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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 13, 2017	2017_505103_0050	018234-17, 020793-17, 023398-17, 024136-17	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): November 8, 9, 10, 2017

Log #018234-17 (alleged staff to resident neglect),
Log #020793-17 (alleged staff to resident neglect),
Log #023398-17 (alleged resident to resident abuse),
Log #024136-17 (alleged resident to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Directors of Care (ADOC), and the Administrator.

During the course of the inspection, the inspector made resident observations, reviewed resident health care records, applicable protocols, the home's investigation into the alleged incidents of abuse and the home's process for managing complaints.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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 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 following finding relates to Log #018234-17 and Log #020793-17:

The licensee has failed to ensure care was provided to resident #001 as specified in the

plan of care.

Resident #001 was admitted to the home on a specified date and had identified diagnoses. The resident was dependent on staff for all aspects of care. On an identified date, resident #001 fell out of bed and sustained an injury.

PSW #100 was in resident #001's room at the time of the fall. The PSW was interviewed and indicated the resident was in bed and had two quarter rails in place when she entered the room. The PSW raised the height of the bed to approximately four feet off of the ground to provide care and lowered the rail on the side where she was standing.

The PSW stated she had rolled the resident to one side to check the continence product and then rolled the resident onto their back. The PSW then stepped away from the resident's bed to retrieve clothing from the closet, leaving the one side rail down and the bed at a raised height. While the PSW's back was turned, the PSW reported hearing a deep gasp. As the PSW turned toward the bed, she observed the resident's upper torso contracting upwards. The PSW grabbed the resident's legs in an attempt to prevent a fall, but the resident's upper body came off of the bed and the resident fell onto the floor.

The resident was assessed by the registered staff at the time of the fall and then transferred to hospital for further assessment. The resident sustained injuries as a result of the fall.

Resident #001's plan of care, in effect at the time of this incident, was reviewed and indicated the following:
Under "Fall prevention", the plan indicated the resident was to have two quarter rails.
Under "Bed Mobility" , the plan indicated bed in lowest position when care not being provided.

ADOC #105 was interviewed and stated it is the home's expectation that bed rails and bed height are to be in place in accordance with the resident plan of care at all times when staff are not providing care to a resident.

The home investigated the incident and the PSW was counselled as a result. [s. 6. (7)]

2. The licensee has failed to ensure care was provided to resident #002 as specified in the plan of care.

Resident #002 was admitted to the home on a specified date and had identified diagnoses. The resident was totally dependent on staff for all aspects of care. On an identified date on or about 2330 hour, PSW #109 found the resident fully dressed and sitting in the wheelchair in the room.

PSW #109 was interviewed and stated she worked the night shift on the identified date. She indicated she began to make her safety rounds at approximately 2330 hour and resident #002 was the first resident she had checked. She stated the door was ajar and the lights were off when she entered the room. She stated when she could not find the resident in either the bed or the bathroom, she turned on the overhead light. She observed the resident in the wheelchair which was positioned between the bed and window area and the resident began to moan. The resident was in street clothing and was slumped to the right over the armrest of the wheelchair. The PSW stated the resident's seat belt was holding them in the chair and the call bell was not accessible to the resident. The PSW stated she notified the RN of the incident immediately and the resident was assisted into bed by herself and another PSW. PSW #109 recalled that the resident had areas of redness under the arm and across the chest from being slumped over the armrest.

RN #104 was interviewed and stated she was notified on the identified date on or about 2345 hour that resident #002 had been found still up and dressed in the wheelchair. The RN stated she assessed the resident and they reported being exhausted. The RN recalled the resident had extensive redness under the axilla and across the chest from being left in the wheelchair. The RN stated she immediately reported the incident to ADOC #105 who was on call that night. The ADOC requested increased monitoring of the resident, another skin assessment to be completed in the morning and ensured the appropriate notifications related to the incident were made.

RN #111 completed the skin assessment the following morning on or about 0755 hour and documented resident #002 had numerous bruises on the right forearm and hand and redness was still present under the right axilla as a result of leaning over the armrest.

PSW"s #102 and #103 were working on resident #002's unit on the evening of the identified date. PSW #102 was interviewed and stated she was unfamiliar with the residents as she rarely worked on this unit. She indicated she was assigned to work on resident #002's hallway and she checked in with PSW #103, who was a regular on the unit, throughout the shift in regards to the care needs of the residents. PSW #102 stated she was aware resident #002's family member visited over supper and that they had left

to go home somewhere around 1900 hour. The PSW was unable to pinpoint the last time she had seen resident #002 that evening. The PSW stated when she returned from her break around 2200 hour, she was told by PSW #103 that a final round had been completed on all of the residents.

PSW #103 was interviewed and stated she was assigned to work the opposite hallway from resident #002. She stated it was usual practice for the PSW's to complete the care for resident's who require one staff for assistance on their assigned hallways and to work together to complete the care for the remainder of the resident's that require two staff for assistance. She stated resident #002 required two staff for transfers, but only one staff to complete the care once the resident was in bed.

She stated on the evening of the identified date, she recalled resident #002's family member visiting until approximately 1900 hour. She stated when she returned from her supper break, she had observed PSW #102 in the hallway in the vicinity of resident #002's room. She stated she assumed the PSW had asked the registered staff to assist with resident #002's transfer and then completed the resident's bedtime care while she was on break. She further indicated she should have confirmed this with PSW #102. She stated the last time she had seen resident #002 was around 1900 hour.

Both PSW's stated they were aware that safety rounds were to be completed hourly and both confirmed they were not completed for resident #002 that evening.

RN#101 was in charge of resident #002's unit on the evening of the identified date. She recalled she had given the resident medications at approximately 1945 hour. She stated at that time the resident was fully dressed, sitting in the wheelchair in the room by the window and was in no distress. She stated that she did not see the resident again that shift.

Resident #002's plan of care, in effect at the time of this incident, was reviewed and indicated the following:
Under "Transfer", resident requires extensive assistance; two staff provide some weight bearing assistance.
Under "Dressing", resident is totally dependent on one staff to complete all aspects of dressing; will remain in day clothing until bedtime.
Under "Toileting", resident wears a containment product and has an individualized toileting plan in place; toilet between 1900-2000 hour and 2200 and 2300 hour.
Under "Sleep and rest", resident prefers to go to bed around 2000 hours.

Under “Fall prevention”, resident is at high risk for falls; ensure call bell is within easy reach.

The home completed an investigation into this incident and the PSW's that worked on the evening shift were counselled as a result. The licensee failed to ensure care set out in resident #002’s plan of care was provided as specified in the plan. [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 resident's care is provided as specified in the plan of care, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The following finding relates to Log #020793-17:

The licensee has failed to ensure a protocol, developed under the required program of fall prevention, was complied with.

The home has a written protocol that outlines all Personal Support Workers are to complete hourly checks on all assigned residents to ensure resident safety. ADOC #105 provided this inspector with a copy of the PSW "Evening routine/Responsibilities" list which was last updated June 18, 2012. This list included the requirement for hourly checks to be conducted for all residents. The ADOC stated all PSW's have this routine available to them on their documentation tool. She stated that hourly checks at a minimum is the expectation and that in some cases, residents may be care planned to be monitored more frequently as required based on their individualized care needs. She confirmed that resident #002 was to be monitored hourly. The ADOC also stated the home is currently reviewing and updating this protocol.

As outlined in WN #1, staff failed to complete hourly checks for resident #002 on the evening of the identified date. [s. 30. (1) 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 safety checks are completed a minimum of hourly for all residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following finding relates to Log #024136-17:

The licensee has failed to ensure incidents of verbal and emotional abuse were reported to the Director (MOHLTC).

Emotional abuse is defined by the legislation as any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

Verbal abuse is defined by the legislation as any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciate its consequences.

Resident #005's health care record was reviewed and for a period of six identified and consecutive months, there were documented incidents of verbal and emotional abuse toward resident #005 by resident #006. The home had documented follow up with the resident and following each incident, staff documented resident #005 was expressing feelings of upset and stress. There were also documented incidents whereby resident #006 made threats of physical harm against resident #005 and staff were documented as

escorting resident #005 to their room to avoid a confrontation with resident #006.

The physician assessed the resident on an identified date and resident #005 told the physician about the incidents, that they were still bothered by the incidents and requested to be prescribed something.

On an identified date, resident #005's family member spoke with the staff on the unit and indicated they would not tolerate any more incidences of abuse from resident #006. A letter outlining these same concerns was also given to the Administrator of the home.

The ADOC #106 indicated resident #006 had been assessed and was deemed capable and able to appreciate the consequences of their actions. The ADOC stated after each of the above outlined incidents, she followed up with resident #005 in regards to their feelings related to being safe in the home. The ADOC indicated resident #005 told her that they felt safe and would call for the staff if they needed help. The ADOC also stated these incidents were reviewed on several occasions during the morning management meetings and that the home struggled with whether these incidents were reportable.

The Administrator was interviewed and confirmed that there had not been any reports submitted in regards to the above noted incidents or upon receiving the written letter of complaint from the family member that made allegations of abuse involving their family member (resident #005) by resident #006. There was documentation to support that the home had investigated the incidents and had tried to address the concerns including supportive listening, and offering resident #005 a room change.

The licensee failed to ensure alleged, suspected and witnessed incidents of emotional and verbal abuse were immediately reported to the MOHLTC. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the requirements related to the restraining of resident #002 was done in accordance with the legislated requirements.

As outlined above in WN #1, resident #002 was found seated in the wheelchair with a seat belt in place on an identified date. PSW #103, #109, #110 and RN #101 all confirmed the resident wore a seat belt when up in the wheelchair and this resident was unable to undo the seat belt.

Resident #002's health care record was reviewed and there was no physician's order for this seat belt. The restraint was not included in the resident plan of care and there were no documented assessments found related to the use of the seat belt. ADOC #106 was interviewed and stated a seat belt that cannot be consistently removed by a resident would require a physician's order. She indicated she was unable to find any documentation related to the use of this seat belt. [s. 110. (2) 1.]

Issued on this 13th day of November, 2017

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

Original report signed by the inspector.