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

# Public Report

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| **Report Issue Date:** March 4, 2025 |
| **Inspection Number:** 2025-1571-0002 |
| **Inspection Type:**<br>Complaint<br>Critical Incident |
| **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 20, 21, 24 - 26, 2025

The following intake(s) were inspected:

- Intake: #00139712 - CIS # M556-000011-25 - Alleged resident to resident physical abuse.
- Intake: #00139763 - CIS # M556-000012-25 - Unexpected Death of Resident.
- Intake: #00139974 - Complaint related to the resident's death.

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

Infection Prevention and Control
Responsive Behaviours

## 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 (7)**
Plan of care
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.

The licensee has failed to ensure that on a specific date a resident had continuous 1-1 monitoring as set out in their plan of care.

Sources: review of resident health care record, observation, and interviews with staff.

## COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 59**
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions.

**The inspector is ordering the licensee to comply with a Compliance Order []:**
Specifically, the licensee must:

(1) Develop and implement written strategies, including techniques and interventions, to prevent, minimize or respond to a resident's responsive behaviours. These strategies must be added to the resident's written plan of care.
(2) Provide education to all staff that interact with the resident on the contents of the revised plan of care, ensuring staff are aware of the responsive behaviours of the resident, the identified triggers, interventions, and actions to take in the event of potentially harmful interactions between a specific resident and all other residents.
(3) Develop and complete a weekly audit tool, to determine if the strategies and interventions from (1) are effective. This tool shall include actions taken if an intervention is noted to be ineffective. The audits should be completed for a minimum of one month.
(4) Maintain a written record of the requirements under (2) and (3). Documentation of education shall include the names of the staff, their designation, and date training was provided.

**Grounds**

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two specific residents and that interventions were identified and implemented.

On a specific date a resident was witnessed in a physical altercation with another resident This incident did not result in injury to either resident.
On a specific date the same above resident exhibited responsive behaviors towards a resident.
On a specific date the same resident allegedly had another physical altercation with the first resident resulting in a fall. The fall resulted in a transfer to hospital and death of the resident.
The identified residents plan of care was not updated to identify interventions to manage responsive behaviours towards residents following the first incident.
During separate interviews with multiple staff they indicated that they were aware

of the resident's responsive behaviour towards co residents on the listed dates. Furthermore, staff indicated that they were unclear as to where they would reference for guidance on interventions in dealing with the resident's responsive behaviors. Staff referenced they may look at resident's kardex, report sheets, or the resident care plan but could not locate any identified interventions when requested by the inspector.

In an interview the ADOC acknowledged that there were no other interventions identified on the care plan to direct staff on how to manage the resident's responsive behaviours towards other residents.

Sources: Resident's health record, Interviews with staff

**This order must be complied with by** April 28, 2025

## 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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
e-mail: 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.