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
Nov 8, 2021	2021_505103_0011	013340-21, 014839-21, 014842-21, 015000-21, 015399-21, 015811-21, 016973-21	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

DARLENE MURPHY (103)

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): October 27-29, November 1-4, 2021.

Log #013340-21 (CIS#3005-000058-21) and Log #015811-21 (CIS#3005-000064-21)-alleged incidents of resident to resident abuse,
Log #015000-21 (CIS#3005-000061-21) -incident of resident elopement,
Log #014839-21 (CIS #3005-000059-21) and Log #016973-21 (CIS #3005-000067-21)-resident falls,
Log #015399-21 (CIS #3005-000062-21)-alleged staff to resident abuse, and
Log #014842-21-follow-up to Compliance Order issued during inspection #2021_779641_0028.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the lead for Infection, Prevention and Control (IPAC), a screener, dietary aides, the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector reviewed the critical incidents submitted, resident health care records, made observations of residents and resident care, resident dining, and IPAC protocols currently in place.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
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)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2021_779641_0028	103

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Persons who had reasonable grounds to suspect residents were victims of abuse which resulted in injuries failed to immediately report the suspicion and the information upon which it was based to the Director.

A resident was pushed and injured by another resident. The ADOC stated the incident should have been immediately reported to the Ministry of Long-term care (MLTC), but believes it was an oversight that it did not get reported. [s. 24. (1)]

2. Staff observed a resident standing over another resident who stated they were being hurt. Following the incident, the resident was found to have an injury. The charge RN was notified of the incident but the critical incident report was not submitted until six days later.

Sources: resident progress notes, the critical incident report and staff interviews. [s. 24. (1)]

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 a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm to the resident are immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate police force was immediately notified of incidents of resident abuse that the licensee suspected constituted a criminal offence.

As outlined in WN #1, a resident was pushed and injured by another resident. The police were not notified of this incident of alleged resident to resident abuse despite the home acknowledging the incident should have been reported. [s. 98.]

2. As outlined in WN #1, staff observed a resident standing over another resident who stated they were being hurt. Following the incident, the resident was found to have an injury. The charge RN was notified of the incident but the police were not notified of the incident until six days later.

Sources: resident progress notes, the critical incident report , interviews with ADOC and DOC. [s. 98.]

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 any alleged, suspected or witnessed incidents of resident abuse that the licensee suspects may constitute a criminal offence are immediately reported to the appropriate police force, to be implemented voluntarily.

Issued on this 9th day of November, 2021

[redacted]

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

Original report signed by the inspector.