Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 17, 2014	2014_280541_0034	O-001151-14	Critical Incident System

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

AMBER MOASE (541)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 22 and 23, 2014

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, a Registered Nurse and Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Nutrition and Hydration
Snack Observation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for Resident #1 set out clear directions to staff and others who provide direct care to the resident.

On a specified date, Resident #1 was found outside his/her room unable to breathe. Large morsels of food were removed from Resident #1's throat during the process of resuscitation. Resuscitation was unsuccessful and Resident #1 passed away.

According to physician orders and the most up to date nutritional care plan, Resident #1 received a pureed texture diet.

Resident #1's care plan in effect at the time of the incident directs staff to monitor resident closely around food and drinks.

During an interview on October 22, 2014 PSW staff member #S101 stated that at the time of the incident she and PSW staff member #S105 were on the unit and approximately 8-10 residents were still up. Staff #S105 stated that at approximately 2200 hrs some residents were asking for food, therefore PSW staff member #S101 was handing out snacks (cookies) while PSW staff member #S105 had prepared and provided a sandwich to another resident on the unit. PSW staff member #S101 observed the back of Resident #1 as the resident was entering his/her room. A few minutes later PSW staff member #S101 then observed Resident #1 fall to the ground, at which time a registered nursing staff member was called.

PSW staff member #S103 stated that there is a designated staff person on the unit to hand out regular snack pass on the units. PSW staff member #S102 informed inspector during an interview on October 22, 2014 that she is the designated staff on the unit where Resident #1 resided to hand out snacks. PSW staff member #S102 stated she was not aware of Resident #1 having a history of taking food. Staff #S102 stated she provided the evening snack pass at approximately 2000 hrs on the date of the incident and did not provide any sandwiches to residents. Staff member #S102's shift ended at 2100 hrs on the date of the incident.

PSW staff members #S102, #S103 and RN staff member #S104 all indicated that they were not aware Resident #1 required monitoring when food was in the vicinity and stated the resident was only required to be monitored when fluids were in the vicinity. PSW staff members #S105 and #101 stated they were aware Resident #1 required monitoring

when both food and/or fluids were in the vicinity.

When asked by Inspector #541 what the monitoring of Resident #1 at snack time entailed, PSW staff members #S101 and #S105 were able to provide specific details as to how Resident #1 was monitored at snack times.

On October 23, 2014 the Director of Care was interviewed about the incident. The DOC informed Inspector #541 that Resident #1 had a large quantity of food suctioned during resuscitation and it was therefore assumed that the resident had collected this food when it was left unattended by other residents after snacks were provided.

An internal investigation report provided by the home states that Resident #1 had a history of stealing food and eating it. A review of Resident #1's admission Minimum Data Set (MDS) data indicates the resident receives a puree texture. An initial physician assessment completed in the home lists impaired swallowing function as part of Resident #1's past medical history. The DOC stated during an interview on October 23, 2014 that Resident #1 does not have swallowing problems, the resident receives a puree texture as a result of having no teeth or dentures. A review of a Nutritional assessment RAP completed by the Registered Dietitian on a specified date does not indicate Resident #1 has any swallowing impairments and it states the resident receives a puree texture due to missing teeth/dentures.

The plan of care at the time of the incident for Resident #1 did not set out clear directions to staff to reflect how or why Resident #1 was to be monitored during snack times. Resident #1 obtained food that was unsafe according to his/her current diet order and as a result, choked on the food and passed away. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified immediately, in as much detail as is possible in the circumstances of an unexpected or sudden death, including a death resulting from an accident or suicide.

On a specified date, a critical incident occurred during which Resident #1 was found by RPN staff member #100 not breathing and no pulse present in the tv lounge of the home. Resuscitation was attempted but was unsuccessful and Resident #1 passed away. As per Resident #1's nutritional care plan, the resident was to receive a pureed diet texture.

On October 22, 2014 Inspector #541 interviewed the Director of Care who confirmed that the Director was not notified until the Critical Incident report was submitted the next day. [s. 107. (1)]

Issued on this 5th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMBER MOASE (541)
Inspection No. / No de l'inspection :	2014_280541_0034
Log No. / Registre no:	O-001151-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 17, 2014
Licensee / Titulaire de permis :	PROVIDENCE CARE CENTRE 340 Union Street, KINGSTON, ON, K7L-5A2
LTC Home / Foyer de SLD :	PROVIDENCE MANOR 275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELAGH NOWLAN

To PROVIDENCE CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall review and update the plans of care for any resident who is known to be at risk of choking for any reason and who requires monitoring to ensure there is clear direction to staff and others who provide direct care to the resident. This direction shall include:
- Why the resident requires monitoring
- Who is responsible for the monitoring
- Frequency and duration of the monitoring
- How the resident will be monitored at snack times

The licensee shall ensure there is a system in place to ensure that the directions indicated in each resident's care plans are being implemented.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care for Resident #1 set out clear directions to staff and others who provide direct care to the resident.

On a specified date, Resident #1 was found outside his/her room unable to breathe. Large morsels of food were removed from Resident #1's throat during the process of resuscitation. Resuscitation was unsuccessful and Resident #1 passed away.

According to physician orders and the most up to date nutritional care plan, Resident #1 received a pureed texture diet.

Resident #1's care plan in effect at the time of the incident directs staff to monitor resident closely around food and drinks.

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snacks were provided.

An internal investigation report provided by the home states that Resident #1 had a history of stealing food and eating it. A review of Resident #1's admission Minimum Data Set (MDS) data indicates the resident receives a puree texture. An initial physician assessment completed in the home lists impaired swallowing function as part of Resident #1's past medical history. The DOC stated during an interview on October 23, 2014 that Resident #1 does not have swallowing problems, the resident receives a puree texture as a result of having no teeth or dentures. A review of a Nutritional assessment RAP completed by the Registered Dietitian on a specified date does not indicate Resident #1 has any swallowing impairments and it states the resident receives a puree texture due to missing teeth/dentures.

The plan of care at the time of the incident for Resident #1 did not set out clear directions to staff to reflect how or why Resident #1 was to be monitored during snack times. Resident #1 obtained food that was unsafe according to his/her current diet order and as a result, choked on the food and passed away. (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amber Moase

Service Area Office /
Bureau régional de services : Ottawa Service Area Office