified date Resident #15 eloped from the home. The resident was found within 15 to 20 minutes. Staff attended to the resident who could not be persuaded to return to the home. The Ontario Provincial Police (OPP) was contacted. Resident #15 was persuaded by a driver who had stopped to assist the staff to return to the home. This individual provided transportation and returned the resident to the home. Staff and OPP followed this individuals car and successfully returned the resident to the home. Resident was assessed as having a skin tear on his\her hand. Resident was then transferred to Willow Wing (secure unit).
Nursing Home staff contacted the Ministry's after hours number on the day of the incident advising the Ministry of Health and Long Term Care of a missing resident.
A review of the Ministry of Health Long Term Care Homes Critical Incident Reporting System indicated that the Licensee failed to complete a Critical Incident Report in respect of this incident.
On October 23rd, 2014 Inspector #143 contacted the home's Administrator who confirmed that a Critical Incident had not been submitted. [s. 107. (4) 1.]

Issued on this 23rd day of October, 2014

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