Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: June 12, 2023	
Inspection Number: 2023-1502-0005	
Inspection Type: Critical Incident System	
Licensee: Providence Care Centre	
Long Term Care Home and City: Providence Manor, Kingston	
Lead Inspector Kayla Debois (740792)	**Inspector Digital Signature** Kayla L Debois Digitally signed by Kayla L Debois Date: 2023.06.14 15:39:29 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23-26, 29-31, and June 1, 5, 2023

The following intakes were inspected:
• Intake: #00020477 - [CI: 3005-000017-23] Staff to resident alleged abuse
• Intake: #00084319 - [IL-11467-AH/CI: 3005-000032-23] and #00087951 - [CI: 3005-000041-23] Resident to resident alleged physical abuse
• Intake: #00085913 - [CI: 3005-000036-23] Fall of resident with injury

The following intakes were completed in this inspection: Intake #00021406, CI: 3005-000022-23; Intake #00084022, CI: 3005-000028-23 were related to falls.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

Rationale and Summary:
Two resident's physician's orders and electronic medication administration records (eMAR) stated 1:1 close monitoring between identified hours, initiated on a day in May 2023. An e-mail was sent from the Director of Care to the staffing office on that day, stating a staff member was to be booked on that day and for eight consecutive days during identified hours for both residents. During an observation on an afternoon in May within that period, the residents did not have one on one supervision. A registered nurse confirmed they did not have one on one supervision at that time.

During an interview with this registered nurse, they stated that the eMAR orders meant the residents were to have a one on one staff member with them. During an interview with a registered practical nurse, they believed the eMAR orders meant both residents were to be closely monitored by the staff working on the unit. The Director of Care stated that one to one involved an additional staff member overseeing the residents while close monitoring did not require an additional staff member. They stated when they don't have one on one, they can utilize close monitoring. The Director of Care agreed that when reading the orders, it could be confusing to staff.

Unclear direction within the resident's plan of care puts the residents at risk for not receiving the correct monitoring.

Sources:
Resident's eMAR's, resident's prescriber digiorders, e-mail from Director of Care, interviews with registered nurse, registered practical nurse and Director of Care.

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WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Rationale & Summary:

On a day in April 2023, a resident had a witnessed fall and was transferred to the hospital that day due to localized pain. The resident was diagnosed with a fracture requiring surgical intervention and then returned to the home.
Two days after returning from the hospital, the resident had an unwitnessed fall and was found on the floor beside their bed.

The resident's care plan indicated hip protectors were to be worn at all times. The resident's e-notes in Med e-care indicated that hip protectors were not being worn by the resident at the time of the fall after they came back from the hospital. In an interview with a registered nurse and the Associate Director of Care, they confirmed that the resident was to be wearing hip protectors at all times when they returned from hospital.

Not following the plan of care related to the use of hip protectors posed an increased risk of injury for the resident.

Sources:
Resident's e-notes, resident's care plan from April 2023, interview with registered nurse and Associate Director of Care.

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