Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 6, 2013	2013_179103_0019	O-000137-13	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF PRINCE EDWARD
603 Highway 49, R R 2, PICTON, ON, K0K-2T0

Long-Term Care Home/Foyer de soins de longue durée

H.J. MCFARLAND MEMORIAL HOME
R.R. #2, 603 HIGHWAY 49, HALLOWELL TOWNSHIP, PICTON, ON, K0K-2T0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 30, May 2, 6, 2013.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses, Registered Nurses, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records, medication administration policies and observed resident care.

The following Inspection Protocols were used during this inspection:
Medication

'ersonal Support Services

'indings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
.egend /N – Written Notification /PC – Voluntary Plan of Correction)R – Director Referral :O – Compliance Order /AO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under he Long-Term Care Homes Act, 2007 LTCHA) was found. (A requirement under the LTCHA includes the equirements contained in the items listed n the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

/N #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 5).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6 (5) whereby the licensee did not ensure that the resident's substitute decision maker or any other person designated by the resident or the substitute decision maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date, Resident #1, who is cognitively impaired, experienced a change in condition. The resident was assessed by the registered staff member at the time of the incident.

According to Registered Practical Nurse(RPN), S#105, the resident was monitored closely and by bedtime appeared to have improved. S#105 reported she intended to notify the family member who was listed as the first contact, but failed to do so because the evening was busy.

The following day, S#105 saw the family member in the home and advised them of the incident at that time. The family member advised the home of the concerns with the delay in notification. The home responded to the concerns in writing and the RPN involved was reprimanded as a result.[s. 6. (5)]

Issued on this 7th day of May, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs