Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 5, 2023	
Inspection Number: 2022-1620-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: County of Lennox and Addington	
Long Term Care Home and City: The John M. Parrott Centre, Napanee	
Lead Inspector Cathi Kerr (641)	**Inspector Digital Signature** Cathi Kerr Digitally signed by Cathi Kerr Date: 2023.01.05 15:53:37 -05'00'
Additional Inspector(s) Ashley Bernard-Demers (740787) Carrie Deline (740788)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 12, 13, 15, 16, 20, 21, 22, 2022

The following intake(s) were inspected:

- Intake: #00001176-[CI: M625-000029-22] Fall of a resident resulting in injuries.
- Intake: #00004501-[M625-000028-22] Alleged staff to resident neglect.
- Intake: #00004609-[CI: M625-000027-22] LTCH C/R 2022 Alleged staff neglect of resident care.
- Intake: #00005417-[CI: M625-000030-22] Fall of a resident resulting in an injury.
- Intake: #00006277-[IL: IL-04103-OT] Complaint related to a fall of a resident resulting in injury.
- Intake: #00010919-[M625-000038-22] Fall of a resident resulting in an injury.
- Intake: #00011156-[M625-000039-22] Fall of a resident resulting in an injury.
- Intake: #00011642-[M625-000041-22] Alleged verbal abuse and neglect of residents.
- Intake: #00012964-[M625-000043-22] Injury to a resident of unknown origin.
- Intake: #00013605-[M625-000044-22] Resident to resident physical abuse resulting in injury

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

Falls Prevention and Management
Prevention of Abuse and Neglect
Infection Prevention and Control
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC ##001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to report abuse, or suspected abuse by anyone that resulted in harm or risk of harm to the resident, immediately to the Director.

Rationale and Summary:

The critical Incident indicated that a personal support worker (PSW) reported to the Registered Nurse (RN) over-hearing another PSW allegedly verbally abuse a resident in the dining room. The Assistant Director of Care, (ADOC) indicated they became aware of the incident 14 days later and submitted a critical incident report to the Director immediately.

There was a risk to the resident as failure to immediately report alleged abuse delays the investigation into the incident and appropriate action to ensure a safe and supportive environment for residents.

Sources: resident's progress notes, interviews with the Assistant Director of Care and other staff. [740788]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC ##002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The Licensee failed to comply with their written policies related to falls prevention and management.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that their falls prevention and management policy and procedure is complied with.

Specifically, staff did not comply with their Post Fall Assessment and Treatment Protocol for Head Injuries Policy #06-09-01, revised August 2022: complete a head injury routine (HIR) if a resident has sustained a blow to the head.

Rationale and summary:

A resident was witnessed falling by a PSW in the hallway. The resident was noted to have sustained a head injury.

During an interview with Inspector #740788, the RPN indicated that when a resident sustained a head injury, they would initiate a HIR that would be continued for 48 hours as per their protocol. A review of the resident's health care record indicated that a HIR did not continue until the end of the 48 hours. The resident was assessed with head injury vitals at the time of the fall and then 15 minutes later, as per policy. No further HIRs were completed on the resident prior to them being sent to the hospital, two and three quarter hours later. Upon return from the hospital the same evening, HIR was not completed routinely as per policy, or continued for the remaining observation period.

During an interview with Inspector #740788, the ADON confirmed that registered nursing staff completed HIR vitals on a HIR sheet. An electronic and hard copy chart review was completed with the ADON which found no further HIR documentation besides the HIR sheet provided.

By not following the Licensee's post fall procedure, this posed a risk to the resident as they were not monitored for neurological symptoms after sustaining a head injury.

Sources: resident's electronic and hard copy health record, Assessment and Treatment Protocol for Head Injuries Policy, interviews with RPN, ADON and other staff. [740788]