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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2018	2018_505103_0033	025281-18, 025747-18, 025997-18, 027958-18, 028598-18, 028879-18	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): November 15-16, 19-21, 2018.

Log #025281-18 (CIS #M625-000022-18) and Log #027958 (CIS #M625-000025-18): resident falls that resulted in an injury,
Log #025747-18 (CIS #M625-000023-18), Log #025997-18 (CIS #M625-000024-18), Log #027958-18 (CIS #M625-000026-18), and Log #028879-18 (CIS #M625-000028-18): incidents of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Physiotherapist, 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, observed residents and resident care, and reviewed applicable policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 30 (2), the licensee failed to ensure the documentation of resident #001's post fall assessment was complied with.

Specifically, RN #108 failed to comply with the licensee's policy, "Falls Investigation and Documentation", #06-01-10Q. This policy states:

-the nurse completes a head to toe assessment for range of motion of all limbs, head injury assessment, vital signs assessment and wound and skin assessment, observing for bruising, skin tears, reddened or open areas and pain assessment.
-document a detailed summary of incident, vital signs, head injury routine and results of all assessments in the progress notes under the "Fall note" type.

On an identified date, resident #001 sustained a fall. RN #108 assessed the resident and indicated in a progress note the details of the fall, but failed to include the assessment related to the resident's range of motion and the assessment of pain.

RN #108 was unavailable for interview. RPN #109 was interviewed and indicated they were called to be a second assessment for resident #001's fall. The RPN confirmed a thorough post fall assessment was completed.

DOC #101 indicated documentation post fall is to be completed in accordance with the home's policy. The DOC stated the electronic charting system has been updated with prompts to ensure thorough documentation is completed including all of the required parameters.

The licensee failed to ensure resident #001's post fall assessment was documented as outlined in the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure results of every investigation into alleged incidents of resident abuse were reported to the Director (MOHLTC).

On an identified date, CIS #M625-000024-18 was submitted to report an incident of resident to resident sexual abuse. The CIS indicated the home was awaiting a call back from the physician and one of the substitute decision makers. There were no additional amendments.

On another identified date, CIS #M625-000026-18 was submitted to report another incident of resident to resident sexual abuse. The CIS indicated the appropriate notifications had not yet been made and that the investigation by the home was ongoing. There were no additional amendments.

ADOC #107 was interviewed and reviewed the critical incidents. They indicated it would have been their responsibility to amend both of the critical incidents and that it was their usual practice to do so. They stated it was an oversight that these two incidents had not been amended. [s. 23. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect an incident of resident to resident abuse had occurred failed to immediately report the suspicion and the information upon which it was based to the Director.

On an identified date, the home submitted CIS #M625-000026-18 to report an incident of resident to resident sexual abuse involving residents #002 and #003. The CIS indicated the incident had occurred on the previous evening.

RPN #110 was working on the resident unit on that evening and was interviewed. They indicated they had been made aware of the incident by a PSW staff member. The RPN indicated the RN in charge of the home was also present during the notification of the incident. The RPN indicated it had been their understanding that RN #111 was aware of the incident and had reported it to the MOHLTC, police and the SDM's. The RPN was able to outline the actions taken that evening to safe guard the residents following the incident and was aware the incident required immediate reporting to the Director.

ADOC #107 was interviewed and stated they were the manager on call on the identified evening and had not received any notifications related to this incident of resident to resident abuse. They stated they became aware of the incident upon their arrival to work the following morning and submitted the CIS to inform the Director.

ADOC #107 stated they spoke with both RPN #110 and RN #111 and indicated RPN #110 had stated RN #111 was aware of the incident and RN #111 indicated they had not been made aware of the incident. As a result of the miscommunication, the incident of resident to resident abuse was not immediately reported to the MOHLTC. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's substitute decision makers (SDM) were immediately notified of an incident of resident abuse that caused distress to the resident.

As outlined in WN #3, an incident of resident to resident abuse occurred involving residents #002 and #003. Resident #003's progress notes were reviewed and indicated resident #003 had expressed upset as a result of the incident and required reassurance by the staff. ADOC #107 was interviewed and also indicated resident #003 had been upset by the incident. The ADOC stated the SDM's were not notified of the incident of resident abuse that occurred on the identified evening until the next morning. [s. 97. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate police force was immediately informed of an incident of resident abuse.

As outlined in WN #3, an incident of resident abuse occurred on an identified evening. In a interview with ADOC #107, they confirmed the police were not notified of the incident of resident abuse until the following morning. [s. 98.]

Issued on this 27th day of November, 2018

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

Original report signed by the inspector.