

**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**

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 rapport public**

---

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 1, 2021	2021_873602_0039	013037-21, 014697- 21, 015439-21, 015898-21, 016669- 21, 017442-21	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): November 18, 19, 22 - 26, 2021**

**The following inspections were completed:**

**Log #017442-21/CIS # M625-000043-21 – regarding alleged staff to resident(s) emotional abuse and neglect.**

**Log #016669-21 & #015898-21/CIS # M625-000040-21 & M625-000038-21 – regarding falls with injury and transfer to hospital.**

**Log #015439-21 & #013037-21/CIS # M625-000037-21 & M625-000032-21 – regarding responsive behaviour management.**

**Log #014697-21/CIS # M625-000035-21 – regarding alleged staff to resident(s) physical and emotional abuse.**

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

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

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**

**Infection Prevention and Control**

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**1 WN(s)  
1 VPC(s)  
0 CO(s)  
0 DR(s)  
0 WAO(s)**

<b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b>	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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 PSW verbally abused a resident; in a second incident that shift another resident was roughly transferred and later verbally abused by the same PSW. The PSW who was present for both incidents did not report the incidents 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 will occur.

SOURCES: CIS report, policy investigation documentation and interviews with the Manager of Nursing (MON), the Assistant MON 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 resident abuse/neglect policy is complied with, to be implemented voluntarily.***

---

**Issued on this 1st day of December, 2021**

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

**Original report signed by the inspector.**