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**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 1, 2020 | 2020_505103_0006 | 023962-19 | Complaint |

### 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 Complaint inspection.**

**This inspection was conducted on the following date(s): March 2-5, 9-13, off site March 16, 2020**

**Log #023962-19-complaint related to resident care.**

**During the course of the inspection, the inspector(s) spoke with a resident, Registered Practical Nurses (RPN), Registered Nurses (RN), the Nurse Practitioner (NP), the Physiotherapist (PT), a Physiotherapy assistant (PTA), the Registered Dietitian (RD), the Assistant Director of Care (ADOC), the interim Director of Care and the Administrator.**

**During the course of the inspection, the inspector reviewed resident health care records and the licensee's complaint process and documented record of complaints.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**
**Pain**
**Reporting and Complaints**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**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 has failed to ensure resident #001's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of resident #001's plan of care.

On an identified date, RPN #107 documented resident #001 had developed an area of impaired skin integrity and that a protective dressing was applied.

Three days later, resident #001's SDM emailed RN #101 and stated they were unaware of the skin impairment until they provided assistance with the resident's care the previous day. RN #101 was interviewed and stated they addressed the email with resident #001's SDM and apologized for staff failing to promptly inform them of the skin impairment. RN #101 stated the resident's SDM should have been notified at the time the skin impairment was discovered. [s. 6. (5)]

2. The licensee has failed to ensure care set out in the plan of care was provided to resident #001 as specified in the plan.

A Direct Observation System (DOS) was ordered to be completed for three days to assess the effectiveness of resident #001's pain management regime. The DOS was reviewed and a legend with codes was included at the top of the DOS to describe any evidence of pain and to reflect times when the resident appeared to be comfortable. Throughout the observation period, there were several identified periods of time where there was no documentation to reflect the resident's level of pain management.

RN #101 and NP #102 were interviewed in regards to the process for the completion the DOS. Both staff members indicated the tool should be completed for each half hour interval using the legend codes at the top of the DOS to capture a complete and accurate picture of the resident's pain control throughout the day and night.

Staff failed to ensure care set out in the plan of care was provided to resident #001as specified in the plan. [s. 6. (7)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

On an identified date, resident #001 was prescribed an analgesic thirty minutes before morning care daily. Resident #001's electronic medication administration record (eMAR) and their progress notes were reviewed. Resident #001 did not receive the injection as prescribed and there was no documentation to reflect the reason the injection was not given.

On another identified date, resident #001 was prescribed an analgesic fifteen to thirty minutes prior to morning and evening care. Resident #001’s eMAR and their progress notes were reviewed. Resident #001 did not receive the injection prior to staff completing the evening care and there was no documentation to reflect the reason the injection was not given. [s. 131. (2)]

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**Issued on this 1st day of April, 2020**

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

**Original report signed by the inspector.**