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
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 6, 2023	
Inspection Number: 2023-1620-0010	
Inspection Type: Complaint	
Licensee: County of Lennox and Addington	
Long Term Care Home and City: The John M. Parrott Centre, Napanee	
Lead Inspector Ashley Bernard-Demers (740787)	**Inspector Digital Signature** Ashley F Bernard-Demers Digitally signed by Ashley F Bernard-Demers Date: 2023.10.06 14:59:52 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25-29, 2023, and October 3, 2023.

The following intake(s) were inspected:

- Intake: #00094835 - Complaint about alleged neglect.

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

Resident Care and Support Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (c)

The licensee has failed to ensure that clear direction was provided regarding a resident's advance directives.

Rationale and Summary

On a day in July 2021, a resident was admitted to the home. A specified advance directive was indicated in the admission note. This direction was consistent with documentation in the Admission Continuing Care Reporting System Minimum Data Set 2.0, and the Medical Plan of Treatment Form.

A specified document with different advanced directive directions was found in the chart. An Order Review Report indicated a specified advance directive different than was indicated in the admission note.

The initial written care plan included two distinct advanced directives. In a Physician Geriatric Admission Exam progress note, it stated "clarify further" regarding the resident's advance directives.

On a day in September 2023, a staff member confirmed that clear direction was not provided regarding the resident's advance directives.

Not ensuring clear direction regarding a residents' advance directives places the resident at risk to not receive their expressed wishes.

Sources: Review of clinical records and an interview with a staff member

[740787]