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
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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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
Nov 5, 2014	2014_199161_0024	O-0000350-14 X O-000928-14	Critical Incident System

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road, OTTAWA, ON, K1G-5Z6

Long-Term Care Home/Foyer de soins de longue durée

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6

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

KATHLEEN SMID (161)

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): October 15, 16, 17, 21, 2014.

During the course of the inspection, the inspector(s) conducted 4 Critical Incident System inspections log # O-000350-14, #O-000928-14, #O-001002-14, #O-001054-14.

During the course of the inspection, the inspector(s) spoke with identified Residents, Personal Support Workers, Registered Nursing staff, Resident Care Managers, Director of Resident Care and the Director of Human Resources.

During the course of the inspection, the inspector(s) observed identified Residents and reviewed their health care records, home's polices and procedures titled "Abuse of Residents" #GEN-AD-1022 dated 2011-07-05, Policy and Procedure titled 'Record of Offences Review" GEN-HR-1762, Policy titled "Resident Abuse - Zero Tolerance" dated April 23, 2012, home's investigative notes and select email correspondence.

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

The licensee has failed to ensure that staff used safe transferring techniques when assisting a Resident.

On a specified date in April 2014 the Director was notified via the Critical Incident Report System that earlier in the day, Resident #002 sustained a fractured left hip as a result of being transferred incorrectly by PSW #S106.

A review of Resident #002's health record indicated that on a specified date in April 2014, PSW #S106 transferred the Resident by him/herself rather than using the prescribed mechanical lift with 2 persons, as per the Resident's care plan dated April 2014. Resident #002 fell to the floor with PSW #S106 falling on top of her/him; as a result, Resident #002 sustained a fractured left hip. PSW #S106 subsequently lifted the Resident from the floor and placed Resident #002 on their bed. PSW #S106 did not inform any registered staff of this incident.

Shortly thereafter, during the provision of care by PSW #S103, Resident #002 cried out in pain and stated to PSW #103 that her/his left hip was hurting and that she/he and PSW #S106 had been on the floor. PSW #S103 notified the registered staff member on duty. Resident #002 was assessed by the registered staff member who determined that Resident #002 required immediate transfer to the hospital. An ambulance was called and Resident #002 was transferred to hospital where she/he was treated for a fractured left leg and returned to the home seven days later.

Later on the specified date in April 2014, upon subsequent questioning by the registered staff member and a Manager of Resident Care, PSW #S106 denied that an incident had occurred that had resulted in Resident #002 falling on the floor. PSW #S106 was immediately suspended from their duties and sent home. The Home immediately initiated an investigation into the incident of April 2014. The following day, PSW #S106 wrote a letter to the home indicating that he/she had transferred Resident #002 by him/herself and that both he/she and the Resident had fallen to the floor.

On October 16, 2014 the Manager of Resident Care Rideau Building provided inspector #161 with a photocopy of the transfer logo dated April 2014 which had been posted at the head of the bed of Resident #002's at the time of the occurrence. The purpose of the transfer logo is to inform the health care provider of the method by which a Resident is to be transferred. In the case of Resident #002, the transfer logo depicted a sit-to-stand mechanical device using 2 persons as well as a two person side-by-side transfer. Resident #002's plan of care dated April 2014 indicates that the Resident was to be transferred using a sit-to-stand mechanical device as well as a 2 person assist.

As such, on a specified date in April 2014, Resident #002 was not transferred safely by PSW #S106 which resulted in the Resident falling to the floor and sustaining a fractured left hip. Three days after the incident, PSW #S106 resigned from the home. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. On October 21, 2014 Inspector #161 asked for and received from the Director of Resident Care, the home's written policy and procedure # GEN-AD-1022 dated 2011-07-05 titled "Abuse of Residents." This policy and procedure was reviewed by Inspector #161 and it does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

On October 22, 2014 discussion held with the Director of Resident Care, Manager of Resident Care Rideau Building and PSW Supervisor who validated with Inspector #161 that the home's written policy to promote zero tolerance of abuse and neglect of residents does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. They also indicated that this policy is currently under review and revision. [s. 96. (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is administered to a Resident in the home unless the drug has been prescribed for the resident.

On a date in August 2014 Resident # 001 was administered two drugs by mouth by RPN # S101. The RPN realized her error immediately and informed the attending physician. Resident #001 was sent to the hospital for further assessment and monitoring and returned to the home several hours later. Upon review of the Physician's orders it is noted that these drugs had not been prescribed for Resident # 001. On October 15, 2014 at 09:30 a.m, the Director of Resident Care indicated to Inspector #161 that RPN # S101 had received re-education on safe medication administration processes. [s. 131. (1)]

Issued on this 5th day of November, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2014_199161_0024
Log No. / Registre no:	O-0000350-14 X O-000928-14
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 5, 2014
Licensee / Titulaire de permis :	THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE 1750 Russell Road, OTTAWA, ON, K1G-5Z6
LTC Home / Foyer de SLD :	THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE 1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Akos Hoffer

To THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee will ensure that staff use safe transferring techniques when assisting Residents based on the Resident's assessed transferring needs.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting a Resident.

On a specified date in April 2014 the Director was notified via the Critical Incident Report System that earlier in the day, Resident #002 sustained a fractured left hip as a result of being transferred incorrectly by PSW #S106.

A review of Resident #002's health record indicated that on a specified date in April 2014, PSW #S106 transferred the Resident by him/herself rather than using the prescribed mechanical lift with 2 persons, as per the Resident's care plan dated April 2014. Resident #002 fell to the floor with PSW #S106 falling on top of her/him; as a result, Resident #002 sustained a fractured left hip. PSW #S106 subsequently lifted the Resident from the floor and placed Resident #002 on their bed. PSW #S106 did not inform any registered staff of this incident.

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As such, on a specified date in April 2014, Resident #002 was not transferred safely by PSW #S106 which resulted in the Resident falling to the floor and sustaining a fractured left hip. Three days after the incident, PSW #S106 resigned from the home. [s. 36.]
(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KATHLEEN SMID

Service Area Office /
Bureau régional de services : Ottawa Service Area Office