Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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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_0016	O-435-13, O -531-13	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

LYNDA HAMILTON (124)

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): August 15, 16, 19, 20, 21, 22, 26, 2013.

Two complaints, log numbers O-000435-13 and O-000531-13 were inspected as part of this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Manager of Nursing, Assistant Manager of Nursing, Dietary Services Manager/Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Staffing Co-ordinators.

During the course of the inspection, the inspector(s) completed walking rounds of the home, observed staff-resident interactions, general observations of resident care, reviewed resident health records and the home's policies and procedures related to safe resident transfers, tray services and Tena Usage Guidelines.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Medication

Nutrition and Hydration

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.71. (3)(a) in that on two occasions, resident #1 was not offered three meals daily.

Resident #1 is at high nutritional risk and has skin breakdown. Resident #1 is wheelchair dependent and requires transfer by mechanical lift.

It is documented in Resident #1's progress notes on a specific date that Resident #1 refused to come to supper. Resident #1 accepted a fluid tray in the bedroom but was not pleased. Staff explained that there is no one available to observe the resident eating solid foods in the bedroom at this time and for the resident's safety that the resident would have fluids when alone in the bedroom. The Registered Practical Nurse explained that if the resident wanted a full meal the resident is to come to the dining area.

On another date, it is documented that the resident was adamant that he/she did not want to go down for supper. The Registered Nurse was consulted and as the resident is capable of making decisions the resident remained in the chair and a fluid tray was taken to the bedroom with no complaints.

The Dietary Services Manager/Dietitian stated that a meal would consist of the menu choices, for example at breakfast it could be juice, cereal, egg and toast. The Dietary Services Manager/Dietitian also reported to the inspector that a clear fluid tray does not equal a meal.

On two occasions, Resident #1 received a fluid tray at dinner and thus did not receive three meals on those days. [s. 71. (3) (a)]

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 residents who have tray service to their rooms are offered three meals daily, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 131. (2) in that Resident #1 did not receive medication in accordance with the directions for use specified by the prescriber.

Resident #1 is at high nutritional risk and has skin breakdown.

Resident #1 had a physician's order for a specific medication at bedtime, as needed.

Staff #102 reported that on a specified date, Resident #1 was given the specific medication at 0910 hours at the family's request.

Later that day, it was documented in the progress notes that the resident had been very confused and lethargic during the day possibly due to receiving the specified medication this morning.

On another day, Staff #103 documented that the specified medication was administered at 0900 hours. Staff #103 reported that the resident's specified medication was being administered when the resident needed it.

On a third day, it is documented in the progress notes that the resident received the specified medication at 0156 hours.

Resident #1 did not receive the specific medication tablet at bedtime as was directed by the physician. [s. 131. (2)]

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 medication prescribed at bedtime on an as needed basis is administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s. 44 in that the equipment to transfer Resident #1 was not readily available.

Resident #1 has diagnoses of skin breakdown and arthritis. Resident #1 is wheelchair dependent and requires assistance with transfers.

The Manager of Nursing(MON) reported that on June 5, 2013, Resident #1 was assessed and recommendations were made regarding the use of a certain lift. As well, the MON had discussion with a company representative regarding the equipment required to transfer this resident by a sling lift.

Staff #101 reported to the inspector that on a specific day, Resident #1 was being transferred by the lift; the resident had difficulty and staff were able to assist and prevent a fall, but is was a "near miss", so the resident was placed on bed rest.

The Manager of Nursing reported that on another date, some of the required equipment arrived at the home and that the other piece of equipment was on back order.

At a later date, the other piece of equipment arrived and the process of transferring the resident by was put in place.

Resident #1 was on bed rest for a specific period of time until the equipment needed to transfer the resident was obtained by the home. [s. 44.]

Issued on this 4th day of September, 2013

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

Lynda Hamilton