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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 3, 2015	2015_280541_0008	O-001591-15	Resident Quality Inspection

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

AMBER MOASE (541), BARBARA ROBINSON (572), PAUL MILLER (143), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 23-27, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Environmental Supervisor, the Dietary Supervisor, the RAI Coordinator, the Registered Dietitian, Registered Nurses, Registered Practical Nurses, a Dietary Aide, Personal Support Workers, Resident and Family Council Presidents, Family Members, and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 30(2) whereby the licensee

has not ensured that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions, and the resident's responses to interventions are documented.

In accordance with O. Reg. 79/10 s. 30 (1) and O. Reg. 79/10 s. 48 (1)1 the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Related to Log O-001405-14:
A review of the health care record of Resident #16 and Critical Incident report indicates that the resident has multiple specified comorbidities.

On a specified date, Resident #16 was found on the floor of his/her room in the early morning after a fall while attempting to go to the bathroom. He/she had discomfort and bruising, as well as a skin tear. He/she was monitored closely, provided analgesic and was assessed by the physician. The physician left instructions to continue to monitor the resident's gait and pain to determine the need for a further x-ray.

On a specified date two days later, Resident #16 was again found on the floor of his/her room in the early morning after a fall while attempting to go to the bathroom. He/she sustained further bruising and pain. A pattern was identified and strategies were implemented.

During the next few days Resident #16 complained of pain which was relieved by analgesic, as well as some limitations to his/her mobility. Five days following the second fall on a specified date, Resident #16 was examined by the physician to rule out a post-fall injury because of ongoing pain and mobility issues. Six days following the second fall on a specified date, Resident #16 refused to get up in the morning because of significant pain as described by RN #S120 and PSW #S123. Resident #16 was administered an analgesic with documented slight effect. The physician was not notified, nor was the x-ray expedited. There were no further progress notes documenting the pain and mobility status of Resident #16 for the next three days. Eight days following the second fall an x-ray was completed and confirmed an injury which was subsequently surgically repaired.

In an interview on a specified date, RN #S117 and RN #S119 acknowledged that no actions were taken and documented for a three day period with respect to Resident #16 who was unstable after two recent falls on specified dates. In an interview on a specified date, the DOC confirmed that Resident #16 should have had assessments,

reassessments, and interventions that included the resident's response documented during that period of time. [s. 30. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian (or dietitians) who is a member of staff of the home is on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

As of February 23, 2014 there were 166 residents in the home requiring a minimum of 83 Registered Dietitian (RD) hours per month.
The RD worked on-site at the home the following hours:

19 hours September 2014
23.5 hours October 2014
24 hours November 2014
19.5 hours December 2014
5.5 hours January 2015
7.0 hours February 2015 (up to February 27, 2015)

It is noted, the Administrator indicated to Inspector #541 that as of February 27, 2015 the home has successfully recruited RD services to ensure all hours will be met. [s. 74. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, r. 129. (1)(a)(ii) whereby the licensee has not ensured that drugs that are stored in an area or on a medication cart are secure and locked.

On a specified date, Inspector #572 observed RPN #S121 administer medications to Residents #17, #47 and #48 in the Rose Garden area. The medication cart was left unlocked and out of sight as the RPN administered medications in each resident's room. Residents were walking in the hallways at the time. RPN #S121 also left the cart unlocked in the hallway outside of the dining area when administering further medications in areas of the dining room. The cart was not in sight at all times as he/she provided medications to residents.

On the same specified date, Inspector #572 observed RPN #S122 leave the medication cart unlocked and unattended in the hallway outside the dining room on Spring Meadow. He/she left the cart to assist staff and administer medications to residents while the cart was out of sight.

In an interview on the specified date, the DOC confirmed that the home's expectation is that medications are locked when unattended. [s. 129. (1) (a)]

Issued on this 3rd day of March, 2015

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

Original report signed by the inspector.