

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité Ministry of Health and Long-Term Care

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

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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Date(s) of inspection/Date(s) de l'inspection

Aug 16, 18, 2011

Inspection No/ No de l'inspection

Type of Inspection/Genre d'inspection

2011_038197_0002

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of Care.

During the course of the inspection, the inspector(s) reviewed complaints policies and communications between Rideaucrest staff and complainant.

The following Inspection Protocols were used in part or in whole during this inspection: Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Definitions	Définitions
WN - Written Notification	WN - Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités



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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.)

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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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 O.Reg 79/10, s. 101. Dealing with complaints Specifically failed to comply with the following subsections:

- s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
- 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
- 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
- 3. A response shall be made to the person who made the complaint, indicating,
- i. what the licensee has done to resolve the complaint, or
- ii, that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits sayants:

- 1. On October 12, 2010 a family member of a resident at Rideaucrest Home sent a letter of concern regarding the care provided by a staff member of the home.
- 2. On November 7, 2010 this same family member then sent a subsequent email to the Director of Care asking for follow-up to her letter of concern.
- 3. On November 8, 2010, the Director of Care sent an email to the family member stating she had just finished her investigation and that she would be sending her a letter within the next two days.
- 4. A letter of response from Rideaucrest dated November 12, 2010 was forwarded by the family to the Ministry of Health and Long-Term Care.
- 5. The licensee failed to comply with O. Reg. 79/10 s.101(1)1, as they did not provide a response to the letter of concern within 10 business days.

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 written complaints are responded to within 10 days as required by O. Reg. 79/10, s. 101(1)., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits sayants:



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1. On October 12, 2010 a family member of a resident at Rideaucrest Home sent a letter of concern regarding the care provided by a staff member of the home.

2. The Director of Care confirmed receipt of this letter of concern.

- 3. On November 8, 2010 the Director of Care responded to the family member's email stating the home had just concluded their investigation and that a letter of response would be sent in the next day or two.
- 4. A letter of response from the Director of Care dated November 12, 2010, was forwarded to the Ministry of Health and Long-Term care by the family.

5. There is no record that Rideaucrest Home forwarded the written complaint or their response to the Director.

6. The licensee failed to comply with O. Reg. 79/10 s.103(1), as they did not submit a copy of the complaint or their response to the Director.

Issued on this 18th day of August, 2011

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