Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 7, 8, 9, 2012	2012_038197_0004	Critical Incident

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, the Social Worker, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, a Dietary Aide and residents.

During the course of the inspection, the inspector(s) reviewed a resident health record, the home's Abuse and Neglect Free Environment policy and procedures (CARE-RC-1), a critical incident report and internal documents related to the investigation of the critical incident and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The following findings indicate that the licensee failed to comply with s. 24(1) in that they did not immediately notify the Director when they had reasonable grounds to suspect that abuse/neglect of a resident had occurred.
In December 2011 there was an incident of alleged abuse/neglect of a resident that was reported to a Registered Practical Nurse (RPN) the day it occurred.
The RPN left a note for the Nurse Supervisor who would be working the next day.
The Nurse Supervisor received the note the day after the incident and reported the incident to the Assistant Director of Care (ADOC).
The ADOC called the Duty Inspector at 14:53 hours the day after the incident to notify the Director of the alleged abuse/neglect.

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 the Director is immediately notified when the licensee has reasonable grounds to suspect that abuse and/or neglect of a resident has occurred, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The following findings indicate that the licensee failed to comply with O. Reg. 79/10 s. 96(c)(e)(i)(ii) in that their written policy to promote zero tolerance of abuse and neglect of residents does not identify measures and strategies to prevent abuse and neglect, nor does it identify the training and re-training requirements for staff.
The home's Abuse and Neglect Free Environment policy and procedures (CARE-RC-1), last updated January 6, 2012, was provided to the inspector by the Administrator on February 8, 2012.
Upon review, it was noted that this written policy did not identify measures and strategies to prevent abuse and neglect, nor did it identify the training and re-training requirements for staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and situations that may lead to abuse and neglect and how to avoid such situations.

Issued on this 15th day of February, 2012

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

Jessica Patton, RD