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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2017	2017_520622_0041	021576-17, 023602-17	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

HEATH HEFFERNAN (622)

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): November 8, 9, 10, 15, 2017.

Log #021576-17 related to a resident fall with injury resulting in hospital transfer and significant change in status.
Log #023602-17 related to alleged/suspected financial abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care, the Admissions and Resident Family Coordinator, the Accounting Manager, a Registered Nurse, a Registered Practical Nurse, a Police Constable, an Accounting Clerk, Personal Support Workers and a resident.

Also during the course of the inspection the inspector observed resident care and services, reviewed health records, the homes policy titled "Abuse and Neglect Free Environment" # Care-RC-1 and the homes related investigation file.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
3 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. 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. This finding of non-compliance is related to critical incident log #023602-17

The Licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents titled; Abuse and Neglect Free Environment - Number: Care-RC-1 was complied with.

The Long-Term Care Homes Act, 2007, c. 8, s. 20 (1) states that 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.

A critical incident Log #023602-17 was filed on a specified date with the Ministry of Health and Long Term Care related to misuse/misappropriation of money for resident #003.

A review of the Licensee's policy titled: Abuse and Neglect Free Environment - Number: Care-RC-1 and dated revised; on a specified date indicated the definition of financial abuse was the misuse and misappropriation of a resident's money and or property. Furthermore policy sections 7.4 and 7.12 indicated the details of the abuse investigation notes are to be documented.

A review of the home's file related to the suspected financial abuse of resident #003 which had been provided to inspector #622 by the Admissions and Resident Family Coordinator #107 contained financial records of resident #003's account at the home, eight letters sent to resident #003's Substitute Decision Maker (SDM) and one document from a collection agency. The Financial documentation indicated resident #003's account was in arrears a specified amount as of a specified date. There was no documentation of the steps taken for the investigation or any related meetings or interviews performed by the home related to the suspected financial abuse of resident #003.

During an interview with inspector #622 on November 10, 2017, Accounting Clerk #108 indicated she had informed the Admissions and Resident Family Coordinator #107 that resident #003's account had been in arrears for years. Accounting Clerk #108 was not able to say when she had reported the concern with resident #003's account to the Admissions and Resident Family Coordinator #107 as she had not documented the interaction.

During an interview with inspector #622 on November 10, 2017, the Admissions and Resident Family Coordinator #107 indicated that she had been informed by accounting clerk #108 sometime within the first week of a specified month in 2017 that resident

#003's accounts were in arrears a specified amount. The Admissions and Resident Family Coordinator #107 indicated she suspected financial abuse at that time and reported to the Administrator immediately, the Administrator scheduled a meeting for a specified date to review information related to the suspected financial abuse of resident #003. The Admissions and Resident Family Coordinator #107 indicated she had also contacted Public Guardian and Trustee for direction related to the suspected financial abuse prior to the meeting on the specified date. The Admissions and Resident Family Coordinator #107 indicated she did not know the dates that she had reported the suspected financial abuse to the Administrator or the discussion she had with Public Guardian and Trustee as she had not documented the discussions.

During an interview with inspector #622 on November 15, 2017, the Administrator indicated the meeting on the specified date was to bring all the people who had information related to the suspected financial abuse of resident #003 together so the information could be reviewed. There was no formal documentation of the meeting except she had written in her daily note book the names of the attendees and the words "police report" and "critical incident report". The Administrator also indicated they had not kept documentation for the steps that were followed for the suspected financial abuse investigation.

Therefore the licensee failed to comply with the Licensee's policy titled: Abuse and Neglect Free Environment - Number: Care-RC-1. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents titled; Abuse and Neglect Free Environment - Number: Care-RC-1 is complied with, to be implemented voluntarily.

WN #2: 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. This finding of non-compliance is related to Critical Incident log #023602-17.

The Licensee has failed to ensure that a person who had reasonable grounds to suspect that financial abuse of resident #003 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident report log #023602-17 was filed on a specified date, indicating that resident #003 had been in arrears for non- payment of his/her long term care home accounts for years. Resident #003's substitute decision maker (SDM) had been contacted numerous times for payment of resident #003's long term care home account without effect.

A review of the home's financial documents indicated as of a specified date, resident #003's account was in arrears a specified amount.

A review of eight letters addressed to resident #003's SDM indicated the home informed the SDM of the amount resident #003's account was in arrears, requested prompt attention and all accounts were due upon receipt. The letters also requested the SDM notify the business office immediately or the outstanding invoice would be referred to the collection agency and the Finance Director.

A review of the documentation from the Collection Agency which was not dated, indicated the original invoice date was on a specified date.

During an interview with inspector #622 on November 10, 2017, Accounting Clerk #108 indicated resident #003 was a specified amount of money in arrears. The SDM had been sent multiple letters indicating the home required follow up related to resident #003’s past due account, the home had only received two payments which had been applied to a specified date's account. Accounting Clerk #108 further indicated she had informed the Admissions and Resident Family Coordinator #107 of the account status for resident #003 however had not documented the date.

During an interview with inspector #622 on November 10, 2017, the Admissions and Resident Family Coordinator #107 indicated that she had been informed by accounting clerk #108 within the first week of a specified month that resident #003’s accounts were in arrears a specified amount. The Admissions and Resident Family Coordinator #107 indicated she questioned financial abuse at that time and reported to the Administrator immediately. The Administrator had suggested a meeting with Accounting Clerk#108, Manager of Accounting Services #109 on a specified date. Furthermore the Admissions and Resident Family Coordinator #107 indicated the suspicion of financial abuse involving resident #003 should have been reported immediately to the Ministry of Health and Long Term Care when it was discussed at the meeting on the specified date.

During an interview with inspector #622 on November 15, 2017, the Administrator indicated the home had discussed the suspected financial abuse of resident #003 during a meeting held on a specified date. During that meeting it had been decided the police would be notified and a Critical Incident would be submitted to the Ministry of Health and Long Term Care. The Administrator indicated that the suspected financial abuse of resident #003 should have been reported immediately but the Ministry of Health and Long Term Care had not been notified until a specified date 11 days after the meeting. [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 a person who has reasonable grounds to suspect that financial abuse of resident has occurred, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: 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. This finding of non-compliance is related to Critical Incident Log #023602-17

The Licensee has failed to ensure that the appropriate police force was immediately notified of the suspected incident of financial abuse of resident #003 that the licensee suspected may constitute a criminal offence.

Critical Incident Log #023602-17 for Misuse/Misappropriation of a resident's money that was filed on a specified date, indicated resident #003 had been in arrears for non-payment of his/her long term care home accounts for years. Resident #003's substitute decision maker (SDM) had been contacted numerous times for payment of resident #003's long term care home account without effect. The CIS report indicated the police had been notified however did not indicate a date.

During an interview with inspector #622 on November 10, 2017, the Admissions and Resident Family Coordinator #107 indicated that she had been informed by accounting clerk #108 within the first week of a specified month that resident #003's accounts were in arrears a specified amount and questioned financial abuse at that time. The Admissions and Resident Family Coordinator #107 indicated the Administrator suggested a meeting be held to review information related to the suspected financial abuse of resident #003 on a specified date where it was decided the police would be notified. Furthermore, the Admissions and Resident Family Coordinator #107 indicated she had not reported the suspected financial abuse of resident #003 to the police unit until 11 days after the meeting on a specified date when she received direction from the Administrator.

During an interview with inspector #622 on November 15, 2017, the Administrator indicated the home had discussed the suspected financial abuse of resident #003 during a meeting held on a specified date. During that meeting it had been decided the police would be notified. The Administrator indicated the police were not notified of the suspected financial abuse of resident #003 until 11 days after the meeting. [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 suspected incidents of financial abuse that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. This finding of non-compliance is related to critical incident log #021576-17

The licensee has failed to ensure that the written report to the Director of the Ministry of Health and Long Term Care related to an incident which resulted in an injury and transfer to hospital with significant change in status for resident #001 had been updated to include the outcome or current status of the resident.

A review of Critical Incident log #021576-17 submitted on a specified date indicated on a specified date, resident #001 had fallen. Resident #001 was assessed by RN #105 and was noted to experience pain. Further assessment indicated a possible injury. The resident’s substitute decision maker was informed and approved the transfer to hospital for further investigation. It was confirmed that resident #001 had a specified injury. The CIS report indicated resident #001 was currently at the hospital and the home had not received any message regarding admission or transfer back at that time. No amendments had been made to critical incident report by the nursing home.

A review of the Ministry of Health and Long Term Care online documentation for critical incident log #021576-17 indicated there had been a request to the nursing home for an amendment of the critical incident on a specified date which included an update of resident #001's status upon return from the hospital.

During an interview with inspector #622 on November 9, 2017, the Administrator indicated she had missed completing an amendment for CIS report #C553-000016-17 and as a result information related to resident #001’s condition upon return from the hospital had not been updated.

Therefore the Licensee failed to ensure that the written report to the Director of the Ministry of Health and Long Term Care related to an incident which resulted in an injury and transfer to hospital with significant change in status for resident #001 had been updated to include the outcome or current status of the resident. [s. 107. (4) 3.]

Issued on this 22nd day of November, 2017

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

Original report signed by the inspector.