Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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 14, 2020	2019_664602_0051	021345-19, 021520-19, 021724-19, 023154-19	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

WENDY BROWN (602)

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): December 9 - 13, 17 & 20, 2019

Four critical incidents were inspected as follows:
Log #021520-19/CIS #C553-000076-19 - regarding a fall with injury and transfer to hospital.
Log #023154-19/CIS #C553-000085-19 - regarding a missing resident.
Log #021345-19/CIS #C553-000071-19 - regarding alleged staff to resident emotional abuse.
Log #021724-19/CIS #C553-000077-19 - regarding alleged staff to resident verbal and emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Social Worker (SW), an Occupational Therapy Assistant (OTA), a resident advocate, the Recreation and Volunteer Coordinator, Personal Support Workers (PSW), reception staff and residents.

As part of the inspection electronic and hard copy health records were reviewed, multiple observations of care and service delivery were made and numerous staff interviews were completed; relevant policies and procedures were also considered.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident for transfers.

On a specified date, resident #002 had a witnessed fall. The resident was immediately assessed and was noted to be experiencing pain; orders to treat pain and complete xrays were obtained. Xray results revealed an injury requiring hospitalization and treatment.

A review of resident #002's plan of care updated on a specified date indicated care was to be completed by a two (2) persons/staff.

On a subsequent specified date, care information indicated care required one (1) person/staff. In an interview with the Assistant Director of Care (ADOC) #102 it was indicated that the plan of care should have been updated to reflect the change in care interventions to require 1 vs. 2 staff assist. Resident #002's written plan of care did not set out clear direction to staff. [s. 6. (1) (c)]

WN #2: 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. The licensee has failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

On a specified date the Director of Care (DOC) #101 was informed by Social Worker (SW) #103 of three (3) staff members resident #009 alleged had been abusive towards them. The resident indicated the staff consistently ignored a specific request.

The licensee policy "Abuse and Neglect Free Environment" CARE-RC-1, revised September 26, 2019 indicates under procedure that:
- Item 2. - page six (6): The attending physician is immediately contacted.
Interviews with the ADOC #102, a review of resident #009's electronic record and the Critical Incident System (CIS) report indicated that although the physician was aware of the resident's request(s), there was no immediate contact with the physician regarding resident #009's allegation of abuse by the 3 staff.
- Item fourteen (14). - page ten(10): Upon completion of the investigation the resident and the Substitute Decision Maker are notified of the results immediately .
DOC #101 advised inspector #602 that they did not have a discussion with the resident as to the results of the investigation, rather, a Registered Nurse (RN) was to make the resident aware of planned interventions specific to their specific request(s)
- Item seventeen (17). - page 10: The CIS report is updated within 10 days to include the results of the investigation and action taken.
The report was updated by DOC #101 within 10 days, however, the update did not include the names of the 3 staff involved and/or whether an interview/re-education was completed with the third staff member. [s. 20. (1)]

2. On a specified date, DOC #101 was informed that Personal Support Worker (PSW) #113 had been verbally abusive with resident #008.
The licensee policy "Abuse and Neglect Free Environment" CARE-RC-1, revised September 26, 2019 indicates under procedure that:

- Item 2. - page 6: The attending physician and the resident's SDM/POA are immediately contacted.
Contact with the DOC #101, a review of resident #008's electronic record and the CIS report indicated that neither the physician nor the POA were contacted. The DOC left a message with the resident's POA indicating there had been an incident at the home; another message was left on a subsequent date detailing that a non-urgent incident had occurred and that the home could be contacted should the POA wish an explanation.
- Item 14. - page 10: upon completion of the investigation the resident and the Substitute Decision Maker are notified of the results immediately .
The DOC #101 left a phone message with resident #008's POA inviting them to contact DOC for an explanation of a non-urgent incident involving resident #008. There was no further contact with the POA, nor was there follow up as to the completion of the investigation with the resident or their POA.
- Item 17. - page 10: the CIS report is updated within 10 days to include the results of the investigation and action taken.
The report was updated by the DOC #101, however, the results of the investigation and action taken with PSW #113 were not included on the amended report..

The licensee failed to ensure compliance with their Abuse and Neglect Free Environment policy in 2 separate critical incidents. [s. 20. (1)]

WN #3: 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 has failed to ensure that appropriate action was taken in response to an allegation of emotional abuse.

On a specified date, DOC #101 was notified by SW #103 that resident #009 disclosed the names of 3 staff who they alleged had been emotionally abusive. According to the CIS report and contact with DOC #101, a meeting was held with PSW #119 and Registered Practical Nurse (RPN) #117 to review the allegation of emotional abuse/neglect. Education was provided specific to managing behaviours; staff were also reminded of their recent abuse training and how language could be perceived as inappropriate if words were not chosen properly. Prior to this meeting, however, both RPN #117 and PSW #119 worked on resident #009's unit, exposing the resident to possible contact with the staff prior to completion of the investigation, review of emotional abuse/neglect training and appropriate response(s) to behaviours. Similarly, PSW #118 worked prior to their meeting with DOC #101 where their re-education included reminders that their response to the resident could "constitute neglect, ... carry the consequence of progressive discipline, ... and re- instruction about supportive means by which [the staff should] address resident needs constructively and lawfully".

The licensee failed to ensure completion of the investigation and re-education as to emotional abuse/neglect occurred prior to allowing the staff to resume caring for/working with resident #009. [s. 23. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

On a specified date, DOC #101 received a report that resident #009 disclosed the names of 3 staff who they alleged had been emotionally abusive. The names of the 3 staff involved in the incident were not included on the original CIS report.

On a specified date, the Centralized Intake, Assessment and Triage Team (CIATT) requested that the CIS report be amended to include the names of all staff involved in the incident. The report was updated by DOC #101 on two subsequent date; no staff names were included.

The licensee failed to include the names of the staff members involved in the incident. [s. 104. (1) 2.]

Issued on this 14th day of January, 2020

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

Original report signed by the inspector.