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**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 7, 2016 | 2016_236622_0021 | 011822-16 / 008202-16 / 004650-16 | 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

HEATH HEFFERNAN (622)

### 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): June 27, 28, 29, 30 2016 and July 04, 05, 06, 2016.**

**During this inspection the following critical incident inspections were completed;**
**M569-000018-16 - alleged staff to resident abuse/neglect**
**M569-000013-16 - alleged staff to resident abuse/neglect**
**M569-000006-16 - alleged staff to resident abuse/neglect**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and the residents.**

**The following Inspection Protocols were used during this inspection:**
**Dignity, Choice and Privacy**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

The following finding is related to log 004650-16

On a specified date resident #002 reported to the Registered Nurse #105 that the registered practical nurse (RPN) #101 had administered him/her a medication without obtaining consent.
In an interview on July 4, 2016, RPN #101 explained that on a specified date he/she informed resident #002 he/she required a medication. RPN #101 reported that resident #002 did not see his/her face and may have had difficulty hearing him/her. RPN #101 then indicated it would have been best to have ensured he/she obtained consent, however he/she did not. RPN #101 confirmed he/she administered the medication to resident #002.
July 4, 2016 inspector #622 reviewed the medical directive procedure - Rideaucrest Home specific policy PHA-13-500.00 dated October 18, 2015 which indicated direction pertaining to the administration of the specified medication.
On July 04, 2016, at 1130 hours, inspector #622 interviewed the Assistant Director of Care #103 who confirmed that it was his/her understanding from his/her investigation into the incident that RPN #101 had not made the care direction clear to the resident.
On July 05, 2016 inspector #622 interviewed resident #002 who indicated that RPN #101 had not informed him/her, he/she was going to give the medication before administering it on the specified date. Resident #002 confirmed he/she was given the medication without knowledge and was not given a choice as to the treatment or care provided.
As resident #002 was not provided clear direction regarding nor had he/she consented to the care provided, he/she was not afforded the opportunity to participate in the implementation of her plan of care. [s. 6. (5)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The following finding is related to log 004650-16

Long Term Care Homes Act section 8(1) every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents.

On a specified date, resident #002 reported to the Registered Nurse (RN) #105 that Registered Practical Nurse (RPN) #101 had administered him/her a medication without obtaining consent.
During the inspection, resident #002's personal health information including; the electronic medication administration record (eMAR), the electronic treatment administration record (eTAR) and progress notes on point click care were reviewed and revealed no documentation had been completed to indicate the medication had been administered, nor the effect of the medication administered that specified date.
On July 04, 2016 inspector #622 interviewed the Assistant Director of Care who indicated the administration of the medication to resident #002 was not documented.
On July 04, 2016 inspector #622 interviewed Registered Practical Nurse (RPN) # 101 who confirmed he/she had not documented regarding the medication he/she gave to resident #002 or the results of the medication administered during his/her shift on the specified date. [s. 30. (2)]

**Issued on this 7th day of July, 2016**

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| **Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs** |

**Original report signed by the inspector.**