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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 6, 2017	2017_520622_0032	014837-17	Resident Quality Inspection

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

HEATH HEFFERNAN (622), DARLENE MURPHY (103), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 25, 26, 27, 28, 29, 2017

The following intakes were included as a part of this inspection:
Log #015304-17 (resident fall with injury)
Log #015629-17 (alleged resident to resident abuse)
Log #020849-16 (Follow up to CO related to maintenance of the home with compliance due date of July 31, 2017)

During the course of the inspection, the inspector(s) spoke with the President/Chief Executive Officer (CEO), the Director of Care (DOC)/interim Administrator, the Physician, the Nurse Practitioner (NP), Facilities Manager, the RAI Coordinator, the Family Council Chair, the Resident Council President, the Resident Council Assistant, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Dietary Aides, the residents and families.

During the course of the inspection, the inspectors conducted a walking tour of the home, observed medication administration and infection control practices, reviewed resident health care records, applicable home policies and the resident and family council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_346133_0025	197

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 O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Care works regularly in that position on site at the home for the following amount of time per week; in a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

Providence Manor is a 243 bed nursing home requiring each the Director of Care (DOC) and the Administrator to work regular hours in those positions of at least 35 hours per week.

During an interview with inspector #622 on September 27, 2017 the DOC/Interim Administrator indicated the Administrator had been off work since July 6, 2017 and she assumed the interim position of Administrator as well as her usual position of DOC on July 10, 2017. The DOC/Interim Administrator indicated she had not worked the 35 hours weekly required for each of the Administrator and DOC positions for a home of that size.

A review of the wage adjustment letter to the Director of Care from the CEO indicated that the DOC had assumed additional responsibilities by assuming the responsibility of the Vice President of Long Term Care (Administrator's) role in their absence and pay would be retroactive to July 24, 2017.

During an interview with inspector #622 on September 28, 2017 at 1546 hours, the CEO indicated the Administrator had been off work since early July 2017 and they did not have a date of return. The DOC was elevated to the interim Administrator position and was given the support of the Vice President of Human Resources and the CEO. The home had two Assistant Directors of Care (ADOC) that would assist the interim Administrator to manage the DOC position and the responsibility. The DOC had been working the hours of the Administrator and the ADOCs were to assist with the DOC role.

During an interview with inspector #622 on September 28, 2017 at 1625 hours, the DOC/Interim Administrator indicated that she had assumed more of the Administrator role, the two ADOCs were assisting with picking up some of the responsibilities in the DOC position. The DOC/interim Administrator further indicated the ADOCs were Registered Practical Nurses and not Registered nurses which did not meet legislative requirements. Furthermore, the DOC/interim Administrator indicated she had made an offer September 27, 2017 to an RN who had the qualifications and was willing to assume the interim DOC position. The offer of interim DOC to the RN was to start Tuesday October 3, 2017 until the Administrator returned or the home got a permanent replacement.

A compliance order is warranted given that the scope of the non-compliance is widespread; affecting all residents, and there is potential for resident harm. There is previous non-compliance in unrelated areas. [s. 213. (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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 9(1)1.2 in that all doors leading to non-residential areas that must be equipped with locks to restrict unsupervised access to those areas by residents, were not kept closed and locked when they are not being supervised by staff.

On the morning of September 25, 2017, during the initial tour of the home, Inspector #197 noted the following non-residential area doors that are equipped with locks, to be unlocked and not supervised by staff:
- clean utility room 1-4005
- clean utility room 1-5005
- supply room 1-5083
- supply room 1-5048
- soiled utility room 1-5035

It was noted by Inspector #197 that supply room 1-5083 contained a hot pot of coffee and a mini-fridge with lunch kits present. This supply room is located on the secure unit of the home and could pose potential safety risk to residents when not locked and not supervised by staff. PSW #130 was interviewed during the initial tour and indicated that supply room 1-5083 should be locked.

At 1403 hours on September 25, 2017, the door to supply room 1-5083 was again found unlocked and unsupervised. At this time, Inspector #197 spoke with RPN #124 and informed her that this door had been found unlocked twice on this day. She indicated she would look into the matter and was observed to put a note on the door to inform staff the lock was not working.

This supply room (1-5083) was noted to be unlocked and unsupervised on two other occasions during the inspection as follows:
- September 26, 2017 at 1024 hours
- September 29, 2017 at 0936 hours

On September 25 and 26, 2017 inspector #622 informed the DOC/Interim Administrator there were multiple non-residential area doors that were equipped with locks which were noted to be unlocked and not supervised by staff. The DOC/Interim Administrator indicated she would look into the concern related to the unlocked doors on each date. [s. 9. (1) 2.]

2. The licensee has failed to ensure all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On September 25, 2017 on or about 0945 hour, inspector #103 observed the following doors open and not in the attendance of a staff member:

-Linen room (1-3048); room contained briefs and linens,
-Staff washroom (1-3062),
-Soiled utility room (1-3081); room contained hopper, commode chairs and bedpans, and
-Linen room (1-3082); room contained briefs, linens, resident used personal care items.

All of the above noted rooms were equipped with locks. Registered Practical Nurse #111 confirmed these rooms are not resident accessible areas and that all of the doors should be closed and locked when not being supervised by staff.

On September 26, 2017, on or about 1110 hour, the staff washroom # 1-3062 was observed to be open and not in the attendance of a staff member.

On September 25 and 26, 2017 inspector #622 informed the DOC/Interim Administrator there were multiple non-residential area doors that were equipped with locks which were noted to be unlocked and not supervised by staff. The DOC/Interim Administrator indicated she would look into the concern related to the unlocked doors on each date. [s. 9. (1) 2.]

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 that will ensure all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: 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 following non-compliance is related to Log #015629-17

The licensee has failed to ensure an alleged incident of resident sexual abuse was immediately reported to the Director.

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

Resident #044 was admitted to the home on a specified date with a specified diagnosis. On a specified date and time, resident #044's family member approached the RPN working on the specified unit and reported to her an allegation of resident to resident sexual abuse of resident #044. The RPN reported the allegation to RN #113 and asked her to come to the unit.

RN #113 was interviewed and stated resident #044's family member did report to her an allegation of resident to resident sexual abuse of resident #044 which caused the resident to be fearful. The RN stated she discounted the information provided by resident #044's family member as a misunderstanding. The RN stated she asked the staff to monitor the accused co-resident and resident #044 every fifteen minutes. The RN stated she did not report the allegation to anyone else.

The DOC was interviewed and stated she was the manager on call that weekend and had received no calls related to this incident. The DOC agreed that the incident would fit the definition of an alleged sexual abuse. She stated she had recently sent an email to all registered staff reviewing their obligation to report all suspected, witnessed and alleged incidents of abuse. The DOC stated the registered staff had been encouraged to speak with the manager on call such that a discussion could be held in regards to the appropriate notifications.

RN #113 confirmed she had received the home's abuse education/training in 2016 and that the information did include mandatory reporting. Additionally, the RN stated she had received and read the email sent from the DOC in regards to abuse reporting. The home stated the abuse training for registered staff had not yet been completed for 2017. [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 that any person who has reasonable grounds to suspect that 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 shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: 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 following non-compliance is related to Log #015629-17

The licensee has failed to ensure the police were immediately notified of an alleged incident of sexual abuse involving resident #044.

As outlined in WN # 3, an alleged incident of sexual abuse was reported to the charge staff on a specified date. The DOC was interviewed and stated the police are to be notified of any incidents of abuse that constitute a criminal offence and agreed this incident would fit that criteria. The DOC stated the home expects the RN 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. [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 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

This inspector reviewed the twenty medication incidents that had occurred in the home from April 30, 2017 to June 30, 2017. Fifteen out of the twenty medication incidents were identified as directly reaching the resident.

The DOC was interviewed and stated the registered staff utilize an on-line "safety net" to report all incidents. She indicated all medication incidents are reviewed by her and all are sent to the pharmacy for their review. There is a notification section within the safety net documentation, but there was no documentation to support the home reporting the medication incidents to the resident, resident SDM, medical director, prescriber of the drug, or the resident's attending physician or registered nurse in the extended class.

The DOC agreed there was no evidence that the appropriate notifications had been done for the identified fifteen medication incidents. [s. 135. (1)]

2. The licensee has failed to ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

As outlined above, this inspector reviewed the home's medication incidents from April 30, 2017 to June 30, 2017. The DOC was asked to provide this inspector with the quarterly reviews of the medication incidents completed for that period of time. The DOC stated the pharmacy reviews all medication incidents that are the result of a pharmacy error with the home on a quarterly basis, but that quarterly reviews of all other medication incidents are not being completed. [s. 135. (3)]

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 that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that family council concerns related to the June 19, 2017 meeting were responded to in writing within ten days of receiving the concerns.

A review of the documentation in the family council meeting binder indicated there had not been written replies within ten days to the family council related to six concerns documented during the June 19, 2017 family council meeting.

During an interview with inspector #622 on September 27, 2017 at 1015 hours, the family council chair #106 indicated the family council had not received a response to the concerns raised during the June 19, 2017 meeting.

During an interview with inspector #622 on September 27, 2017 at 1100 hours, the DOC/Interim Administrator indicated that she had started her new dual position July 2017. The Administrator/DOC indicated that she did not have time to reply to the family council related to the concerns brought forward in June 2017. The DOC/Interim Administrator indicated there was a conversation between herself and the Family Council Chair who was aware the concerns had not been addressed within the legislated time frame. [s. 60. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 63. If invited by the Residents' Council or the Family Council, the licensee shall meet with that Council or, if the licensee is a corporation, ensure that representatives of the licensee meet with that Council. 2007, c. 8, s. 63.

Findings/Faits saillants :

1. The licensee has failed to ensure that the corporate representative of the licensee meets with family council when they have been invited.

During a meeting with inspector #622 on September 27, 2017, the Family Council Chair #106 indicated that she invited the DOC/Interim Administrator in August 2017 to attend the September 2017 family council meeting related to concerns about safety and she did not attend.

During an interview with inspector #622 on September 27, 2017, the DOC/Interim Administrator indicated she did not receive a formal request to attend the September 2017 family council meeting, the Family Council Chair may have spoken with her verbally but the DOC/Interim Administrator could not recall. The DOC/Interim Administrator indicated she had been working an interim dual position, which increased her workload and limited her availability. She indicated she informed the Family Council Chair that due to this it may be difficult for her to attend family council meetings. The DOC/Interim Administrator indicated she had not attended the September 2017 meeting as she had to attend a senior leadership meeting that date. [s. 63.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

On September 25, 2017 on or about 1424 hour, inspector #103 noted a strong urine odour in a specified resident room. The room had no obvious signs of the source of this odour. The inspector returned to the same room on several occasions including Sept 26/17 at 1417 hour, September 27/17 at 1100 hour and 1400 hour and September 28 at

0915 hour.

The room was noted to have a strong urine smell each time and there continued to be no obvious signs of the source of this odour. On September 27, 2017, PSW's #103, #107, and #108 were interviewed. All confirmed the presence of the urine odour in the room and all stated this had been an ongoing issue for an extended amount of time. Each PSW indicated they felt the odour was related to the presence of the fall prevention mats which were placed on the floor beside the resident bed.

On September 27, 2017, Housekeeping staff #109 was interviewed and stated the urine odour had been ongoing despite daily cleaning of the room and the fall prevention mats. The housekeeping staff member showed this inspector the cleaning products used: Ecolab 125 was being used for the floors and fall mats and Ecolab 456 was used for the furniture and contact surfaces in the room. Both products were labelled as disinfectants and odour removers. #109 stated the floor mats were cleaned daily in addition to the regular cleaning of the room. The staff member added, she believed the registered staff had been asked to replace the fall prevention mats, but was unsure if this had occurred. Additionally, #109 stated she believed the source of the odour was the area of the floor beneath the fall mats. The housekeeper lifted the fall mats and showed the inspector areas of dark yellow staining which she indicated are not removed with regular cleaning.

The DOC was interviewed and stated she was aware of the issue related to the urine odours in this room. She stated the staff had replaced the fall mats and were using deodorizing bags in the bedside commode to control the odours. The DOC was unaware that this strategy had not been effective and that the urine odours were still present.

Housekeeping Manager #112 was interviewed and asked to describe the home's process for addressing incidents of lingering offensive odours. He indicated all staff have access to the on-line maintenance care system to report any housekeeping issues. A ticket is then generated and the issue is addressed. He indicated the home has a number of strategies to address odours including increased cleaning of a resident room and high level cleaning. He indicated if these strategies are not effective, the home will further investigate until the source of the odour is determined and removed. He stated this can include replacement of resident furniture, flooring and walls. #112 checked the maintenance log and there had been no notifications in regards to the odours associated with the specified resident room.

The licensee has failed to ensure the procedures used in the home to address the

lingering offensive odours in the specified resident room were fully implemented. [s. 87. (2) (d)]

Issued on this 6th day of October, 2017

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HEATH HEFFERNAN (622), DARLENE MURPHY (103), JESSICA PATTISON (197)
Inspection No. / No de l'inspection :	2017_520622_0032
Log No. / No de registre :	014837-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 6, 2017
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 :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee shall ensure that there is a Director of Nursing and Personal Care who works regularly in that position on site at the home at least 35 hours per week.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Director of Care works regularly in that position on site at the home for the following amount of time per week; in a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

Providence Manor is a 243 bed nursing home requiring each the Director of Care (DOC) and the Administrator to work regular hours in those positions of at least 35 hours per week.

During an interview with inspector #622 on September 27, 2017 the DOC/Interim Administrator indicated the Administrator had been off work since July 6, 2017 and she assumed the interim position of Administrator as well as

her usual position of DOC on July 10, 2017. The DOC/Interim Administrator indicated she had not worked the 35 hours weekly required for each of the Administrator and DOC positions for a home of that size.

A review of the wage adjustment letter to the Director of Care from the CEO indicated that the DOC had assumed additional responsibilities by assuming the responsibility of the Vice President of Long Term Care (Administrator's) role in their absence and pay would be retroactive to July 24, 2017.

During an interview with inspector #622 on September 28, 2017 at 1546 hours, the CEO indicated the Administrator had been off work since early July 2017 and they did not have a date of return. The DOC was elevated to the interim Administrator position and was given the support of the Vice President of Human Resources and the CEO. The home had two Assistant Directors of Care (ADOC) that would assist the interim Administrator to manage the DOC position and the responsibility. The DOC had been working the hours of the Administrator and the ADOCs were to assist with the DOC role.

During an interview with inspector #622 on September 28, 2017 at 1625 hours, the DOC/Interim Administrator indicated that she had assumed more of the Administrator role, the two ADOCs were assisting with picking up some of the responsibilities in the DOC position. The DOC/interim Administrator further indicated the ADOCs were Registered Practical Nurses and not Registered nurses which did not meet legislative requirements. Furthermore, the DOC/interim Administrator indicated she had made an offer September 27, 2017 to an RN who had the qualifications and was willing to assume the interim DOC position. The offer of interim DOC to the RN was to start Tuesday October 3, 2017 until the Administrator returned or the home got a permanent replacement.

A compliance order is warranted given that the scope of the non-compliance is widespread; affecting all residents, and there is potential for resident harm. There is previous non-compliance in unrelated areas. (622)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 06, 2017

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

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 6th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Heath Heffernan

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