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

Public Report

Report Issue Date: April 30, 2025

Inspection Number: 2025-1502-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Providence Care Centre

Long Term Care Home and City: Providence Manor, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 7-11,14-17, 22-25, 28-30, 2025.

The following intake(s) were inspected:

- Intake: #00136267 - CI #3005-000003-25 – Alleged staff to resident neglect.
- Intake: #00138208 – CI #3005-000011-25 - Failure/breakdown of major system - Door access control system
- Intake: #00139187 – CI #3005-000017-25- Alleged staff to resident verbal abuse.
- Intake: #00139537 – CI #3005-000026-25- Missing resident less than 3 Hours.
- Intake: #00139552 - Complaint - Concerns regarding improper care of a resident.
- Intake: #00139892 – CI #3005-000029-25 – Alleged staff to resident neglect.
- Intake: #00140209 – CI #3005-000030-25 - Fall of resident resulting in injury and transfer to hospital.
- Intake: #00140990 – CI #3005-000031-25 – Alleged staff to resident neglect.
- Intake: #00141009 – CI #3005-000033-25 - Alleged resident to resident physical abuse.
- Intake: #00141392 – CI #3005-000035-25 – Alleged staff to resident neglect.
- Intake: #00141499 – CI #3005-000037-25 – Alleged visitor to resident abuse.
- Intake: #00141754 – CI #3005-000038-25 – Alleged staff to resident neglect.
- Intake: #00142863 – CI #3005-000041-25 - Alleged improper/incompetent treatment of resident.
- Intake: #00144769 – CI #3005-000048-25 - Alleged staff to resident emotional and physical abuse.
- Intake: #00145163 - Complaint - Concerns regarding safe and secure home.

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

Resident Care and Support Services
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure their written policy to promote zero tolerance of abuse was complied with. Specifically policy item 5. indicates when there is suspected improper care of a resident that resulted in a risk of harm the Ministry of Long-Term Care (MLTC) will be notified immediately

The licensee has failed to ensure their written policy to promote zero tolerance of

abuse was complied with. On a specified date in February, 2025, a resident reported they were not provided with their specified care or meal. A Personal Support Worker (PSW) failed to immediately report this alleged incident of neglect.

Sources: Licensee's abuse policy, CIS #3005-000031-25, and an interview with the DOC.

WRITTEN NOTIFICATION: Complaints procedure-licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that they immediately forwarded to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint had been submitted in the format provided for in the regulations and complied with any other requirements that may be provided for in the regulations.

A resident's Power of Attorney (POA) had submitted two written complaints to the home's DOC on two specified dates in April, 2025. The DOC confirmed they did not

submit a critical incident report to the Director related to these written complaints.

Sources: Review of DOC e-mails, critical incidences submitted to the Director, and an interview with DOC.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(ii) neglect of a resident by the licensee or staff, or

The licensee has failed to ensure that an alleged incident of neglect of a resident was immediately investigated. On a specified date in February, 2025, A PSW alerted Assistant Director of Care (ADOC) that a resident had not been provided their specified care or meal by a PSW on the previous day. The investigation into the incident did not begin until a specified date in April, 2025.

Sources: Review of CIS #3005-000031-25, investigation documentation and interviews with the DOC and a PSW.

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(b) appropriate action is taken in response to every such incident; and

The licensee has failed to take appropriate action in response to an incident of alleged neglect. On a specified date in February, 2025 an alleged incident of neglect of a resident by a PSW was reported. In an interview with the the home's DOC they indicated the action taken in response was re-education of the PSW on the abuse and neglect free environment policy, which did not occur until a specified date in April, 2025.

Sources: Interview with the DOC, CIS # 3005-00035-25, and the home's internal investigation file.

WRITTEN NOTIFICATION: Responsive behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that a resident with a documented history of specified behaviours received a specified assessment quarterly. The home's DOC confirmed that the last specified assessment was completed in November 2024 and a more recent assessment was not completed.

Sources: Resident progress notes on Lumeo, specified assessment, CI #3005-000026-25, and an interview with the DOC.

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee has failed to provide five final reports to the Director within a period of time specified by the Director.

1. On a specified date in January, 2025, a critical incident was submitted to the

Director to report an alleged incident of staff to resident neglect. The licensee provided the final report on a specified date in April, 2025.

Sources: Review of Critical Incident System (CIS) report #3005-000003-25, resident progress notes on Lumeo, and interviews with a Registered Nurse (RN) and an Assistant Director of Care (ADOC).

2. On a specified date in March, 2025, a critical incident was submitted to the Director to report an alleged incident of abuse of a resident by staff. The licensee has not provided a final report to the Director to date.

Sources: CIS report #3005-000041-25 and an interview with the DOC.

3. On a specified date in February, 2025, a critical incident was submitted to the Director to report an alleged incident of abuse of a resident by staff. The licensee provided the final report on a specified date in March, 2025.

Sources: Review of CIS report #3005-000027-25 and interviews with the DOC.

4. On a specified date in March, 2025, a critical incident was submitted to the Director to report alleged neglect of two residents by staff. The licensee has not provided the final report to date.

Sources: Review of CIS report #3005-000038-25 and interviews with the DOC.

5. On a specified date in March, 2025, a critical incident was submitted to the Director to report an alleged incident of staff to resident neglect. The licensee has not yet provided a final report to the Director to date.

Sources: Review of CIS report #3005-000035-25, the home's internal investigation file, and an interview with the DOC.

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