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: August 6, 2025

Inspection Number: 2025-1502-0005

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): July 23-25, 28-31, 2025 and August 1, 5-6, 2025

The following intake(s) were inspected:

- Intake: #00143695 - CI #3005-000045-25; Intake: #00150531 - CI #3005-000079-25; Intake: #00150589 - CI #3005-000080-25; Intake: #00152576 -CI #3005-000090-25 - Alleged resident to resident physical abuse
- Intake: #00145013 - CI #3005-000049-25; Intake: #00145132 - CI #3005-000051-25; Intake: #00145940 - CI #3005-000054-25; Intake: #00151416 - CI #3005-000083-25; Intake: #00152260 - CI #3005-000087-25 - Falls of residents with injury
- Intake: #00149232 - CI #3005-000070-25 - Missing resident for less than three hours
- Intake: #00150390 - CI #3005-000076-25 - Alleged physical abuse of resident
- Intake: #00150439 - Complaint related to falls and resident care
- Intake: #00152328 - CI #3005-000089-25 - Alleged staff to resident verbal abuse

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

Resident Care and Support Services
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
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 specific to mobility off the unit for a resident, was provided to the resident as specified in the plan.
On a day in June, 2025, a Personal Support Worker (PSW) did not intervene when they observed the resident leave the unit unattended.

Sources: Review of a resident's care plan document, and interview of a PSW, and Assistant Director of Care (ADOC).

WRITTEN NOTIFICATION: Falls prevention and management

NC #002 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 has failed to comply with the licensee's head injury assessment policy for two residents.

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, the licensee's head injury assessment policy indicated that nursing would perform a neurological assessment and document in the resident's 'Head Injury-Sudden Change Record' every 30 minutes for the first 2 hours, then every hour for the next 8 hours, then every 2 hours for the next 24 hours. A resident was initiated on head injury monitoring on a day in April, 2025, and a day in July, 2025, for sustained falls. This policy was not complied with when there was neurological assessment documentation omitted on two occasions for the fall in April, 2025 and six omitted for the fall in July, 2025.

The second resident was initiated on head injury monitoring on two separate dates in June, 2025, and a day in July, 2025 for sustained falls. This policy was not complied with when there was neurological assessment documentation omitted on

six occasions in June, 2025, and three occasions in July, 2025.

Sources: Two resident's progress notes and post fall evaluations on Lumeo, two resident's head injury record, the licensee's 'Head Injury Assessment' policy #PM-NURSE-1, reviewed on March 8, 2025, and an interview with a Registered Practical Nurse (RPN) and Director of Care (DOC).

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 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); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when two residents fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A resident sustained falls on two dates in June, 2025, and two dates in July, 2025. No post-fall evaluations were completed for these dates.

Sources: A resident's progress notes and post-fall evaluation review on Lumeo, and interviews with an RPN and DOC.

A resident sustained a fall on a day in April, 2025. There was no post-fall evaluation completed for the resident on this date.

Sources: A resident's progress notes and post-fall evaluation review on Lumeo, and an interview with an RPN and DOC.