Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: June 10, 2024	
Inspection Number: 2024-1578-0002	
Inspection Type: Critical Incident	
Licensee: The Corporation of the City of Kingston	
Long Term Care Home and City: Rideaucrest Home, Kingston	
Lead Inspector Kayla Debois (740792)	Inspector Digital Signature
Additional Inspector(s) Tracey-Anne Chapman (000809) Wendy Brown (602)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 3-5, 7, 10, 2024

The following intake(s) were inspected:

- Intake: #00113797 [CI: M569-000010-24] -Physical abuse of a resident by a co-resident.
- Intake: #00117378 [CI: M569-000021-24] -Fall of resident resulting in an injury.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The licensee has failed to ensure that a resident's wheelchair was placed out of sight when the resident was in bed as set out in the plan of care.

Sources:
Review of the resident's plan of care, observations on two days in June, 2024, and interviews with an RPN, an ADOC, and a PSW.

[000809]

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9)
Plan of care

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.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care.

The licensee has failed to ensure that the provision and outcome of care related to a resident was documented on the clinical monitoring record following a sustained head injury from a physical altercation with a co-resident on a day in April, 2024.

Sources:
The resident's progress notes, the resident's Clinical Monitoring Record, and an interview with the DOC.

[740792]