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
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Public Report

Report Issue Date: June 12, 2025
Inspection Number: 2025-1502-0004
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): May 29, June 3-6, and 9-12, 2025

The following intake(s) were inspected:

- Intake: #00146129 - CI# 3005-000055-25- regarding alleged resident to resident sexual abuse.
- Intake: #00146123 - Complaint regarding the reporting of alleged resident to resident sexual abuse.
- Intake: #00146443 - Complaint (Anonymous) regarding sufficient staffing.
- Intake: #00147180 - CI# 3005-000060-25- regarding alleged resident to resident sexual abuse.
- Intake: #00147184 - CI# 3005-000061-25 - regarding alleged resident to resident sexual abuse.
- Intake: #00147189 - CI# 3005-000062-25- regarding alleged resident to resident sexual abuse.
- Intake: #00148131 - Complaint regarding resident care and services.

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

Resident Care and Support Services
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a Registered Nurse (RN) reported an alleged attempted sexual abuse of a resident by a co-resident that resulted in a risk of harm to the resident was immediately reported to the Director.

On a specified date a resident was found in another resident's room attempting to undo the resident's briefs. The incident was not reported or documented. Follow up on the next day by a Registered Practical Nurse (RPN) resulted in the reporting of the incident to a RN, management, resident POAs and the police, however, the Director was not notified until three days after the incident.

Sources:

Review of resident progress notes, a Critical Incident (CI) report and interviews with the Director of Care (DOC), a RN and two RPNs.