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 # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 13, 2018 | 2018_505103_0009 | 002930-18 | 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): March 8, 9, 12, 13, 2018.**

**Log #002930-18-alleged staff to resident neglect.**

**During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse, the Assistant Directors of Care and the Administrator.**

**During the course of the inspection, the inspector reviewed the resident health care record and the licensee's zero tolerance of abuse policy.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**

**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<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. 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 :**

1. The licensee has failed to ensure the licensee's zero tolerance of abuse policy was complied with.

Resident #001 had identified diagnoses. On an identified evening, PSW #104 reported to RPN #100 that resident #001 had reported feeling unwell. RPN #100 went to assess the resident.

RPN #100 was interviewed and stated resident #001 told RPN #100 that they had reported feeling unwell to PSW #103 prior to PSW #104, but PSW #103 left the room abruptly without acknowledging the resident's complaints. The RPN stated the resident indicated PSW #103 was always in a hurry.

RPN #100 stated the following morning they sent an email to ADOC #102 to advise them of the incident because they knew PSW #103's actions were not right and the incident should be reported.

The licensee's abuse policy, "Zero tolerance of Resident Abuse and Neglect", #RC-02-01 -01 was reviewed. Under Procedures, the following was stated:
-any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time.

RPN #100 stated as a result of the late reporting they received retraining on the licensee's abuse policy and was counselled by ADOC #102 in regards to the need for immediate reporting for all suspected, witnessed or alleged incidents of resident neglect.

At the time of this incident, the licensee had an existing compliance order related to this area of non-compliance. Order #001 was issued on January 18, 2018 during inspection #2017_505103_0052 and had a compliance date of February 14, 2018. [s. 20. (1)]

**Issued on this 14th day of March, 2018**

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

**Original report signed by the inspector.**