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 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: May 23, 2024
Inspection Number: 2024-1620-0002
Inspection Type: Complaint Critical Incident
Licensee: County of Lennox and Addington
Long Term Care Home and City: The John M. Parrott Centre, Napanee

Lead Inspector	Inspector Digital Signature
Erica McFadyen (740804)	Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2024.05.24 10:55:39 -04'00'

Additional Inspector(s) Stephanie Fitzgerald (741726)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 14-17, and 21-22, 2024

The following intake(s) were inspected:

- Intake: #00111783/ CIS #M625-000018-24 - Disease outbreak in the long-term care home
- Intake: #00113241/ CIS #M625 000024-24 - Alleged staff to resident physical abuse
- Intake: #00114405/ CIS #M625-000028-24 - Fall of a resident resulting in injury

- Intake: #00115175- Complaint regarding the care of a resident in the long-term care home
- Intake: #00115526 / CIS #M625-000032-24 - Alleged neglect of a resident

The following Inspection Protocols were used during this inspection:

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

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.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary

On a specified date Personal Support Worker (PSW) #110 performed a specified intervention on a resident.

Review of the investigation records for the incident indicated that PSW #109 felt that this action was abusive and reported their concerns the next day. A Critical Incident System (CIS) Report was submitted to the Director two days after PSW #109 made their report to the long-term care home.

In separate interviews with a registered practical nurse (RPN) and the Director of Care (DOC), it was stated that PSW #109 did not report their concern until the day after the incident occurred. The DOC confirmed that the incident required immediate reporting to the Director, and was not immediately reported.

Failing to immediately notify the Director of alleged resident abuse places residents at risk of additional harm.

Sources: CIS report #M625-000024-24, Investigation notes for related incident, interviews with the RPN and the DOC, [741726]