Ontario

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

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

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Public Report

Report Issue Date: December 31, 2024
Inspection Number: 2024-1502-0004
Inspection Type: Proactive Compliance Inspection
Licensee: Providence Care Centre
Long Term Care Home and City: Providence Manor, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 13, 16-20, 23, 24, 27, 30, 31, 2024.

The following intake(s) were inspected:

- Intake: #00134199 - Proactive Compliance Inspection (PCI).

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices

Pain Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 63 (3)
Powers of Residents' Council
s. 63 (3) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The licensee has failed to ensure that they responded in writing when advised of concerns related to the lack of continence product availability and missing resident clothing by the Residents' Council on September 16, 2024.

On December 17, 2024, the home introduced a template to be used in response to resident council questions and concerns in writing.

Sources: Review of Residents' Council meeting minutes and interview of the Social Worker and Admissions Coordinator.

Date Remedy Implemented: December 17, 2024.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

On December 12, 2024, the visitor policy was not posted within the long-term care home.

The Administrator posted the visitor's policy on December 19, 2024.

Sources: Observation of the visitor policy and interview of the Administrator.

Date Remedy Implemented: December 19, 2024.

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care specific to activities of daily living, as set out in the plan of care was documented for two residents on multiple dates during a one month period.

Sources: Review of the care plan document, the Point of Care task documentation and interview of Personal Support Workers (PSWs).

The licensee has failed to ensure that the provision of the care set out in two residents' plans of care was documented. On a specified date, documentation for the two residents' breakfast and lunch intake was omitted.

Sources: Residents' food/fluid intake documentation, interview with Director of Care (DOC).

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)
Resident and Family/Caregiver Experience Survey
s. 43 (1) Every licensee of a long-term care home shall ensure that, unless otherwise directed by the Minister, at least once in every year a survey is taken of the residents, their families and caregivers to measure their experience with the home and the care, services, programs and goods provided at the home.

The licensee has failed to ensure that, the Resident and Family/Caregiver Experience Survey was completed for the 2023/2024 fiscal year.

Sources: Review of Resident Council meeting minutes, the Continuous Quality Improvement Initiative documentation, interview of the Administrator and the Social Worker/Admission Coordinator.

WRITTEN NOTIFICATION: Doors in a home

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that four doors leading to non-residential areas, on two separate residential units, were kept closed and locked when they were not being supervised by staff.

Sources: Observation of doors #1- 4018, #1- 4035, # 1-5005, # 1- 5047 and interview of the Director of Care.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that two residents who exhibit altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds were reassessed at least weekly by an authorized person if clinically indicated.

A resident did not receive a weekly wound assessment for a wound within a 23 day

period.
A second resident did not receive weekly wound assessments for three separate wounds within a 13 day period.

Sources: Residents' weekly wound assessments on Med-E-Care and Lumeo, and interviews with a Registered Practical Nurse (RPN), Nurse Practitioner (NP), and two Assistant Directors of Care (ADOC)s.

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The licensee has failed to ensure that a resident who required assistance with eating was served a meal until someone was available to provide the assistance required. The resident was served their meal and then provided with the required assistance to eat 20 minutes later.

Sources: Observations of meal service, resident care plan, and an interview with a Personal Support Worker (PSW).

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.
In accordance with additional requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that Routine Practices were followed in the IPAC program, specifically related to the completion of hand hygiene by three Personal Support Workers (PSW's) during a meal service.

Sources: Inspector's observations.

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with.
In accordance with additional requirement 9.1 (d) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection and application were followed in the IPAC program, specifically related to a staff member wearing only an N95 respirator in a resident room that was on aerosol and contact precautions.

Sources: Inspector's observations.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that an insulin pen was stored within the medication cart, and that the medication cart was kept secured and locked.

Sources: Observation of the medication cart.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement committee included a Personal Support Worker (PSW).

Sources: Review of the Continuous Quality Improvement Initiative documentation and interview of the Administrator.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee has failed to ensure that the continuous quality improvement committee included a Resident Council member.

Sources: Review of the Continuous Quality Improvement Initiative documentation, interview of the Administrator and Social Worker and Admission Coordinator.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the Continuous quality improvement initiative report was provided to the Residents' Council in 2024.

Sources: Review of the Resident Council meeting minutes and interview of the Social Worker and Admission Coordinator.