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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
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Amended Public Report (A1)

Report Issue Date July 21, 2022
Inspection Number 2022_1571_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Corporation of the County of Prince Edward

Long-Term Care Home and City
H.J. McFarland Memorial Home

Lead Inspector
Wendy Brown (602)

Inspector who Amended Digital Signature
Wendy K Brown
Digitally signed by Wendy K Brown
Date: 2022.09.30 10:47:39 -04'00'

Additional Inspector(s)
Cathi Kerr (641)
Anna Earle (740789) and Carrie Deline (740788) were also present during this inspection

AMENDED INSPECTION REPORT SUMMARY

On September 28, 2022, a written request was received from the Administrator of H.J. McFarland Memorial Home requesting an extension to Compliance Order #001 issued as a result of complaint inspection # 2022_779641_0004. The Administrator indicated that progress has been made towards compliance, however, due to extenuating circumstances related to two COVID-19 outbreaks, an extension of four weeks was requested. This licensee inspection report has been revised to reflect an extension to the above **Compliance Order #001 due date of September 30, 2022 to October 30, 2022.**

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 20, 23, 24, 27-30, and July 5-7, 2022
The following intake(s) were inspected:
Log #009041-22 - Complaint regarding behaviour management and sufficient staffing
Log #008861-22 - Complaint regarding alleged financial abuse
Log #005017-22 - Complaint regarding behaviour management and alleged resident to resident abuse
Log #004998-22 - Complaint regarding alleged resident to resident abuse
Log #002147-22 - Follow up inspection regarding skin and wound care
Log #010306-22/CIS: M556-000021-22 and Log #009004-22/CIS: M556-000019-22 - regarding responsive behaviours and alleged resident to resident abuse.

Log #005280-22/CIS: M556-000011-22; Log #003193-22/CIS: M556-000008-22; Log #002884-22/CIS: M556-000007-22 and Log #001532-22/CIS: M556-000005-22 - regarding falls with injury and transfer to hospital

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s.50 (2)(b)(iv)	2022_779641_0004	001	#641

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL PROGRAM

NC#001 written notification pursuant to O. Reg. 246/22 s.102 (15) 2

Non-Compliance with: O. Reg. 246/22 s.102 (15) 2 Every licensee of a long-term care home with more than 69 beds but less than 200 beds shall ensure that the infection prevention and control (IPAC) lead works regularly in that position on site at the home at least 26.25 hours per week.

Rationale and summary:
On commencement of the inspection, the Director of Care (DOC) identified themselves as the acting IPAC lead however they indicated that they were working full time, at least 35 hours per week, as the DOC and was not able to work regularly in the IPAC position at least 26.25 hours per week.

On July 5, 2022, the Administrator, DOC and Environmental Supervisor (ES) met to review IPAC lead hours. It was decided to assign the ES the IPAC lead role. The ES's schedule was adjusted to provide for 26.25 hours each week in IPAC role with DOC support as needed; the home went into a COVID-19 outbreak on July 5, 2022.

Sources: Observations on multiple units, interviews with the Administrator, DOC and the ES. [602]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 27 (1) (a) (b)

The licensee failed to ensure that a witnessed incidence of abuse of a resident #015 was immediately investigated and appropriate action taken in response.

Rationale and summary:
A personal support worker (PSW) overheard two residents threatening another resident. The PSW reported the incident to Registered Nurse (RN) who spoke with both residents urging them to try and get along with the other resident. The PSW also alerted a Registered Practical Nurse (RPN) to the incident later that same day. There was no assessment of the threatened resident documented. The DOC indicated an investigation into the bullying and abuse of the resident was initiated; bruising and swelling was noted on assessment of the resident. The resident was moved to a different unit for safety reasons. Failing to immediately investigate and take appropriate action in response to threats to a resident put the resident at risk for further harm.

Sources: Critical Incident System (CIS) report, resident progress notes, interviews with the DOC, PSWs, a RPN and other staff. [602]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

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

Non-compliance with: FLTCA, 2021 s. 28 (1)
The licensee failed to immediately report abuse that resulted in harm or a risk of harm to resident to the Director

Rationale and summary:
A PSW witnessed two residents threatening another resident. The incident was reported to registered staff. The incident was not immediately reported to the Director.

Sources: CIS report, resident progress notes, interviews with the DOC, a PSW and other staff. [602]

WRITTEN NOTIFICATION – PREVENTION OF ABUSE AND NEGLECT

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 104 (1) (b)
The licensee failed to ensure a resident's power of attorney (POA) was notified within 12 hours upon becoming aware of a witnessed incident of verbal abuse.

Rationale and summary:
A PSW witnessed two residents threatening another resident. The incident was reported to registered staff . The resident's POA was notified three days later when the licensee contacted them to discuss moving the resident to a different unit.

Sources: CIS report, resident progress notes, interviews with the DOC, a PSW and other staff. [602]

WRITTEN NOTIFICATION – CONDITION OF LICENCE

NC#005 Written Notification pursuant to: FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 101(4) CO #001 from inspection #2022_779641_0004 served on Mar 31, 2022, with a compliance due date of May 4, 2022, to O. Reg. 79/10 s.50(2)(b)(iv), related to residents not receiving weekly reassessment of their wounds, was found to be in non-compliance at the time of this inspection, as outlined below.

The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

Rationale and summary:
Inspector #641 reviewed a resident's health care record related to skin and wound care assessments of the resident's chronic vascular leg wounds. The resident's wounds had not been assessed weekly using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

The licensee failed to complete a weekly audit of all residents where a weekly wound reassessment was clinically indicated. Inspector #641 reviewed the weekly skin and wound care audits to be completed for residents requiring wound care. Between the review dates of May 4, 2022 and June 24, 2022, there was 1 audit completed for a resident, and 1 audit completed for another resident.

This posed a risk to the resident as a lack of weekly reassessments of the resident's wound could allow for potential deterioration of the wounds.

The education component of the order had been completed as requested.

Sources: resident's health care records, interview with the Wound Care Lead, other registered staff, and the DOC, skin and wound care policies. [#641]

COMPLIANCE ORDER #001 – FALLS PREVENTION AND MANAGEMENT

NC#006 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10 s. 48 (1)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

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O. Reg. 79/10 s. 48 (1)The Licensee failed to ensure their falls prevention and management program was complied with; specifically, staff did not comply with their post fall assessment procedure: initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is un-witnessed.
The Licensee shall:
1. Ensure registered staff comply with their post fall assessment procedure and initiate the head injury routine (HIR) for all residents who fall and a head injury is suspected and/or if the fall is un-witnessed.
2. Complete a weekly audit of all resident falls and ensure that where a fall results in the resident hitting their head, or the fall is unwitnessed the HIR is completed. The audits are to be completed until all staff are compliant with the process.
3. Maintain documentation of the audits, including when the audit was completed, who completed the audit, the findings and any corrective actions taken.

Grounds

Non-compliance with: O. Reg. 79/10 s. 48 (1) The Licensee failed to comply with their written policies related to falls prevention and management for two residents.

In accordance with O. Reg 79/10 s. 8 (1) b, the licensee is required to ensure that their falls prevention and management policy and procedure is complied with.

Specifically, staff did not comply with their post fall assessment procedure: initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is un-witnessed.

Rationale and summary:
1. A resident was found in the bathroom with an injury to their head. The resident indicated that they may have fallen but did not remember.

   During an interview a RN advised they assessed the resident following the unwitnessed fall; the head injury routine (HIR) protocol was not initiated. The resident subsequently passed away the following day. An electronic and hard copy chart review was completed with RN and found no HIR documentation. The RN confirmed that a HIR should be conducted for any unwitnessed fall.

2. Another resident had an unwitnessed fall while attempting to walk unassisted resulting in a hematoma and laceration to their head.

   During an interview a RN indicated that when a resident received a head injury or had an unwitnessed fall, they would initiate a HIR that would be continued for 24 hours as per their protocol. A review of the resident's health care record indicated that a HIR was initiated at the time of the fall and continued until the resident was sent to the hospital. The resident was assessed on return from hospital, however, there was no further assessment until the resident was noted to be unresponsive, 19 hours after the last assessment.

This posed a risk to both residents as they were not monitored for neurological symptoms after sustaining a head injury.

Sources: CIS reports; resident electronic and hard copy health records, Falls Prevention Policy, interviews with RNs and other staff.

This order must be complied with by October 30, 2022 (A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.

- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.