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

Public Report

Report Issue Date: March 12, 2025

Inspection Number: 2025-1620-0002

Inspection Type:
Complaint
Critical Incident

Licensee: County of Lennox and Addington

Long Term Care Home and City: The John M. Parrott Centre, Napanee

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 25 - 27, March 3 - 7, and 10 -12, 2025

The following intake(s) were inspected:

- Intake: #00134550/CI #M625-000073-24 – regarding alleged resident to resident physical abuse.
- Intake: #00135270/CI #M625-000074-24 – regarding alleged improper/incompetent care of a resident.
- Intake: #00137033/CI #M625-000002-25- regarding alleged staff to resident neglect.
- Intake: #00138180/CI #M625-000007-25, Intake: #00139476/CI #M625-000018-25 and Intake: #00141087/CI #M625-000019-25– regarding three enteric outbreaks.
- Intake: #00138473/CI #M625-000009-25 – regarding a fall with injury and transfer to hospital.
- Intake: #00140384 – Complaint regarding alleged improper/incompetent care of a resident.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that Point of Care (POC) documentation was completed regarding laying three residents down in the afternoon during a three month period, on eleven occurrences.

Regarding the documentation of wound treatments, for three residents, there were seven occurrences where the treatment administration record (TAR) was not signed as completed during a three month period.

Sources: Review of POC & TAR documentation, and interviews with Personal Support Worker and Nursing staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that there were weekly wound assessments completed for two residents' skin breakdown. During a one month period, a resident had one Skin and Wound Evaluation completed for their wound. During a two week period, another resident had no Skin and Wound Evaluations completed for four wound areas.

Sources: Review of resident Point Click Care assessments and progress notes, and interviews with nursing staff.

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