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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 30, 2016	2016_236622_0014	013499-16	Resident Quality Inspection

Licensee/Titulaire de permis

County of Lennox and Addington
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

HEATH HEFFERNAN (622), AMBER MOASE (541), JESSICA PATTISON (197), 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): May 17 - 20, 24 - 27, 2016

During the course of the Resident Quality Inspection log # 013499-16, the following Critical Incident intakes were inspected;
log# 024056-15 - staff to resident neglect
log #015816-16 - alleged staff to resident abuse
log #09509-16 resident to resident abuse - responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Registered Dietitian (RD), the Activation Coordinator, RAI Coordinator, Food Services Supervisor (FSS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Worker (ESW), Family members, and residents.
The inspectors conducted a tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, and restraint practices, reviewed resident and family council minutes, applicable home policies, the home's staffing schedules for the nursing department

The following Inspection Protocols were used during this inspection:
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
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)8 in that residents were not served their meal course by course.

On a specified date during a meal observation, the following was observed:

- Residents #051 and 052 were served their main entree while they were still eating their soup.
- Resident #050 was observed with his/her main entree to the side of his/her place setting while he/she was still eating their soup.

During a second meal observation on a specified date, the following was observed:

- Resident #021 was observed to have just started eating his/her soup and his/her main entree was observed off to the side of their place setting.
- Resident #053 was observed eating his/her soup while the main entree was placed beside them.

The plans of care for the residents noted above were reviewed and there is no indication that they should not be getting their meals served course by course.

An interview was conducted with the Dietary Supervisor who indicated that the current

process is for staff to serve each resident course by course. They further indicated that an exception is being made with desserts, as residents have stated they would like dessert served to everyone as soon as all main entrees have been delivered. [s. 73. (1) 8.]

2. The licensee failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide assistance.

On a specified date, a dining observation was conducted during a specified meal service.

Resident #045 was served his/her entrée but there was no staff person present to provide assistance. The entrée remained in front of the resident for several minutes after the meal was served.

Resident #045's plan of care identified the resident required assistance at meals.

Resident #046 was observed with his/her entree in front of him/her. There was no staff sitting with resident #046 when they were served the entrée.

Resident #046's plan of care indicated he/she required assistance at meals.

Resident #047 was observed eating soup while the entrée was left beside him/her. Resident #047 appeared unable to eat independently.

Staff approached Resident #047 on three separate occasions, no assistance was provided.

Resident #047's current plan of care indicated he/she required assistance at meals.

Resident #016 was served his/her entrée, due to interruptions, resident #016 was not provided assistance with his/her entree until 10 minutes after the entrée had been served.

Resident #016's plan of care stated the resident required assistance at meals.

The home failed to ensure that residents #016, #045, #046 and #047 who require assistance with eating or drinking were only served a meal when someone was available to provide assistance. [s. 73. (2) (b)]

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 residents who require assistance with eating or drinking are only served a meal when someone is available to provide assistance., to be implemented voluntarily.

Issued on this 30th day of May, 2016

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

Original report signed by the inspector.