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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Original Public Report

Report Issue Date: June 26, 2023	
Inspection Number: 2023-1571-0005	
Inspection Type: Critical Incident System	
Licensee: The Corporation of the County of Prince Edward	
Long Term Care Home and City: H.J. McFarland Memorial Home, Picton	
Lead Inspector Carrie Deline (740788)	**Inspector Digital Signature** Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.06.28 10:07:21 -04'00'
Additional Inspector(s) Patricia OBrien 000730)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 14 - 16, 19, 2023

The following intake(s) were inspected:

- Intake: #00019312 - CI # M556-000003-23 Alleged Improper/Incompetent treatment of a resident.
- Intake: #00020893 - CI # M556-000005-23 Complaint regarding alleged neglect of a resident.
- Intake: #00021917 - CI # M556-000007-23: Fall of resident resulting in injury.
- Intake: #00089035 - CI # M556-000014-23 Alleged resident to resident abuse.

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

Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 26

The licensee failed to ensure the staff used transferring equipment in the home in accordance with the manufacturers' instructions.

Rationale & Summary

A review of manufacturers' instructions provided by DOC indicate that before raising the lift each of the sling's loops must be securely fastened to the carry-bar. A Critical Incident System (CIS) was submitted with notification that a resident had been transferred with a lift which the bottom two straps were not connected as per manufacturers' instructions. During this transfer a resident fell out of the lift onto the floor.

Interviews with staff confirm that the resident does require two staff assistance and a hoyer lift for all transferring. Staff interviews also confirmed that all four straps must be connected to the lift prior to transfer.

Failure to follow the manufacturers' instructions with transferring equipment places a resident at risk for injury.

Sources:
Resident progress notes and care plan, Critical Incident System, Resident observations, interviews with staff, and review of manufacturers' instructions for the lift/sling used.
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WRITTEN NOTIFICATION: Reporting and complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.

The licensee failed to ensure that the complaint response provided to a person who made a complaint shall included the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman.

Rationale & Summary

A review of a CIS submitted indicated that a written complaint was received by the Long Term Care Home. The LTCH responded to the complaint in writing but did not provide the contact information for the Ministry or the ombudsman.

Interview with the Administrator confirmed that the information had not been provided to the complainant.

Failure to provide the contact information could result in a complainant not being aware of additional complaint reporting options.

Sources:

CIS, LTCH complaint documentation, and interview with Administrator.

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