Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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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347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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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 11, 2020	2020_717531_0017	005115-20, 016317-20	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

SUSAN DONNAN (531)

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, August 4, 5, 6, 10, 11, 12, 13 14 and 17, 2020.

Log # 005115-20 related to resident care and services
Log # 016317-20 related to unexpected death of resident

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Food Services Supervisor, the Registered Dietitian (RD), the Corporate Food Services Manager(CFSM), the Nurse Practitioner (NP), and resident Substitute Decision Makers (SDM).
The inspector reviewed resident health care records, observed resident care and services, observed meal service, staff to resident interactions, and observed residents environment.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
1 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 failed to ensure that the written plan of care related to the texture modified diet for a resident, sets out clear direction to staff and others who provide care to the resident.

On an identified date, PSW #107 was seated between the resident and a co-resident monitoring the residents during the evening meal.
The PSW turned to respond to a co-resident, turned back and noted the resident slumped over and drooling. The PSW notified the RPN who was preparing medication in the corridor a few feet away. RPN #109 noted the resident was pale and unresponsive and provided emergency assistance with the aide of PSW #107,108 and RPN #111. The RN supervisor had been immediately notified of the situation and went to aide RPN #109 and RPN #111. The resident was transferred to their room where further emergency response measures were performed by the registered staff and the Nurse Practitioner. The emergency response measures were unsuccessful. The coroner’s preliminary report indicated that the resident had choked.

As per the resident's nutritional status the resident was on a regular diet with cut-up meat. The plan of care identified that the resident’s ability to participate in eating fluctuated. No further directions were provided to staff related to the interventions associated with the provision of a regular diet with cut-up meat.

During a discussion with inspector #531, PSW #107 and 108, told the inspector that the resident, had been prescribed a regular diet with cut-up meat. PSW #107 told the inspector that the evening of the incident the resident had been served an entree of beef stew. The PSWs further indicated that the resident required monitoring with assistance when they experienced difficulty. The PSWs advised that a large piece of meat would be cut up for the resident. The PSWs said that they would cut the meat into bite size pieces, however the description of bite size as demonstrated was inconsistent.
During an interview with the Registered Dietitian (RD), the RD indicated that the resident was prescribed a regular diet with cut-up meat. The RD further indicated that the expectation would be to cut the meat into bite size pieces of approximately 2.5 cm. In addition the RD indicated that the plan of care did not provide clear direction specific to the resident's regular diet with cut-up meat.

The licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide care to residents, specifically to the provision of a regular diet with cut-up meat. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 14th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care	Ministère des Soins de longue durée
Order(s) of the Inspector	**Ordre(s) de l'inspecteur**
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8	Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2020_717531_0017
Log No. / No de registre :	005115-20, 016317-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 11, 2020
Licensee / Titulaire de permis :	Providence Care Centre 752 King Street West, KINGSTON, ON, K7L-4X3
LTC Home / Foyer de SLD :	Providence Manor 275 Sydenham Street, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Krystal Mack

To Providence Care Centre, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with the LTCHA 2007, s. 6 (1) c
Specifically the licensee shall:
a) Ensure that the plan of care sets out clear direction for all residents identified to receive a regular diet with cut-up meat.
b) Review with all staff that provide feeding assistance, the appropriate dimensions for cut-up meat and clearly define bite size pieces. Measure the adherence to cutting up of meat on a weekly basis until adherence is demonstrated and take necessary corrective actions if staff do not adhere to the established dimensions.
c) A written record must be kept of all actions taken by the licensee under section b.

Grounds / Motifs :

1. The licensee failed to ensure that the written plan of care related to the texture modified diet for a resident, sets out clear direction to staff and others who provide care to the resident.

On an identified date, PSW #107 was seated between the resident and a co-resident monitoring the residents during the evening meal.
The PSW turned to respond to a co-resident, turned back and noted the resident slumped over and drooling. The PSW notified the RPN who was preparing medication in the corridor a few feet away. RPN #109 noted the resident was pale and unresponsive and provided emergency assistance with the aide of PSW #107,108 and RPN #111. The RN supervisor had been immediately

notified of the situation and went to aide RPN #109 and RPN #111. The resident was transferred to their room where further emergency response measures were performed by the registered staff and the Nurse Practitioner. The emergency response measures were unsuccessful. The coroner's preliminary report indicated that the resident had choked.

As per the resident's nutritional status the resident was on a regular diet with cut-up meat. The plan of care identified that the resident's ability to participate in eating fluctuated. No other directions were provided to staff related to the interventions associated with the provision of a regular diet with cut-up meat.

During a discussion with inspector #531, PSW #107 and 108 told the inspector that the resident, had been prescribed a regular diet with cut-up meat. PSW #107 told the inspector that the evening of the incident the resident had been served an entree of beef stew. The PSWs further indicated that the resident required monitoring with assistance when they experienced difficulty. The PSWs advised that a large piece of meat would be cut up for the resident. The PSWs said that they would cut the meat into bite size pieces, however the description of bite size as demonstrated was inconsistent.
During an interview with the Registered Dietitian (RD), the RD indicated that the resident was prescribed a regular diet with cut-up meat. The RD further indicated that the expectation would be to cut the meat into bite size pieces of approximately 2.5 cm. In addition the RD indicated that the plan of care did not provide clear direction specific to the resident's regular diet with cut-up meat.

The licensee failed to ensure that the plan of care sets out clear direction to staff and others who provide care to residents, specifically to the provision of their regular diet with cut-up meat.

The severity of this issue was determined to be a level 3 as there was actual harm.
The scope was a level one, isolated.
The home had a level 2 Compliance History, with non-compliance being issued under a different subsection.
- LTCHA s.6 (7) and s. 6 (5)

(531)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 11th day of September, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Susan Donnan

Service Area Office / Bureau régional de services : Ottawa Service Area Office