Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 23, 2018	2018_505103_0010	025816-17, 028753-17, 004971-18	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): March 27-29, 2018

Log #025816-17 (CIS #M625-000013-17),
Log #028753-17 (CIS #M625-000017-17),
Log #004971-18 (CIS #M625-000008-18)-all related to resident falls.

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the critical incidents submitted by the home, and made resident observations.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to notify the Director (MOHLTC) of an injury within three business days for which resident #003 was sent to hospital and for which the licensee was unable to determine whether the injury resulted in a significant change in the resident's health condition within one business day.

Resident #003 had diagnoses that included a cognitive impairment. On an identified date on or about 0755 hour, resident #003 was found on the floor in the doorway between the resident's bedroom and the bathroom. The resident was assessed for injuries and staff suspected the resident had sustained an injury. The resident was sent to hospital for further assessment. The following day, resident #003's family member notified the staff that the resident was awaiting treatment. On an identified date, the staff spoke with the hospital and confirmed the resident had received treatment and would be returning to the home the following day. Resident #003 returned to the home and was non weight bearing at that time. PSW #102 and RPN #104 were interviewed and indicated prior to the fall, resident #003 was ambulatory with the use of a walker and required no physical assistance from staff.

The home submitted critical incident (CIS) #M625-000013-17 on an identified date to report resident #003's fall and significant change in condition. ADOC #107 was interviewed and stated the CIS was the means by which the MOHLTC was notified of resident #003's significant change in condition. ADOC #107 was unsure of the reason for the late submission of the CIS.

DOC #106 was interviewed and stated they were unable to determine the full extent of the resident's injuries and change in condition until the resident returned to the home three business days following the incident. The DOC was unable to determine why the CIS was not submitted until seven business days following the incident. [s. 107. (3.1)]

Issued on this 23rd day of April, 2018

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

Original report signed by the inspector.