Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 7, 2020	2020_505103_0009	003464-20, 008476-20, 011383-20	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), CATHI KERR (641)

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 23, 25, 2020 (on-site), and June, 24, 26, 29, July 2, 2020 (off-site).

The following intakes were completed during this inspection:
Log #003464-20 (CIS# M569-000007-20)-alleged staff to resident abuse,
Log #008476-20 (CIS# M569-000014-20) and Log #011383-20 (CIS # M569-000017-20)-resident falls that resulted in injuries.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Assistant Director of Care-RPN, Assistant Director of Care-Registered Nurse (RN), and the Director of Care (DOC).

During the course of the inspection, the inspectors made resident observations, reviewed resident health care records, the licensee's policy, “Safe Operation of Electric Beds”, RC-08-01-08, last updated June 2019, Manufacturer's instructions, “Invacare Carroll CS Series, CS3, CS5, CS7, CS9FX600”, dated 2014, and the Director's Memorandum dated March 22, 2016.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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	Légende 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident regarding the pendent bed controller.

A critical incident was submitted to report resident #001 fell from their bed when the bed was elevated to the highest position off of the floor. Resident #001 sustained injuries as a result of this incident.

Resident #001's plan of care was reviewed related to fall prevention measures specific to resident #001's use of the pendant bed controller. Despite resident #001 having known risks related to the use of the pendant bed controller prior to the fall, none of the fall prevention measures addressed this risk.

Following the fall, additional fall preventions measures were added, but none were specific to the resident's use of the pendant bed controller. Resident #001's plan of care was revised to reflect the need to place the pendant bed controller out of resident #001's reach when the resident was discovered again with the bed elevated to the highest height.

The licensee failed to ensure clear directions were provided to staff and others who provided direct care to resident #001 related to the pendant bed controller to ensure resident #001's safety. [s. 6. (1) (c)]

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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure staff used variable height electronic beds in the home in accordance with manufacturers' instructions.

As outlined in WN #1, resident #001 fell from their bed when the bed was elevated to the highest position off the floor and sustained injuries as a result of the fall. Interviews with staff members indicated resident #001 had a cognitive impairment.

The resident's bed was identified as an Invacare CS7 bed and had a Hi/Lo lock out feature attached to the foot of the bed. The manufacturer's instructions for this bed titled "Invacare Carroll CS Series, CS3, CS5, CS7, CS9FX600, dated 2018, indicated on page 16, "To avoid injury or damage when operating product: …Close supervision is necessary when… this product is operated by or near people with physical /mental disabilities." Page 37 of the same manual indicated that "To avoid unintentionally pressing the pendant buttons and causing injury or damage… Do not place pendant under or between objects."

PSW's #108 and #109 were interviewed regarding pendant bed controls and stated they are typically placed under resident pillows. PSW #109 stated that due to resident #001's cognitive impairment, their pendant bed controller was being placed at the top end of the bed below the mattress so that it was out of their reach.

Resident #001's plan of care was reviewed and there were no directions to reflect close monitoring of the resident related to the resident's use of the pendant bed controller or for the placement of the pendant bed controller as directed in the manufacturer's instructions.

The Director of Care (DOC) and the ADOC #102 were interviewed separately and both indicated they were unaware the manufacturer's instructions recommended close supervision for this make and model of bed for resident's with a cognitive impairment and both also indicated close supervision was not being provided for resident #001.

The licensee failed to ensure that staff used resident #001's variable height electronic bed in accordance with manufacturers' instructions. [s. 23.]

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 staff use variable height electronic beds in the home in accordance with manufacturer's instructions, to be implemented voluntarily.

Issued on this 18th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103), CATHI KERR (641)
Inspection No. / No de l'inspection :	2020_505103_0009
Log No. / No de registre :	003464-20, 008476-20, 011383-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 7, 2020
Licensee / Titulaire de permis :	The Corporation of the City of Kingston 216 Ontario Street, KINGSTON, ON, K7L-2Z3
LTC Home / Foyer de SLD :	Rideaucrest Home 175 Rideau Street, KINGSTON, ON, K7K-3H6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Casie Keyes

To The Corporation of the City of Kingston, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s.6(1)(c).

Specifically, the licensee shall ensure that:

1. Resident #001 and all other residents with an identified cognitive impairment that are using a height adjustable electric bed equipped with a pendant (to raise and lower the bed) shall have a documented interdisciplinary assessment completed to ensure their safe use of the pendant controls.

2. If a risk is identified as a result of this assessment, ensure all interventions are clearly documented in the residents' plan of care related to their use of the pendant or electric controls, the placement of the controls and the level and frequency of monitoring required by staff to ensure resident safety related to the use of the height adjustable bed.

3. Audits shall be conducted a minimum of every two weeks on residents who were assessed as cognitively impaired and incapable of safely operating the pendant or other bed controls until such time the management team determines the resident's are being safeguarded and the auditing is no longer required.

4. Maintain documented records to support each step taken to achieve compliance with this order.

Grounds / Motifs :

1. The licensee failed to ensure there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident regarding the pendent bed controller.

A critical incident was submitted to report resident #001 fell from their bed when the bed was elevated to the highest position off of the floor. Resident #001 sustained injuries as a result of this incident.

Resident #001's plan of care was reviewed related to fall prevention measures specific to resident #001's use of the pendant bed controller. Despite resident #001 having known risks related to the use of the pendant bed controller prior to the fall, none of the fall prevention measures addressed this risk.

Following the fall, additional fall preventions measures were added, but none were specific to the resident's use of the pendant bed controller. Resident #001's plan of care was revised to reflect the need to place the pendant bed controller out of resident #001's reach when the resident was discovered again with the bed elevated to the highest height.

The licensee failed to ensure clear directions were provided to staff and others who provided direct care to resident #001 related to the pendant bed controller to ensure resident #001's safety. [s. 6. (1) (c)]

The decision to issue a Compliance Order (CO) was based on the following:
The severity of this incident resulted in actual harm to resident #001.
The scope was identified as isolated.
The home had related compliance history with this section of the LTCHA that included:
Written notification (WN) issued January 21, 2020 (2019_505103_0035),
WN issued July 11, 2019 (2019_664602_0031),
WN, Voluntary Plan of Correction (VPC) issued May 9, 2019 (2019_505103_0012),
WN issued January 12, 2018 (2017_505103_0052),
WN, VPC issued November 13, 2017 (2017_505103_0050).

(641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 09, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) Commission d'appel et de revision des services de santé 151, rue Bloor Ouest, 9e étage Toronto ON M5S 1S4	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of August, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

Service Area Office / Bureau régional de services : Ottawa Service Area Office