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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: September 1st, 2023

Inspection Number: 2023-1502-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Providence Care Centre

Long Term Care Home and City: Providence Manor, Kingston

Lead Inspector	**Inspector Digital Signature**
Erica McFadyen (740804)	Erica McFadyen Digitally signed by Erica McFadyen Date: 2023.09.22 14:04:48 -04'00'

Additional Inspector(s)
Stephanie Fitzgerald (741726)
Polly Gray-Pattemore (740790)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31st, August 1st-4th, 8th-11th, and 14th, 2023

The following intake(s) were inspected:
· Intake: #00089706 - CI#3005-000049-23 - Fall of resident resulting in injury
· Intake: #00090169 - IL-14268-AH/CI# 3005-000050-23 - resident-to-resident alleged physical abuse
· Intake: #00091261 - CI#3005-000057-23 – resident-to-resident alleged physical abuse
· Intake: #00091412 - IL-14888-AH/CI#3005-000059-23; Intake: #00091484 - IL-14954-AH/CI#3005-000060-23; CI#3005-000062-23 - alleged episode of resident-to-resident sexual abuse
· Intake: #00092268 - complaint regarding the long-term care homes abuse reporting process
· Intake: #00093430 and Intake: #00093638 -CI# 3005-000077-23- complaint regarding a resident receiving the incorrect diet texture resulting in resident requiring assessment at the hospital

The following intakes were completed in this inspection: Intake: #00089696 - CI# 3005-000048-23 and Intake: #00092610 - CI# 3005-000064-23 related to falls

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care. When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that resident's plan of care was revised when the resident care needs changed.

Rationale and Summary:

A review of the resident's progress notes indicated that on a specified date, an RPN received complaints from both the resident and their Substitute Decision Maker (SDM) about care received by PSWs during the a specified shift The SDM requested avoidance of specified PSWs doing resident care on an identified shift. The RPN reported the SDM's request to the RN in charge. The same evening, the RN contacted the on-call management ADOC and explained the request by the SDM. After the request, there were three occasions where the resident had received care by the specified PSWs during a specified shift and was upset.

During an interview with the RPN, RN and ADOC , they confirmed they were aware the SDM requested no specified staff during the specified shift. A review of the resident's care plan showed no revisions to

the care plan related to this request. During an interview with the ADOC, they acknowledged the plan of care was not updated to reflect the request by the SDM.

By not ensuring the plan of care was updated related to the SDM's request, the resident was at increased risk of emotional distress.

Sources: Resident progress notes; and interviews with RPN RN and ADOC [740790]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary:

A review of a resident's progress notes indicated that on a specified date, an RPN received complaints from both the resident and the Substitute Decision Maker (SDM) about care received by PSWs during a specified time. The SDM reported to the RPN that the resident felt like they were being abused and requested avoidance of specified PSWs doing resident care during a specified time. The RPN reported the alleged suspected abuse to the In Charge RN, who contacted the on-call management ADOC and reported the incident.

During an interview with the RPN and RN they acknowledged they were aware the resident had complaints of feeling like they were being abused. The RN indicated they reported the alleged suspected abuse to the ADOC. During an interview with the ADOC, they acknowledged they were made aware that the SDM was upset about care happening and that the resident was upset about specified staff members going into their room. The ADOC indicated they were not informed that the resident felt like they were being abused.

A delay in reporting certain matters to the Director can increase risk of harm/injury to the resident.

Source: Resident progress notes; and interviews with RPN , RN and ADOC . [740790]

WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee failed to comply with their written policy related to falls prevention and management for a resident.

In accordance with O. Reg 246/22 s. 11(1)(b) the licensee is required to ensure that their written policy related to falls prevention and management is complied with.

Specifically, staff did not comply with the licensee's falls prevention and management policy (CARE-RC-18, revised July 5, 2022): if head injury is suspected and fall unwitnessed, initiate the Head Injury Routine for 72 hours due to possible memory loss or cognitive impairment.

Rationale and Summary:
Review of a resident's progress notes indicate the resident had an unwitnessed fall on a specified date and a head injury routine was initiated.
Review of the resident's Head Injury-Sudden Change Record indicates assessment of resident to be completed at intervals of every 30 minutes for the first two hours, then every hour for the next eight hours, then every two hours for the next 24 hours. Assessment of the resident was not completed according to these intervals.

During an interview with an RN they indicated a head injury routine for an unwitnessed fall is expected to be completed every 30 minutes for the first two hours, then every hour for the next eight hours, then every two hours for the next 24 hours.
During an interview with the DOC, they confirmed a Head Injury Routine to be initiated for 72 hours post unwitnessed fall and acknowledged the Head Injury-Sudden Change Record for the resident was not within the policy due to gaps in assessment and documentation.

By not ensuring the written policy related to falls prevention and management was complied with, the resident was at an increased risk of injury.

Sources: Providence Care Providence Manor Care Delivery Manual Falls Prevention and Management Policy CARE-RC-18, initial approval date of October 19, 2005, revised date of July 5, 2022; resident Head Injury-Sudden Change Record: and interviews with RN and DOC. [740790]

COMPLIANCE ORDER CO #1 Behaviours and Altercations

NC #4 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee shall:
1. Implement a plan of care and corresponding interventions related to physically responsive behaviours for resident #009

2. Provide education to all registered staff regarding the written process for assessment of residents who display physically responsive behaviours, including education on the interventions that may be considered and implemented following an episode of physically responsive behaviours between residents.

3. Develop and implement a written process to audit the care plans for each resident of the long-term care home who displays responsive behaviours to ensure that they have a corresponding responsive behaviour plan of care.

4. A written record must be kept of everything required under step (1) (2) and (3) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order, including dates, topics reviewed, name of instructor, and completed audit tool(s).

Grounds
The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #009 and #010, including by failing to identify and implement interventions.

Rationale and Summary

The clinical record for resident #009 indicated that on a specified date an altercation occurred where resident #009 pushed resident #010, which resulted in resident #010 sustaining a fall. The clinical record

for resident #010 and resident #009 indicate a second incident occurred three days later where resident #009 punched resident #010, which resulted in injuries to the face of resident #010 and which required resident #010 to be evaluated at the hospital.

During a review of the clinical record for resident #009 no plan of care related to physically responsive behaviours could be located. During a review of the clinical records for resident #009 and resident #010 no evidence of interventions being put in place to address the physically responsive behaviours of resident #009 following the first incident could be located.

During an interview with the ADOC it was stated that there were no interventions put in place following the initial altercation and that there was no plan of care in place related to the physically responsive behaviours of resident #009.

The risk of not implementing interventions for resident #009 following the episode of physical responsive behaviours towards resident #010 is that an additional altercation between the two residents could occur. Three days after the first incident, a second incident of physically responsive behaviour from resident #009 to resident #010 did occur, which resulted in resident #010 requiring assessment at the hospital.

Sources
clinical records for resident #009 and #010, interviews with ADOC
[740804]

This order must be complied with by September 29, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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