



**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
Direction de l'amélioration de la
performance et de la conformité**

**Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670**

**Bureau régional de services d'Ottawa
347, rue Preston, 4^{ième} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670**

Public Copy/Copie du public

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



Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) 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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #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