

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

347 Preston Street, Suite 410 Ottawa, ON, K1S 3J4 Telephone: (877) 779-5559

Public Report

Report Issue Date: July 4, 2025

Inspection Number: 2025-1578-0004

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): June 23, 24, 26, 27, 2025 and July 2-4, 2025

The following intake(s) were inspected:

- Intake: #00146128/CI#M569-000014-25 was related to fall of resident.
- Intake: #00148856/CI#M569-000018-25 was related to alleged physical and emotional abuse of resident by staff.
- Intake: #00148874/CI#M569-000019-25 was related to alleged neglect of resident by staff.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control Safe and Secure Home Prevention of Abuse and Neglect Falls Prevention and Management



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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 the care set out in the plan of care for a resident was provided to the resident as specified in the plan. Specifically, during the month of May, 2025, a staff member did not reinforce a fall intervention as specified in the care plan.

Sources: record review of resident's plan of care, CIS report, and the licensee's Investigation File; and interviews with resident and two specific staff.

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.



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The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents, was complied with. Specifically, during the month of May, 2025, three staff members failed to report alleged abuse by staff toward a resident. And one of these staff members did not provide the resident with a supportive environment and treat them in a respectful and dignified manner, as per the licensee's Zero Tolerance of Abuse and Neglect Program Policy.

Sources: record review of resident's plan of care, CIS report, licensee's Investigation File, and the licensee's Extendicare Zero Tolerance of Abuse and Neglect Program Policy; and interviews with resident and two specific staff.