Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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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
Aug 30, 2021	2021_873602_0023	010997-21, 011058-21	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

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 19 - 21 & 23, 2021

Log #011058-21 - regarding alleged staff to resident neglect
Log #010997-21/CIS #M625-000026-21 - regarding alleged staff to resident verbal abuse

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Manager of Nursing (AMON) /Infection Prevention & Control (IPAC) management lead, housekeeping staff, residents, family members and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care & progress notes, investigation documentation, related policies & procedures and made resident care & service observations.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure their written policy to promote zero tolerance of resident abuse was complied with.

A resident's family forwarded an email to the Administrator detailing concerns specific to alleged staff to resident verbal abuse by a Registered Practical Nurse (RPN). A Critical Incident report was submitted. A review of the investigation file found that the incident occurred in the dining area and was witnessed by several staff. The resident told a Personal Support Worker (PSW) that they felt bullied and demeaned by the RPN. The incident was not reported to the charge nurse/team leader as outlined in the licensee's abuse policy. Abuse must be reported immediately due to the risk that further abuse could occur.

SOURCES: Critical Incident report, Abuse-Resident Rights and Safety Policy, investigation documentation and interviews with Assistant Manager of Nursing (AMON) and other staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure their written policy to promote zero tolerance of resident abuse is complied with, to be implemented voluntarily.

WN #2: 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:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that peri-care was provided with a brief change and that menu options were offered to a resident when they did not attend the dining room for a meal.

While changing a resident's brief, peri-care was not provided contrary to plan of care direction specific to toileting; change incontinent product, provide peri-care, and readjust clothing. Peri-care is required with each brief change in order to maintain hygiene and skin integrity.

When the same resident declined attending the evening meal, the PSW staff did not respond that they would return with the resident's choice of meal in a specified time frame as directed in the plan of care. The licensee's behavioural support strategies outline that structured, consistent messages and care are needed for effective behaviour management.

Sources: Resident progress notes & plan of care, investigation documentation and interviews with the resident, resident family, an RPN, the AMON and other staff. [s. 6. (7)]

Issued on this 31st day of August, 2021

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

Original report signed by the inspector.