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
Apr 18, 2017	2017_505103_0016	019592-16, 019849-16, 024483-16, 027027-16, 029140-16, 030894-16, 000764-17, 000969-17, 002119-17	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): April 11-13, 18, 2017

The following intakes were included in this inspection:
019592-16 (resident fall),
019849-16 (resident fall),
024483-16 (resident fall),
027027-16 (unexpected death),
029140-16 (resident fall),
030894-16 (alleged staff to resident abuse),
000764-17 (alleged staff to resident abuse),
000969-17 (alleged resident to resident abuse),
002119-17 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with Personal Support workers (PSW), a Registered Practical Nurse (RPN), the Assistant Directors of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records made resident observations and reviewed the home's investigation into the allegations of abuse.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The following finding relates to Logs #019849-16, #024483-16, #029140-16, and #019592-16 :

The licensee has failed to ensure that incidents that resulted in injuries and for which residents #001, #002, #004, and #005 were taken to the hospital and resulted in a significant change to the resident's condition was reported to the Director no later than one business day.

On an identified date, the home submitted a critical incident report which indicated resident #001 had been experiencing an increase in pain and a decrease in mobility. The critical incident report stated the resident was transferred to hospital for further investigations and was diagnosed with a specified injury. The resident progress notes were reviewed and indicated the home was made aware of the injury on the same date as the transfer to hospital.

On a specified date, the home submitted a critical incident report to report resident #002 had sustained a fall on a specified date. The critical incident report indicated the fall occurred when the resident attempted to self transfer from the bed to the bathroom. The resident was transferred to the hospital the same day for further assessment of injuries. The resident progress notes were reviewed and indicated the staff received an update from the hospital on the same date and were informed the resident had sustained a specified injury as a result of the fall.

On a specified date, the home submitted a critical incident report to report resident #004 had sustained a fall on a specified date. The critical incident report indicated the fall occurred when the resident became resistive and fell backwards while being assisted by two PSW's to the bathroom. The resident was transferred to the hospital the same day for further assessment of injuries. The resident progress notes were reviewed and

indicated the staff received an update from the hospital on the following day and were informed the resident had sustained specified injuries as a result of the fall.

On a specified date, the home submitted a critical incident report to report resident #005 had sustained a fall on a specified date. The resident was transferred to the hospital the same day for further assessment of injuries. The resident progress notes were reviewed and indicated the staff received an update from the hospital the same day and were informed the resident had sustained a specified injury as a result of the fall.

The DOC and ADOC were interviewed and confirmed the MOHLTC was notified of all of the above incidents by means of submitting a critical incident report and that in each of the incidents, the notifications had not been done within one business day.

The home failed to inform the Director (MOHLTC) of the incidents for which residents #001, #002, #004 and #005 were taken to hospital and which resulted in a significant change in the resident's health status within one business day. [s. 107. (3) 4.]

Issued on this 18th day of April, 2017

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

Original report signed by the inspector.