Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2019	2019_664602_0046	018227-19, 018939-19	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

WENDY BROWN (602)

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): October 30, 31 and November 1, 2019

Log# 018227-19/CIS#M625-000021-19 - regarding a fall with injury and transfer to hospital
Log# 018939-19/CIS#M625-000022-19 - regarding a fall with injury and transfer to hospital

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Manager of Nursing (AMON), Registered Nurses (RN), Personal Support Workers (PSW), an Activity Aid and the RAI Coordinator.

As part of the inspection, reviews of electronic and hard copy health records and relevant policies and procedures were completed. Multiple interview(s) and observations of resident care and services were also conducted.

The following Inspection Protocols were used during this inspection:
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	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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

On two specified dates resident #002 fell in attempts to get up from their chair. Post fall interventions included use of alarms.

In an interview with Registered Nurse (RN) #107, it was explained that resident fall interventions are documented on the unit's special needs board and on an information reference logo sheet in the resident's room. A subsequent observation by inspector #602 found that resident #002's alarms had not been documented. Interviews with Personal Support Worker (PSW) #112, Activity Aid #108, Assistant Manager of Nursing (AMON) #110 and the RAI Coordinator #111 confirmed that fall interventions should be documented on resident special needs list(s) and on resident room logo(s).

Resident #002's fall interventions were not documented on the special needs list or their resident room logo reference sheet. [s. 30. (2)]

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.