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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 15, 2018	2018_505103_0001	023799-17, 025964-17, 027126-17	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

DARLENE MURPHY (103)

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): January 9, 10, 11, 2018

Log #023799-17 (resident fall that resulted in injury),
Log #025964-17 (alleged improper/incompetent care),
Log #027126-17 (alleged staff to resident neglect).

During the course of the inspection, the inspector(s) spoke with Personal support workers (PSW), a Registered Practical Nurse (RPN), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, made resident observations, reviewed the home's investigation notes related to allegations of incompetent care and alleged staff neglect and reviewed the home's complaint process and complaints log.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The following finding related to Log #025964-17:

The licensee has failed to ensure resident #003 was reassessed and the plan of care was revised when the resident's care needs changed.

Resident #003 was admitted to the home in an identified year and had identified diagnoses. On a specified date, the resident was seen and treated on-site by the home's dental services provider. The resident's health care record was reviewed in addition to the dentist's post treatment instructions.

On a specified date, PSW #100 assisted resident #003 with their lunch. Following lunch, the staff noted a specified change in the resident's condition. RN #103 was notified of the specified change and documented her observations related to the change.

RN #105 worked on the night shift following the dental appointment and documented concerns related to the resident's specified change. The RN wrote in the doctor's book to have the resident assessed. The physician made regular rounds that morning and did assess resident #003. RPN #104 notified the family of the specified change. The specified change continued to deteriorate and the physician prescribed a course of antibiotics on a specified date.

RN #103 failed to have resident #003 reassessed upon being made aware of the specified change in condition. [s. 6. (10) (b)]

2. The following finding related to Log #027126-17:

The licensee has failed to ensure resident #002 was reassessed and the plan of care was revised when the resident's care needs changed.

Resident #002 was admitted to the home in an identified year and had identified diagnoses. PSW staff were interviewed about this resident's behaviours and stated resident #002 can be resistive to care and combative at times. The staff indicated re-approach or trying a different staff member are usually effective strategies to complete the care. The resident's plan of care related to behaviours reflected the same approach. The resident's health care record was reviewed and on two consecutive identified dates the resident was documented as being non-compliant with care, resistive and fighting

with staff.

RPN #107 was interviewed and indicated the resident would not allow any hands on care and the staff were unable to get the resident out of bed. Additionally, the staff were having difficulty getting the resident to eat or drink. The RPN stated RN #103 was notified on an identified date in regards to this change in the resident's behaviours. The RPN stated the resident did not have any medication ordered on an as needed basis to address the behaviours and the PSW's attempts to provide care to this resident were ineffective.

The DOC was interviewed and stated she became aware of the change in resident #002's behaviours the following afternoon. Upon reviewing the resident's health care record, she noted the resident's as required medication had been discontinued by the physician approximately one month earlier. During the identified month, the resident had required the as needed medication seven times and each entry indicated the medication had been effective. The DOC indicated she was unaware the physician had discontinued the medication and no additional strategies were put in place to address incidents when the strategies outlined in the plan of care were ineffective. The DOC indicated RN #103 failed to notify the physician or the family related to the increase in resident #002's behaviours upon being made aware of this change on an identified date.

The licensee failed to ensure resident #003 and #002 were reassessed when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident #003 and #002 are reassessed when their care needs change, to be implemented voluntarily.

Issued on this 15th day of January, 2018

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

Original report signed by the inspector.