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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 12, 2016	2016_280541_0002	002424-16	Resident Quality Inspection

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

AMBER MOASE (541), HEATH HEFFERNAN (622), JESSICA PATTISON (197), WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 28, 29, February 1 -5 and February 8, 2016.

A critical incident related to a resident fall with injury, five critical incidents related to allegations of resident abuse and a complaint related to food quality and air temperature were inspected concurrently with this RQI.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Directors of Care, Registered Nurses, Registered Practical Nurses, a Life Enrichment Coordinator, Dietary Aides, an Environmental Services staff member, a Maintenance staff member, Personal Support Workers, the President of the Resident Council, the President of the Family Council and Residents. In addition to those spoke with, inspectors conducted a tour of the home, completed observations of the lunch meal service, observed a medication pass and reviewed relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access must be,
i. kept closed and locked

On January 28, 2016 while conducting the initial tour of the home, Inspector #622 noted the doorway to the stairwell D1 was unlocked and opened freely when pushed. This stairwell is located in a small hallway connecting the long-term care home and the retirement home and is accessible to all residents. The door had signage in red stating "door releases upon activation of fire alarm". The key pad red light was lit. No residents were noted in the area. Home staff state they figure it must have been unlocked since the last fire drill a day or two ago.

While touring the secure unit on January 28, 2015 Inspector #622 noted the linen chute room door to be ajar on approach. This door has an automatic closure and button access door handle. Inspector #622 closed the door and it did lock however PSW #117 reopened the door and let close on its own and it was noted that the door did not close all the way, leaving the room accessible. The laundry chute is noted on the right hand wall of the room, it is closed shut and requires a push button release to open. The opening to the chute was noted to be approximately 2 foot by 2 foot square.

On February 2, 2016 at 0945 hrs while on the C wing of 3rd floor Inspector #541 checked to ensure the room to the laundry chute was locked. The door to the room is closed tight however when Inspector turned the handle, the door opened. The laundry chute is noted on the right hand wall of the room, it is closed shut and requires a push button release to open. The opening to the chute was noted to be approximately 2 foot by 2 foot square. At the time of this observation, there was a resident noted to be wandering in the area. At 0955 hrs Inspector #541 informed RPN #116 of the unlocked door to the laundry chute. When Inspector and RPN returned to the door, environmental services staff member #118 was in the laundry chute room. Inspector showed RPN #116 and staff #118 that the door opened without the code being entered (ie. it was unlocked). RPN #116 informed maintenance immediately. Inspector #541 informed the Administrator of the observations of unlocked doors.

On February 3, 2016 Inspector #541 observed the doors leading to the laundry chute rooms on all 4 units to be locked. [s. 9. (1)]

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 the following rules are complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked, to be implemented voluntarily.

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 :

The following non-compliance is related to a critical incident inspection.

The licensee has failed to comply with their written policy to promote zero tolerance of abuse and neglect of residents. On a specified date, PSW #103 witnessed PSW #102 speak to resident #046 in a manner he/she considered to be verbal abuse while in the dining room at supper time. The verbal abuse was not reported until fifteen days later when PSW #103 informed ADOC #112. This incident was not immediately reported by the ADOC to the Director; rather reporting was delayed until the following day.

The Home's Resident Abuse policy directs staff to "immediately report (verbally) the witnessed abuse to the Administrator, Director of Care or their designate". The home's abuse policy was not followed as PSW #103 did not report the verbal abuse to the home until 15 days after witnessing it. [s. 20. (1)]

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 37 (1)(a) in that resident's personal items were not labelled in shared bathrooms.

During stage 1 of the Resident Quality Inspection (January 28, 29, February 1, 2, 2016) the following observations were made by inspectors:

Rm 205 - soiled urinal on back of toilet, two toothbrushes sitting crossing each other, a tube of toothpaste and a deodorant stick all unlabelled and on the vanity in a shared bathroom (622)
Rm 214 - a blue denture cup, two bottles of mouth wash, a tube of polygrip, an electric toothbrush and another toothbrush, all unlabelled on the vanity in shared bathroom (622)
Rm 221 - hair brush on the vanity with hair in it and one stick of deodorant both unlabelled in shared washroom (622)
Rm 227 - unlabeled urinal on the floor under the vanity in shared bathroom (622)
Rm 236 - two deodorant sticks, a toothbrush, a black hair pick with hair in it, one denture brush, makeup and two jars of cream on vanity in shared bathroom, all unlabelled (622)
Rm 237 - K basin with a bar of soap on the vanity and a urinal on the back of the toilet in shared bathroom, both unlabelled (622)
Rm 328 - Unlabelled toothbrush, toothpaste, comb and brush in shared bathroom (197)
Rm 329 - Toiletries and two hairbrushes unlabeled in shared bathroom (197)
Rm 331 - Two unlabelled denture cups in resident's shared bathroom on counter (197)
Rm 332 - Unlabelled denture cup in shared bathroom (197)
Rm 335 - Unlabelled denture cup in shared bathroom (197) [s. 37. (1) (a)]

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting a pressure wound was reassessed weekly by a member of the registered nursing staff.

On February 05, 2016 Inspector #622 spoke with RPN #115 who revealed resident #002 had a pressure ulcer which was noted to have worsened in condition on a specified date. Further discussion with RPN #115 on February 08, 2016, revealed registered nursing staff are expected to perform a weekly skin assessment on residents who have compromised skin integrity. The Assistant Director of Care (ADOC) #111 later that day advised that weekly wound assessment documentation may be found in progress notes, however, staff should complete a weekly wound assessment in point click care under the assessment tab. ADOC #111 then provided a copy of the assessment history report for a specified period of time.

On February 08, 2016 the weekly wound progress notes in point click care were reviewed for a specified 14 week time period; there were three entries made during this period on specified dates, confirming that weekly assessments were not completed as required.

Review of resident #002's treatment records for a specified three month time period revealed the treatment plan for resident #002 had not changed.

The following two policies, provided by ADOC #111, indicate that registered nursing staff are to reassess and document the need for all treatments on a weekly basis:

Policy: Wound Care Record, Policy # 03-09 dated June 2010 establishes that a weekly wound care record is to be completed to assess and track wound healing.

Policy: Skin Treatments, Policy # 11-08 dated September 2010 outlines that registered staff will reassess and document the need for all treatments on a weekly basis.

ADOC #111 confirmed that the Home's expectation is that registered nursing staff complete weekly wound assessments for any resident with altered skin integrity. The weekly wound assessment should be completed under the assessment tab in point click care.

A subsequent review of the Assessment history for a specified four month time period revealed only two weekly skin assessments and two quarterly skin assessments completed on specified dates. Wound assessments were not completed on a weekly basis to track resident #002's pressure ulcer which worsened in condition requiring re-staging of the pressure ulcer. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that meals served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On January 28, 2015 an observation of the lunch meal service was conducted in the dining room on the secure unit.

At 1206 hours resident #047 was served soup and no assistance was provided to eat. At 1215 hours the resident was provided with the entrée while the soup remained untouched and no assistance was provided.

Resident #048 was provided with an entrée while the soup remained at the place setting untouched and no assistance was provided to eat. Resident began to eat the soup as the hot entrée remained on the table. Approximately 15 minutes after resident was served the entrée, staff did obtain a new hot entrée and provided resident assistance to eat this.

Resident #049 was served a hot entrée while the soup remained at the place setting untouched.

The nutritional care plans were reviewed for residents #047, 048 and 049 and there are no interventions indicating the residents were assessed to have all courses served at once. [s. 73. (1) 8.]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.

On January 28, 2015 an observation of the lunch meal service was conducted in the dining room on the secure unit.

According to the current nutritional care plan for resident #047, the resident requires staff to feed him/her part or all of each meal, at times the resident may assist.

At 1206 hours resident #047 was served the soup and no assistance was provided to eat. At 1215 hours the resident was provided with an entrée while the soup remained untouched and no assistance was provided. A PSW provided resident #047 half a sandwich in his/her hand which the resident was then able to eat independently however there was no staff sitting to provide resident assistance with items requiring utensils. At 1232 hours resident #047 was provided with assistance to eat the soup which had been sitting on the table for over 20 minutes.

According to the current nutritional care plan for resident #048, the resident requires extensive to total assistance with each meal and 1 staff member is to assist during the whole meal.

Resident #048 was provided with an entrée while the soup remained at the place setting untouched and no assistance was provided to eat. Resident began to eat the soup as the hot entrée remained on the table. Approximately 15 minutes after resident was served the entrée, staff did obtain a new hot entrée and provided resident assistance to eat this.

The Nutrition Supervisor indicated during an interview with Inspector #541 that his expectation is all residents who require assistance are not served until there is a staff member present to assist them. [s. 73. (2) (b)]

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 the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs and to ensure that, (b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening and/or cleaning of dentures.

On February 04, 2016 Inspector #622 observed Personal Support Worker (PSW) #106 and PSW student #107, assist resident #025 using the washroom and bring the resident from the room immediately following. Staff #106 and #107 had been interviewed immediately before assisting resident #025 in the washroom; they confirmed oral care had not been given this morning. Resident stated on leaving the washroom that mouth

care had not been provided.

Inspector #622 interviewed resident #025 who revealed that no mouth care was provided this morning. The resident stated he/she had not been offered set up for mouth care by staff. Resident #025 was asked if he/she had been given a cup of water to rinse, he/she said no. Resident #025 was asked if he/she refused the set up for oral care or to rinse his/her mouth, he/she said; how could I, I wasn't asked.

The Registered Practical Nurse (RPN) #104 indicated during an interview that resident #025 would be getting oral care first thing in the morning and after meals.

Interview of PSW #106 February 04, 2016 at 0920 hours, by inspector #622 revealed that dental/oral care is done twice daily; once in the morning and at night. PSW # 106 stated resident #025 had care performed by the PSW student this morning and was not aware if oral care was given.
PSW student #107 confirmed he had not performed oral care on resident #025 this morning. [s. 34. (1) (a)]

2. On February 3 and 4, 2016 inspector #622 interviewed resident #011 who stated that oral care was not provided by staff on either date.

Inspector #622 observed on February 3 and 4, 2016, resident #011 had eight bottom teeth in the front which were discoloured and had large amount of plaque build-up around the bottom and sides of the teeth.

On February 03, 2016 PSW #110 stated while being interviewed that the homes expectation for oral care would be at least three times after each meal. Oral care is offered twice daily to resident #011; after nourishment and at bedtime.

RN #109 stated resident #011 would receive oral care in the morning and bedtime and as needed. RN #109 stated resident #011 has difficulty brushing his/her own teeth so staff members are to assist with that.

Interview by inspector #622 with RPN #104 February 04, 2016 revealed resident #011's mouth care is automatically done in the morning except when the resident is scheduled for a bath as they will do the mouth care then.

On February 04, 2016 at 1010 hours, inspector #622 interviewed resident #011, who was

now in bed. Resident revealed no oral care or set up for oral care was provided.

Inspector #622 interviewed PSW #108 who confirmed oral care is to be completed twice daily; days and evenings. PSW staff #108 revealed she did not have time for resident #011's oral care including dentures this morning so resident #011 did not have dentures for breakfast. PSW staff #108 confirmed she had not performed oral care on resident #011 that morning. [s. 34. (1) (a)]

Issued on this 12th day of February, 2016

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

Original report signed by the inspector.