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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 23, 2017	2017_520622_0001	000986-17, 001660-17	Critical Incident System

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

HEATH HEFFERNAN (622)

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): January 25 - 26, 30 - 31, 2017 and February 01, 2017.

This critical incident inspection was related to the following;
C553-000002-17 - unexpected death
C553-000003-17 - alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Manager of Nutritional Services, Human Resources Consultant (HR), Nurse Practitioner (NP), Registered Dietitian (RD), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), the Cook, Dietary Aides and residents.
The inspector observed the provision of care and services to residents including meal services, staff to resident interactions, resident's health care records and reviewed licensee policies.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

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

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. 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 was provided to resident #001 as specified in the plan.

This finding is related to critical incident #C553-000002-17

A Critical Incident (CI) was submitted to the Director under the LTCHA related to an incident resulting in the unexpected death of resident #001 occurring on a specified date. It was reported in the CI that resident #001's condition deteriorated. The coroner found the cause of death was accidental.

A review of resident #001's progress notes pertaining to the incident by inspector #622 indicated:

On a specified date, the RPN responded to a PSW's request that resident #001 was in distress. Resident #001 became unresponsive despite attempts of staff.The coroner attended the home, pronounced resident #001's death and noted the death to be accidental.

A review of the homes documentation, resident health records and interviews with registered staff, management and PSWs pertaining to the incident indicated: Resident #001 was at moderate risk related to his/her medical condition which required staff to perform specific interventions, this direction would be located in the care plan.

During interviews with two staff members who were working on the specified date the incident occurred indicated the specific interventions resident #001 required had not been performed by staff as specified in the plan of care.

During an interview the DOC #100 indicated that staff locate direction for the specified interventions in the care plans. DOC #100 stated resident #001 should have received the specified intervention.

As documented in resident #001's health care record and confirmed by interviews with staff, resident #001 had a medical condition and was at risk. There were interventions in place on the care plan to manage this risk. At the time of the incident on the specified date, resident #001 was not provided the interventions included in the plan of care. [s. 6.(7)]

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

According to O. Reg 79/10, section 2 (1):

Physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A Critical Incident (CI) was submitted to the Director under the LTCHA related to a concern which was reported to DOC #100 by PSW #114 on a specified date. The CI alleged that over the past several months PSW #115 had allegedly been verbally,

emotionally and physically abusive towards two residents.

A Review of the homes policy and procedure titled ABUSE and NEGLECT FREE ENVIRONMENT number CARE-RC-1 indicates that the purpose of the document is to assist personnel in identifying, investigating, managing, reporting and documenting of situations that may be considered to be abuse or neglect and to promote zero tolerance of abuse and neglect of residents.
The Policy Statement on page 2 of 21 indicated;
all personnel are to report any incidents of actual or suspected abuse to their immediate supervisor/manager or other management personnel even when the information is thought to be confidential or privileged.
Section 4.0 ABUSE or NEGLECT of a RESIDENT by PROVIDENCE CARE PERSONNEL on page 12 of 21 indicated:
4.2 Immediately notify the charge nurse/delegate for the resident care area in which the events were alleged to have occurred.

A review of the letter submitted to DOC #100 by PSW #114 on a specified date indicated PSW #114 had noted issues of alleged abuse by PSW #115 since a specified month.

During an interview the RN supervisor #116 indicated the home has a prevention of abuse policy and procedure. RN #116 stated the homes expectation if she were to witness abuse of a resident would be to remove the resident from the situation and right away inform the DOC of the situation. RN #116 stated that if someone reported to her that they witnessed abuse of a resident, she would inform the DOC that the person witnessed abuse, and ask for direction. Furthermore RN #116 stated she would also tell the person who witnessed the abuse to report directly to the DOC as they witnessed the incident. RN #116 further stated PSW #114 had not reported to her, nor was she aware of the issues of alleged staff to resident abuse until PSW #114 approached her months after the alleged incidents took place. RN #116 stated she gave PSW #114 direction to report her concerns to the DOC.

During an interview PSW #114 indicated that the home has a prevention of abuse policy and procedure. PSW #114 also stated the homes expectation is to immediately report all resident abuse. PSW #114 listed the concerns of alleged abuse and stated she did not have actual dates and times.

During an interview the DOC #100 indicated she was not aware of the allegations of the alleged staff to resident abuse until she met with PSW #114 on a specified date. DOC

#100 stated that when she met with PSW #114 on a specified date she informed PSW #114 the allegations she had brought forward were resident abuse and she was required to report the abuse immediately. DOC #100 further stated the homes expectation would be staff report abuse immediately.

The Licensee failed to ensure that the homes policy and procedure titled Abuse and Neglect Free Environment; number: CARE-RC-1 was complied with by PSW #114. [s. 20. (1)]

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 that the homes policy and procedure titled; Abuse and Neglect Free Environment; number: CARE-RC-1 is followed by PSW staff #114 in the future to prevent further alleged acts of staff to resident abuse from occurring, to be implemented voluntarily.

Issued on this 23rd day of February, 2017

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATH HEFFERNAN (622)
Inspection No. / No de l'inspection :	2017_520622_0001
Log No. / Registre no:	000986-17, 001660-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 23, 2017
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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall develop and implement:
1. a process to ensure dietary and nursing staff provide the required interventions for each resident receiving meals in a modified consistency and texture, in accordance with the plan of care;
2. clear communication protocols between nursing and dietary staff to ensure that every resident at risk of choking is appropriately monitored during meal time; and
3. training for all nursing and dietary staff regarding the risks associated with the provision of care to residents at risk of choking and the interventions used to mitigate those risks.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

This finding is related to critical incident #C553-000002-17

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staff.The coroner attended the home, pronounced resident #001's death and noted the death to be accidental.

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Resident #001 was at moderate risk related to his/her medical condition which required staff to perform specific interventions, this direction would be located in the care plan.

During interviews with two staff members who were working on the specified date the incident occurred indicated the specific interventions resident #001 required had not been performed by staff as specified in the plan of care.

During an interview the DOC #100 indicated that staff locate direction for the specified interventions in the care plans. DOC #100 stated resident #001 should have received the specified intervention.

As documented in resident #001's health care record and confirmed by interviews with staff, resident #001 had a medical condition and was at risk. There were interventions in place on the care plan to manage this risk. At the time of the incident on the specified date, resident #001 was not provided the interventions included in the plan of care.
[s. 6.(7)] (622)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 07, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 23rd day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Heath Heffernan

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