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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2015	2015_444602_0034	O-002877-15	Resident Quality Inspection

Licensee/Titulaire de permis

PROVIDENCE CARE CENTRE
340 Union Street KINGSTON ON K7L 5A2

Long-Term Care Home/Foyer de soins de longue durée

PROVIDENCE MANOR
275 SYDENHAM STREET KINGSTON ON K7K 1G7

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

WENDY BROWN (602), AMBER MOASE (541), HEATH HEFFERNAN (622), JESSICA LAPENSEE (133), JESSICA PATTISON (197), KARYN WOOD (601), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 30, and December 1- 11, 2015

Log O-005414-14, O-003322-15, O-009276-15, O-033702-15, O-033703-15, O-033704-15,O-009629-15, O-009634-15, O-011232-15, O-013542-15, O-013543-15, O-022545-15 and O-027434-15 were also included a part of the inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Resident Council President, Family Council President, Personal Support Workers (PSW),
Registered Practical Nurses (RPN), Registered Nurses (RN), Administration staff, Advanced Practice Nurse (APN) - Wound Care Specialist, Facility Manager, Project Manager – Planning/Redevelopment, Housekeeping staff, Pharmacist, Dietary staff, Director of Care (DOC), Assistant Director of Care (ADOC), and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed resident dining, reviewed medication administration including drug destruction practices and drug storage areas, observed resident care, the home's infection control practices including hand hygiene for staff and residents, tested all door alarms and the call bell system, reviewed resident health care records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #001	2014_179103_0024	133
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_390602_0010	602
O.Reg 79/10 s. 36.	CO #002	2015_390602_0010	602
O.Reg 79/10 s. 9. (1)	CO #003	2014_179103_0024	133
O.Reg 79/10 s. 9. (1)	CO #004	2014_179103_0024	133
O.Reg 79/10 s. 9. (1)	CO #002	2014_179103_0024	133

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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The home failed to comply with compliance order #005 in the following ways:
- The home's maintenance program and system of ongoing auditing to ensure that all maintenance issues are corrected promptly to meet the overall maintenance needs of the home, has not been effective as evidenced by the widespread disrepair observed in the home.
- The home did not have written schedules and procedures for remedial maintenance until Inspector #197 requested them on December 7, 2015. [s. 15. (2) (c)]

2. During the initial tour of the home and throughout stage 1 of the Resident Quality Inspection, Inspectors noted the following disrepair in the home:

Sydenham/Montreal 3:
- Sydenham 3 hallways – equipment markings along lower wall
- Room 338 - rust is noted around the base of the washroom faucet and the drain.
- Room 347 - inside the lower right side of the door next to the closet, noted a two and a half inch x one inch area of plaster chipped from the wall leaving the steel corner bead exposed. Paint is scratched in several areas on the door from two thirds of the way down
- Room 354 - wall in resident's bathroom has many gouges out of the drywall
- Room 370 - lower bathroom door paint chipping and gouges
- Room 376 - paint chipping from bathroom door frame

Sydenham/Montreal 4:
- Whirlpool room across from room 422 - drywall pieces missing, round hole in wall
- Wall along entire length of hallway has many black marks along the bottom
- Wall to entrance of clean utility room has piece of drywall falling off, wall at entrance of dining room is heavily scarred with black marks, wall to entrance of elevator has piece of drywall peeling away from the wall
- Common area at end of hallway- radiator has a piece missing.
- Across from room 476 - piece of radiator is falling off the wall
-Wall to entrance of whirlpool room across from room 461 has 2 pieces of drywall missing approx 1.5 feet long, metal exposed
- Activity room at end of hallway, radiator piece missing below window, small gouges out of drywall to right of door entrance
- Room 447 - pieces of drywall missing from wall in room, metal exposed
- Room 458 - baseboard is missing from one wall in bathroom

Sydenham/Montreal 5:
- Across from room 560 at entrance to unlabeled door is a large piece of drywall missing from the lower part of wall approx 2 feet long, 4 inches across. Metal is exposed.
- Wall is heavily marked along hallway with black marks and gouges
- Small common room facing water, large(3inches x 3 inches) pieces of drywall missing from wall to left of window, and next to light switch at entrance of room
- Room 559: chunks of drywall missing to left of entrance to room, sharp
- Wall going into nursing station is heavily marked with black marks and small gouges, as is wall directly across from nursing station and wall leading into small common room.
-Room 543 - wall outside room has large pieces of drywall missing, which have been repaired but not painted.
- Common area at end of hallway (facing Sydenham St) - baseboard missing to right of entrance, radiator dirty with brown debris and scuffed with black marks along entire length. Large area of drywall in disrepair to left of window, appears a long mirror was removed but drywall not repaired.
- Floor heavily scuffed with black marks outside room 524
- Whirlpool room next to room 540 - Sink has Brown stained caulking around it, drywall missing from lower part of wall below sink, metal exposed, wall across from tub has many gouges and pieces of drywall missing. Tub drain is rusty, radiator in room heavily scratched with black marks.
- Dining room walls are heavily damaged, with a large piece of wall repaired (white) but has not been painted
- Room 501 - wall in bathroom has many gouges out of drywall, drywall outside of bathroom on wall has been gouged and metal visible.
- Room 503 - many scuffs/scrapes on bathroom door and just outside. Drywall missing and corner bead exposed just outside bathroom door - same in shared bathroom. Many scrapes on backs of bathroom doors.
- Room 513 - baseboard outside bathroom is coming away from wall
- Room 538 - black marks on the floor and walls are also chipped along the bottom on right hand side. The toilet seat is loose.
- Room 546 - toilet seat and arm rest not secure.
- Room 564 - the inside of the bathroom doors have black marks and the walls have scuffs that require paint
- Room 580 - scuffs/scrapes on wall across from bed and on both doors (bathroom/bedroom)

On December 7, 2015 the Maintenance Manager indicated that the home has a

computerized system for managing maintenance in the home; any staff member can create a ticket for a repair to be completed. He stated that audits are done daily and each area of the home is done at least once per week. Specifically, he stated these audits are checking mainly ceiling tiles and door security. When asked how they check for wall damage and areas requiring paint, he stated that he randomly checks rooms on his monthly audits, but there is no sequential order and he may not get in to check all resident rooms. He stated that wall repair and paint is done between residents, either upon a new admission or when there is an internal transfer. Otherwise, a ticket could be created at the resident, family or staff's request. The Maintenance Manager was asked to provide the home's written schedules and procedures that are in place for remedial maintenance, as required by O. Reg. 79/10, s. 90(1)(b) and 30(1)1. He indicated that at this time the home did not have their schedules and procedures in writing for their maintenance program. The Maintenance Manager later provided the inspector with a document titled "Maintenance Department Procedure". [s. 15. (2) (c)]

3. The licensee has failed to comply with LTCHA 2007, s. 15 (2)(c) in that the home has not been maintained in a safe condition and good state of repair.
Compliance Order #005 related to LTCHA 2007, s. 15(2)(c) was issued on September 16, 2014 with a compliance date of March 16, 2015. The licensee was ordered to:

- correct the extensive list of items identified during the Resident Quality Inspection
- develop and implement an effective system of ongoing auditing to ensure that all maintenance issues identified by this auditing system are corrected promptly
- ensure that the maintenance program is organized and effective in meeting the overall maintenance needs of the home
- ensure that schedules and procedures are in place for remedial maintenance as per O. Reg. 79/10 s. 90 (1)(b)
- the schedule and procedures must be written as per O. Reg. 79/10 s. 30(1)1.

The home provided inspectors with a document titled "Ministry Order Report 2015". This document details all maintenance issues identified and what the home did to fix the issue. Inspector #197 found that all issues identified on the report were fixed, but through observation found the following:
3rd Floor
- S380 (just outside) - heavy scarring on walls and chunk out of wall in the hallway
- S377 - many paint chips on outside of room door
- S3 elevator (just outside) - paint heavily chipped on wall corners
- S376 - heavy scarring on wall just outside room

- S3 Dining Room - lower walls are scuffed, paint chipped on walls and radiators along the floor, pieces of metal sticking out of radiator that could be hazardous to residents
- S373 - scarring on back of bathroom door, paint chipped on door frame
- Whirlpool/Shower room across from S309 - many paint chips/scuffs on walls, one ceiling tile is water stained, wall tile missing as you enter the bathroom
- Whirlpool room across from 332 - wall damage on the right wall, hole in drywall by baseboard, metal strapping dented and visible on corner of wall by sink

4th Floor
- scarring/black marks on walls throughout S4 hallways and paint chips out of many resident room doors
- paint peeling off outside elevator on S4, paint chips on either side of elevator
- paint/wall surface peeling off outside housekeeping/clean utility rooms on S4
- M459 - gouges out of drywall to the right of resident's computer which resident indicates have been there for approximately six months, gouges in shared bathroom in front of sink, baseboard missing to the left of the sink
- M426 - kick plate appears to have been torn off the back of the bathroom door showing disrepair and chunk out of door
- M4 Shower room - just outside the shower and tub rooms metal strapping is exposed on both corners, drywall damage throughout the shower room, corner beads exposed, cover missing over pipes and sharp metal studs in the wall right beside the toilet. A PSW indicated this shower room is in use and that the missing cover was reported to maintenance about 2 weeks ago. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan.

Re: Log # 005414-15

Resident #37 resides in a shared room and has the bed closest to the window; the co-residents mat(s) are to be moved when they are not in use as they are a possible tripping hazard for Resident #37 when mobilizing to/ from the bed.

On December 10, 2015 inspector #541 observed Resident #37's room and noted that the roommate's mats were on the floor. The roommate was not in the room. Resident #37 was in his/her wheelchair at the entrance to the room and indicated that it is difficult to get to his/her side of the room. The Resident stated that he/she cannot roll the wheelchair over the mat requiring that he/she attempt to manoeuvre between the mat and his/her roommate's bureau.

On December 10, 2015, PSW #134 indicated that the mats for Resident #37's roommate are not to be left on the floor when the roommate is not in bed. Despite this direction, on December 11, 2015 Inspector #541 observed Resident #37's room at approximately 1000 hrs. The Resident's roommate was sitting up in a wheelchair beside his/her bed and the mats were on the floor. Resident #37 was not in the room. [s. 6. (7)]

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 the care set out in the plan of care for a resident is provided to a resident as specified in the plan,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their wound care policy, specifically the pressure ulcer prevention and management policy was complied with in that residents identified as having a pressure ulcer are to have a wound assessment form initiated and updated once a week.

The homes pressure ulcer prevention and management policy (Policy number: CARE-RC-56) states the following:
Providence Manor is committed to the following principles:
- Any pressure ulcer will be assessed at the time of identification and at least weekly thereafter

- Residents identified with a pressure ulcer will have a:
  - Wound assessment form initiated and updated once a week

On a specified date, during a chart review a recent worsening of skin integrity /pressure ulcer status was noted. When wound care assessment documentation could not be found a registered staff indicated the inspector should look for it in the progress notes, and/or the skin or foot care section of the chart, no wound care assessment form or flow sheet was found in either section. Another registered staff advised that reassessments of the Resident's pressure ulcer(s) would be completed every two days and more often if/when necessary, however, the staff was unable to name a specific tool or scale used in the assessment/ reassessment of wounds/ulcers. A registered staff then indicated an advanced practice nurse does wound assessment/ reassessment; however, none were found.

On a specified date a registered staff indicated that RPNs do a full skin and wound

assessment on admission and that any concerns are reported to the RN who would likely alert tan advanced practice nurse. The registered staff further shared that no specific flow sheet or wound care documentation form is completed; and that reassessment information is found in the progress notes. In a telephone interview with an advanced practice nurse it was confirmed that assessments are completed on admission; a full head to toe skin assessment, on return from hospital; anytime a resident has been away from the home for greater than 24 hours. A Wound Care Resource binder has been developed for reference by staff and contains algorithms, Policies and Procedures (P&P) and other reference materials. There are P&Ps in place for pressure ulcers, skin tears, debridement and "Wound Management Protocol" (when resident presents with wound that requires advanced wound care products to promote healing and/or improve quality of life). The advanced practice nurse also advised that there is a wound care flow sheet (incorporates Braden assessment) - that is supposed to be used with every wound, even with a skin tear if it is not healing (e.g. no improvement over 2 weeks).

On further discussion a registered staff indicated that the wound care flow sheet is instituted, for some residents, but is not for all. The staff advised that the Resident for whom the chart review was completed should have a wound care form on the chart given his/her wound/skin problems. Two registered staff then discussed whether a form should be started or not; the inspector pointed out the policy, located in the wound resource binder on all units, which directs that a wound assessment form must be initiated and updated once a week for residents identified with a pressure ulcer. One of the registered staff then acknowledged he/she was not aware of this and will begin to advise/share with staff accordingly.

The use of the pressure ulcer prevention and management policy wound assessment form was reviewed with the DOC who acknowledged that the policy was not being complied with. [s. 8. (1)] [s. 8. (1) (a),s. 8. (1) (b)]

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 the home's pressure ulcer prevention policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Re: Log # 005414-15

According to a Resident's progress notes, on a specified date, a large lump that was tender to touch was noted. A note was left in the physician's book to be assessed. Two days later a progress note indicated family was concerned about the lump and wanted it assessed. The progress note indicates the area was red, warm, hard and raised. A staff informed the family that this information was left in the physician's book to be assessed when the physician came in (3 additional days) The family, concerned about lump, took the resident to the hospital where the lump was treated.

On a specified date Inspector #541 interviewed the Resident who recalled having the lump, advised it was painful and that it had been looked at twice by the home however nothing was done about it.

During an interview with the home's ADOC # it was indicated that a lump such as the one described in the progress note should not have been left as a note in the physician's book and that the home has an on-call physician that should have been notified to assess the area. The home failed to provide immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection for the Resident's wound. [s. 50. (2) (b) (ii)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who is both an employee of the licensee and a member the regular nursing staff on duty and present at all times in the home LTCHA 2007, s. 8 (3)

On a specified date the DOC alerted Inspector #602 that an RN called in to advise that they needed to be off. The home was unable to schedule coverage for one of the shifts. At least five (5) RNs were approached regarding covering the shift. The ADOC and DOC were unable to come in, and the remaining RN's were unable to cover the shift. An extra RPN was scheduled and the shift was fully staffed with PSWs.

The staffing schedule was reviewed from January 2015 – December 2015.
Three shifts were identified as having no RN on duty and present in the home:
1. shift 1900 - 0700 hours
2. shift 0400 – 0700 hours
3. shift 1900 - 0700 hours
The staffing plan was reviewed and the home's staffing plan states the following:
When an RN's shift cannot be filled options that may be utilized are:
? Leave vacant (as long as one RN still in home during shift)
? Short shifts
? Flex shifts
? Additional RPN support staff
? Overtime
? Mandatory overtime
When choosing an option the 24 hour RN requirement and risk to residents and staff are always to be considered. In extenuating circumstances the DOC or the Quality Improvement facilitator may work as the RN taking in to consideration the requirements

of the LTC Homes Act and the current Collective Agreement.

2. Re log: O-003322-15 - A staffing complaint was made with the Director on two specified dates in 2015 regarding no RN being present on two different shifts (see above). Inspector#602 confirmed with Administration - Staffing that there was no RN scheduled for either date:

An emergency or a planned or extended leave of absence by a RN were not the reasons for the three uncovered shifts. Therefore, the exception to the requirement that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff is not applicable as per Ontario Regulations 79/10 s. 45 (1)(2). [s. 8. (3)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9 (1) 1. iii. in that the licensee failed to ensure that all resident accessible doors leading to stairways, and all resident accessible doors leading to the outside, other that doors that lead to secure outside areas that preclude exit by a resident, were equipped with an audible door alarm that was connected to an audio visual enunciator (AV enunciator) that is connected to the nurses' station nearest to the door.

On a specified date the licensee was served with an order (CO #002), pursuant to O. Reg. 79/10, s. 9 (1) 1. iii, as a result of the 2014 Resident Quality Inspection

(#2014_179103_0024). This order applied to resident accessible stairway doors and resident accessible doors that led to the outside of the home, throughout all levels of the home.

On two separate dates in 2015, inspector #133 tested applicable doors throughout the home and ascertained that they had all been equipped with audible door alarms.

On a specified date the home's Facility Manager (FM) explained to inspector #133 that doors on level 1 had been connected to AV enunciators at nurses' stations on level 3. The FM explained that doors on level 2 had been connected to AV enunciators at nurses' stations on level 4. There are no nurses' stations on level 1 and level 2. Level 3 nurses' stations are the closest nurses' stations to doors on level 1 and level 2, therefore doors on level 2 had not been connected to the closest nurses' station, as is required.

Inspector #133 worked with the home FM, to test door alarm connections to the AV enunciators at the nurses' stations. The FM went to all doors on level 1 and level 2 and activated the alarms, while the inspector was at the associated nurses' station to observe the enunciator on the desk. When activated, the alarm for stairway #2 and #3 on level 1, on the Montreal side of the building, did not register on the AV enunciator at the Montreal 3 nurses' station.

Following the testing process, the FM contacted the Project Manager for Planning & Redevelopment (PMPR), who had responsibility for the door alarm project. The inspector, the FM and the PMPR met to discuss the continued non-compliance, the inspector was advised that the contractor who worked on the doors would be in the next day to correct the issues. On the next specified day the inspector and the PMPR worked together and ascertained that all level 2 doors were now connected to AV enunciators at nurses' station on level 3. As well, it was verified that stairway #2 and #3 doors, on level 1, were now connected to the AV enunciator at the Montreal 3 nurses' station. As such, all of the doors were compliant as of December 4th, 2015. [s. 9. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 57(2) in that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The Resident Council meeting minutes were reviewed for the last 3 months (Sept - Nov 2015).

The September 8, 2015 minutes indicated the following resident concerns:
1- Chairs are missing in the Sydenham 4 "link" area, need some chairs.

2- The wooden piano cover is missing. Piano keys should be covered. There are chairs in the link that are soiled and should be replaced.

3- The tv converter on M4 welcome room is missing

A note then states that the Administrator will follow-up on all concerns expressed.

No written response was found in the September minutes. In the October 2015 minutes, the September minutes were re-attached and items 1-3 were starred as still pending. There was a note that the remote on M4 was "chained" but this response is one month later.

The October 13, 2015 minutes expressed one resident concern as follows:
1 - Sydenham 5 missing items, needs lock

The minutes noted that all concerns expressed or pending will be referred to the Administrator. No written response was found.

The November 2015 minutes expressed one resident concern as follows:

1 - Resident concerned about the front entrance and cement decay.

No response was documented and it was noted that the Council President would refer all concerns expressed to the Administrator.

During an interview with the Administrator it was indicated that there had been no response to the Resident's Council concerns in writing and not always within 10 days; however, a new form was being implemented to provide written responses to the Resident's Council that would assist the home in being compliant going forward. [s. 57. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 60(2) in that when the Family Council advised the licensee of concerns or recommendations related to the operation of the home, the licensee did not respond to the Council within ten (10) days of receiving the advice.

During a Family Council interview it was indicated that they were unsure if the home responded to their concerns in writing.

Inspector #197 then reviewed the Family Council meeting minutes from the last three (3) months (September - November 2015).

The September 21, 2015 minutes indicated concerns brought forward as follows:
1 - Not all staff wearing name tags that are visible on the floor
2 - smoke butts at front of building needs cleaning up
3 - Families would like resident's preferred name on clothing - name residents like to be called as opposed to legal name provided at admission

The Administrator was noted to have responded to the September 2015 meeting issues via the October 2015 minutes, however, the written response was not provided within the required 10 days.

The November 2015 meeting minutes indicated the following new concerns:
2. Staff still not wearing name tags - Montreal 3 & Sydenham 3, 4, 5
3. Staff observed on sydenham 5 marking the tick falls sheet incorrectly
4. Concerns about lack of activities on a daily basis for Sydenham 5
5. Family not notified of hand injury Montreal 5

No responses to these concerns had been provided within the required 10 days.

The Administrator confirmed that there had not been responses to the family council concerns in writing and within 10 days. It was indicated that they have just adopted a new form for responding to the Family Council and stated that this would help them to be compliant. [s. 60. (2)]

Issued on this 13th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602), AMBER MOASE (541), HEATH HEFFERNAN (622), JESSICA LAPENSEE (133), JESSICA PATTISON (197), KARYN WOOD (601), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_444602_0034
Log No. / Registre no:	O-002877-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 2015
Licensee / Titulaire de permis :	PROVIDENCE CARE CENTRE 340 Union Street, KINGSTON, ON, K7L-5A2
LTC Home / Foyer de SLD :	PROVIDENCE MANOR 275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELAGH NOWLAN

To PROVIDENCE CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_179103_0024, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee will ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. The licensee must develop, implement and maintain a scheduled preventative maintenance and repair program that includes a regular audit of the home to identify areas that are in need of repair and ensure that required maintenance, repairs and service issues are corrected promptly.

The licensee will ensure written schedules and procedures are in place for remedial maintenance as per O. Reg. 79/10 s. 30 (1) 1.

Grounds / Motifs :

1. The home failed to comply with compliance order #005 in the following ways:
- The home's maintenance program and system of ongoing auditing to ensure that all maintenance issues are corrected promptly to meet the overall maintenance needs of the home, has not been effective as evidenced by the widespread disrepair observed in the home.
- The home did not have written schedules and procedures for remedial maintenance until Inspector #197 requested them on December 7, 2015. (197)

2. During the initial tour of the home and throughout stage 1 of the Resident Quality Inspection, Inspectors noted the following disrepair in the home:

Sydenham/Montreal 3:
- Sydenham 3 hallways – equipment markings along lower wall
- Room 338 - rust is noted around the base of the washroom faucet and the drain.
- Room 347 - inside the lower right side of the door next to the closet, noted a two and a half inch x one inch area of plaster chipped from the wall leaving the steel corner bead exposed. Paint is scratched in several areas on the door from two thirds of the way down
- Room 354 - wall in bathroom has many gouges out of the drywall
- Room 370 - lower bathroom door paint chipping and gouges
- Room 376 - paint chipping from bathroom door frame

Sydenham/Montreal 4:
- Whirlpool room across from room 422 - drywall pieces missing, round hole in wall
- Wall along entire length of hallway has many black marks along the bottom
- Wall to entrance of clean utility room has piece of drywall falling off, wall at entrance of dining room is heavily scarred with black marks, wall to entrance of elevator has piece of drywall peeling away from the wall
- Common area at end of hallway- radiator has a piece missing.
- Across from room 476 - piece of radiator is falling off the wall
-Wall to entrance of whirlpool room across from room 461 has 2 pieces of drywall missing approx 1.5 feet long, metal exposed
- Activity room at end of hallway, radiator piece missing below window, small gouges out of drywall to right of door entrance
- Room 447 - pieces of drywall missing from wall in room, metal exposed
- Room 458 - baseboard is missing from one wall in bathroom

Sydenham/Montreal 5:
- Across from room 560 at entrance to unlabeled door - large piece of drywall missing from the lower part of wall approx 2 feet long, 4 inches across. Metal is exposed.
- Wall is heavily marked along hallway with black marks and gouges
- Small common room facing water, large(3inches x 3 inches) pieces of drywall missing from wall to left of window, and next to light switch at entrance of room
- Room 559: chunks of drywall missing to left of entrance to room, sharp
- Wall going into nursing station is heavily marked with black marks and small

gouges, as is wall directly across from nursing station and wall leading into small common room.
-Room 543 - wall outside room has large pieces of drywall missing, which have been repaired but not painted.
- Common area at end of hallway (facing Sydenham St) - baseboard missing to right of entrance, radiator dirty with brown debris and scuffed with black marks along entire length. Large area of drywall in disrepair to left of window, appears a long mirror was removed but drywall not repaired.
- Floor heavily scuffed with black marks outside room 524
- Whirlpool room next to room 540 - Sink has Brown stained caulking around it, drywall missing from lower part of wall below sink, metal exposed, wall across from tub has many gouges and pieces of drywall missing. Tub drain is rusty, radiator in room heavily scratched with black marks.
- Dining room walls are heavily damaged, with a large piece of wall repaired (white) but has not been painted
- Room 501 - wall in bathroom has many gouges out of drywall, drywall outside of bathroom on wall has been gouged and metal visible.
- Room 503 - many scuffs/scrapes on bathroom door and just outside. Drywall missing and corner bead exposed just outside bathroom door - same in shared bathroom. Many scrapes on backs of bathroom doors.
- Room 513 - baseboard outside bathroom is coming away from wall
- Room 538 - black marks on the floor and walls are also chipped along the bottom on right hand side. The toilet seat is loose.
- Room 546 - toilet seat and arm rest not secure.
- Room 564 - the inside of the bathroom doors have black marks and the walls have scuffs that require paint
- Room 580 - scuffs/scrapes on wall across from bed and on both doors (bathroom/bedroom)

On December 7, 2015 the Maintenance Manager advised that the home has a computerized system for managing maintenance in the home; any staff member can create a ticket for a repair to be completed. He stated that audits are done daily and each area of the home is done at least once per week. Specifically, he stated these audits are checking mainly ceiling tiles and door security. When asked how they check for wall damage and areas requiring paint, he stated that he randomly checks rooms on his monthly audits, but there is no sequential order and he may not get in to check all resident rooms. He stated that wall repair and paint is done between residents, either upon a new admission or when there is an internal transfer. Otherwise, a ticket could be created at the

resident, family or staff's request. The Maintenance Manager was asked to provide the home's written schedules and procedures that are in place for remedial maintenance, as required by O. Reg. 79/10, s. 90(1)(b) and 30(1)1. He indicated that at this time the home did not have their schedules and procedures in writing for their maintenance program. The Maintenance Manager later provided the inspector with a document titled "Maintenance Department Procedure". (197)

3. The licensee has failed to comply with LTCHA 2007, s. 15 (2)(c) in that the home has not been maintained in a safe condition and good state of repair.

Compliance Order #005 related to LTCHA 2007, s. 15(2)(c) was issued on September 16, 2014 with a compliance date of March 16, 2015. The licensee was ordered to:

- correct the extensive list of items identified during the Resident Quality Inspection
- develop and implement an effective system of ongoing auditing to ensure that all maintenance issues identified by this auditing system are corrected promptly
- ensure that the maintenance program is organized and effective in meeting the overall maintenance needs of the home
- ensure that schedules and procedures are in place for remedial maintenance as per O. Reg. 79/10 s. 90 (1)(b)
- the schedule and procedures must be written as per O. Reg. 79/10 s. 30(1)1.

The home provided inspectors with a document titled "Ministry Order Report 2015". This document details all maintenance issues identified and what the home did to fix the issue. Inspector #197 found that all issues identified on the report were fixed, but through observation found the following:
3rd Floor
- S380 (just outside) - heavy scarring on walls and chunk out of wall in the hallway
- S377 - many paint chips on outside of room door
- S3 elevator (just outside) - paint heavily chipped on wall corners
- S376 - heavy scarring on wall just outside room
- S3 Dining Room - lower walls are scuffed, paint chipped on walls and radiators along the floor, pieces of metal sticking out of radiator that could be hazardous to residents
- S373 - scarring on back of bathroom door, paint chipped on door frame

- Whirlpool/Shower room across from S309 - many paint chips/scuffs on walls, one ceiling tile is water stained, wall tile missing as you enter the bathroom
- Whirlpool room across from 332 - wall damage on the right wall, hole in drywall by baseboard, metal strapping dented and visible on corner of wall by sink

4th Floor
- scarring/black marks on walls throughout S4 hallways and paint chips out of many resident room doors
- paint peeling off outside elevator on S4, paint chips on either side of elevator
- paint/wall surface peeling off outside housekeeping/clean utility rooms on S4
- M459 - gouges out of drywall to the right of resident's computer which resident indicates have been there for approximately six months, gouges in shared resident bathroom in front of sink, baseboard missing to the left of the sink
- M426 - kick plate appears to have been torn off the back of the resident's bathroom door showing disrepair and chunk out of door
- M4 Shower room - just outside the shower and tub rooms metal strapping is exposed on both corners, drywall damage throughout the shower room, corner beads exposed, cover missing over pipes and sharp metal studs in the wall right beside the toilet. A PSW indicated this shower room is in use and that the missing cover was reported to maintenance about 2 weeks ago.

(197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

Service Area Office /
Bureau régional de services : Ottawa Service Area Office