Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 3, 2014	2014_179103_0005	O-001187-13	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

DARLENE MURPHY (103)

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): April 3-4, 2014

During the course of the inspection, the inspector(s) spoke with a Registered Practical Nurse (RPN), a Registered Nurse (RN), the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records, the home's investigation notes into the allegation of neglect and reviewed the home's policy, "Resident Abuse-Staff to Resident, OPER-02-02-04".

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 24 (1) whereby an allegation of neglect was not immediately reported to the Director.

The legislation defines neglect as "a failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

On an identified date, Resident #1 was overheard asking staff when he\she could be toileted and that he/she had been asking since that morning. Staff #100 further investigated the resident's concerns and was advised by the staff member caring for this resident that he/she would not toilet the resident because he/she did not have split clothing. S#100 stated the resident was tearful following the incident and was reassured he/she would be toileted. S#100 reported the incident to management and stated he/she believed the refusal to toilet a resident was neglect.

The Assistant Director of Care was interviewed and her investigation notes were reviewed. She spoke with Resident #1 immediately following the allegation. Resident #1 stated he/she had requested to be toileted three times since the morning. The PSW who was providing his/her care encouraged the resident to wear another resident's split clothing but the resident had refused. Resident #1 confirmed he/she had not been toileted since that morning.

The Director of Care stated the PSW involved in the incident was interviewed. A critical incident report was not submitted to the Director until one month following the allegations. The staff member responsible was terminated by the home. [s. 24. (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 all allegations of abuse and neglect are immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 51 (2) (c) whereby a resident who was unable to toilet independently did not receive staff assistance to maintain continence.

A bladder continence assessment was completed on an identified date for Resident #1 and indicated the resident was continent during the day, utilized a commode for voiding and required staff assistance due to limited mobility. The care plan in effect at this time indicated the resident utilized a commode and required two staff to transfer by mechanical lift.

On an identified date, Resident #1 requested to be toileted on three separate occasions and was told by staff he/she would not be toileted until split back clothing was available. Alternative means of toileting were not considered or utilized to assist the resident in maintaining urinary continence. [s. 51. (2) (c)]

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 Resident #1 receives staff assistance to maintain continence, 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 has failed to comply with LTCHA, 2007 s. 20 (1) whereby the written policy to promote zero tolerance of abuse and neglect of residents was not complied with.

The home policy, "Resident Abuse-Staff to Resident, OPER-02-02-04" was reviewed. Under "Notification" the policy indicates the resident's substitute decision maker (SDM), if any and family will be immediately notified if the resident experiences abuse that resulted in physical injury or pain or distress that can be detrimental to the health and well being of the resident or within 12 hours of becoming aware of any other alleged, suspected or witnessed incident of abuse.

A critical incident was submitted to report an allegation of resident neglect that resulted in the termination of a staff member. The Director of Care confirmed the resident's SDM or family were not notified of the allegation.

Additionally, the policy under "Actions to be taken against the perpetrator" indicates, immediately remove the employee from the work schedule, with pay, pending investigation. During the investigation into the allegation of resident neglect, the PSW accused of the allegations continued to work a total of eighteen shifts which included directly providing care to the resident involved in the allegations. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 104 (1) 3 whereby a report to the Director failed to include the outcome or current status of the individual involved in the incident.

A critical incident was submitted to report an incident of resident neglect. The home failed to indicate pertinent information related to the outcome or current status of the resident involved in the incident of neglect. [s. 104. (1) 3.]

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Issued on this 3rd day of April, 2014

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

Darlene Murphy