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

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Public Report

Report Issue Date: February 4, 2025
Inspection Number: 2025-1502-0001
Inspection Type: Complaint Critical Incident
Licensee: Providence Care Centre
Long Term Care Home and City: Providence Manor, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21-24, 27-31, and February 3, 4, 2025

The following intake(s) were inspected:

- Intake: #00125933 - CIS# 3005-000113-24 - regarding alleged staff to resident unlawful conduct.
- Intake: #00126401 – CIS# 3005-000116-24/ Intake: #00133489 – CIS# 3005-000163-24/ Intake: #00135257 – CIS# 3005-000175-24- regarding alleged staff to resident physical abuse.
- Intake: #00130158 – CIS# 3005-000145-24/ Intake: #00131944 – CIS# 3005-000156-24/ Intake: #00133565 – CIS# 3005-000164-24 – regarding alleged staff to resident emotional abuse.
- Intake: #00133666 – CIS# 3005-000167-24 - regarding alleged staff to resident verbal abuse.
- Intake: #00126876 – CIS# 3005-000117-24/ Intake: #00127872 – CIS# 3005-000123-24/ Intake: #00135384 – CIS# 3005-000178-24 - regarding alleged resident to resident physical abuse.
- Intake: #00130032 – CIS# 3005-000144-24 - regarding alleged resident to resident sexual abuse.

- Intake: #00133631 – CIS# 3005-000166-24 – regarding alleged improper care of a resident.
- Intake: #00134198 – Complaint regarding improper care of a resident.
- Intake: #00134213 – CIS# 3005-000172-24 – regarding a resident injury of unknown origin.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan.

NC #001 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 was provided to the resident as specified in the plan, specifically the licensee failed to ensure that a Personal Support Worker (PSW) notified a nurse immediately of a new bruise they observed on a resident.

Sources: Resident care plan, the licensee's investigation notes and an interview with the Director of Care (DOC).

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 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 has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents, was complied with, specifically the licensee failed to ensure that a PSW immediately reported an incident of suspected abuse. The PSW waited several days to report their concern of alleged abuse / neglect.

Sources: Licensee's Investigation Report, the Abuse and Neglect Free-Environment policy and procedure, the Critical Incident report and an interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care that resulted in a risk of harm to a resident was immediately reported to the Director.

A resident, who was a two person transfer, was transferred by one staff member and sustained a fall. This was reported to the Director two days after the incident.

Sources: Resident progress notes, physiotherapy assessment, the licensee's investigation notes, and interviews with a Registered Practical Nurse (RPN) and the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 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 has failed to ensure that staff used safe transferring techniques when assisting a resident.

A resident, who was a two person transfer, was transferred by one staff member and fell during the transfer.

Sources: Resident care plan, physiotherapy assessment, the licensee's investigation

notes, and interviews with a PSW, RPN and DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 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; and

The licensee has failed to ensure that for a resident demonstrating responsive behaviours, strategies were implemented to respond to these behaviours.

On two separate occasions, staff members did not follow the responsive behaviour interventions for a resident; the strategies indicated that when the resident was upset, give them their space, and re-approach 5-10 minutes later using a calm, non-threatening manner.

Sources: Resident care plan and progress notes, Inspector's observations, and interviews with a Registered Nurse (RN) and an Assistant DOC (ADOC).