

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

| |
|---|
| Report Issue Date: October 4, 2024 |
| Inspection Number: 2024-1502-0003 |
| Inspection Type: Complaint Critical Incident Follow up |
| Licensee: Providence Care Centre |
| Long Term Care Home and City: Providence Manor, Kingston |

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-27, 2024 and October 1-4, 2024

The following intake(s) were inspected:

- Intake: #00120871 - Follow-up #1: O. Reg. 246/22, s. 102 (7) 11 related to hand hygiene.
- Intake: #00120872 - Follow-up #1: O. Reg. 246/22, s. 59 (b) related to altercations between residents.
- Intake: #00122341 - complaint regarding IPAC.
- Intake: #00120860 -CI #3005-000085-24; Intake #00121598 -CI #3005-000090-24; Intake: #00125980 -CI #3005-000114-24 - fall of resident with injury.
- Intake: #00120938 -CI #3005-000086-24; Intake: #00125265 -3005-000110-24; Intake: #00125660 -CI #3005-000112-24 - alleged resident to resident physical abuse.
- Intake: #00121892 - CI #3005-000094-24 - alleged unlawful conduct of resident.
- Intake: #00122414 -CI #3005-000097-24 - alleged resident to resident sexual abuse.
- Intake: #00122844 -CI #3005-000099-24 - alleged resident financial abuse.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

- Intake: #00124173 -CI #3005-000101-24 - alleged improper/incompetent treatment of resident.
- Intake: #00125043 -CI #3005-000102-24 - alleged staff to resident physical abuse.
- Intake: #00125086 -CI #3005-000107-24 - elopement of resident.
- Intake: #00126296 -CI #3005-000115-24 - alleged staff to resident neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1502-0002 related to O. Reg. 246/22, s. 59 (b).
Order #002 from Inspection #2024-1502-0002 related to O. Reg. 246/22, s. 102 (7) 11.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

WRITTEN NOTIFICATION: Plan of care

NC #001 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; and

The licensee has failed to ensure that there is a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident, in relation to responsive behaviour interventions.

Sources: A resident's progress notes and interview with staff.

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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 has failed to ensure that the care set out in the plan of care for a resident related to smoking was provided to the resident as specified in the plan. The written plan of care indicated to never leave matches/lighter in the resident's possession. During interviews, it was determined that the resident keeps the lighter in their possession.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Sources: A resident's plan of care and interviews with resident, and staff.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. 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.

The licensee has failed to ensure that the door leading to a non-residential area was kept closed and locked when not supervised by staff.

On a day in August 2024, the door leading to a storage room on a unit was left open and unattended. A resident entered the room and became locked inside.

Sources: A resident's progress notes, observation of signage posted on doors leading to non-residential areas, and interviews with staff.

WRITTEN NOTIFICATION: Required programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with their written policy related to falls prevention and management for a resident.

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

Specifically, staff did not comply with the licensee's falls prevention and management policy (CARE-RC-18, revised July 5, 2022,) for a resident's unwitnessed fall that occurred on a day in July 2024, regarding the completion of the head injury sudden change record.

Sources: Providence Manor Care Delivery Manual Falls Prevention and Management Policy CARE-RC-18, Providence Manor Nursing Manual Head Injury Assessment Policy and Procedure #PM-NURSE_1, a resident's Head Injury-Sudden Change Record and progress notes, and interviews with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by an authorized person described in subsection (2.1), using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that on a day in July 2024, a skin assessment that was required to be done for a resident's scratch/abrasion was completed.

Sources: A resident's progress notes, assessments and interviews with staff.

The licensee has failed to ensure that on a day in August 2024, a skin assessment that was required to be done for a resident's eye was completed.

Sources: resident #014 progress notes, assessments and an interview with staff.

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #006 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. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

(b) identifying and implementing interventions.

The licensee has failed to ensure that on a day in July 2024, supervision was

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

provided to a resident as per their plan of care to minimize the risk of a sexual interaction towards another resident.

Sources:

A resident's care plan, progress notes, and interviews with staff.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.

In accordance with additional requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that Routine Practices were followed in the IPAC program, specifically related to the completion of hand hygiene by a Personal Support Worker (PSW), a Registered Nurse (RN), and a Recreation Aide.

Sources: Observations made by Inspector on two days in September 2024.