

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

**Ottawa District**  
347 Preston Street, Suite 420  
Ottawa, ON, K1S 3J4  
Telephone: (877) 779-5559

<b>Original Public Report</b>	
<b>Report Issue Date:</b> June 12, 2023	
<b>Inspection Number:</b> 2023-1578-0004	
<b>Inspection Type:</b> Complaint Critical Incident System	
<b>Licensee:</b> The Corporation of the City of Kingston	
<b>Long Term Care Home and City:</b> Rideaucrest Home, Kingston	
<b>Lead Inspector</b> Ashley Bernard-Demers (740787)	<b>Inspector Digital Signature</b>
<b>Additional Inspector(s)</b> Gabriella Kuilder (000726)	

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 15 - 18, 23 - 24, 2023.

The following intake(s) were inspected:

- Intake: #00084878 - CI #M569-000017-23 – Medication incident
- Intake: #00086888 - CI #M569-000022-23 – Resident to resident alleged sexual abuse
- Intake: #00087067 - Complaint regarding concerns about a resident's behaviours

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

- Medication Management
- Infection Prevention and Control
- Responsive Behaviours
- Prevention of Abuse and Neglect

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Safe storage of drugs

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

#### Rational and Summary

On May 15th, 2023, an Inspector observed a Registered Practical Nurse (RPN) leaving a medication cart unattended and unlocked outside of a dining room with residents in close proximity to cart.

On May 15th, 2023, an Inspector observed a RPN leaving a medication cart unattended and unlocked in common area with residents in proximity of the unsecured cart.

On May 16th, 2023, in an interview with a RPN it was validated that during a medication administration pass if carts are unattended, the nurse is required to ensure the top of the cart is clear of medications, and the cart is locked.

On May 18th, 2023, on two other occasions an Inspector observed a RPN leaving the medication cart unattended and unsecured outside the entrance to a dining room. It was also noted that residents were walking in proximity of the unsecured cart.

Failure to lock medication carts presents potential risk to resident as the medication were not secured and locked.

**Sources:** Observation by Inspector #00726, Interview with staff # 110. [000726]



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

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