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 soins de longue durée

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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
Jan 26, 2017	2017_505103_0005	019749-16, 025887-16, 029046-16, 029234-16, 031479-16, 032433-16	Critical Incident System

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

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): January 23, 25, 2017

The following intakes were inspected:
Log #019749-16 (alleged staff to resident abuse),
Log #025887-16 (alleged resident to resident abuse),
Log #029046-16 (resident fall),
Log #029234-16 (resident fall),
Log #031479-16 (alleged resident to resident abuse),
Log #032433-16 (alleged staff to resident neglect).

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

During the course of the inspection, the inspector reviewed resident health care records, made resident observations, observed a resident room, and reviewed the home's investigation notes into alleged incidents of abuse and shift routines.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 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 following finding relates to Log #032433-16:

The licensee has failed to ensure the care set out in the plan of care was provided to resident #007 as specified in the plan.

The home submitted a critical incident that reported on an identified date on or about 0400 hour, resident #007 was discovered by the Registered Practical Nurse (RPN) in the wheelchair positioned next to the bed and the bed appeared to be completely made. Upon further investigation by RPN #100, it was determined the resident had been there since the previous evening. The Personal Support worker (PSW) staff working the night shift were directed to assist the resident to bed and the resident was provided with continence care. The RPN completed a head to toe skin assessment, assessed the resident's vital signs and checked the resident's blood sugar. The resident was found to be in stable condition at that time.

At the time of this incident, resident #007's plan of care indicated the following:
Under "Toileting"-toilet every morning, every bedtime, before meals and as required; one person total assistance,
Under "Dressing"-likes to go to bed at 2100 hour and get up at 0730 hour, and
Under "Falls"-2 staff assist with all transfers, encourage resident to wait for assistance, monitor hourly for safety, call bell within reach when in bed.

The home completed an investigation into this incident. The Director of Care (DOC) was interviewed and indicated the evening staff had toileted resident #007 at approximately 1930 hour and the resident had been assisted into their night clothing. The DOC stated the resident's room-mate was known to pull the privacy curtains around resident #007's bed and that the staff had failed to look behind the curtains when doing the required hourly safety checks.

The staff failed to provide resident #007 with the care set out in the plan of care by failing to assist the resident into bed in accordance with their desired bed time, and failed to complete the hourly safety checks.

According to the DOC, all three PSW's working on the evening of the identified date were disciplined as well as the PSW staff member working on the night of the identified date for failing to provide resident #007 with the care and monitoring as outlined in the resident plan of care. [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 resident #007 receives the care set out in the plan of care, to be implemented voluntarily.

Issued on this 26th day of January, 2017

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

Original report signed by the inspector.