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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
May 29, 2015	2015_390602_0010	O-001553-14	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

WENDY BROWN (602), AMBER MOASE (541), JESSICA PATTISON (197)

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): April 1, 2, and 14, 15,16, 2015

The inspector(s) observed resident care, reviewed resident health care records, Fall Prevention & Management Policy, Abuse & Neglect Policy, Staff Safety Plan, Lift, Sling & Cushion/Mattress in-service summaries, Lift & Sling product information/instructions, and internal investigation files

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
1 VPC(s)
2 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that Resident#4 was not neglected by staff, and failed to ensure that staff protected residents from abuse by Resident#1.

Re: Resident#4
Neglect is defined in O.Reg 79/10 s. 5 as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well- being of one or more residents".

On an identified date, staff assisting Resident#4 with toileting noted skin discolouration and large bruise in the shape of a bedpan across the Resident's buttocks. A subsequent wound care assessment indicated that Resident#4 had "a large area of suspected deep tissue injury to both buttocks consistent with laying on foreign object for an extended period of time". During an interview on April 1, 2015 regarding the Licensee's investigation into the incident, the ADOC#109 and DOC advised they were unable to confirm the staff that left the Resident on the bedpan long enough to result in the injury to Resident#4's coccyx. They shared that this likely occurred on nights over an identified period as Resident#4 frequently requests toileting via bedpan on the night shift. PSWs S#112 and S#107 confirmed Resident #4s frequent requests to be put on the bedpan especially on nights and agreed that it would be hard to know which time resulted in the injury. The difficulties establishing a time line and the name(s) of staff involved in the neglect resulted in a subsequent DOC message to nursing staff directing that all residents requiring toileting by bedpan never be left on the bedpan for longer than 10 minutes.

On an identified date, progress notes indicate that PSW#107 reported the concern immediately to RN#106 who alerted ADOC#109. The DOC contacted the MOHLTC via the LTC Home pager twelve + hours later. Progress notes indicate that Resident#4's Substitute-Decision-Maker (SDM) was not alerted until the following day.

Prior to the date of the incident Resident#4's plan of care contained a single reference to "bedpan" use noting the Resident experienced increased urgency at night and that staff were to toilet/bedpan at request to decrease anxiety. After the incident, ADOC#109 revised the care plan to include frequent assessment and monitoring of comfort and success of bedpan use. Over the next 5 weeks further updates included: Resident#4's tendency to fall back to sleep prior to being removed from bedpan, direction to use commode on days and evenings and bedpan only on nights; and only if commode refused, and a 10 minute limit. Additionally the DOC emailed nursing staff on an identified date advising that the plan of care for all residents who use a bedpan are to include a limit of 10 minute on a bedpan, as well as a reminder that staff are responsible

for checking resident status at the beginning and end of each shift.

ADOC#112 investigation documentation regarding bedpan incidents included two additional incidents where Resident#4 was left on the bedpan beyond established limits resulting in skin discolouration and indentation markings on two separate identified dates. Subsequent investigations revealed a communication breakdown between direct care support staff and a failure to provide care as the causes of the incidents respectively. The wound care assessment completed following the last identified incident indicated a small blistered area was found to right side of the coccyx dressing. Review of progress and investigation notes, and incident follow up documentation, indicated that direct care staff involved were identified and appropriate actions taken by the Licensee. Resident#4's revised plan of care was not followed and neither incident of neglect was reported to the Director.

In summary, non-compliance specific to reporting to the Director and the SDM, clear direction in the plan of care and in provision of care was found as follows:

1)The Licensee failed to comply with LTCHA 2007, c.8, s.24. in that suspected neglect of Resident#4 on an identified date was not immediately reported to the Director and that further neglect on two separate identified dates resulting in risk of harm were not reported to the Director. Refer to WN#6

2)The Licensee failed to ensure that Resident#4's SDM was immediately notified upon becoming aware of the December 18, 2014 incident of neglect that resulted in a physical injury. Refer to WN#8

3) The Licensee failed to comply with LTCHA 2007, c.8, s. 6 (1) in that the written plan of care in place prior to the first incident did not set out clear directions to staff and others who provide direct care to Resident#4. Refer to WN#3

4)The licensee has failed to comply with LTCHA, 2007, c.8, s. 6 (7) in that care set out in the revised plan of care was not provided as specified in the plan. Refer to WN#3

Re: Resident#1
Related to log# O-001071-14 the Director was notified of a physical altercation between Resident #1 and Resident #2 via the Critical Incident reporting system on an identified date.

Physical abuse is defined in O.Reg 79/10 s. 5 as the use of physical force by anyone other than a resident that causes physical injury or pain, and/or administering or withholding a drug for an inappropriate purpose, and/or the use of physical force by a resident that causes physical injury to another resident.

Resident#1’s Mood State Resident Assessment Protocol (RAP) completed on an identified date identifies Resident#1 as becoming upset when other residents enter his/her room and notes that Resident#1 must be closely monitored as s/he may attempt to push other residents. The RAP's goal was for Resident#1 to have fewer altercations with other residents. Resident#1’s plan of care following the completion of the RAP assessment did not identify Resident#1’s physically aggressive behaviour nor did it identify strategies to manage or minimize the risk of these physically aggressive behaviours. According to Resident#1’s progress notes, entered on an identified date Resident #1 and another Resident had a physical altercation.

Resident#1 continued to exhibit responsive behaviours and physical aggression towards other residents in four separate incidents occurring over a six month period including pushing a walker into a co-resident, entering another residents room, an attempt to run over a resident with whom s/he was arguing with a wheelchair and throwing a glass of juice at a co-resident.

According to progress notes, on a subsequent identified date another incident of physical abuse occurred; Resident#1 was found in another residents room striking that resident repeatedly. Following this incident Resident#1 was referred to the Mobile Response Team (MRT) who assessed Resident#1 at the Home and suggested that a bed alarm be put in place.

Inspector#541 interviewed Registered Staff S#100 regarding MRT recommendation implementation; S#100 stated MRT recommendations are added to the plan of care following a post assessment meeting. As of the date of Inspection Resident#1’s plan of care did not indicate Resident#1 was at risk of being physically abusive toward other residents nor did the plan of care contain strategies to protect other residents from Resident#1. During an interview with Inspector#541, PSW S#101 stated Resident#1 does not have a bed alarm in place and was unable to indicate a reason why.

Interviews with Registered Staff S#103 and PSWs S#102 and S#104 confirmed that the “Staff Safety Plan” created to protect staff providing care to Resident#1 does not include

interventions for ensuring the protection of other residents. In subsequent interviews with another staff, S#113 stated that Resident#1 received "as needed" medications but was unable to provide interventions in place to keep other residents safe from Resident#1. S#113 indicated that s/he did not think Resident#1 was at risk of being physically abusive toward other residents nor had s/he reviewed any documentation to this end.

The Licensee failed to take steps to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions for Resident #1's physically aggressive behaviour resulting in two incidents of physical abuse. Specifically the Licensee failed to ensure Staff followed their abuse/neglect policy in that they failed to address resident to resident abuse when creating a safety plan nor did Staff document investigation interviews as outlined in the policy. In summary, non compliance was found as follows:

1) The Licensee has failed to comply with LTCHA 2007, c.8, s. 20 (1) in that they did not ensure compliance with their policy to promote zero tolerance of abuse and neglect specific to implementing a safety plan for Resident #1 nor were investigation interviews specific to an identified occurrence documented. Refer to WN#4

2) The Licensee failed to comply with O. Reg. 79/10, s. 54. (b) in that they did not take steps to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions to protect other residents from abuse by Resident#1. Refer to WN#7 [s. 19. (1)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 36 in that staff did not use safe transferring techniques when moving a resident with a mechanical lift.

On an identified date, staff members S#114 and S#115 were transferring Resident#4 off a commode with a mechanical lift when the resident fell to the floor and hit his/her head. As a result of the fall, Resident#4 sustained an injury and was transferred to hospital for further assessment.

ADOC#109 immediately removed the mechanical lift from service and completed an assessment to ensure it was in safe working condition. An investigation into the incident was conducted and included interviews with staff that were present.

Inspector#602 conducted interviews with the two staff members that were present when the incident occurred. Staff member S#114 recalled that Resident#4 didn't like to stand so they always used a mechanical lift with two staff for transfers. On the morning of the incident, the resident had been on the commode. Resident#4's sling was still behind him/her and the resident moved around to get comfortable. Staff member S#114 indicated that s/he and staff member S#115 hooked up the sling straps, removed the commode and proceeded to lift the resident up in the air so they could slide the wheelchair in underneath Resident#4 and this is when the resident fell. S#114 noted that all the straps from the sling were still hooked on the lift. The Resident was assessed right away by RN#116 and the head injury protocol was initiated. S#114 theorized that the straps were hooked up but the left strap wasn't underneath Resident#4's leg, allowing the resident to slide out. S#114 indicated that s/he and S#115 must have missed this sling strap.

In another interview, staff member S#115 recalled that Resident#4 was on the commode, both staff members hooked Resident#4's sling up to the portable lift with S#115 controlling the lift. S/he indicated that s/he was facing the Resident and S#114 was on the left. S#114 pulled the commode out from underneath Resident#4 and s/he fell. The RPN#111 and a Doctor assessed the Resident. PSW S#115 stated that all the straps were hooked up, but the sling wasn't properly underneath Resident#4's left leg.

The internal investigation into the incident concluded that the mechanical lift was functioning properly and that all loops were hooked and fastened. The probable cause of the incident was that the left leg strap was not placed properly under Resident#4's bottom prior to being lifted and the subsequent fall was the end result. [s. 36.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) in that the written plan of care for Resident#4 failed to set out clear directions to staff and others who provide direct care to the resident.

Prior to the initial incident of neglect, Resident#4's care plan contained a single reference to "bed pan" use noting the Resident's increased urgency at night and that staff were to toilet/bedpan at request to decrease anxiety. After the incident, ADOC#109 revised the care plan to include frequent assessment and monitoring of comfort and success pan use. Over the next several weeks further updates clarifying care and limits specific to bedpan use included:
- Resident is frequently unable to alert night staff when finished due to lethargy will fall back to sleep and coccyx ulcer requires frequent monitoring report findings to RPN.
- use commode only during days and evenings. If Resident refuses, registered staff to assess, document in chart and then they can use bedpan, and bedpan only to be used at night.
- remove from bedpan after 10 minutes if no results.

On an identified date the DOC emailed nursing staff advising that "care plans for all residents who use a bedpan are to include that the residents are to only be on for a limit of 10 minutes. Please discuss with staff and remind them that they are responsible for checking the status of the residents at the beginning of the shift and at the end before they leave". [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA, 2007, c.8, s. 6 (7) in that the care set out in the plan of care was not provided to Resident#4 as specified in the plan.

ADOC#112 investigation documentation regarding bedpan incidents included two additional occurrences of neglect where Resident#4 was left on the bedpan beyond established limits resulting in skin discolouration and indentation markings on two separate identified dates. Post incident wound care referrals were made and subsequent investigations revealed a "communication breakdown" and "failure to provide care" as the causes of the two occurrences respectively. The wound care assessment completed following the failure to provide care incident noted that along with skin discolouration and indentation markings, a small blistered area was found to right side of the coccyx dressing.

A review of the investigation notes for the failure to provide care incident specifically documents that Resident#4 was found on a bedpan by Night shift staff, it was determined that the resident had been left on the bedpan for approximately 45 minutes as staff caring for the Resident left for break without alerting covering staff and despite knowledge of 10 minute bedpan limit in the plan of care. The review of progress and investigation notes and incident follow up documentation indicate that Resident#4's care was not provided as specified in the revised plan of care in both incidents. [s. 6. (7)]

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 specific to shift to shift communication between direct care nursing and support staff regarding changes in plan of care, resident health status, and residents requiring assistance immediately following shift report, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, c.8, s. 20 (1) in that every licensee must ensure compliance with their policy to promote zero tolerance of abuse and neglect.

Related to log# O-001071-14 the Director was notified of a physical altercation between Resident #1 and Resident #2 via the Critical Incident reporting system.

Physical abuse is defined in O.Reg 79/10 s. 5 as the use of physical force by anyone other than a resident that causes physical injury or pain, and/or administering or withholding a drug for an inappropriate purpose, and/or the use of physical force by a resident that causes physical injury to another resident.

Resident#1’s Mood State Resident Assessment Protocol (RAP) completed on an identified date identifies Resident#1 as becoming upset when other residents enter his/her room and notes that Resident#1 must be closely monitored as s/he may attempt to push other residents. The RAP's goal was for Resident#1 to have fewer altercations with other residents. Resident#1’s plan of care following the completion of the RAP assessment did not identify Resident#1’s physically aggressive behaviour nor did it identify strategies to manage or minimize the risk of these physically aggressive behaviours. According to Resident#1’s progress notes, entered on an identified date Resident #1 and another Resident had a physical altercation.

Resident#1 continued to exhibit responsive behaviours and physical aggression towards other residents in four separate incidents occurring over a six month period including pushing a walker into a co-resident, entering another residents room, an attempt to run over a resident with whom s/he was arguing with a wheelchair and throwing a glass of

juice at a co-resident.

According to progress notes, on a subsequent identified date another incident of physical abuse occurred; Resident#1 was found in another residents room striking that resident repeatedly. Following this incident Resident#1 was referred to the Mobile Response Team (MRT) who assessed Resident#1 at the Home and suggested that a bed alarm be put in place.

On April 2, 2015 the DOC provided the Home’s Abuse and Neglect Free Environment Policy. The policy directs that the person who received the report of alleged abuse "Immediately notify the Charge Nurse/Delegate personally or by phone and document the incident in Safe T -Net as an initial severity Level 3 incident. Submit the incident report". A safety plan was not implemented for Resident#1 following the incident of resident to resident physical abuse. Staff#103 explained that the plan was not implemented as s/he was not made aware of abuse incidents via the Safe T-Net system nor did s/he receive any other notification regarding the incident.

Policy#CARE-RC-1 directs that the person responsible for the abuse investigation is to record details of the alleged abuse in investigation notes, including documentation of all interviews, written statements from other residents, witnesses. Investigation documentation provided to Inspector#541 did not include staff interview documentation; when asked ADOC#112 stated that although all staff members present were interviewed the interviews were not documented as all staff interviewed repeated “word for word” what was in the progress notes.

Contrary to Abuse/Neglect policy a safety plan including interventions to ensure the protection of other residents was not implemented for Resident#1. Additionally, although the Abuse/Neglect policy requires documentation of all investigation interviews, this was not completed as part of the incident investigation. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 23 in that staff did not use a mechanical lift in accordance with manufacturers' instructions.

On an identified date staff members S#114 and S#115 were transferring Resident#4 off the commode with a mechanical lift when the resident fell to the floor.

The manufacturers' instructions for the Liko Universal Sling, Mod. 000, 002 that were used on the date of the incident state the following:

Before lifting, keep the following points in mind:
- Make sure the patient is sitting securely in the sling before transferring to another location.

Pull the sling’s leg supports forward along the outside of the patient’s thighs. Place the palm of your hand between the patient’s body and the sling and push the leg supports lower edge down towards the seat. Simultaneously, pull the leg support forward with the other hand to stretch it.

Pull the leg supports forward to smooth out any creases in the back. Check that both leg supports protrude the same distance. Note: a gentle hold under the knee-cap makes it easier to pull the leg supports forward.

Insert the leg supports under each thigh. Make sure the fabric lies flat and that is reaches properly around the leg. Note: The application of the leg supports is facilitated if the patient’s legs are slightly raised from the seat. This can be achieved by placing the patient’s feet on the foot-rests or on your own leg, as illustrated.

On an identified date SA#114 demonstrated the use of the mechanical lift and sling for Inspector#602. S/he advised that on the date of the incident s/he thought the left leg support had not been placed under Resident#4's left thigh and this was missed on the strap cross “double check” prior to lifting the resident.

The Licensee’s internal investigation into the incident concluded that the mechanical lift was functioning properly and that all loops were hooked and fastened. Probable cause of the incident was that the left leg strap was not placed properly under the resident’s bottom prior to being lifted and the subsequent fall was the end result. [s. 23.]

WN #6: 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:

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

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA 2007, c.8, s.24. in that suspected neglect of a resident was not immediately reported to the Director.

On an identified date staff assisting Resident#4 with toileting noted a large "bruise in the shape of the pan". S#107 reported the concern immediately to registered staff who assessed Resident#4, documented the incident, reported it to ADOC#109 and made a referral for a wound care assessment. The DOC contacted the MOHLTC via the LTC Home pager 12+ hours later. The CI Report indicates the report was submitted for the first time by the ADOC to the MOHLTC the following day.

The DOC agreed that the documentation by registered staff and ADOC#109 confirmed awareness of possible abuse/neglect on the identified date/time. The DOC agreed that his/her documentation also reflected that the incident was reported to the Director via LTC Home pager 12+ hours later.

The ADOC#109 advised Inspector#602 that the understanding is that reporting to the MOHLTC and/or the SDM/POA would occur "as soon as everyone is made safe". ADOC#109 explained that if there wasn't an injury, or risk of injury, or change in condition, as a result of an incident they might hold off on reporting to the SDM/POA until after 7:00 [am.] or so, but no more than 3 or 4 hours later".

Additionally, a review of the licensee's investigation notes for subsequent incidents occurring on separate identified dates indicate the following:
- On an identified date, Resident#4 was found on a bedpan by Day shift staff, the resident's skin was discoloured and indented in the shape of the bedpan. The subsequent investigation revealed a communication breakdown at change of shift incident as the cause of the .
- On a subsequent identified date, Resident#4 was found on a bedpan by Night shift staff, the investigation that followed indicated that Resident#4 had been left on a bedpan for approximately 45 minutes resulting in discolouration, and a small blistered area on the coccyx. It was discovered that staff caring for Resident#4 had left for break without alerting covering staff and despite knowledge of 10 minute bedpan limit.

There were no reports submitted to the Director for either incident. The DOC stated that the incidents were not reported to the Director as Resident#4's "skin cleared up", however, on review, the DOC agreed that both incidents should have been reported as there was risk of injury as a result of the neglect. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 54. (b) in that steps to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions to protect other residents from Resident#1 were not taken.

Related to log# O-001071-14 the Director was notified of a physical altercation between Resident #1 and Resident #2 via the Critical Incident reporting system on an identified date.

Resident#1's Mood State Resident Assessment Protocol (RAP) completed on an identified date identifies Resident#1 as becoming upset when other residents enter his/her room and notes that Resident#1 must be closely monitored as s/he may attempt to push other residents. The RAP's goal was for Resident#1 to have fewer altercations with other residents. Resident#1's plan of care following the completion of the RAP assessment did not identify Resident#1's physically aggressive behaviour nor did it identify strategies to manage or minimize the risk of these physically aggressive behaviours. According to Resident#1's progress notes, entered on an identified date Resident #1 and another Resident had a physical altercation.

Resident#1 continued to exhibit responsive behaviours and physical aggression towards other residents in four separate incidents occurring over a six month period including pushing a walker into a co-resident, entering another residents room to arrest him/her for

noise, an attempt to run over a resident with whom s/he was arguing with a wheelchair and throwing a glass of juice at a co-resident.

According to progress notes, on a subsequent identified date another incident of physical abuse occurred; Resident#1 was found in another residents room striking that resident repeatedly. Following this incident Resident#1 was referred to the Mobile Response Team (MRT) who assessed Resident#1 at the Home and suggested that a bed alarm be put in place.

Inspector#541 interviewed Registered Staff S#100 regarding MRT recommendation implementation; S#100 stated MRT recommendations are added to the plan of care following a post assessment meeting. As of the date of Inspection Resident#1’s plan of care did not indicate Resident#1 was at risk of being physically abusive toward other residents nor did the plan of care contain strategies to protect other residents from Resident#1. During an interview with Inspector#541 PSW S#101 stated Resident#1 does not have a bed alarm in place and was unable to indicate a reason why.

Interviews with Registered Staff S#103 and PSWs S#102 and S#104 confirmed that the “Staff Safety Plan” created to protect staff providing care to Resident#1 does not include interventions for ensuring the protection of other residents. In a subsequent interviews with another staff, S#113 stated that Resident#1 received "as needed" medications but was unable to provide interventions in place to keep other residents safe from Resident#1. S#113 indicated that s/he did not think Resident#1 was at risk of being physically abusive toward other residents nor had s/he reviewed any documentation to this end.

The Licensee failed to take steps to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions for Resident #1’s physically aggressive behaviour resulting in two incidents of physical abuse.
[s. 54. (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that Resident#4's SDM was immediately notified upon becoming aware of an incident of neglect that resulted in a physical injury.

On an identified date, staff assisting Resident#4 with toileting noted a large "bruise in the shape of the pan". S#107 reported the concern immediately to registered staff who assessed Resident#4, documented the incident, and reported it to ADOC#109. The DOC contacted the MOHLTC via the LTC Home pager 12+ hours later. Progress notes indicate that Resident#4's SDM was alerted the following day, 27+ hours later, despite the ADOC#109 understanding that reporting to the MOHLTC and/or the SDM/POA occurs immediately "as soon as everyone is made safe". [s. 97. (1) (a)]

Issued on this 8th day of June, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur
Aux termes 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) :	WENDY BROWN (602), AMBER MOASE (541), JESSICA PATTISON (197)
Inspection No. / No de l'inspection :	2015_390602_0010
Log No. / Registre no:	O-001553-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 29, 2015
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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee is to prepare, implement and submit a corrective action plan to ensure that the following measures are in place to protect residents from abuse/neglect.

1) Ensure all allegations of abuse and neglect involving residents are reported immediately to the Director. LTCHA, 2007 s. 24(1)

2) Re-education of all staff related to the Licensee's Policy on "Abuse and Neglect Free Environment CARE-RC-1". Specifically focusing on:
- staff responsibility as it relates to immediate notification of the Director
- the definition of abuse/neglect of residents
- notification of the Resident's substitute decision-maker, if any, and any other person specified by the Resident

3) Ensure there is a process in place to monitor that all direct care staff are following the Home's Abuse/Neglect policy and that measures are in place and will be implemented should the policy not be followed.

The plan shall be submitted in writing to Inspector Wendy Brown by fax #613 569 9670 no later than June 16, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that Resident#4 was not neglected by staff, and failed to ensure that staff protected residents from abuse by Resident#1.

Re: Resident#4
Neglect is defined in O.Reg 79/10 s. 5 as the "failure to provide a resident with

the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well- being of one or more residents".

On an identified date, staff assisting Resident#4 with toileting noted skin discolouration and large bruise in the shape of a bedpan across the Resident's buttocks. A subsequent wound care assessment indicated that Resident#4 had "a large area of suspected deep tissue injury to both buttocks consistent with laying on foreign object for an extended period of time". During an interview on April 1, 2015 regarding the Licensee's investigation into the incident, the ADOC#109 and DOC advised they were unable to confirm the staff that left the Resident on the bedpan long enough to result in the injury to Resident#4's coccyx. They shared that this likely occurred on nights over an identified period as Resident#4 frequently requests toileting via bedpan on the night shift. PSWs S#112 and S#107 confirmed Resident #4s frequent requests to be put on the bedpan especially on nights and agreed that it would be hard to know which time resulted in the injury. The difficulties establishing a time line and the name(s) of staff involved in the neglect resulted in a subsequent DOC message to nursing staff directing that all residents requiring toileting by bedpan never be left on the bedpan for longer than 10 minutes.

On an identified date, progress notes indicate that PSW#107 reported the concern immediately to RN#106 who alerted ADOC#109. The DOC contacted the MOHLTC via the LTC Home pager twelve + hours later. Progress notes indicate that Resident#4's Substitute-Decision-Maker (SDM) was not alerted until the following day.

Prior to the date of the incident Resident#4's plan of care contained a single reference to "bedpan" use noting the Resident experienced increased urgency at night and that staff were to toilet/bedpan at request to decrease anxiety. After the incident, ADOC#109 revised the care plan to include frequent assessment and monitoring of comfort and success of bedpan use. Over the next 5 weeks further updates included: Resident#4's tendency to fall back to sleep prior to being removed from bedpan, direction to use commode on days and evenings and bedpan only on nights; and only if commode refused, and a 10 minute limit. Additionally the DOC emailed nursing staff on an identified date advising that the plan of care for all residents who use a bedpan are to include a limit of 10 minute on a bedpan, as well as a reminder that staff are responsible for checking resident status at the beginning and end of each shift.

ADOC#112 investigation documentation regarding bedpan incidents included two additional incidents where Resident#4 was left on the bedpan beyond established limits resulting in skin discolouration and indentation markings on two separate identified dates. Subsequent investigations revealed a communication breakdown between direct care support staff and a failure to provide care as the causes of the incidents respectively. The wound care assessment completed following the last identified incident indicated a small blistered area was found to right side of the coccyx dressing. Review of progress and investigation notes, and incident follow up documentation, indicated that direct care staff involved were identified and appropriate actions taken by the Licensee. Resident#4's revised plan of care was not followed and neither incident of neglect was reported to the Director.

In summary, non-compliance specific to reporting to the Director and the SDM, clear direction in the plan of care and in provision of care was found as follows:

1)The Licensee failed to comply with LTCHA 2007, c.8, s.24. in that suspected neglect of Resident#4 on an identified date was not immediately reported to the Director and that further neglect on two separate identified dates resulting in risk of harm were not reported to the Director. Refer to WN#6

2)The Licensee failed to ensure that Resident#4's SDM was immediately notified upon becoming aware of the December 18, 2014 incident of neglect that resulted in a physical injury. Refer to WN#8

3) The Licensee failed to comply with LTCHA 2007, c.8, s. 6 (1) in that the written plan of care in place prior to the first incident did not set out clear directions to staff and others who provide direct care to Resident#4. Refer to WN#3

4)The licensee has failed to comply with LTCHA, 2007, c.8, s. 6 (7) in that care set out in the revised plan of care was not provided as specified in the plan. Refer to WN#3

Re: Resident#1
Related to log# O-001071-14 the Director was notified of a physical altercation between Resident #1 and Resident #2 via the Critical Incident reporting system

on an identified date.

Physical abuse is defined in O.Reg 79/10 s. 5 as the use of physical force by anyone other than a resident that causes physical injury or pain, and/or administering or withholding a drug for an inappropriate purpose, and/or the use of physical force by a resident that causes physical injury to another resident.

Resident#1's Mood State Resident Assessment Protocol (RAP) completed on an identified date identifies Resident#1 as becoming upset when other residents enter his/her room and notes that Resident#1 must be closely monitored as s/he may attempt to push other residents. The RAP's goal was for Resident#1 to have fewer altercations with other residents. Resident#1's plan of care following the completion of the RAP assessment did not identify Resident#1's physically aggressive behaviour nor did it identify strategies to manage or minimize the risk of these physically aggressive behaviours. According to Resident#1's progress notes, entered on an identified date Resident #1 and another Resident had a physical altercation.

Resident#1 continued to exhibit responsive behaviours and physical aggression towards other residents in four separate incidents occurring over a six month period including pushing a walker into a co-resident, entering another residents room, an attempt to run over a resident with whom s/he was arguing with a wheelchair and throwing a glass of juice at a co-resident.

According to progress notes, on a subsequent identified date another incident of physical abuse occurred; Resident#1 was found in another residents room striking that resident repeatedly. Following this incident Resident#1 was referred to the Mobile Response Team (MRT) who assessed Resident#1 at the Home and suggested that a bed alarm be put in place.

Inspector#541 interviewed Registered Staff S#100 regarding MRT recommendation implementation; S#100 stated MRT recommendations are added to the plan of care following a post assessment meeting. As of the date of Inspection Resident#1's plan of care did not indicate Resident#1 was at risk of being physically abusive toward other residents nor did the plan of care contain strategies to protect other residents from Resident#1. During an interview with Inspector#541, PSW S#101 stated Resident#1 does not have a bed alarm in place and was unable to indicate a reason why.

Interviews with Registered Staff S#103 and PSWs S#102 and S#104 confirmed that the “Staff Safety Plan” created to protect staff providing care to Resident#1 does not include interventions for ensuring the protection of other residents. In subsequent interviews with another staff, S#113 stated that Resident#1 received "as needed" medications but was unable to provide interventions in place to keep other residents safe from Resident#1. S#113 indicated that s/he did not think Resident#1 was at risk of being physically abusive toward other residents nor had s/he reviewed any documentation to this end.

The Licensee failed to take steps to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions for Resident #1's physically aggressive behaviour resulting in two incidents of physical abuse. Specifically the Licensee failed to ensure Staff followed their abuse/neglect policy in that they failed to address resident to resident abuse when creating a safety plan nor did Staff document investigation interviews as outlined in the policy. In summary, non compliance was found as follows:

1) The Licensee has failed to comply with LTCHA 2007, c.8, s. 20 (1) in that they did not ensure compliance with their policy to promote zero tolerance of abuse and neglect specific to implementing a safety plan for Resident #1 nor were investigation interviews specific to an identified occurrence documented. Refer to WN#4

2) The Licensee failed to comply with O. Reg. 79/10, s. 54. (b) in that they did not take steps to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions to protect other residents from abuse by Resident#1. Refer to WN#7 [s. 19. (1)] (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee is to prepare, submit and implement a corrective action plan to ensure safe transferring and positioning devices or techniques are being utilized when assisting residents.
This plan is to include who is to complete the task and by when:

1) Review and revise the plan of care for all current residents requiring the use of any mechanical lifting device including use of the GOLVO lift and Liko Universal Slings, to ensure there is clear direction to staff and others who provide direct care to residents; the care plan should include the type of assistance required, the type of mechanical lifting device and slings required, and any safety devices or measures to be taken when utilizing the mechanical device/associated slings.

2) Re-train all direct care staff on the Licensee's policies and procedures specific to Safety in Ambulating, Lifting and Transferring to ensure all direct care staff are aware of requirements related to safe transfers and or lifts, and the use of mechanical lifting devices and associated slings, including safe use of the GOLVO lift and the Liko Universal Sling.

3) To ensure there is a process in place to monitor that all direct care staff are following the Licensee's transfer policies and procedures and that measures are in place and implemented should the policy and/or procedures not be followed.
This plan is to be submitted in writing to the attention of: LTC Homes Inspector Wendy Brown and emailed to wendy.brown2@ontario.ca on or before June 16, 2015

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s. 36 in that staff did not use safe transferring techniques when moving a resident with a mechanical lift.

On an identified date, staff members S#114 and S#115 were transferring Resident#4 off a commode with a mechanical lift when the resident fell to the floor and hit his/her head. As a result of the fall, Resident#4 sustained an injury and was transferred to hospital for further assessment.

ADOC#109 immediately removed the mechanical lift from service and completed an assessment to ensure it was in safe working condition. An investigation into the incident was conducted and included interviews with staff that were present.

Inspector#602 conducted interviews with the two staff members that were present when the incident occurred. Staff member S#114 recalled that Resident#4 didn't like to stand so they always used a mechanical lift with two staff for transfers. On the morning of the incident, the resident had been on the commode. Resident#4's sling was still behind him/her and the resident moved around to get comfortable. Staff member S#114 indicated that s/he and staff member S#115 hooked up the sling straps, removed the commode and proceeded to lift the resident up in the air so they could slide the wheelchair in underneath Resident#4 and this is when the resident fell. S#114 noted that all the straps from the sling were still hooked on the lift. The Resident was assessed right away by RN#116 and the head injury protocol was initiated. S#114 theorized that the straps were hooked up but the left strap wasn't underneath Resident#4's leg, allowing the resident to slide out. S#114 indicated that s/he and S#115 must have missed this sling strap.

In another interview, staff member S#115 recalled that Resident#4 was on the commode, both staff members hooked Resident#4's sling up to the portable lift with S#115 controlling the lift. S/he indicated that s/he was facing the Resident and S#114 was on the left. S#114 pulled the commode out from underneath Resident#4 and s/he fell. The RPN#111 and a Doctor assessed the Resident. PSW S#115 stated that all the straps were hooked up, but the sling wasn't properly underneath Resident#4's left leg.

The internal investigation into the incident concluded that the mechanical lift was functioning properly and that all loops were hooked and fastened. The probable cause of the incident was that the left leg strap was not placed properly under

Resident#4's bottom prior to being lifted and the subsequent fall was the end result. [s. 36.] (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2015

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 29th day of May, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Wendy Brown

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