Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: June 25, 2023
Inspection Number: 2023-1620-0007
Inspection Type: Complaint Critical Incident System
Licensee: County of Lennox and Addington
Long Term Care Home and City: The John M. Parrott Centre, Napanee

Lead Inspector	**Inspector Digital Signature**
Carrie Deline (740788)	Carrie E Deline Digitally signed by Carrie E Deline Date: 2023.08.01 08:22:59 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 14, 17 - 20, 2023

The following intake(s) were inspected:

- Intake: #00090623 - CIS # M625-000040-23 - Fall of resident resulting in injury
- Intake: #00091545 - CIS # M625-000042-23 - Alleged physical abuse of resident with unknown etiology.
- Intake: #00091588 - CIS # M625-000043-23 Fall of resident resulting in injury.
- Intake: #00091697 - CIS # M625-000044-23 - Fall of resident resulting in injury.
- Intake: #00091712 - CIS # M625-000045-23 - Alleged emotional abuse of resident by staff.
- Intake: #00091866 - Complaint regarding resident care.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The Licensee failed to comply with their written policies related to falls prevention and management.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that their falls prevention and management policy and procedure is complied with.

Specifically, staff did not comply with their post fall assessment procedure: complete a head injury routine (HIR) if the scene of a fall indicates a head injury occurred.

Rationale and summary:

A resident had an unwitnessed fall in their room. The resident was assessed by a Registered Staff member who initiated HIR due to the residents change in health status.

Staff indicated that when a resident sustains a head injury they would initiate HIR assessment and vitals. The HIR assessment would be continued as per the policy and the intervals listed on the top of the HIR form provided by the Long Term Care home. A review of the resident's health care record indicated that a HIR was initiated at the time of the fall and did not continue as listed on the HIR record or as per policy. The resident was assessed with head injury vitals immediately post fall. Post falls vitals were not completed at all required intervals post fall.

Staff were not able to locate the required HIR documentation to complete the voids in the documentation. Staff confirmed that HIR documentation was missing from the record.

Not completing the HIR put the resident at risk as they were not monitored for neurological symptoms after sustaining a head injury as per policy.

Sources: CIS report M625-000040-23; resident electronic and hard copy health record, Assessment and Treatment Protocol for Head Injuries Policy #06-09-01 revised March 2023, interviews with staff. [740788]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure their zero tolerance of abuse and neglect policy was complied with.

Rationale and Summary

A staff member was witnessed by another staff member speaking to a resident in an inappropriate manner and threw an item at the resident. The staff member that witnessed the incident did not report the incident to a supervisor. The staff member failed to immediately report the information to the most senior supervisor on shift as per the licensee's Abuse - Resident's Rights and Safety Policy.

Failure to immediately report alleged abuse delays investigation into the incident and taking appropriate action to ensure a safe and supportive environment for residents

Sources: Critical Incident System (CIS) report # M625-000045-23, investigation documentation, resident progress notes, interviews with the Director of Care and other staff.
[740788]