Ministry of Health and Long-Term Care

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

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

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2013	2013_184124_0019	O-000834-13	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

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

This inspection was conducted on the following date(s): September 10, 11, 12, 13, 16, 2013.

This inspection related to Critical incident #C533-000027-13.

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator/Vice President Long Term Care, Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Human Resources staff.

During the course of the inspection, the inspector(s) completed walking tour of one home area, observed staff-resident interactions, made general observations regarding resident care, reviewed resident health records, reviewed criminal reference checks for new employees and reviewed the home's "Abuse and Neglect-Free Environment" policy and procedure.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

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.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 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. 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, s.6.(1).(a)(b)(c) in that the plan of care for Resident #2 did not address the resident's wandering behaviour.

Resident #2 has a diagnosis of dementia with a Cognitive Performance Scale rating of 4/6.

Review of Resident #2's progress notes indicated that Resident #2 was found unattended on the second floor of the home seven times over a six week period.

It is documented in the progress notes that on a specific day, Resident #2 was last seen at a certain time at the nursing station. Ten minutes later, Resident #2 was not noted to be on the unit. Levels three, one and two were searched and Resident #2 was found in the laundry room. The search lasted twenty-five minutes and Resident #2 remained agitated because the door to the laundry room was shut and the resident was unable to get out.

Staff #104 reported to the inspector that Resident #2 will actively exit seek for a number of days and then will be quiet for several days.

Resident #2's plan of care does not identify that the resident wanders or exit-seeks, has no goals identified related to the resident's wandering and does not provide any direction to staff regarding Resident #2's wandering. [s. 6. (1)]

2. The licensee failed to comply with the LTCHA 2007, s.6.(7) in that Resident #1 did not receive care as set out in the plan of care.

Resident #1 has diagnoses of Alzheimer's Disease and osteoarthritis. Resident #1's Resident Assessment Protocol (RAP) of a specific date describes Resident #1 as having impaired decision making with problems understanding others and making himself/herself understood. The RAP stated the resident is resistive to care and could become aggressive with staff.

Staff #104 described Resident #1 as having severe cognitive impairment, saying that Resident #1 does not always understand the message given by staff. Staff #104 went on to say that Resident #1 has pain in the knees and hips.

Staff #106 reported to the inspector that on a specific date, Resident #1 was observed

to have feces on the hands, nightgown and bedrail. Staff #106 asked Staff #100 and #101 to assist in providing care to Resident #1.

Staff #100 reported to the inspector that Staff #106 approached him/her and said that Resident #1 had a bowel movement and could be resistive so help was needed to give care to the resident. Staff #100 reported that both of Resident #1's wrists were held so Staff #106 could wash the resident's hands and complete peri care. Staff #100 described Resident #1 as struggling to get out of the hold. Staff #100 reported that talking to the resident wasn't effective and Resident #1 struggled because, "the resident was really just trying to get away from my grasp."
Staff #100 stated that Staff #106 finished the care and Resident #1 was agitated but "a lot less" once the care was completed and staff were leaving the room.

Later that morning, it is documented that Resident #1 had fresh bruises on both wrist areas. Staff #104 described the bruises as a band around the resident's lower forearm and the colour was the purple of a fresh bruise.

Resident #1's plan of care in effect at the time of this incident, identified that the resident was resistive to care and directed staff to leave the resident if the resident refused care and to return, trying several attempts until the care was completed.

On this specific date, staff did not follow Resident #1's plan of care and as a result Resident #1 sustained bruising. [s. 6. (7)]

3. The licensee failed to ensure that staff who provided direct care to Resident #1 were kept aware of the contents of the plan of care.

Resident #1 is a resident with a diagnosis of Alzheimer's Disease and a documented history of being resistive to care.

Resident #1's plan of care identified that the resident was resistive to care and directed staff that if the resident refused care, staff was to leave and return, try several attempts until the care was completed.

On a specific date, staff #100, #101 and #106 were assigned to Resident #1's home area and were responsible for providing care to Resident #1.

During an interview staff #101 reported to the inspector that he/she had never met Resident #1 prior to this shift and had no knowledge of the resident.

Staff #100 reported not working on Resident #1's home area for five to six months and knew only what staff #106 told him/her about Resident #1.

On this specific date, when staff #100, #101 and #106 provided care to Resident #1 the resident was resistive and staff did not leave and return to the resident. Later that morning, it was documented that the resident had fresh bruises on both wrist areas. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #2's plan of care reflects the resident's wandering behaviour including goals of care and clear direction to staff and others who provide care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, s.26.(3)5. in that potential behavioural triggers were not identified for Resident #1.

Resident #1 is a resident with diagnoses of Alzheimer's Disease and osteoarthritis.

Review of Resident #1's progress notes for a three month period indicated that there were twelve documented incidents of Resident #1 resisting care, with descriptions such as "kicking, punching, defensive", "resident became agitated/defensive, striking out, punching staff whenever they attempted to help the resident".

Staff #103 and #104 reported that Resident #1 can be unpredictable and triggers have not been identified for this resident.

Resident #1's plan of care stated that the resident resists treatment or refuses care but had no behavioural triggers identified. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that potential behavioural triggers are identified for Resident #1, to be implemented voluntarily.

Issued on this 20th day of September, 2013

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

Lynda Hamilton

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2013_184124_0019
Log No. / Registre no:	O-000834-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 18, 2013
Licensee / Titulaire de permis :	PROVIDENCE CARE CENTRE 340 Union Street, KINGSTON, ON, K7L-5A2
LTC Home / Foyer de SLD :	PROVIDENCE MANOR 275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SHELAGH NOWLAN

To PROVIDENCE CARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that residents with responsive behaviours receive care as specified in their plan of care.

Grounds / Motifs :

1. The licensee failed to comply with the LTCHA 2007, s.6.(7) in that Resident #1 did not receive care as specified in her plan of care.

Resident #1 has diagnoses of Alzheimer's Disease and osteoarthritis. Resident #1's Resident Assessment Protocol (RAP) of a specific date describes Resident #1 as having impaired decision making with problems understanding others and making herself understood. The RAP stated the resident is resistive to care and could become aggressive with staff.

Staff #104 described Resident #1 as having severe cognitive impairment, saying that Resident #1 does not always understand the message given by staff. Staff #104 went on to say that Resident #1 has pain in the knees and hips.

Staff #106 reported to the inspector that on a specific date, Resident #1 was observed to have feces on the hands, nightgown and bedrail. Staff #106 asked Staff #100 and #101 to assist her in providing care to Resident#1.

Staff #100 reported to the inspector that Staff #106 approached him/her and said that Resident #1 had a bowel movement and could be resistive so help would be needed to give care to the resident. Staff #100 reported that both of Resident #1's wrists were held so Staff #106 could wash the resident's hands and complete peri care. Staff #100 described Resident #1 as struggling to get

out of the hold. Staff #100 reported that talking to the resident wasn't effective and Resident #1 struggled because, "the resident was really just trying to get away from my grasp."
Staff #100 stated that Staff #106 finished the care and Resident #1 was agitated but "a lot less" once the care was completed and staff were leaving the room.

Later that morning, it is documented that Resident #1 had fresh bruises on both wrist areas. Staff #104 described the bruises as a band around the resident's lower forearm and the colour was the purple of a fresh bruise.

Resident #1's plan of care in effect at the time of this incident, identified that the resident was resistive to care and directed staff to leave the resident if the resident refused and to return, trying several attempts until the care was completed.

On this specific date, staff did not follow Resident #1's plan of care and as a result Resident #1 sustained bruising.

(124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of September, 2013

Signature of Inspector / Signature de l'inspecteur : Lynda Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

Service Area Office / Bureau régional de services : Ottawa Service Area Office