Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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
Feb 2, 2021	2021_520622_0001	022084-20, 000538-21, 000541-21	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): January 8, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 2021

**The following intakes were completed during this complaint inspection:
Log #022084-20, Log #000541-21 and Log #000538-21, related to alleged abuse, neglect and resident care and services.**

NOTE: A Written Notification related to LTCHA, s. 6. (7) was identified in a concurrent inspection #2021_520622_0002 (000041-21, CIS#M569-000001-21 and Log #023030-20, CIS#M569-000033-20) and issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Public Health Inspector, Public Health Nurse, Supervisor (Environmental Services), Best Practice Champion, Physiotherapist, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a laundry aide, and the resident.

Also during the course of the inspection, the inspector reviewed the licensee's investigation documents, resident health records, record of lost or missing items, licensee policies specific to: Coronavirus (COVID-19) - IC-05-01-13, Home's Visitor Policy During COVID-19 (Ontario) - CRG-01-ON, Management of Resident Belongings - RC-07-01-03, Personal Care Equipment: Cleaning and Disinfecting - IC-02-01-12, Zero Tolerance of Resident Abuse and Neglect Program - RC-02-01-01, the KFLA Public Health COVID-19 Home Visit records, and made observations of resident care and services.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Infection Prevention and Control
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)**
- **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	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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care related to lifts and transfers was provided to a resident as specified in the plan.

Two Personal Support Workers (PSWs) stated that they had used a particular type of lift to get a resident out of bed.

The plan of care indicated that a different type of lift should have been used for the resident's transfers.

Sources: resident’s care plan; and interviews with the PSW and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care for falls prevention was provided to a resident as specified in the plan.

A review of the most recent plan of care included interventions to communicate the resident’s risk for falls.

The resident’s room was observed not to have the intervention in place to communicate fall risk.

Sources: Observation of fall prevention intervention, resident’s health records, interviews with Best Practice Champion and other staff. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of dental hygiene care, set out in the care plan for two residents was documented.

A resident stated that they did not receive regular mouth care twice daily.

The resident's most recent plan of care stated that they were to receive dental hygiene twice a day.

Point of Care documentation on Point Click Care related to dental hygiene for the resident indicated that documentation was missing on four dates and a second resident was missing documentation on two dates.

Sources: resident's care plans; resident health records and interviews with the PSW and other staff. [s. 6. (9) 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 will ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 licensee has failed to ensure that a person who had reasonable grounds to suspect that verbal abuse of a resident by a Registered Practical Nurse (RPN) had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A resident stated that an RPN had verbally abused them on a date in December 2020. The resident stated that a second RPN was a witness during the incident.

The licensee's investigation interview documentation stated that on a date in December 2020, an RPN #108 witnessed another RPN verbally abusing the resident. RPN #108 stated that they did not report the incident.

Sources: the licensee's investigation documents, resident health records and interview with the resident, ADOC and other staff. [s. 24. (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 will ensure a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection, Prevention and Control program.

The licensee's policy titled Personal Care Equipment: Cleaning and Disinfecting, IC-02-01-12, last reviewed December 2020, stated that all dedicated personal care equipment must be in a good state of repair and labelled.

A resident stated that an item of personal care equipment used on them during care did not belong to them.

A Personal Support Worker (PSW) verified that the item of personal care equipment that was used on the resident during care was not labelled.

Sources: Review of the licensee’s policy; Personal Care Equipment: Cleaning and Disinfecting IC-02-01-12, observation of resident care and services, interview of resident, PSW and other staff. [s. 229. (4)]

Issued on this 10th day of February, 2021

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

Original report signed by the inspector.