Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 2, 2020	2020_717531_0011	005472-20, 005795-20, 008635-20, 010421-20, 010812-20	Critical Incident System

Licensee/Titulaire de permis

County of Prince Edward
603 Highway 49 R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

H.J. McFarland Memorial Home
603 Highway 49, R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

SUSAN DONNAN (531), AMBER LAM (541)

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): June 23, 2020 and off-site June 24, 25, 26, 29 and 30, 2020.

The following logs were completed concurrently during this inspection:
Log #005472-20 Critical Incident #M556-000015-20 related to alleged resident to resident abuse
Log #005795-20 Critical Incident #M556-000016-20 related to alleged resident to resident abuse
Log #008635-20 Critical Incident #M556-000017-20 related to alleged resident to resident abuse
Log #010812-20 Critical Incident #M556-000019-20 related to fall prevention
Log #010421-20 Critical Incident #M556-000018-20 related to responsive behaviors

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers and residents.
During the course of the inspection, the inspectors reviewed resident health care records, observed resident care and services, reviewed fall prevention policy and procedures and abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 had a 1:1 staff member assigned to monitor their behavior, as specified in the resident's plan of care.

On a specified date, critical incident #M556-000016-20 occurred whereby resident #001 abused resident #002.

According to an interview with the Director of Care and resident #001's progress notes, resident #001 had a 1:1 staff assigned to monitor behavior following the incident on the specified date.

The Director of Care indicated to Inspector #541 that on a specified date resident #001 was not assigned a 1:1 staff person due to short staffing. As a result, resident #001 approached resident #002, touching their arm. [s. 6. (7)]

Issued on this 8th day of July, 2020

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

Original report signed by the inspector.