Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: November 30, 2023	
Inspection Number: 2023-1502-0009	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Providence Care Centre	
Long Term Care Home and City: Providence Manor, Kingston	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2023.12.20 11:26:44 -05'00'
Additional Inspector(s) Ashley Bernard-Demers (740787) Kayla Debois (740792)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 17-20, 23-27, 30, 31, November 1-3, and 6-9, 2023

The following intake(s) were inspected:

- Intake: #00092554/CIS #3005-000063-23 and intake: #00095094/ CIS #3005-000079-23 - regarding missing resident(s).
- Intake: #00093092/CIS #3005-000068-23 and intake: #00097164/CIS #3005-000101-23 - regarding alleged staff to resident emotional abuse.
- Intake: #00093279/CIS #3005-000069-23, intake: #00095459/CIS #3005-000083-23, intake: #00100865/CIS #3005-000122-23 and intake: #00100931/CIS #3005-000123-23 - regarding alleged resident to resident physical abuse.
- Intake: #00093308/CIS #3005-000070-23, intake: #00097708/CIS #3005-000105-23 and intake: #00097842/CIS #3005-000106-23 - regarding alleged staff to resident neglect.
- Intake: #00096746/CIS #3005-000097-23, intake: #00095931/CIS #3005-000089-23 and intake: #00097951/CIS #3005-000107-23 - regarding a fall with injury and transfer to hospital.
- Intake: #00093579/CIS #3005-000073-23 - regarding a fall with injury and transfer to hospital and related intake: #00093584/CIS #3005-000074-23 - regarding improper treatment of a resident.
- Intake: #00096737/CIS #3005-000096-23 - regarding alleged improper/incompetent treatment of resident.

- Intake: #00093044/CIS #3005-000067-23 and intake: #00099308/CIS #3005-000113-23 - regarding alleged staff to resident neglect and emotional abuse.
- Intake: #00099615/CIS #3005-000115-23 - regarding improper/incompetent treatment of resident.
- Intake: #00096924 - Complaint regarding alleged staff to resident abuse.
- Intake: #00094749 - Complaint regarding resident care and alleged neglect.
- Intake: #00097028 - Complaint regarding alleged improper care of residents.
- Intake: #00096550 - Complaint regarding sufficient staffing, safety and comfort of resident(s).
- Intake: #00099543 - Complaint regarding alleged staff to resident physical abuse.
- Intake: #00096024 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (7) regarding plan of care – diet.
- Intake: #00096025 - Follow-up #: 1 - O. Reg. 246/22 - s. 59 (b) regarding responsive behaviors.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1502-0007 related to FLTCA, 2021, s. 6 (7) inspected by Wendy Brown (602)

Order #001 from Inspection #2023-1502-0006 related to O. Reg. 246/22, s. 59 (b) inspected by Wendy Brown (602)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee failed to ensure that Infection Prevention and Control (IPAC) practices were followed in the home.

Rationale and Summary
A personal support worker (PSW) was observed at the Montreal 4 nursing station with their surgical mask pulled down, exposing their nose and mouth. In an interview with the PSW, they indicated the expectation for masking on Montreal 4 was that a surgical mask was required.

The impact of not following the home's direction for masking places residents at risk of infection.

Sources: Observation made on Montreal 4, Interview with the PSW. [740787]

Date Remedy Implemented: October 19, 2023

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

The licensee failed to ensure that clear directions were set out regarding a resident's diet type for staff and others who provide direct care to the resident.

Rationale and Summary
Upon review of a resident's eating care plan, it specified that their diet had been changed to puree until reassessed by a SLP (Speech Language Pathologist); however, the resident's nutritional status care plan indicated the resident was to have a minced diet.

The Registered Dietitian (RD) acknowledged the diet type discrepancy between the eating care plan and the nutritional status care plan. The RD noted that the nutritional status care plan should indicate pureed, not minced, and made the revision to the care plan. The Registered Dietitian confirmed that there was potential for confusion for staff regarding the direction provided for diet type in the resident's care plan.

Not providing clear direction regarding the resident's diet type placed the resident at risk of not receiving the appropriate diet.

Sources:
Resident care plan, and an interview with the RD. [740787]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure the resident's Power of Attorney (POA) was given the opportunity to participate fully in the development and implementation of a resident's plan of care.

Rationale and Summary
A resident fell from their wheelchair during a suspected self-transfer. Progress notes indicated the POA was notified of the fall the following day and expressed significant concern regarding the home's lack of communication; they asked why staff did not assist the resident to their room and why there was no clip/chair alarm in place as this had been previously communicated would be part of the plan of care. A clip/chair alarm was added to the care plan and provided the following day.

Failure to communicate with the POA/family regarding the plan of care could place the resident's health, safety, and comfort at risk.

Sources:
Resident progress notes, care plan, interviews with the POA/Family, Assistant Director of Care (ADOC) and other staff. [602]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care - Duty of licensee to comply with plan
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.

The licensee failed to ensure that the care set out in the plan of care for two residents was provided as specified in the plan.

Rationale and Summary
1. A resident was ordered the following diet: minced, added moisture to meats and breads.

In an interview, a RPN confirmed that a PSW provided the resident with the incorrect diet, and thus, they were not offered the minced option for the supper meal's dessert.

Providing the incorrect diet type to a resident placed them at risk for choking.

2. A resident was assessed by physiotherapy following their return home from hospital. The physiotherapist indicated the resident required a manual wheelchair with portering provided with the assistance of one person. On a subsequent day the resident fell from their wheelchair in a suspected attempt to self-transfer; progress notes indicated staff were aware the resident was attempting to mobilize in their wheelchair on their own, despite the need for assistance of staff.

Failure to follow direction in the plan of care put the resident's health and safety at risk.

Sources:
Resident progress notes, plan of care, dietitian orders, and interviews with a RPN, a POA/family and an ADOC. [740787] [602]

WRITTEN NOTIFICATION: Documentation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care - Documentation
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of activities of daily living care was documented.

Rationale and Summary
Point of Care (POC) documentation for a resident revealed multiple missed documentation opportunities e.g. bathing, toileting, dressing, and transferring were not noted. In an interview with a PSW, it was identified that the resident's care is completed; however, charting doesn't always reflect the care that was provided.

Failure to complete documentation makes it unclear as to whether the resident received care.

Sources:
Resident POC documentation, and an interview with a PSW. [740787]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A Registered Nurse (RN) documented they spoke with a resident's POA who expressed multiple issues with resident care; the RN alerted the DOC to the POA's concerns.

In the POA's subsequent letter of concern, it was identified that they spoke to a RN and expressed their concerns regarding the resident being denied toileting and that their call bell was not answered during a specific shift.

The licensee's Abuse and Neglect Free Environment Policy provides a definition of neglect to assist staff members to recognize abuse and/or neglect of residents.

In an interview, the DOC confirmed that the RN requested they call the resident's POA as they had concerns. The DOC advised that the RN did not indicate there were allegations that the resident was not toileted and/or had no access to their call bell during a specified shift.

The RN's failure to identify allegations of neglect, as defined in the home's policy, placed the resident at risk for harm.

Sources:
Resident progress notes, POA's written letter of concern, Abuse and Neglect Free Environment Policy and interviews with the DOC. [740787]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee failed to make a immediate reports to the Director regarding possible improper or incompetent treatment or care that resulted in harm or a risk of harm to resident #012 and #007.

Rationale and Summary

1. A Critical Incident System (CIS) Report regarding alleged improper or incompetent treatment of a resident that resulted in harm or risk of harm for a resident's choking was not immediately submitted to the Director. In an interview with the DOC they confirmed that the RN did not make an immediate report to the Director regarding resident's choking incident.

Failure to report improper or incompetent treatment placed the resident at risk for harm.

2. A resident sustained a fall during a one-person assisted transfer, resulting in an injury. The resident's plan of care indicated that they were a two-person transfer during the time of the incident. This incident of improper care was reported to the Director the next day. In an interview with the DOC, they acknowledged that the above incident was not reported to the Director immediately.

Failure to report critical incidents immediately to the Director can delay the investigation and response time of the home.

Sources:

Review of resident progress notes, care plan, a CIS report and interviews with a RN and the DOC. [740787] [740792]

WRITTEN NOTIFICATION: Initial plan of care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 28 (1) (b)
Initial plan of care
s. 28 (1) Every licensee of a long-term care home shall ensure that, (b) the initial plan of care is developed within 21 days of the admission.

The licensee failed to ensure that the initial plan of care was developed within twenty-one (21) days of admission.

Rationale & Summary:

A resident was admitted to the Long-Term Care (LTC) home and eloped approximately three weeks later. They were located several hours later and returned to the home the next day.

Prior to the resident's admission from hospital to the LTC home a Personal Health Profile was completed. The assessment indicated that the resident goes outside independently, they do not like their freedom restricted, and they prefer to be able to come and go as they wish.

Progress notes indicated that the resident exhibited behaviours specific to going outside prior to the elopement incident including: verbal aggression with staff when they did not allow them to go out and refusing to come inside. A review of the resident's initial care plan found that there was no planning for behaviour patterns specific to going outside or elopement risk.

The Assistant RAI Supervisor reviewed the resident's care plans and confirmed that the initial care plan was not completed within 21 days after admission as per legislative requirements.

Failure to develop resident #011's care plan may have resulted in staff being unaware of resident behaviour patterns putting the resident at risk.

Sources:
Review of the resident's care plan, progress notes and Personal Health Profile and an interview with the Assistant RAI Supervisor. [740792]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff use safe transferring techniques when assisting a resident.

Rationale and Summary:
A resident fell while being transferred by one PSW. The resident was immediately assessed by a RN and sent to the hospital for treatment as they had sustained an injury.

A physiotherapy assessment completed prior to the fall indicated that the resident was a two-person transfer. The resident's care plan at the time of the transfer outlined that they required two staff members for all transfers. The post fall event summary noted that the resident asked why they were being transferred with one person when the logo in their room indicated they needed two people to transfer.

In an interview with a PSW, they stated they completed the transfer alone because they thought that the resident was able to be transferred with one person. They acknowledged that they should have had a second person to complete the transfer. In an interview with the DOC, they confirmed that this was an unsafe transfer and the PSW was provided education on the importance of proper transferring.

Failure to transfer the resident appropriately resulted in harm to the resident.

Sources:
Review of the resident's care plan, progress notes, physiotherapy assessment, fall event summary, and interviews with a PSW and the DOC. [740792]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee failed to comply with their falls prevention and management policy and procedure.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee is required to ensure their falls prevention and management policy and procedure is implemented

Specifically, the staff failed to implement their "Falls Prevention and Management" policy and procedure, in that they did not initially provide a resident a chair/clip alarm.

Rationale and Summary:
A resident returned from hospital following surgery; two days later the resident was heard calling out and was found in the hallway having fallen from their wheelchair in a suspected attempt to self-transfer. The resident was assessed and assisted back to their chair via mechanical lift; a chair/clip alarm was applied the following day. In an interview an ADOC indicated the chair alarm should have been in place on the resident's return to the home as this falls intervention is standard procedure for residents who mobilize via wheelchairs who have a history of falls.

Failure to follow the home's falls prevention and management policy and procedures put a resident at increased risk for falls and associated injury(ies).

Sources:
Resident progress notes, Falls Prevention and Management Policy), interviews with the resident's POA and an ADOC.[602]

WRITTEN NOTIFICATION: Falls prevention and management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the

resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2).

The licensee failed to complete a post-fall assessment using a clinically appropriate assessment instrument for a resident.

Rationale and Summary:
A resident was pushed by a co-resident and fell. The resident was transferred to hospital for further assessment and required surgery.

A chart review was completed, and no documentation of a post-fall assessment tool was found. An ADOC confirmed that a post-fall assessment tool is to be completed for all falls and that an assessment was not completed for this resident.

Failure to complete a post fall assessment increased the resident's risk of injury.

Sources:
Review of the resident's electronic and hard copy health record, the Falls Prevention and Management Policy, and an interview with an ADOC. [740792]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee failed to ensure that strategies were implemented to respond to a resident's wandering and exit seeking behaviours.

Rationale and Summary:
A resident eloped from the secure floor using the unit keypad and elevator and attempted to use the keypad at the front door to exit the building. The home's review of security camera footage found that a staff member used their access pass to unlock the door and allowed the resident outside. Four hours later, another staff member, leaving the home, noticed the resident sitting on a bench on the street corner. The staff member notified a charge nurse and they assisted the resident to return to their unit.

The resident's care plan indicated they were at risk of wandering and elopement and were to be checked hourly. The DOC indicated that the resident had not been checked hourly as staff assumed the resident was off unit with activity/programming staff. The DOC further indicated that the staff member who allowed resident to exit the front door of the building thought the resident was a visitor. The DOC

acknowledged that the resident's safety was at risk.

Failure to check on the resident/confirm their whereabouts hourly put them at risk for injury while outside on their own.

Sources:
Review of the resident's care plan, progress notes and a Home Care Assessment Form, and an interview with the DOC. [740792]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Rationale and Summary:
1. A resident's plan of care indicated they have a history of wandering behaviours including pacing around the unit and into other resident rooms. The resident had a motion sensor on their room door to alert staff when they were leaving their room, ensuring that staff could respond immediately.

An Inspector observed the motion sensor on the resident's door, but noted that it did not alarm when walking through the doorway. A RPN was asked and advised they were unaware that the resident had a motion sensor alarm, but on observing the doorway with Inspector, they indicated the alarm was supposed to sound at the nursing station when anyone entered or exited the room. They stated they were unsure why it was not working.

An ADOC advised they were unaware that the alarm was not working and that it should be on if the resident was in their room. A PSW stated the motion alarm was supposed to be on all the time.

Failure to ensure the motion alarm was working limits staff ability to respond to the resident's wandering behaviours posing an increased risk of harm to co-residents.

2. A resident was involved in a physical altercation with a co-resident that caused the co-resident to fall and sustaining an injury requiring transfer to hospital. Two days after this incident, a physician ordered one-to-one PSW care, for the aggressive resident due to agitation and responsive behaviours.

During an observation on the unit an Inspector heard the one-to one PSW staff advise another staff that they were going on break; the staff indicated they would watch the resident. The covering PSW was observed completing other tasks and intermittently observing the resident. The resident was observed stroking another resident's arm; the co-resident asked the resident to stop, and they did. The covering PSW staff was not present during this interaction.

Observations on the unit on the following day found that there was no one-to-one PSW staff present. In a subsequent interview, a PSW indicated they were the resident's one-to-one that day, but they did not sit with the resident as they like to help other staff on the unit. The PSW acknowledged that they went on morning break, but had communicated this to co-workers on the floor. In an interview with another PSW, they stated that one-to-one was a team effort, so it was everyone's responsibility to watch the resident when the designated one-to-one was on break. They also stated that their co-worker was the assigned one-to-one that day, but they were unsure where they were at that time.

An ADOC indicated the resident was to have one-to-one care during the day and evening shifts and that this means having "having eyes on" the resident, "generally one on one is either in [the] room … or eyes on the door waiting until" the resident leaves their room. They advised that a specific staff member is assigned as the one-to-one and that this is indicated on the staffing sheet on the unit. The ADOC further advised that if the one-to-one goes on break they should communicate this, and another staff member should cover them and supervise the resident. They stated that the resident posed a risk to other residents on the unit, which is why a one-to-one staff was put in place.

Failure to ensure the resident had the prescribed one-to-one care increased the risk of harm to other residents.

Sources:
Review of the resident's care plan, physician order, progress notes, unit observations and interviews with a RPN, a PSW, and the ADOC. [740792]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that, (a) drugs are stored in an area or a medication cart, and (ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in a medication cart that was secure and locked.

Rationale and Summary
A medication cart was observed stationed at the entrance to the Montreal 4 dining room; it was observed to be unlocked, with the bottom drawer left ajar. There was no staff member in the proximity

of the medication cart, and residents were noted in the area.

In an interview with a RN, they confirmed the medication cart was left unlocked and that the bottom drawer was left ajar. The RN stated the medication cart should be closed and locked when unattended.

Failure to secure a medication cart places residents at risk by having access to medications.

Sources:
Observation of the medication cart, and an interview with a RN. [740787]

COMPLIANCE ORDER CO #001 Duty to Protect

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Conduct education on the one-to-one assignment process, including expectations specific to: how one obtains their assignment, responsibilities when providing one-to-one care, communication at the beginning/end of each shift and coverage requirements, with all direct care staff.

2. Ensure that staff comply with the written plan of care for the resident related to responsive behaviours.

In ensuring the requirements under steps (2), are met, the licensee shall:

3. Develop and complete a weekly audit of staff compliance with the written plan of care for responsive behaviours for the resident. This audit shall be completed for a period of four weeks.

4. Maintain documentation of the one-to-one education, including the names of the staff, their designation, and the date training was provided.

Grounds
The licensee failed to protect residents from abuse by resident #020.

Rationale and Summary:
Physical abuse is defined by O. Reg. 246/22 s. 2 (1) as the use of physical force by a resident that causes physical injury to another resident.

A resident exhibited responsive/physically aggressive behaviours on multiple occasions over several months.

During this inspection a critical incident was submitted indicating the resident entered a co-resident's room and pushed them causing the co-resident to fall; the resulting injury required that the co-resident be transferred to hospital for surgery. Progress notes indicated the RN called the physician to review the aggressive resident's behaviours. The physician advised the resident already receives antipsychotic medication twice daily and that the PRN dose for agitation could be administered; no further recommendations specific to behaviours were provided. A review of resident's medication record indicated that PRN antipsychotic medication was not administered.

Two days after the incident, a physician ordered one-to-one PSW care for two weeks due to the resident's agitation and aggressive behaviours.

In an interview a Staffing Clerk indicated that staff members were to check daily assignments at a table near the entrance of the building. A review of the assignments for the day and evening shifts for a five day period found that a one-to-one staff was not clearly identified on four shifts.

In another interview, a RPN indicated they obtain the assignments from the staffing office at start of their shift and note them on the unit sheet for staff reference. Review of the staffing sheets on the unit for a five day period found no notations beside the resident's name indicating they had one-to-one care. An ADOC stated there should be a specific staff member assigned as the one-to-one on the staffing sheet for the unit and that when the staff takes break they are to communicate this to co-workers to ensure the resident is not left unsupervised.

During an interview, a PSW advised they were the resident's one-to-one that day, but that they had not been made aware until a co-worker told them earlier that morning. The PSW further indicated that they do not look at the daily assignments at the table near the building entrance. They also advised they do not sit with the resident as they prefer to assist their co-workers. The PSW noted they had gone on morning break and that this was communicated with co-workers on the floor. Another PSW indicated that one-to-one care was a team effort, thus, it was everyone's responsibility to watch the resident when the designated one-to-one staff was on break. They stated that another PSW was the one-to-one that day, but they were unsure where they were at that time. A third PSW was interviewed and advised that they were unsure if the resident had one-to-one that day and that if they did they were unsure as to who was assigned.

Inspector observations revealed that the resident did not always have a one-to-one staff with them.

Failure to protect co-residents from physical abuse by the aggressive resident placed them at risk of harm.

Sources:
Review of the resident's progress notes, medication administration record, CIS reports, current care plan, behaviour mapping sheets, physician orders, unit observations, and interviews with PSWs, a RPN, an ADOC and other staff. [740792]

This order must be complied with by January 30, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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