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
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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
Oct 16, 2014	2014_396103_0005	O-000946-14	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KINGSTON
216 Ontario Street, KINGSTON, ON, K7L-2Z3

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

RIDEAUCREST HOME
175 RIDEAU STREET, KINGSTON, ON, K7K-3H6

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

DARLENE MURPHY (103)

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): October 9, 14-16, 2014

The following logs were inspected as a part of this report: O-000946-14, O-000949-14, O-001001-14, O-001095-14 and O-001146-14.

During the course of the inspection, the inspector(s) spoke with a Resident, Personal support Workers, Registered Practical Nurses, the Nurse Practitioner, the Assistant Director of Care, the Acting Director of Care and the Administrator.

During the course of the inspection, the inspector(s) made resident observations, reviewed resident health care records, the home's investigation into allegations of abuse, the home's abuse policy and staff education records for abuse.

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written zero tolerance of abuse policy was complied with.

On an identified date, Personal Support Worker S#102 was assigned to care for Resident #1. The staff member was interviewed and recalls asking the resident how they had slept. The resident replied "good" but then stated a male had entered the room during the night and described an incident alleging sexual abuse. S#102 reported this to Registered Practical Nurse (RPN) S#104.

S#104 went to speak with the resident and Resident #1 repeated the story involving an unidentified man entering the room at night. S#104 made an entry in the progress notes on an identified date, but did not further report this information.

On another identified date six days later, RPN S#105 received a message from Resident #1's family member. The family member stated the resident said one week prior, an unidentified man had entered the room during the night and alleged sexual abuse. S#105 stated she immediately interviewed Resident #1 and the resident's account of the incident was much the same as that reported to the family member. S#105 contacted the Assistant Director of Care (ADOC) who then directed the staff member to immediately notify the Ministry of Health and Long Term Care(MOHLTC) and the police.

S#104 failed to follow the home's Zero Tolerance of Abuse Policy, #OPER-02-02-04. The policy statement indicates, "every person in the home, including staff, has a mandatory and legal obligation to immediately report suspected or witnessed abuse. S#104 had received abuse training on March 3, 2014. The home had also been ordered during a recent Resident Quality Inspection (RQI) to complete retraining of all direct care staff in the area of abuse. S#104 had completed this retraining on July 22/14. The home has taken disciplinary action against S#104 and according to the DOC, the staff member will receive one to one abuse training prior to being reinstated to work. [s. 20. (1)]

Issued on this 16th day of October, 2014

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