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: 2023-1502-0007
Inspection Type: Complaint
Licensee: Providence Care Centre
Long Term Care Home and City: Providence Manor, Kingston

Lead Inspector	**Inspector Digital Signature**
Erica McFadyen (740804)	Erica V McFadyen Digitally signed by Erica V McFadyen Date: 2023.09.22 14:09:37 -04'00'

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31st, and August 1st, 2nd, 4th, 8th-11th, 2023

The following intake(s) were inspected:

- Intake: #00091986: complaint regarding alleged abuse of a resident, the long-term care home's complaint process, and staffing

This inspection report contains grounds from inspection #2023-1502-0006, which occurred concurrently with this inspection.

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

Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Plan of Care

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021, s. 6 (7).

The licensee shall:

1) Ensure that staff comply with the written plan of care for resident #003 related to diet texture and resident #004 related to responsive behaviours and transfers.

In ensuring the requirements under steps (1), are met, the licensee shall:

2) Develop and complete a weekly audit of staff compliance with the written plan of care for the above-identified residents. This audit shall be completed for a period of four weeks.

3) Corrective action will be taken if deviations from the plan of care are identified.

A written record must be kept of everything required under this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds (1)
The licensee has failed to ensure that the care set out in the plan of care for resident #003, related to diet texture, was provided to them, as specified in the plan.

Rationale & Summary
On a specified date, resident #003, who is prescribed a specified mechanically altered diet, was provided a regular diet during tray service. Resident #003 experienced a choking episode, which resulted in being transferred to the emergency department for further assessment.

A review of resident #003's care plan and kardex at the time of the incident, show their prescribed diet as a specified mechanically altered diet.

A review of resident #003's progress notes from the date of the incident, as well as the Culinary Service Record for the unit of resident #003, indicates the resident was eating a regular texture diet tray, when they should have been receiving a specified mechanically altered diet.

Interviews with an RPN, Dietary Aide, and Dietician confirmed the residents plan of care included a specified mechanically altered diet at the time of the incident, and that resident received a regular diet texture, and confirmed the residents plan of care was not followed.

By not ensuring the plan of care for resident #003 related to texture of meals, was not complied with, as specified in the plan, actual harm occurred.

Sources: Resident #003's electronic care plan, Kardex, Progress Notes; Culinary Service Record from residents unit on July 28, 2023; Interviews with RPN, Dietary Aide, and Dietician. [741726]

Grounds (2)

The licensee has failed to ensure that the care set out in the plan of care for resident #004, related to responsive behaviours, was provided to them, as specified in the plan.

Rationale and Summary

As recorded in CIS #3005-000056-23, on a specified date, a PSW provided personal care to resident #004. During the provision of care resident #004 was physically responsive.

The responsive behaviour care plan for resident #004 includes two interventions which involve leaving the resident and reapproaching if the resident exhibits physically responsive behaviours during care.

During an interview with a PSW it was stated that resident #004 was verbally and physically responsive immediately prior to and during the provision of care. In an interview with the PSW it was stated the intervention implemented was to engage in a verbal discussion with resident #004 about their actions. The PSW stated that they did not follow the responsive behaviour plan of care when providing care to resident #004.

In an interview with an ADOC it was confirmed that the PSW did not follow the responsive behaviour plan of care when providing care to resident #004.

Not following the responsive behaviour plan of care may put resident #004 at risk of harm during care.

Sources:
Interviews with PSW and ADOC, CIS Report #3005-000056-23, clinical record for resident #001 [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.