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

Division de la responsabilisation et de la performance du système de santé
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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
Jul 11, 2013	2013_049143_0037	O-000416-13	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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 9-11th, 2013.

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

During the course of the inspection, the inspector(s) reviewed responsive behaviours policies and procedures, plan of care policies and procedures, reviewed resident health care records inclusive of plans of care, assessments, physician orders, medication administration records, consults, assessments and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A review of Extendicare Resident Care Manual, dated 2011, policy number Resi-03 -01-023 Care Plan Requirements, page 4 of 6 identifies the following requirements for care plan focus on behaviours:
*triggers to behaviours including dining room behaviours
*approaches to care that are successful
*what to do if interventions aren't successful
*if PRN (as necessary) medications are available refer user to the MAR for current orders and indicated under what conditions the medications can be use
*External resources the resident has been referred to including any recommendations for approaches to care
*ABS score from MDS and any chances since past assessment
*Include wandering as a behaviour if it is present.

A review of Resident #1's plan of care dated initiated and created on a specified date identified interventions to monitor behaviour.
Resident #1 was referred for an external consult and assessed on specified dates. .
PRN medications were ordered to manage behaviours.
Successful approaches to care were not addressed in the plan of care nor were interventions that were found to be successful.
No triggers to responsive behaviours were identified and addressed in the plan of care.

The licensee has failed to comply with Ontario Regulation 79/10 section 26. (3) 5. by not ensuring that the plan of care identifies mood and behaviour patterns, responsive behaviours, potential behavioural triggers as well as variations in resident functioning at different times of the day. [s. 26. (3) 5.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to comply with sec. 53(4) by not identifying behavioural triggers for resident #1 who was demonstrating responsive behaviours resulting in aggression towards resident #2, resident #3 as well as physical aggression towards staff.
This finding of non-compliance is supported by the following evidence that was documented within the progress notes of Point Click Care (Resident #1's Health Care Record):
On a specified date a Health Care Aid reported that resident #1 ripped the call bell cover off the wall and threw it behind a door.
On a specified date the Nurse Practitioner documented increase responsive behaviours.
On a specified date an attending physician documented severe agitation with aggression.
On a specified date three documented incidents of responsive behaviours.
On a specified date resident #1 assaulted a staff and resident #2. No injuries to the resident. Resident #1 on a specified date was transferred to hospital for assessment.
On a specified date resident #1 pushed resident #3. No injury to resident #3.
On a specified date resident #1 was transferred to hospital. [s. 53. (4) (a)]
The licensee failed to comply with sec. 53(4) by not identifying behavioural triggers for resident #1 who was demonstrating responsive behaviours

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Issued on this 12th day of July, 2013

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