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
Oct 7, 2021	2021_873602_0031	008927-21, 011179-21, 014440-21	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

WENDY BROWN (602)

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): September 21 - 23, 28, 29 & October 1, 2021

The following inspections were completed:
Log #014440-21/CIS #M569-000027-21 - regarding skin and wound care.
Log #011179-21/CIS #M569-000022-21 - regarding alleged staff to resident emotional abuse.
Log #008927-21/CIS #M569-000019-21 - regarding alleged staff to resident neglect.

It is noted that inspector Cheryl Leach (#719340) participated in the inspection as an observer.

During the course of the inspection, the inspector(s) spoke with with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC), the Director of Care (DOC), environmental service staff, screening staff, residents, family members and the Administrator.

In addition, the inspector reviewed resident health care records: including plans of care, progress notes, policies & procedures, investigation documentation and made resident care & service, and infection prevention and control practice observations.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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).

Findings/Faits saillants :

A resident was placed on a bedpan. The resident's brief was not checked until the resident complained of discomfort; they were found to still be sitting on the bedpan. The resident's care plan indicates they are on a individualized toileting schedule with scheduled brief checks.

In an interview with Assistant Director of Care (ADOC) it was indicated that the staff who put a resident on a bed pan are responsible for assisting the resident off the bed pan and/or alerting staff at change of shift that a resident still needed to be removed from the bed pan. Interviews with registered and unregistered staff indicated it is the expectation that staff are aware of what care is to be provided for their assigned residents. There is a risk of skin breakdown if a resident is left sitting on a bed pan and/or remains in soiled briefs for a prolonged period of time.

SOURCES: Critical Incident System (CIS) report #M569-000019-20, progress notes & plan of care and interviews with the ADOC and other staff. [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 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the skin and wound program policies and procedures were complied with:
O. Reg. 79/10, s. 48 (2). requires that there is a skin and wound care program that promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions.

A personal support worker (PSW) staff noted an odor from an old dressing area. The area was assessed by Nurse Practitioner (NP) who diagnosed an infection and prescribed oral antibiotics.

The investigation found that Registered Practical Nurse (RPN) assessed the area and identified a new wound. A reminder prompting routine daily and weekly monitoring was not entered into the electronic Treatment Administration Record as outlined in the licensee's skin & wound policy; resulting in no follow-up by registered staff. The investigation further identified, that another RPN completed a routine head to toe assessment and failed to note the wound as they did not visualize all areas of the resident’s skin as outlined in the skin & wound policy. The lack of follow-up resulted in an infection requiring the prescription of antibiotics.

SOURCES: CIS report #M569-000027-21, Skin and Wound Program policy, resident health care records and interviews with the ADOC, RPNs and other staff. [s. 8. (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 that their skin and wound program policies and procedures are complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure their written policy to promote zero tolerance of resident abuse was complied with.

A PSW informed the ADOC that another PSW, assisting in the care of a resident, used inappropriate measures while assisting in the toileting of a resident. The resident had been resisting care and became increasingly agitated. The resident was eventually transferred to their bed where their care was completed. An RPN provided the resident with medication for agitation. An investigation was commenced immediately upon management being informed of the incident and concluded that the allegation of emotional abuse of the resident was founded. The licensee's abuse and neglect policy indicates anyone who witnesses or suspects abuse of a resident by staff must immediately report the incident; this incident was not reported until several days after it occurred. Delaying the report of suspected abuse placed this and other residents at risk for further abuse.

Sources: CIS report #M569-000022-21, Zero tolerance of resident abuse and neglect policy, investigation documentation and interviews with the ADOC and other staff. [s. 20. (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 that their policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 12th day of October, 2021

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

Original report signed by the inspector.