Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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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
Aug 27, 2015	2015_444602_0022	O-002527-15	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)

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): July 31 and August 4, 5 & 7, 2015

The inspector reviewed the resident health record, interviewed staff, observed the resident's room and bed mechanics as well as reviewed the Home's investigation documents and nursing/oxygen related policy & procedures.

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

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 c.8, s. 6 (9) 1. in that the provision of care for Resident#1 with a specific treatment was not documented on appropriate sheet or in progress notes.

On a specified date the Resident was found in bed, unresponsive. The Resident had been prescribed a treatment which the Resident disliked requiring that staff remind the Resident to continue with the treatment. PSW staffs monitor resident treatment status and are to document it on specified sheets each shift. Registered Staff are required to note treatment status through documentation in progress notes on each shift.

The Staff working on the date of the incident confirmed that an observation of the treatment occurred on every shift, however, monitoring was not documented during one of the three shifts

A review of progress notes revealed that there was no treatment status monitoring documentation completed by registered staff on numerous shifts reviewed over a several days prior to the incident. Staff confirmed in an interview that registered staff are to document treatment status monitoring in the progress notes on each shift.

Issued on this 30th day of October, 2015

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

Original report signed by the inspector.