Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 11, 2020	2020_717531_0018	004141-20, 004519-20, 004818-20, 007101-20, 008753-20, 010832-20, 011581-20, 014265-20, 014995-20	Critical Incident System

Licensee/Titulaire de permis

Providence Care Centre
752 King Street West KINGSTON ON K7L 4X3

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

SUSAN DONNAN (531), 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): July 27, 28, 29, 30 and 31, August 4, 5, 6 ,10, 11, 12, 13, 14 and 17, 2020.

The following intake logs were inspected concurrently during this inspection:
Log #004141-20 Critical Incident #C553-000012-20 related to fall prevention program
Log #004519-20 Critical Incident #3005-000002-20 related to alleged abuse
Log #004818-20 Critical Incident #3005-000003-20 related to alleged abuse
Log #007101-20 Critical Incident #3005-000007-20 related to fall prevention program
Log #010832-20 Critical Incident #3005-000015-20 related to alleged abuse
Log #011581-20 Critical incident #3005-000015-20 related to alleged abuse
Log #014265-20 Critical Incident #3005-000020-20 related to medication administration
Log #014995-20 Critical Incident #3005-000022-20 related to alleged abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Physiotherapist (PT), the Restorative Care Coordinator (RCC), Personal Support Workers (PSW), the Nurse Practitioner (NP) residents and resident Substitute Decision Makers (SDM).
During the course of the inspection the inspectors reviewed residents health care records, observed resident care and services, reviewed the fall prevention policy and procedures, medication administration practices, reviewed the fall prevention program policy and procedures and the abuse and neglect policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
1 VPC(s)
0 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	Légende 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. 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 has failed to ensure that drugs were administered to multiple residents in accordance with the directions for use specified by the prescriber.

On a identified date, the medication room keys were locked in the medication room on one resident home area. Multiple residents did not receive their medications which were prescribed for the noon and early afternoon medication pass as a result.

The electronic Medication Administration Records (eMAR), indicated that the three residents were not administered their medications.

During an interview with inspector #622, Registered Practical Nurse (RPN) #106 stated that due to the keys being locked in the medication room and not having access to the medications, the residents on the resident home area, did not receive their medications during the noon and early afternoon medication pass on the identified date.

Director of Care (DOC) #101 reviewed the eMAR for the identified date, for the residents noon and early afternoon medication pass. DOC #101 stated that the medications for the residents were documented as not being administered that date, when the medication room keys were locked in the medication room and the nurse did not have access to the medications. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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 comply with LTCHA 2007, s. 20. (1) whereby the written policy to promote zero tolerance of abuse and neglect of residents was not complied with.

Under O. Reg.79/10 s. 2 (1) physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

Review of the "Abuse and Neglect Free Policy: CARE-RC-1
Policy statement 3 reads: all personnel must promptly report any incidents of actual or suspected abuse of a resident by anyone to their immediate supervisor/manager or delegate.

PSW #105 advised inspector #531, that on a identified date, they and a co-worker were providing evening care for a resident, when the resident became aggressive, striking out, kicking and spat at their co-worker, who was distracting the resident. PSW #105 further alleged that the co-worker slapped the side of the resident’s face while distracting the resident. PSW #105 further advised that they completed the resident's care, the resident was their usual self, no distress.
PSW #105 told inspector #531 that they had not reported the incident to the nurse in charge as directed by the policy.

During an interview with the DOC and review of the critical incident report including investigative documentation, they
advised that PSW #105 acknowledged not immediately notifying the nurse in charge.

The home's abuse policy specifically stated that every incident/suspicion of abuse must be reported. Despite this policy direction, a PSW staff failed to immediately report the alleged abuse. [s. 20. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Under O. Reg.79/10 s. 2 (1) physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

During an interview with the DOC, they indicated that PSW #125 reported that PSW #105 alleged that a co-worker while providing care, slapped a resident on the side of the face when distracting the resident during care provision.
The DOC indicated they immediately assessed the resident and immediately initiated an investigation, suspended the co-worker and determined the allegations to be unfounded. However, the Director was not notified until four weeks later.

At the time the Administrator was interviewed, the critical incident report and investigative documentation were reviewed. The Administrator acknowledged that the Director was not immediately notified.

The licensee failed to ensure that the Director was immediately notified. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

**s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure a resident's SDM was notified immediately upon becoming aware of an alleged incident of abuse.

During an interview with the DOC, they indicated that on an identified date, PSW #125 reported that PSW #105 alleged that a co-worker while providing care slapped a resident on the side of the face, when distracting the resident during care provision.
The DOC further indicated they immediately assessed the resident, noted no injuries, initiated an investigation and determined the allegations to be unfounded. However, the resident's SDM was not immediately notified.

The Administrator acknowledged that the SDM had not been immediately notified.

The licensee has failed to ensure that resident's SDM was immediately notified upon becoming aware of the alleged abuse. [s. 97. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged incident of abuse of resident to resident abuse that led to the report:
The long-term actions planned to correct the situation and prevent recurrence.

Critical Incident System report (CIS) was submitted on an identified date for an incident of alleged sexual abuse between two residents.
The CIS report stated that the long-term actions planned to correct the situation and prevent recurrence, was to be determined after discussion with team the next day.

During an interview with inspector #622, the Administrator #100 stated that CIS report had not been amended to include the long-term actions planned to prevent recurrence or correct the situation. [s. 104. (1) 4.]

Issued on this 14th day of September, 2020

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

Original report signed by the inspector.