Ontario

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 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
Jul 26, 2019	2019_505103_0018	007005-19, 009669-19	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): June 20, 21, 24, 25, 27, July 2-5, 8-11, 2019.

Log #007005-19 (CIS #C553-000012-19) and Log #009669-19 (CIS #C553-000022-19)- resident falls that resulted in an injury.

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

During the course of the inspection, the inspector reviewed resident health care records and made resident observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in resident #002’s plan of care was provided to the resident as specified in the plan.

Resident #002’s plan of care related to fall prevention was reviewed and indicated the following:
Resident is high risk for falls; bed alarm-ensure it is on and working when in bed; ensure both fall mats are at bedside when in bed; one on either side of the bed.

On an identified date, resident #002 was found on the floor beside their bed. RPN #102 was interviewed and stated they had been notified of the fall and had assessed the resident. RPN #102 stated the resident's bed alarm did not ring to alert staff to the fall and the resident had fallen onto the side of the bed without a fall mat. RPN #102 stated they recalled seeing a second fall mat rolled up in the corner of the room.

ADOC #103 stated RN #101 had reassessed resident #002 on the following shift for an injury to an identified area they believed was as a result of the fall. ADOC #103 further stated at the time of the fall, it was determined the resident bed alarm was not plugged in and the fall mats were not in place as outlined in the resident plan of care. ADOC #103 stated all staff are expected to ensure resident fall prevention measures are in place and in good working order at the beginning of each shift.

The licensee failed to ensure resident #002’s plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 resident #002's fall prevention measures are in place in accordance with the resident's plan of care, to be implemented voluntarily.

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.