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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa ON K1S 3J4
Telephone: 1-877-779-5559
OttawaSAO.moh@ontario.ca

Original Public Report

Report Issue Date July 12, 2022
Inspection Number 2022_1620_0003
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
County of Lennox and Addington
97 Thomas Street East,
Napanee, ON
K7R 4B9

Long-Term Care Home and City
The John M Parrott Centre
Napanee, ON

Lead Inspector
Darlene Murphy (103)

Inspector Digital Signature
Darlene Murphy
Digitally signed by Darlene Murphy
Date: 2022.07.12 15:25:04 -04'00'

Additional Inspector(s)
Inspectors #740804 (Erica Mc Fadyen) and #740790 (Polly Gray-Pattemore) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 20, 22, 23, 27-29, July 4-7, 2022.

The following intake(s) were inspected:

- Log #008627-22 (CIS #M625-000019-22) and Log #009813-22-complaint letter related to resident care.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Reporting and Complaints
- Resident Care and Support Services

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INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (2)

The licensee has failed to ensure the care set out in the plan of care for a resident was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary

A resident had a fall with an injury, was placed into a transfer chair and then had another fall from the transfer chair a short time later. The Physiotherapist (PT) indicated a transfer chair is designed for short term use only such as taking a resident to and from a car. The PT stated the seating for this resident was challenging and using a transfer chair for this resident for any length of time was a safety concern. The home did have other available options for a temporary wheelchair that were not explored at the time, and this placed the resident at risk of additional harm.

Sources: review of resident progress notes, interviews with Physiotherapist, Activity Aide and Activity Manager responsible for the management of facility owned wheelchairs.

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WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 26 (1) (c)

Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

Rationale and Summary

The long-term care home (LTCH) received a letter of complaint regarding resident care issues, including an allegation staff were very rough when turning a resident. The Administrator acknowledged this was an allegation of resident abuse and was aware such allegations should be immediately forwarded to the Director, but stated they failed to do so. The failure to immediately forward all allegations of resident abuse puts residents at risk of harm.

Sources: Complaint letter and interview with Administrator.

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WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 27 (1) (a) (i)

27 (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone.

Rationale and Summary

As outlined in written notification (WN) #02, the LTCH received a letter of complaint that alleged staff were very rough when turning a resident. The Administrator acknowledged this was an allegation of resident abuse and was aware these allegations should be immediately investigated but stated they failed to do so. The failure to immediately investigate all allegations of resident abuse puts residents at risk of harm.

Sources: interview with Administrator.

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WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (1) 3. ii. A.

s. **108.** (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,

ii. an explanation of,

A. what the licensee has done to resolve the complaint

Rationale and Summary

As outlined in WN #02, the LTCH received a letter of complaint that outlined concerns related to the care of a resident. The Administrator stated the complainant was contacted by telephone fours days after the complaint was received and responded by email approximately one month later. The response was reviewed and failed to include what the licensee had done to resolve the complaint. The Administrator stated the complaint items had been previously identified at various times by the complainant prior to the submission of the complaint letter and therefore did not believe a summary of these actions were required in the response.

Sources: complaint response email and interview with the Administrator.

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WRITTEN NOTIFICATION REPORTING AND COMPLAINTS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (1) 3. iii.

s. **108.** (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,

iii. if the licensee was required to immediately forward the complaint to the Director under clause 26 (1) (c) of the Act, confirmation that the licensee did so.

Rationale and Summary

As outlined in WN #02, the email response submitted by the LTCH to the complainant failed to include confirmation that the licensee was required to immediately forward the complaint to the Director as the letter contained an allegation of resident abuse.

Sources: complaint response email and interview with the Administrator.

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