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
Sep 17, 2014	2014_347197_0020	O-000482-14	Critical Incident System

Licensee/Titulaire de permis

Lennox and Addington County General Hospital
97 Thomas Street East, NAPANEE, ON, K7R-4B9

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

THE JOHN M. PARROTT CENTRE
309 BRIDGE STREET WEST, NAPANEE, ON, K7R-2G4

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

JESSICA PATTISON (197)

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): August 29 and September 2, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, a Registered Nurse, a Registered Practical Nurse and a Resident.

During the course of the inspection, the inspector(s) reviewed a resident's health care record and the home's internal investigation file and observed a resident's room.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – 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 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.) 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.

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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that care was not provided to a resident as specified in the plan of care.

On a specified date, a critical incident was reported by the home indicating that Resident #1 was found not in bed in their bedroom at 0630 hours by a staff member at the end of the shift. It was determined after an investigation that Resident #1 had not been assisted into bed the night before and was last seen by staff at 2145 hours. Resident #1 showed no signs of physical or emotional distress after the incident.

Resident #1's plan of care at the time of the incident indicated a specific time they liked to go to bed, specific toileting times, as well as the fact that the resident required assistance to go to bed and should have the call bell in reach at all times.

The licensee did not follow Resident #1's care plan in the following ways:
- the resident was not assisted with getting ready for and into bed
- the investigation notes and interviews with the Assistant Director of Care and the Director of Care indicated that the resident was last taken to the bathroom and provided with care at 1700 hours the night before and then not again until 0630 hours the next day
- a statement by a witnessing staff member indicated that when Resident #1 was found the call bell was not within reach [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in residents' plans of care is provided as specified in the plan, to be implemented voluntarily.

Issued on this 3rd day of October, 2014

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