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

Original Public Report

Report Issue Date: February 21, 2024

Inspection Number: 2024-1578-0001

Inspection Type:
Complaint
Critical Incident

Licensee: The Corporation of the City of Kingston

Long Term Care Home and City: Rideaucrest Home, Kingston

Lead Inspector	**Inspector Digital Signature**
Ashley Bernard-Demers (740787)	Ashley F Bernard -Demers Digitally signed by Ashley F Bernard-Demers Date: 2024.02.22 11:22:55 -05'00'

Additional Inspector(s)
Wendy Brown (602)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12 - 16, 20 - 21, 2024

The following intake(s) were inspected:
Intake: #00101269 / CIS #M569-000042-23- Unwitnessed fall resulting in injury and transfer to hospital
Intake: #00105413 / CIS #M569-000001-24- Alleged resident to resident physical abuse
Intake: #00106644 / CIS #M569-000005-24 - Alleged neglect of resident
Intake: #00105539 / CIS #M569-000002-24 - Alleged improper/ incompetent treatment of a resident

Intake: #00107832 - Complaint regarding resident care

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

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 care was provided to a resident as per their plan of care on a day in January 2024.

Sources: Critical incident System (CIS) report, resident's clinical records and an interview with a staff member
[602]

WRITTEN NOTIFICATION: Falls prevention and management

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

Non-compliance with: O. Reg. 246/22, s. 54 (2)

Falls prevention and management

s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that written policies and protocols for the falls prevention and management program are complied with.

The licensee has failed to comply with the home's Fall Prevention and Management Program Policy regarding the completion of the Clinical Monitoring Record for a resident's fall on a specified day in November 2023.

Specifically, staff did not comply with the Falls Prevention and Management Program Policy regarding the monitoring for a resident's fall on a specified day in November 2023 regarding completing monitoring hourly for the first four hours post unwitnessed fall.

Sources: Review of the Falls Prevention and Management Program Policy; resident's Clinical Monitoring Record; interviews with staff members [740787]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee has failed to ensure that a monthly weight was obtained for a resident in July 2023 .

Sources: Review of resident's monthly weight documentation and an interview with a staff member
[740787]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that on a specified day in December 2023, a resident's medication was administered as per the prescriber's specified directions.

Sources: Review of resident's eMAR (electronic medication administration record) and an interview with a staff member
[740787]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that a medication incident report was documented for a resident's medication error that occurred on a specified day in December 2023.

Sources: Review of resident's eMAR (electronic Medication Administration Record); review of the Medication Incident and Reporting policy; and staff interviews
[740787]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions

s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a resident's medication error that occurred on a specified day in December 2023 was reported to the required individuals.

Sources: Review of resident's eMAR (electronic Medication Administration Record); review of the Medication Incident and Reporting policy; and staff interviews [740787]