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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347 Preston St Suite 420
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Telephone: (613) 569-5602
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347 rue Preston bureau 420
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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 |
|---|---|---|---|
| Sep 16, 2021 | 2021_779641_0028 | 008340-21, 009259-21, 010805-21, 011453-21, 012548-21, 013050-21 | 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

CATHI KERR (641)

## 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): August 17, 18, 19, 20, 24, 25, 26, 27, 31, September 1, 2, 2021.**

**This inspection was conducted in reference to intake logs #008340-21, CIS #3005-000036-21, #009259-21, CIS #3005-000040-21, #011453-21, CIS #3005-000050-21, and #010805-21, CIS #3005-000046-21 related to alleged resident abuse; and log #012548-21, CIS #3005-000053-21 related to a resident having fallen sustaining an injury; and log #013050-21, CIS #3005-000057-21 related to a resident sustaining an injury of unknown causes.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Environmental Service Manager, Registered Nurses, the Infection, Prevention and Control Lead, Registered Practical Nurses, Personal Support Workers, Housekeeping staff, Maintenance staff, family and residents.**

**During this inspection, the Inspector completed a tour of the home, observed residents' environments, the provision of care and services to residents, reviewed relevant resident health care records, and policies and procedures related to Zero tolerance of Abuse and Neglect, Falls Prevention, Bed Safety, Responsive Behaviours, Infection Prevention and Control and Cooling and Air Temperatures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)**
**1 VPC(s)**
**1 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. |

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**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home is a safe and secure environment for the resident.

The Licensee submitted a critical incident report which indicated that a resident had fallen out of the bed sustaining an injury.
Inspector #641 interviewed staff who were present at the time of the incident, who indicated that when the resident was found injured on the floor, the bed was in a high position. All staff interviewed including management indicated that the resident had been observed with the bed elevated to its highest position on multiple occasions. The Assistant Director of Care advised that the licensee didn't have a policy related to the safe use of the height adjustable bed, nor did they do an assessment as to the resident's cognitive ability to safely use the height adjustable bed.

Sources: Interviews with staff, resident, the Director of Care and the Assistant Director of Care; policies and procedures related to bed safety; observations of the resident's bed and SPAN bed user manual. [s. 5.]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature**

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

**s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the temperature in the home was maintained at a minimum 22 degrees Celsius.

Inspector #641 observed the temperature logs maintained by the licensee for the designated cooling areas, two residents' rooms, and common areas on each unit. It was noted by the Inspector that multiple temperatures recorded in the logs for the months of July and August were documented to be below 22 degrees Celsius on multiple locations on multiple days, some as low as 18.28 degrees Celsius.

During an interview with Inspector #641, the Environmental Service Manager (ESM), indicated that the temperatures were recorded electronically, and were deemed to be accurate. The ESM advised that there was an alert on the system but currently no one was being notified if the temperatures were not within the appropriate range.
This posed a risk to the residents as the staff were unaware when the temperatures were below 22 degrees Celsius.

Source: Interviews with staff, residents, the Director of Care and the Environmental Service Manager; policies and procedures related to heat related illness and air conditioning units; observations of temperatures logs. [s. 21.]

2. The licensee failed to ensure that the temperature is measured and documented in writing at a minimum at least once every morning, once every afternoon between 12 pm and 5 pm and once every evening or night.

During an interview with Inspector #641, the Environmental Service Manager (ESM), indicated being aware that the licensee was currently not in compliance as they were not recording temperatures three times per day as required. The ESM advised that the automated system was documenting the temperatures in the morning and the afternoon only. The home had recently implemented having a Registered nurse taking the temperatures on midnights, but only in the two residents' rooms. This was on the weekend only. The ESM stated that no one was taking the temperatures during the nights from Monday to Friday in these rooms or in any of the cooling areas. This posed a risk to the residents as the staff were unaware what the temperatures were during these times and if they were being maintained above 22 degrees Celsius.

Source: Interviews with staff, residents, the Director of Care and the Environmental

Service Manager; policies and procedures related to heat related illness and air conditioning units; observations of temperatures logs. [s. 21. (3)]

***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 temperature in the home is maintained at a minimum 22 degrees Celsius and that the temperature is measured and documented in writing at a minimum at least once every morning, once every afternoon between 12 pm and 5 pm and once every evening or night, to be implemented voluntarily.***

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**Issued on this 17th day of September, 2021**

**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

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

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**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | CATHI KERR (641) |
| **Inspection No. / No de l’inspection :** | 2021_779641_0028 |
| **Log No. / No de registre :** | 008340-21, 009259-21, 010805-21, 011453-21, 012548-21, 013050-21 |
| **Type of Inspection / Genre d’inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 16, 2021 |
| **Licensee / Titulaire de permis :** | Providence Care Centre<br>752 King Street West, Kingston, ON, K7L-4X3 |
| **LTC Home / Foyer de SLD :** | Providence Manor<br>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:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

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**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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

**Order / Ordre :**

The licensee shall be compliant with O. Reg. 79/10, s.5.

Specifically, the licensee shall ensure that:
1. The resident shall have a documented interdisciplinary assessment completed to ensure their safe use of their height adjustable bed.
2. If a risk is identified as a result of this assessment, ensure all interventions are clearly documented in the resident's plan of care to ensure resident safety related to the use of the height adjustable bed.
3. Audits shall be conducted at a minimum weekly, of the resident while they are in bed, to ensure their safety with respect to the height adjustable bed, until such time the management team determines the resident is being safeguarded and the auditing is no longer required.
4. Maintain documented records to support each step taken to achieve compliance with this order.

**Grounds / Motifs :**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

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

1. The licensee failed to ensure that the home is a safe and secure environment for the resident.

The Licensee submitted a critical incident report which indicated that a resident had fallen out of the bed sustaining an injury.
Inspector #641 interviewed staff who were present at the time of the incident, who indicated that when the resident was found injured on the floor, the bed was in a high position. All staff interviewed including management indicated that the resident had been observed with the bed elevated to its highest position on multiple occasions. The Assistant Director of Care advised that the licensee didn't have a policy related to the safe use of the height adjustable bed, nor did they do an assessment as to the resident's cognitive ability to safely use the height adjustable bed.

The decision to issue a Compliance Order (CO) was based on the following: The severity of this incident resulted in actual harm to the resident. The scope was identified as isolated. The home did not have related compliance history with this section of the LTCHA in the last 36 months.

Sources: Interviews with staff, resident, the Director of Care and the Assistant Director of Care; policies and procedures related to bed safety; observations of the resident's bed and SPAN bed user manual. (641)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Sep 27, 2021

## 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON  M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 16th day of September, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Cathi Kerr

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