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

Public Report

Report Issue Date: October 31, 2025

Inspection Number: 2025-1502-0006

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): October 16, 17, 20 - 24, 27- 30, 2025

The following intake(s) were inspected:

Intake: #00152849/CI #3005-000093-25 - Missing controlled substance.
Intake: #00153616/CI #3005-000096-25 - Alleged resident to resident abuse.
Intake: #00153896/CI #3005-000097-25 - Alleged resident to resident abuse.
Intake: #00154239/CI #3005-000099-25 - Alleged staff neglect of multiple residents.
Intake: #00154409/CI #3005-000104-25 - Alleged resident to resident sexual abuse.
Intake: #00154578/CI #3005-000103-25 - Alleged staff neglect of multiple residents.
Intake: #00154618/CI #3005-000107-25 - Alleged staff to resident physical abuse.
Intake: #00156177/CI #3005-000115-25 - Alleged staff neglect of multiple residents.

Intake: #00156638/CI #3005-000119-25 - Fall of a resident resulting in injury.
Intake: #00157682/Complaint regarding homes response to missing narcotic.
Intake: #00158745/CI #3005-000130-25 - Fall of a resident resulting in injury.
Intake: #00158806/CI #3005-000131-25 - Fall of resident resulting in injury.
Intake: #00159624/CI #3005-000134-25 - Regarding conduct of resident.
Intake: #00160070/CI #3005-000140-25 - Alleged resident to resident physical and verbal abuse.
Intake: #00160105/CI #3005-000139-25 - Fall of resident resulting in injury.

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

Medication Management
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 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 a resident 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 specified dates in September, 2025. No post-fall evaluations were completed for these dates.

Sources: Resident's progress notes and post-fall evaluation documentation on Lumeo, and interviews with a Registered Nurse (RN) and the Director of Care (DOC).