



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Bureau régional de services d'Ottawa
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 26, 2013	2013_184124_0007	O-000075- 13, O- 000163-13	Critical Incident System

Licensee/Titulaire de permis

**PROVIDENCE CARE CENTRE
340 Union Street, KINGSTON, ON, K7L-5A2**

Long-Term Care Home/Foyer de soins de longue durée

**PROVIDENCE MANOR
275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7**

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 24, 25 and 26, 2013

This inspection included three Critical Incidents; #C553-000005-13 (log O-000163-13), #C553-000003-13 (log O-000075-13) and #C553-000015-13 (log O-000333-13).

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and the RAI Co-ordinator.

During the course of the inspection, the inspector(s) completed a walk through of the Montreal 3 home area, observed staff-resident interactions, observed residents being assisted to and from the dining room at breakfast, reviewed resident health records including Medication Administration Records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131.

Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber as demonstrated by the following findings.

On a specified date the physician ordered a medication every four hours as needed for Resident #4.

The Director of Care reported to the inspector that on a different day, staff #109 administered an incorrect dose of the specified medication to Resident #4.

Staff #112 reported that Resident #4 did not show any untoward effects from receiving the incorrect dose of the medication.

Resident #4 did not receive the medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]



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Issued on this 29th day of April, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs