Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: May 23, 2024	
Inspection Number: 2024-1571-0003	
Inspection Type: Critical Incident	
Licensee: The Corporation of the County of Prince Edward	
Long Term Care Home and City: H.J. McFarland Memorial Home, Picton	
Lead Inspector Ashley Bernard-Demers (740787)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 21 and 22, 2024

The following intake(s) were inspected:
- Intake: #00111753/ CIS #M556-000016-24 - Alleged resident to resident abuse.
- Intake: #00113841/ CIS #M556-000013-24 - Alleged resident to resident abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that a PSW staff member complied with their written policy to promote zero tolerance of abuse and neglect of residents by not immediately reporting suspected resident to resident abuse.

Sources: Review of the home's policy and an interview with IPAC Lead/ ADOC and DOC
[740787]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (2)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

The licensee has failed to ensure that the Director was notified in writing within ten days of becoming aware of an alleged incident of resident to resident abuse that occurred on a specified day in March 2024.

Sources: Review of Critical Incident System (CIS) report and an interview with IPAC Lead/ ADOC and DOC
[740787]