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

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Public Report

Report Issue Date: March 10, 2025

Inspection Number: 2025-1571-0001

Inspection Type:
Other
Complaint
Critical Incident
Follow up

Licensee: The Corporation of the County of Prince Edward

Long Term Care Home and City: H.J. McFarland Memorial Home, Picton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 11-12, 14, 18-21 and 24-26, 2025.

The following intake(s) were inspected:

- Intake: #00130762 - CIS: #M556-000045-24 - Alleged neglect of resident by staff.
- Intake: #00131864 - Follow-up #: 1 - FLTCA, 2021 - s. 25 (1)- CDD January 13, 2025, regarding the policy to promote zero tolerance.
- Intake: #00132681 - CIS: #M556-000049-24 - Alleged neglect of resident by staff.
- Intake: #00134173 - CIS: #M556-000054-24 - Alleged physical/verbal abuse of resident by staff.
- Intake: #00136907 - CIS: #M556-000004-25- Alleged physical abuse of resident by a resident.
- Intake: #00136979 - Complaint alleging improper care of a resident.
- Intake: #00139182 - Outstanding Emergency Planning Annual Attestation.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #002 from Inspection #2024-1571-0007 related to FLTCA, 2021, s. 25 (1)

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provide direct care to the resident, in

relation to falls prevention and management interventions.

Specifically, review of a resident's progress notes identified the use of specified interventions, which was confirmed during interviews with staff. The written plan of care and kardex did not include these interventions.

Sources: Resident's progress notes, written plan of care, and Kardex; interviews with the RAI Coordinator, Personal Support Worker (PSW), Registered Nurse (RN) and the Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from abuse by a PSW and has failed to ensure the resident was not neglected by the PSW.

“Neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

“Physical abuse” means the use of physical force by anyone other than a resident that causes physical injury or pain.

“Verbal abuse” means any form of verbal communication of a threatening or

intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On an identified date, an alleged neglectful incident towards a resident by a PSW occurred, resulting in a resident feeling embarrassed and upset. Following the Long-Term Care Home's internal investigation, the allegation was of neglect was founded, and corrective action was issued to the PSW with a required completion date. During interviews with the Administrator and the ADOC, it was confirmed that the PSW did not complete the required corrective action.

On an identified date, a second incident of alleged abuse occurred, which resulted in a resident's fall with injury. During both incidents, it was confirmed that the PSW used a negative tone towards the resident.

Sources: Resident's care plan, progress notes, and physician progress notes; a PSW's employee file, education and training records of a PSW, interviews with PSW's, an RN, and the ADOC.

WRITTEN NOTIFICATION: Licensee must comply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee failed to comply with Compliance Order (CO) #002, from inspection #2024-1571-0007 served on November 12, 2024, with a compliance due date of January 13, 2025. The following components of the order were not complied with:

1. Conduct education on the policy to promote zero tolerance of abuse and neglect of residents, with all direct care staff, with focus on the requirements for mandatory reporting.
2. Maintain written a record of the requirements under (1). Documentation of education shall include the names of the staff, their designation, and date training was provided.

The licensee has failed to conduct education on the policy to promote zero tolerance of abuse and neglect of residents, with a focus on mandatory reporting, for 21 direct care staff members.

Sources: Review of staff signature list for document titled "Mandatory Reporting Of Abuse and Neglect- Promotion of Zero Tolerance"; Review of Surge Learning course completion list for "Mandatory Reporting Critical Incidents and Whistle- Blower Protection"; absence of Surge Learning course completion list for Prevention of Abuse & Neglect of a Resident policy #VII-G-IO.OO; interviews with the ADOC and the Administrator.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:
In the past 36 months, a CO under FLTCA (2021), s. 25(1) was issued (2024-1571-0007).

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure the service door, leading to non-residential areas was kept closed and locked when they were not being supervised by staff. Specifically on February 11, 2025, inspectors observed the hallway door leading to the kitchen, receiving door, and maintenance area was unlocked and accessible.

Sources: Inspector observations on February 11, 2025

WRITTEN NOTIFICATION: Plan of care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
Plan of care
s. 29 (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs.

The licensee has failed to ensure that a resident's plan of care was based on an interdisciplinary assessment of pain. A resident was identified as having a pain. Interviews confirmed pharmacological and non-pharmacological interventions, that were effective in minimizing the resident's pain.

Sources: resident's progress notes, written plan of care, and Kardex; interviews with a PSW, the RAI Coordinator, an RN and the ADOC

WRITTEN NOTIFICATION: Required programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that their written policy related to falls prevention and management was complied with, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with. Specifically, the Falls Prevention policy indicates that when a fall occurs:

1. all staff will ensure the resident is not moved prior to the charge Registered Nurse (RN) assessment
2. registered staff will monitor Head Injury Routine (HIR) as per the schedule on the Post Head Injury form for signs of neurological changes, if a head injury is suspected and/or if the resident fall is un-witnessed (and cognitively unable to state if they hit their head) and/or if they are on anticoagulant therapy.

A resident had a fall on a specified day in December 2024, where they sustained a head injury. A PSW mobilized the resident prior to being assessed by the RN. The HIR was not completed during two specified time periods, where the required frequency was every four hours.

Sources: Falls Prevention Policy# VII-G-30.00(July 2024); Resident progress notes; HIR Form from December 2024; interviews with PSW staff, an RN, and the ADOC.

WRITTEN NOTIFICATION: Required programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 4.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

4. A pain management program to identify pain in residents and manage pain. O. Reg. 246/22, s. 53 (1); O. Reg. 66/23, s. 10.

The licensee has failed to ensure that their written policy related to pain management was complied with, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that written policies and protocols were developed for the pain management program and ensure they were complied with. Specifically, the Pain & Symptom Management policy revised in July 2024; states to conduct and document "N Adv Can- RNAO Pain: Screening, Assessment, and Management electronically" with any existing scheduled or Pro re nata (PRN) pain medications.

A resident was prescribed a specified PRN pain medication which was administered eleven times in October, 2024; eight times in November, 2024; and once in December, 2024. The resident was also prescribed a specified scheduled pain medication, three times daily effective November 01, 2024. The N Adv Can- RNAO Pain: Screening, Assessment, and Management assessment was completed on October 16th, 2024, during admission, and again on October 31, 2024. There were no other assessments located within the resident's electronic record.

Sources: Electronic records of Resident; including: EMARs from October, November, December 2024 and N Adv Can- RNAO Pain: Screening, Assessment, and Management assessments; Pain & Symptom Management policy #Vil-G-30.10 (July 2024); interviews with the RAI Coordinator, an RN and the ADOC.

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.
Additional training — direct care staff
s. 261 (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 82 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 82 (7) of the Act.

The licensee has failed to ensure that a PSW, who provided direct care to residents, received the training provided for in subsection 82 (7) of the Act annually.

In accordance with subsection 82 (7) of the Act (7), every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, receives training in the areas set out in the following paragraphs.
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations.

In accordance with subsection 261(1) of the regulations, For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which

training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

Specifically, a PSW did not have any documented record of the required training, since 2019.

Sources: PSW's employee file, including training records; interviews with the Administrator and the ADOC.

WRITTEN NOTIFICATION: Attestation

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 270 (3)
Attestation
s. 270 (3) The licensee shall ensure that the attestation is submitted annually to the Director.

The licensee failed to submit the annual Emergency Planning Attestation form in December 2024, to the Director.

Sources: Interview with the Administrator on February 11, 2024.