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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 2, 2019	2018_505103_0035	031214-18	Critical Incident System

Licensee/Titulaire de permis

Providence Care Centre
752 King Street West KINGSTON ON K7L 4X3

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): November 28, 29, December 12, 13, 14, 17, 18, 19, 20, 2018.

Log #031214-18 (CIS# C553-000032-18)-alleged incident of resident to resident abuse.

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

During the course of the inspection, the inspector reviewed resident health care records including hospital records related to this incident, the investigation into the alleged incident, interventions put into place to safeguard residents, and the abuse policy.

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.
- **3 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	Légende 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure appropriate action was taken in response to every incident of alleged abuse.

On a specified date, on or about 0030 hour, resident #001 was observed by PSW #104 entering resident #002's room. PSW #104 was interviewed and indicated they observed resident #001 standing at resident #002's bedside. PSW #104 stated resident #001 was holding resident #002's blankets up, indicated they were just saying good night and that resident #002 remained asleep. PSW #104 stated resident #001 was redirected out of the room with resistance. The incident was reported to RPN #105 who in turn reported it to RN #106. The staff were directed by the RN to document the incident and to monitor resident #001.

On the same identified date, on or about 0600 hour , RPN #105 was asked by PSW #104 to assess resident #001 for a specified complaint. RPN #105 was interviewed and stated while in resident #001's room, the resident began asking numerous questions about resident #002. During that conversation, RPN #105 stated they became concerned about the type of questions and reported their concerns to RN #106.

RN #106 was interviewed and indicated they spoke with resident #001 on the identified date, on or about 0615 hour, after being notified by RPN #105 of their concerns. During RN #106's conversation with resident #001, the resident stated to RN #106 they had been involved in a specified sexual act with resident #002. RN #106 stated they notified

ADOC #107 by telephone immediately following the conversation with resident #001. RN #106 indicated they were advised by ADOC #107 to monitor resident #001 and to remain in the home until they arrived.

ADOC #107 was interviewed and stated upon being notified by RN #106 of the alleged abuse, they advised the staff to place resident #001 on every thirty minute checks and asked RN #106 to remain in the home. ADOC #107 indicated they arrived at the home at approximately 0800 hour and later became aware resident #001 had subsequently left the unit and attended a specified activity with co-residents on another floor of the home. None of the staff interviewed were able to identify how or when the resident left the unit.

Administrator #109 was interviewed and stated they were unable to determine how resident #001 left the unit following the alleged incident and that constant monitoring of resident #001 would have been a more effective means of safeguarding the residents in the home.

The licensee failed to ensure appropriate action was taken in response to every incident of alleged abuse. [s. 23. (1) (b)]

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 appropriate actions are taken in response to every incident of alleged resident abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure strategies were developed and implemented to respond to resident #001's responsive behaviours.

As outlined in WN #1, an alleged incident of resident to resident abuse occurred involving resident #001 and resident #002 on a specified date. During interviews with PSW #104, PSW #110, RPN #105 RPN #103, and ADOC #107, all reported resident #001 had known prior incidents, as recent as one week earlier of entering resident rooms of the opposite gender and that the behavior had been present since admission to the home.

Resident #001's health care record was reviewed including the resident's plan of care. There were no strategies developed or implemented until after the documented incident on the specified date to address or mitigate the risk to residents related to this responsive behavior.

The licensee failed to ensure strategies were developed and implemented to respond to resident #001's known responsive behaviours. [s. 53. (4) (b)]

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 strategies are developed and implemented to respond to resident #001's responsive behaviours, 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. A person who had reasonable grounds to suspect there had been an abuse of a resident failed to immediately report the suspicion and the information upon which it was based to the Director (Ministry of Health and Long-Term Care).

As outlined in WN #1, an alleged incident of resident to resident abuse occurred involving resident #001 and resident #002 on a specified date.

RN #106 was interviewed and indicated they came to speak with resident #001 on the specified date, on or about 0615 hour after being notified by RPN #105 of their concerns. During RN #106's conversation with resident #001, the resident stated to RN #106 they had been involved in a specified sexual act with resident #002. RN #106 stated they notified ADOC #107 by telephone immediately following the conversation with resident #001.

ADOC #107 was interviewed and stated they were notified of the alleged incident of abuse on or about 0645 hour by RN #106 and they notified DOC #108 on or about 0730 hour. ADOC #107 indicated they attended the home and notified the police on or about 0800 hour. ADOC #107 stated they notified the Director (MOHLTC) of this alleged resident abuse for the first time by contacting the after-hours pager at approximately 1200 hour. According to the ADOC #107, they had been unable to call the Director (MOHLTC) prior to this time and did not delegate this to either RN #106 or DOC #108.

A person who had reasonable grounds to suspect there had been an abuse of a resident failed to immediately report the suspicion and the information upon which it was based to the Director.

At the time of this alleged incident of resident abuse, the home had a compliance order in place related to the late reporting of alleged incidents of resident abuse to the Director (MOHLTC). Order #001 was issued under LTCHA, 207, s. 24 during inspection #2018_505103_0024 and had a compliance date of November 30, 2018. [s. 24. (1)]

Issued on this 3rd day of January, 2019

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

Original report signed by the inspector.