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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 26, 2013	2013_184124_0017	341-13	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

LYNDA HAMILTON (124)

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): August 20, 21, 22, 2013.

Critical Incident report M625-000013-13 was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant Manager of Nursing and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident health record and the home's policy related to safe transfers and the document "Safe Transfer-Training Tool".

The following Inspection Protocols were used during this inspection:
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.36. in that the staff did not use safe transferring and positioning techniques when assisting the resident in the tub room as evidenced by the following finding.

Resident #1 had diagnoses of Alzheimer's Disease and osteoarthritis with a plan of care that identified the resident at risk of falls.

The home submitted Critical Incident Report #M625-000013-13 on a specific date to advise the Ministry of Health and Long-Term Care that there had been an injury that resulted in transfer to hospital because of a resident fall.

Staff #100 reported that Resident #1 was lifted up while seated on the lift chair with the seat belt in place. Staff #100 rang the call bell for assistance and moved away from the resident. When staff #100 turned back to the resident, the resident was leaning forward, the lift chair began to tip and the resident, lift chair and staff #100 went down on the floor.

Resident #1 sustained an injuries and was sent to hospital for treatment.

Staff #100 provided the inspector with a document, "Safe Transfer-Training Tool" that stated "When the lift is moved up or down there must be two staff present." Staff #100 said he/she did not remember this statement directing staff to have two staff present when the lift is moved up or down. [s. 36.]

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 that there are two staff present when the lift is moved up or down, to be implemented voluntarily.

Issued on this 9th day of September, 2013

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

Lynda Hamilton