Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 30, 31, Nov 1, 2, 2012	2012_049143_0043	Critical Incident

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, Nurse Practitioner, Physicians, Registered Nurses, Registered Practical Nurses and residents.

During the course of the inspection, the inspector(s) observed resident care and services, reviewed fall prevention policies and procedures, medication policies and procedures, observed medications administration, reviewed resident health care records inclusive of assessments, advanced directives, physician orders and plan of care.
Two critical incidents (Log #O-002233-12 and Log # O-001315-12) were reviewed as part of this inspection.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Hospitalization and Death

Medication

Personal Support Services

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Safe and Secure Home

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 O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The following finding is related to Log # O-001315-12:
Resident # 1 fell while being transferred in an Arjo tub lift. Arjo manufacturers' instructions included pictographs labeled to the lift demonstrating that seat components required to be properly attached to the frame, transfer strap to be applied and armrests to be lowered. A Personal Support Worker (S105) did not follow these manufacturers' instructions and resident # 1 fell from the lift requiring medical attention at the Emergency Department.
The licensee has failed to comply with ON/Regulation 79/10 section 23 by not ensuring that all staff use equipment in accordance with manufacturers' instructions.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The following finding is related to Log # O-001315-12:
A Personal Support Worker (PSW) Staff #S105 transferred Resident # 1 onto an Arjo tub lift (model number 210081-04/Rideaucrest inventory # 0279). Prior to transferring the resident onto the tub lift S105 failed to inspect the tub lift. The tub lift had a middle piece of the seat missing as well as the front portion of the seat was not securely attached to the frame of the lift. S105 attempted to transfer the resident, without fastening the safety strap and failed to lower one of the arm rests. The resident fell and required a transfer to hospital for assessment. A review of the incident with the Director of Nursing indicated that the transfer of the resident required two staff members present during the transfer.
The licensee has failed to comply with ON/Regulation 79/10 section 36 by not ensuring staff use safe transferring techniques when assisting residents.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The following finding is related to Log # O-001315-12:
On November 1, 2012 it was observed that resident # 1, 7 and # 8 had controlled substances stored in individual resident medication bins in the medication cart.
The licensee has failed to comply with ON/Regulation 129 (1)(b) by not ensuring that controlled substances are stored in a separate, double-locked cupboard in the locked area or stored in a separate locked area within the locked medication cart.

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 that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The following finding is related to Log # O-002233-12:
On a specified date a resident had an unexpected death. The Assistant Director of Nursing notified the Ministry of Health and Long Term Care (Ottawa Service Area Office) approximately 17 hours following this unexpected death.
The licensee has failed to comply with ON/Regulation 79/10 section 107 (1)2. by not informing the Director immediately of an unexpected or sudden death.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Issued on this 2nd day of November, 2012

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