Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2019	2019_702197_0027	021798-19, 022759-19, 022845-19, 022847-19, 022855-19, 023202-19, 023558-19	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

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): December 9-12 (on-site) 17, 18 and 23 (off-site), 2019

All logs / critical incidents listed below were inspected as part of this report and were related to resident to resident abuse and responsive behaviours:

021798-19 - M625-000024-19
022759-19 - M625-000026-19
022845-19 - M625-000027-19
022847-19 - M625-000028-19
022855-19 - M625-000029-19
023202-19 - M625-000030-19
023558-19 - M625-000031-19

During the course of the inspection, the inspector(s) spoke with the Director, the Manager of Nursing, the Assistant Manager of Nursing, a Physician, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Maintenance and Housekeeping staff.

The inspector also reviewed a resident's health care record, reviewed policies related to responsive behaviours and prevention of abuse and observed care.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care set out clear directions to staff and others who provide direct care to the resident related to the use of a specified intervention.

Upon review of resident #001's current plan of care, a specified intervention is listed to be put into place each evening when the resident goes to bed and removed each morning when up for the day.

During interviews on resident #001's home area, staff indicated that the specified intervention was no longer in use. When asked, they could not recall exactly why or when it was discontinued.

Upon review of the Medication Administration Record during a specified month for resident #001, it was noted that registered staff were documenting the use of the intervention. On the last day of the month, the registered staff documented to see nursing notes. Nursing notes were reviewed by the inspector and a note on the specified date, indicated "no longer applied?"

During an interview with Behavioural Support RPN #112, they indicated that they recalled the specified intervention being discontinued around a certain time. They stated that it

had been discontinued because it was ineffective. They indicated that any ineffective interventions should be taken out of the written plan of care by registered staff.

The inspector did note that the one page “Behavioural Care Plan Interventions” sheet did have a line drawn through the specified intervention, but there was no date on the sheet or a signature to indicate when and who crossed it out. There was also no assessment documented to indicate why the intervention had been deemed ineffective for resident #001.

Therefore, the resident’s written plan of care did not set out clear direction to staff and others who provide direct care to the resident, related to the use of a specified intervention. [s. 6. (1) (c)]

2. The licensee has failed to ensure that when a resident is reassessed and the plan of care reviewed and revised because it has been ineffective, that different approaches are considered in the revision of the plan of care.

Resident #001 had a history of responsive behaviours. Seven incidents in total were reported to the Ministry of Long-Term Care over a certain time period.

Review of resident #001’s current written plan of care (including the full care plan and 1 page Behavioural Care Plan) showed the following interventions related to the resident's responsive behaviours:

- Gently remind resident they are not to have residents in their room if they appear to be pacing and gravitating towards them.
- Keep resident busy with specified jobs
- Monitor resident’s whereabouts frequently to ensure their safety and that of other residents. Direct resident to their room if they require privacy.
- Provide privacy
- Registered staff to place specified intervention each evening when they go to bed and remove each morning when they are up for the day.
- Staff to encourage resident to attend activities daily. Take them to music programs, trivia, movies, etc. on other resident home areas (RHA's).

Hand-written on the paper copies of the resident #001's plan of care on the home area, on specified dates, were the following interventions:

- On Intervene immediately if they do (related to the resident gravitating towards specified residents and/or having them in their room)
- Q15 min in place to monitor resident's whereabouts.
- 15 min checks and sign for this.

The last noted new intervention in the resident's written plan of care on the resident's home area was on a specified date. After this date, there continued to be incidents of responsive behaviours displayed by resident #001. Medication changes were noted to be made on three dates in this time and then again after the last two incidents occurred. The Physician indicated in a progress note made on the date of the last two incidents, that they had attempted several different medication changes with unsustained effects. RN #101 also noted on this date, that 15 minute checks were followed during the shift but resident #001 knows staff's routine and whereabouts.

There was no evidence in resident #001's written plan of care during a specified time period, where medication changes proved ineffective, that different approaches were considered in the revision of the resident's plan of care. [s. 6. (11) (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 resident #001's plan of care sets out clear direction to staff and others who provide direct care to the resident and also, that when the plan of care is reviewed and revised because it has been ineffective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of resident #001 had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Resident #001 had a history of abusive behaviours towards other residents.

While inspecting the most recent allegation of abuse related to resident #001, the inspector was interviewing staff member #109. During this interview, the staff member indicated that they witnessed an incident between resident #001 and resident #005 on a specified date in the morning. They said they were walking past resident #001's room and saw them with resident #005 standing in front of them. Resident #001 was observed to be be doing a specified action that involved resident #005. The housekeeper indicated that they immediately entered the room and resident #001 walked away. The staff member indicated that they called down the hall to RPN #110 for them to come and when they did, reported what they had seen.

RPN #110 was interviewed and indicated that they didn't recall exactly what was reported to them at the time by staff member #109, but felt that what they witnessed when they arrived at the resident's room, did not fit the definition of abuse. They went on to say that they did not report the incident to the Director due to this fact.

An interview was conducted with the Assistant Manager of Nursing and they indicated that when they interviewed staff member #109, they felt that what the staff witnessed fit the definition of abuse and needed to be reported. A Critical Incident Report was then submitted to report the alleged abuse, six days after the incident occurred.

Therefore, alleged abuse of a resident was not immediately reported to the Director. [s. 24. (1)]

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 any person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 24th day of December, 2019

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

Original report signed by the inspector.