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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 17, 2017	2017_505103_0026	009200-17	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

DARLENE MURPHY (103)

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): June 16, 19, 22, July 4, 11, 2017.

Log #009200-17 (resident to resident alleged sexual abuse).

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Nurse Practitioner (NP), the Admissions Coordinator, the Quality Improvement Facilitator, the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector made resident observations, reviewed the critical incident submitted by the home, the resident health care records including progress notes, physicians orders, plan of care, electronic medication and treatment administration records for April, May and June 2017, direct observation charting and geriatric psychiatry consultation notes.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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 ensure a witnessed incident of resident sexual abuse was immediately reported to the Director (MOHLTC).

O. Reg 79/10, s. 2 (1) defines sexual abuse as any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #001 and resident #002 were admitted on identified dates and had identified diagnoses.

On the evening of an identified date on or about 2100 hour, RPN #107 witnessed resident #001 sitting at the nursing station inappropriately touching resident #002. The residents were immediately separated and RPN #107 notified RN #101 of the incident. RN #101 was interviewed and confirmed she was the Registered Nurse in charge of the building at the time of the incident. She confirmed RPN #107 notified her of the witnessed sexual abuse on or about 2100 hour and asked her to come and assess the residents. The RN indicated resident #002 had no visible injuries, appeared to be in no distress and had no recall of the incident. The RN stated resident #001 had initially been angry and agitated when removed from the area and was being monitored by the staff on the unit. The RN indicated she completed a safety report, which she explained was an internal electronic reporting system used by the home, but did not make any additional

notifications. The RN indicated she was unsure if the incident constituted abuse. The RN stated she did not consult with the manager on call that evening.

RN #101 indicated she had been hired to the home in September 2016 and at that time received abuse training. The RN was unsure if the abuse training included mandatory reporting. The RN also indicated she was aware of the abuse algorithms that were available in the home, but did not utilize them on the evening of this incident.

S#106 was identified as the person responsible for the abuse education/training for all staff. S#106 was interviewed and confirmed the annual abuse training does include mandatory reporting and that RN #101 did receive this education during her orientation. In addition, S#106 indicated the home had not yet completed the 2017 abuse education/training.

The ADOC was interviewed and stated she was the manager on call on the evening of the identified incident. She stated she did not receive any calls related to the incident involving residents #001 and #002. The ADOC stated she and the remainder of the management team became aware of the incident during their morning review of the twenty-four hour report the following day.

The DOC was interviewed and stated she became aware of the incident during the management's morning meeting and the appropriate notifications to the MOHLTC, family members and the police were made at that time. The DOC further indicated the RN in charge of the building should have notified the manager on call who would have then made the notifications or directed the RN to do so. To date of this inspection, the DOC had not reviewed the incident with RN #101. [s. 24. (1)]

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 to ensure all abuse of a resident by anyone that resulted in harm or risk of harm to the resident is immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the police were immediately notified of a witnessed incident of abuse of resident #002 that the licensee suspected may constitute a criminal offence.

As outlined above in WN #1, the witnessed incident of resident abuse was not reported to the local police until the following day on or about 1150 hour. In an interview with the Director of Care (DOC), she indicated she became aware of the incident the following morning during the management meeting. She confirmed the RN in charge of the home on the evening of the incident failed to notify the police at the time of the witnessed abuse. The DOC stated the home expects the Registered Nurse in charge of the building to report all alleged, suspected or witnessed incidents of abuse to the manager on call who then either makes the appropriate notifications or directs the RN to do so. [s. 98.]

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 to ensure all alleged, suspected or witnessed incidents of resident abuse that may constitute a criminal offence is immediately reported to the appropriate police force, to be implemented voluntarily.

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Issued on this 18th day of July, 2017

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

Original report signed by the inspector.