Ontario

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

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347 Preston St, 4th Floor
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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
Nov 25, 2014	2014_396103_0007	O-000753-14	Follow up

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 Follow up inspection.

This inspection was conducted on the following date(s): Nov 12-14, 17-19, 2014

Log #O-001263-14 was included in this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Dietitian, Education Consultant for Extendicare, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) reviewed the required education provided to all direct care staff and managers in accordance with the orders previously issued, reviewed the home's abuse policy, the home's complaint process, and reviewed resident health care records.

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

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Neglect is defined in O.Regs 79/10 s. 5 as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and

includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

On an identified date, Staff #112 sent an email to the DOC advising her that Resident #1 had been found on or about 0700 hour, seated in the recliner at the bedside and incontinent of a large amount of urine.

S#112 was interviewed and stated that while administering the morning medications, she entered Resident #1's room and noted a strong smell of urine. S#112 offered to assist the resident to the bathroom and the resident agreed stating they had been in the chair since the evening before. S#112 noted the resident was wearing a PJ top on the upper body and underwear, a yellow liner, slacks and socks on the lower body. S#112 noted the resident to have increased stiffness and soreness while being transferred to the bathroom.

S#112 spoke with the day staff working on the unit at that time and they stated they had not assisted the resident to the recliner or assisted the resident in partially dressing. S#112 stated the resident would not have been capable of getting out of bed on their own or getting their bottom half dressed and stated the resident wears a full brief to bed for overnight. The staff member stated that the resident can refuse care at times but that no refusals had been documented during the night shift and nothing untoward had been brought forward during the shift report in regards to Resident #1.

The following day, an email was sent to the DOC and the Administrator from a family member of Resident #1 outlining an allegation of resident neglect. The DOC was interviewed and stated she had received the email from the family member and replied within the hour. The email expressed concern over the incident and stated "will look into this further upon my arrival back to the home tomorrow." The DOC stated she was ill the following day, therefore the ADOC began the investigation. The DOC stated she did not view the incident as an allegation of neglect because the resident has refused care in the past. The inspector reinforced all allegations of resident neglect or abuse are to be immediately investigated.

The ADOC was interviewed and stated she spoke with Resident #1's regular PSW to obtain tips to reduce the resident's refusals for care and also spoke with S#106 in regards to the resident's continence care. There was no documentation to support an internal investigation was started.

The DOC's documentation related to this allegation was reviewed and was incomplete. No staff members were suspended pending investigation. The DOC was asked what the outcome of the investigation was and she advised there would be no disciplinary actions taken. The DOC stated she did not feel there was sufficient evidence to support the allegation despite the conflicting information provided by the night and day staff, the lack of documentation to support any refusals of care by the resident and the lack of continence care provided to the resident. According to the DOC, the investigation was complete.

The home failed to immediately notify the Director (MOHLTC) of the allegation of resident neglect. The first notification was done through a critical incident (CI) submitted on an identified date. The CI incorrectly identified the date of the allegation. The investigation was not initiated immediately and to date of this inspection, the Director was not advised of the outcome of the investigation.

The home was ordered during inspection #2014_179103_0015 to provide additional abuse education to all direct care staff. Despite evidence that the education was provided, the home has demonstrated ongoing weakness in the area of abuse reporting and has been unable to apply the information provided when instances of abuse and neglect are reported. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 zero tolerance of abuse policy was complied with.

On an identified date, the DOC and the Administrator received an email from a family member alleging neglect of Resident #1. The home failed to follow the zero tolerance of abuse policy as follows:

According to the home's abuse policy, OPER-02-02-04, under "Upon Notification",

-The home did not initiate an internal investigation upon being notified of the allegation of neglect and a preliminary report was not completed,

Under "Actions to be taken against the Perpetrator"

-staff involved in the allegation of neglect were not immediately removed from the work schedule pending investigation,

Under "Required Documentation",

-the pertinent details of the investigation were not documented including actions taken during the investigation and any actions taken as a result of the outcome of the investigation. The policy further directs that all statements from witnesses are to be written and signed by the witness, if possible or by the Administrator.

During inspection #2104_179103_0015, the home was ordered to provide additional abuse education to all management staff. The education was to include how to conduct and document an investigation into every alleged, suspected or witnessed incident of abuse. Despite evidence that the eduction was provided, the home has shown weakness in the ability to apply the information provided. [s. 20. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date, Resident #1 was observed to be seated in a recliner at the bedside and was found incontinent of a large amount of urine by S#112.

S#112 was interviewed and stated that while administering the morning medications, she entered Resident #1's room and noted a strong smell of urine. S#112 offered to assist the resident to the bathroom and the resident agreed stating they had been in the chair since the evening before. S#112 noted the resident was wearing a PJ top on the upper body and underwear, a yellow liner, slacks and socks on the lower body. S#112 noted the resident to have increased stiffness and soreness while being transferred to the bathroom.

S#112 spoke with the PSW's working on the unit at that time and they had not assisted the resident to the recliner or assisted the resident in dressing. S#112 stated the resident would not have been capable of getting out of bed on their own or getting their bottom half dressed.

At the time of this incident, Resident #1's care plan under "bed mobility" indicated:

-specific instructions to be tried if the resident refused to go to bed. There was no documentation to support the resident had refused to go to bed.

Under "Incontinence" the care plan indicated:

-yellow liner in underwear on days and evenings; brief when goes to bed at night only.

Additionally the resident had been started on a voiding record the previous day. The record was reviewed and there had been no entries made during the two shifts prior to the incident. There was no documentation to support the resident had refused to be toileted during the evening or night shift on the specified date. [s. 6. (7)]

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 care is provided to Resident #1 as specified in the plan of care, to be implemented voluntarily.

Issued on this 25th day of November, 2014

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

Ontario

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

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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2014_396103_0007
Log No. / Registre no:	O-000753-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 25, 2014
Licensee / Titulaire de permis :	THE CORPORATION OF THE CITY OF KINGSTON 216 Ontario Street, KINGSTON, ON, K7L-2Z3
LTC Home / Foyer de SLD :	RIDEAUCREST HOME 175 RIDEAU STREET, KINGSTON, ON, K7K-3H6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debra A Green

To THE CORPORATION OF THE CITY OF KINGSTON, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_179103_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee is hereby ordered to ensure all allegations of resident abuse and neglect are reported and investigated in accordance with the legislated requirements.

The home shall develop a written process to audit each investigation into allegations of resident neglect and abuse to ensure ongoing compliance with all aspects of reporting in accordance with the legislation. Additionally, the home will develop a written plan of corrective action to address any failures identified.

The plan shall be submitted in writing to Inspector Darlene Murphy by fax #613-569-9670, no later than December 3, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Neglect is defined in O.Regs 79/10 s. 5 as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well- being of one or more residents".

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S#112 was interviewed and stated that while administering the morning medications, she entered Resident #1's room and noted a strong smell of urine. S#112 offered to assist the resident to the bathroom and the resident agreed stating they had been in the chair since the evening before. S#112 noted the resident was wearing a PJ top on the upper body and underwear, a yellow liner, slacks and socks on the lower body. S#112 noted the resident to have increased stiffness and soreness while being transferred to the bathroom.

S#112 spoke with the day staff working on the unit at that time and they stated they had not assisted the resident to the recliner or assisted the resident in partially dressing. S#112 stated the resident would not have been capable of getting out of bed on their own or getting their bottom half dressed and stated the resident wears a full brief to bed for overnight. The staff member stated that the resident can refuse care at times but that no refusals had been documented during the night shift and nothing untoward had been brought forward during the shift report in regards to Resident #1.

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information provided by the night and day staff, the lack of documentation to support any refusals of care by the resident and the lack of continence care provided to the resident. According to the DOC, the investigation was complete.

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(103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_179103_0015, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee is hereby ordered to ensure the home's zero tolerance of abuse policy, OPER-02-02-04 is complied with.

The licensee shall ensure a written process is developed and implemented to audit compliance with the abuse policy for each allegation of resident abuse and neglect. The licensee shall also ensure there is a written process that clearly defines the corrective actions the home will take with any identified failures in reporting.

The plan shall be submitted in writing to Inspector Darlene Murphy by fax #613-569-9670, no later than December 3, 2014.

Grounds / Motifs :

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

On an identified date, the DOC and the Administrator received an email from a family member alleging neglect of Resident #1. The home failed to follow the zero tolerance of abuse policy as follows:

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(103)

Ontario

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 15, 2014

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 25th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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