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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 9, 10, 11, 2012	2012_041103_0026	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

DARLENE MURPHY (103)

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 Personal support workers, Registered Practical Nurses, the RAI Coordinator, a family member, and the Manager of Nursing Services.

During the course of the inspection, the inspector(s) reviewed the resident health care records. This complaint is logged as #O-001139-12.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

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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.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 6 (5) whereby the home failed to give the substitute decision maker an opportunity to participate fully in the development and implementation of the resident plan of care.

During a review of Resident #1's health care record, the following was documented:
-On March 9, 2012 on or about 1730 hour, a bruise was discovered by a Personal support worker (PSW) on Resident #1's left thigh.
-The bruise was reported to the Registered Practical Nurse (RPN), staff #101 and the PSW advised her the bruise had not been present on the previous evening. RPN staff #101 assessed the area.
- The RPN documented, Resident #1 had a hematoma of considerable size on the left, outer aspect of the thigh and the bruise appeared to be new, dark blue and purple in color.
-The bruise was documented as measuring eight inches down the length of Resident #1's thigh and three to four inches in width and was tender to touch.
-During an interview with RPN staff #101, she recalled the resident had returned from hospital thirty minutes prior to the discovery of the bruise and the PSW had noticed it when toileting the resident. The RPN stated to her knowledge the resident had not sustained a fall at any time in the days prior to the discovery of the bruise. RPN staff #101 confirmed she had not notified the substitute decision maker (SDM) about the bruise. Upon reviewing Resident#1's health care record, there was no indication any staff member had reported this bruise to the SDM.

Issued on this 11th day of July, 2012

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

Darlene Murphy