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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 3, 2017	2016_520622_0010	034711-16, 034893-16	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): December 21, 22, 2016

This critical incident inspection was related to the following;
M569-000050-16 - Medication Administration
M569-000051-16 - alleged staff to resident neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Health Care Aid (HCA) and residents. The inspector also reviewed resident's health records, licensee's policies and procedures, observed the delivery of care, services and staff to resident interaction.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee's policy and procedures were complied with as a resident was administered a medication/treatment that was not prescribed for them.

O. Reg. 79/10, s. 114 (2). indicates that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the critical incident report indicated on a specified date and time registered nurse (RN) #101 had administered a medication/treatment to resident #001 that had not been prescribed for him/her.

A review of the licensee's policy indicated that there was procedure to ensure the right resident receives the right medication/treatment which has been prescribed for them.

A review of the progress notes for the date of the incident indicated RN #101 administered resident #001 a medication/treatment that had not been prescribed for them.

During interviews with the inspector, Registered Practical Nurses (RPN) #105 and #106 stated licensee policy indicates there are procedures the registered nurses follow to ensure the right resident receives medications/treatments as prescribed.

During an interview with the inspector, RN #101 stated that on the specified date he had not followed the licensee's policy and administered resident #001 medications/treatments that were not prescribed for him/her.

During an interview with the inspector, the Assistant Director of Care (ADOC) #104 stated that on the specified date and time, RN #101 had administered a medication/treatment to resident #001 in error; RN #101 had not followed the licensee's policy and procedures.

The licensee failed to ensure that RN #101 complied with the licensee's policies and procedures.

The scope of the issue was isolated, the severity was actual harm to the resident. Non-

compliance related to O.Reg. 79/10 s. 8 was previously issued as a VPC on June 3, 2014 during the Resident Quality Inspection. [s. 8. (1) (b)]

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. 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 for a resident was provided to the resident as specified in the plan.

A review of the critical incident report indicated that on a specified date and time resident #003 was found unattended. Staff assisted resident #003 to bed and a head to toe skin assessment was completed with no injuries noted.

A review of resident #003's health records indicated resident #003 had multiple diagnoses.

A review of the care plan in place at the time of the incident indicated resident #003 was not to be left unattended.

A review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) dated for a specified date prior to the incident indicated resident #003 was not to be left unattended.

During an interview with the inspector, HCA #107 and PSW #108 indicated that on the specified date, contrary to resident #003's care plan they left the resident unattended.

A review of the progress notes dated for the specified date indicated that at a specified time, resident #003 was left unattended.

During an interview with the inspector, the Assistant Director of Care #110 stated on the specified date resident #003 was left unattended which was contrary to direction on the resident's care plan.

The licensee failed to ensure that care for a resident was provided according to the plan of care. [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 that the care set out in the plan of care related to safe lifts and transfers is provided to resident #003 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no medication/treatment is used by or administered to a resident in the home unless the medication/treatment has been prescribed for the resident.

A review of the critical incident report dated for a specified date indicated registered nurse RN # 101 administered resident #001 medications/treatments that were not prescribed for him/her.

A review of resident #001's progress notes dated for the specified date indicated resident #001 was administered medications/treatments that were not prescribed for him/her.

A review of resident #001's physician's orders and electronic medication/treatment record indicated resident #001 was not prescribed the medications/treatments he/she received.

During an interview with the inspector, RN #101 indicated on the specified date he administered resident #001 medications/treatments that were not prescribed for the resident.

During an interview with the inspector, the Assistant Director of Care #104 indicated on the specified date, RN #101 administered medications/treatments to resident #001 that were not prescribed for him/her.

The licensee failed to ensure that no medication/treatment was used by or administered to a resident unless the medication/treatment was prescribed for the resident. [s. 131. (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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident., to be implemented voluntarily.

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Issued on this 4th day of January, 2017

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

Original report signed by the inspector.