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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2020	2020_520622_0011	009737-20, 009863-20	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

HEATH HEFFERNAN (622)

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): July 27, 28, 29, 30, 31, 2020 and August 4, 5, 6, 2020.

Complaint log #009863-20 - related to an incident that caused injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health status and resident care and services.

Critical Incident log #009737-20/IL-78017-AH/CIS #3005-000013-20 related to the same incident as complaint log #009863-20.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Assistant Director of Care (ADOC), the Clinical Business and Patient Flow Manager at Providence Care, the Intake Coordinator at Providence Care, the Dietary Supervisor, Plant Services Manager, RAI Coordinator, Physiotherapist, Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

Also during the course of the inspection, the inspector reviewed electronic and hard copy health records, the licensee's summary of incident documents, the licensee's Policy # CARE-RC-22 - LOST ITEMS – LAUNDRY, documentation between the licensee and the family, the licensee's complaint tracking form, and made observations of resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 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 has failed to ensure that the care set out in the Falls Prevention plan of care for resident #001 was provided to the resident as specified in the plan.

Critical Incident System report (CIS) # 3005-000013-20, and the progress notes stated that resident #001 was found on the floor of their room, sustained injury, and the resident was transferred to the hospital.

A review of the document titled; Falling Leaf Interventions for resident #001 indicated that the resident was to use a specified device.

During an interview with inspector #622, PSW #107 stated that they had provided care for resident #001 and placed them in a chair in their room prior to the fall. PSW #107 stated they had not placed the specified device on the resident at that time.

The Assistant Director of Care (ADOC) #102 and lead of the Falls Prevention team stated that when a resident is high risk for falls and has had 2-3 falls in a month, they are placed in the Falling Leaf program. As part of the Falling Leaf program, a Falling Leaf intervention sheet which includes the current falls prevention interventions for staff to follow would be placed in the report book and reviewed at each report. ADOC #102 stated that resident #001's Falling Leaf intervention sheet included the specified device that should have been followed when resident #001 fell. [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 that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

O. Reg. 79/10, s. 89 (1). (a) (iv). states, as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, there is a process to report and locate residents' lost clothing and personal items.

The Plant Services Manager #112 stated that accommodation services would follow corporate policies including, Policy # CARE-RC-22 - LOST ITEMS – LAUNDRY. Plant Services Manager #112 stated that this policy would include personal items and not just laundry.

The licensee's Policy # CARE-RC-22 - LOST ITEMS – LAUNDRY, stated on page 2 of 2 that the resident/POA or family would be notified if the item was not found in six weeks.

During an interview with inspector #622, the Substitute Decision Maker (SDM) for resident #001 stated that the resident had a personal item that went missing. The home had not notified them of the missing personal item until the family brought it forward three months later.

Progress notes documented by Registered Practical Nurse (RPN) #104 stated that resident #001's personal item was reported missing on a specified date. There was no documentation to indicate that the SDM was notified of resident #001's missing personal item. Three months later, resident #001's SDM spoke with staff at the home about the missing personal item.

RPN #104 and the Director of Care (DOC) #101 were interviewed separately by inspector #622. The RPN said that resident #001's SDM had not been notified of the resident's personal item when it went missing. The DOC stated that there was a policy for locating missing and lost items, and that staff would be required to notify the resident or SDM of the missing article and in this case this did not happen. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: 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:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

O. Reg. 79/10, s. 107 (4).

2. A description of the individuals involved in the incident, including,

i. names of any 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. 107 (4).

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).

4. Analysis and follow-up action, including,

i. the immediate actions that have been taken to prevent recurrence, and

ii. the long-term actions planned to correct the situation and prevent recurrence.

O. Reg. 79/10, s. 107 (4).

5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a licensee who is required to inform the Director of an incident under subsection (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:
Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

Critical Incident System report (CIS) # 3005-000013-20 was submitted for an incident which resulted in injury, a hospital transfer and a significant change in resident 001's condition. The (CIS) report was not amended to include the immediate actions to prevent recurrence or the long-term actions planned to correct the situation

During separate interviews with inspector #622, Director of Care (DOC) #101 and Assistant Director of Care (ADOC) #102, stated that the CIS report #3005-000013-20 was not amended to include the immediate or long-term actions to prevent recurrence. [s. 107. (4)]

Issued on this 2nd day of September, 2020

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

Original report signed by the inspector.