Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 5, 6, 7, 8, 9, 2012	2012_035124_0010	Complaint

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

LYNDA HAMILTON (124), JANET MCPARLAND (142)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and the Assistant Manager of Nursing.

During the course of the inspection, the inspector(s) reviewed resident health records.
One Written Notification was issued as a result of this inspection.

WN #1: The Licensee has failed to comply with the Long-Term Care Homes Program Manual Standards and Criteria

Unmet criterion B4.3 which stated: Each resident's care and services shall be modified in response to resident's changing needs, wishes and preferences.
Findings:
-A resident was admitted with a diagnosis of depression.

-Shortly after admission, it was documented that the resident was refusing meals and was depressed. The resident was assessed by the physician and medication was adjusted.

-Two Resident Assessment Protocols (RAP)indicated that the resident was not happy and refused care. The subsequent RAP indicated that the resident was generally unhappy with life, including feeling low or depressed.

The changes noted in the subsequent RAP were supported by the Personal Support Worker observations documented on the Behavioral Flow Records:
-One month the resident appeared sad for thirteen days and for 28 days the following month.
-One month the resident was lethargic on eleven days and for twenty-six days the following month.
-There was a marked increase in the number of days of reduced social interaction from the one month to the next month.

The changes noted in the subsequent RAP were supported by the documentation of registered nurses:
-It was documented that the registered nurse advised the physician that the resident was staying in their room all day and not as active in programs.
-The next day, the resident remained in bed all day, having feelings of low spirits.
-The following day, the registered nurse updated the physician on the difficulty they were experiencing on motivating the resident to get up.
-Thirteen days later, the resident was noted in bed with covers up to the neck, curtains closed and stated feeling depressed.

-The subsequent RAP indicated that the resident took medication daily to help with the depression. The RAP further indicated staff was to continue with current interventions in an effort to have the resident be more accepting of their care.

- The resident's plan of care was initiated on admission and subsequently reviewed three and six months later. The plan of care contained interventions related to the depression that were not pertinent to current symptoms. There were no changes in the identified interventions to manage the resident's depression.

The home failed to modify the resident's care and services in response to changing needs related to depression.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death

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There are no findings of Non-Compliance as a result of this inspection.

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	Legendé 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.

Issued on this 15th day of March, 2012

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

L Hamilton