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

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Public Report

Report Issue Date: April 2, 2025

Inspection Number: 2025-1578-0002

Inspection Type:
Critical Incident

Licensee: The Corporation of the City of Kingston

Long Term Care Home and City: Rideaucrest Home, Kingston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 24 - 28, 31 and April 1, 2025

The following intake(s) were inspected:

- Intake: #00137102 - CI #M569-000002-25 - Alleged staff to resident abuse
- Intake: #00137609 - CI #M569-000003-25 - Norovirus outbreak
- Intake: #00137991 - CI #M569-000004-25 - Fall of a resident resulting in injury
- Intake: #00141342 - CI #M569-000008-25 - Alleged staff to resident abuse
- Intake: #00142464 - CI #M569-000010-25 - Fall of a resident resulting in injury and death
- Intake: #00143036 - CI #M569-000011-25 - Fall of a resident resulting in injury

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a report was made to the Director regarding an allegation of abuse made by a resident. On a specified day in March 2025, a resident reported an allegation of abuse to a staff member. The staff member confirmed that they did not make an immediate report to the Director. The allegation of abuse was not reported to the Director until the next day.

Sources: Review of the critical incident report and an interview with a staff member

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that Routine Practices were followed in the IPAC program, specifically related to the completion of hand hygiene by staff members.

Specifically, on a day in March 2025, an Inspector observed six missed opportunities for hand hygiene on a home area, and one missed opportunity for hand hygiene on different home area.

Sources: Observations made by Inspector

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was complied with. In accordance with additional requirement 9.1 (f) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April, 2022), the licensee has failed to ensure that additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal were followed in the IPAC program.

Specifically, on a day in March 2025, a staff member did not correctly select or don the required PPE to enter a resident's room. The resident was on additional

precautions which required the use of specified PPE. The staff member was observed donning their PPE in the incorrect sequence and did not apply some of the required PPE when entering the room to provide care to the resident.

Sources: Observations made by Inspector; review of resident's clinical records; and interviews with staff members