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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2016	2016_384161_0011	007975-16	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): on site April 1, 4, 5, 2016.

During the course of the inspection, the inspector(s) spoke with a Personal Support Worker (PSW), Food and Nutrition Aide (FNA), Registered Practical Nurse (RPN), Charge Nurse, RAI Coordinator, Food Service Supervisor, two Managers of Resident Care, Pharmacy Manager, Director of Resident Care and the Chief Nursing Officer.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was based on the needs and the preferences of resident #001.

On a specific date in March 2016 the home's Chief Nursing Officer notified the Director that a sudden, unexpected death had occurred at dinner in a dining room that involved resident #001. On that same date in March 2016 a Critical Incident Report (CIR) was submitted to the Director which provided additional information regarding this incident and the report was updated as required.

On April 1, 4, 5, 2016, an on-site inspection was conducted by MOHLTC Compliance Inspector #161. Resident #001's health care records were reviewed. The resident was admitted to the home on a specific date in early 2014 with multiple medical diagnoses. On the day of admission, resident #001's Substitute Decision Maker (SDM) signed the home's Advance Directives document and indicated a Level 4 on behalf of the resident. The home defines Level 4 as: in the event of a sudden witnessed collapse, cardiopulmonary resuscitation (CPR) would be attempted by the staff at the home and an ambulance would be called immediately for transfer of a resident to an acute care hospital for treatment. The Advance Directives document is supported by the home's policy and procedure titled "Advance Directives #Gen-CL-1618" last revised 2011.07.22.

Inspector #161 reviewed resident #001's plan of care and noted that the completed Advance Directives document that was signed on admission which was kept at the front of the resident's chart. This information was recorded monthly on the physician's orders and in the resident's most recent care plan.

On April 1, 2016 Inspector #161 discussed the sudden, unexpected death of resident #001 with the Food and Nutrition Aide (FNA) #106, Personal Support Worker (PSW) #107 and Registered Practical Nurse (RPN) #108 who were on duty on the specific date in March 2016 and attended to the resident.

On a specific date in March 2016, resident #001 was seated in the dining room eating dinner. According to discussions with FNA #106 and PSW #107, in accordance with his/her prescribed diet and texture, the resident was served vegetables and meat. A few minutes later, resident #001 stood up from his/her chair and started walking around the dining room. PSW #107 directed the resident to return to his/her chair to complete eating his/her dinner. PSW #107 observed resident #001 sit down in his/her chair. Shortly thereafter, PSW #107 observed that resident #001 was leaning to his/her right side, legs stretched out and arms at his/her sides. Simultaneously, FNA #106 observed resident #001 slumped in the chair. FNA #106 asked PSW #107 to get RPN #108 who was in the resident home area administering medication to a resident. FNA #106 told Inspector

#161 that she felt that PSW #107 was slow to get assistance, so she ran to get RPN #108 as did PSW #107.

According to RPN #108, he/she was approached by FNA #106 and PSW #107 who were visibly upset and indicated to him/her to come urgently to the dining room. He/she ran to the dining room and observed resident #001 slumped in the chair and noted that on the resident’s dinner plate there were some vegetables, gravy but no meat. RPN #108 immediately thought that resident #001 had choked. RPN #108 performed a finger sweep of the resident’s mouth which retrieved some vegetables; and started performing abdominal thrusts while calling out to staff to summon a registered nurse. RPN #108 recalled that an RPN and Charge Nurse #111 arrived on the scene. RPN #108 continued performing abdominal thrusts while Charge Nurse #111 assessed the resident. The Charge Nurse #111 indicated to RPN #108 that resident #001 was not breathing, did not have a pulse and left without informing RPN #108 where she/he was going. RPN #108 continued to perform abdominal thrusts on resident #001. Charge Nurse #111 returned to resident #001 and told RPN #108 that the resident had level 4 advance directives however it was too late to perform CPR because resident #001 had not been breathing nor had a pulse for a long time, and that CPR was futile. Upon hearing this information from Charge Nurse #111, RPN #108 indicated to Inspector #161 that he/she stopped performing abdominal thrusts. RPN #108 did not perform CPR nor did any other staff member in attendance at the scene.

On April 4, 2016 Inspector #161 discussed the sudden, unexpected death of resident #001 with Charge Nurse #111 who was on duty on the specified date in March 2016. Charge Nurse #111 indicated to Inspector #161 that on that date, she/he was in a dictation room when she/he heard their name called. The Charge Nurse looked up and observed PSW #112 and RPN #113 at the door asking her/him to “come, come” with them to the unit where resident #001 resided. During the time that Charge Nurse #108, RPN #113 and PSW #112 were on the elevator, PSW #112 informed Charge Nurse #111 that resident #001 may be deceased. When Charge Nurse #111 arrived on the unit, she/he observed that RPN #108 and RPN #114 were holding the resident in his/her chair and that resident #001 was not breathing nor had a pulse. Charge Nurse #111 did not perform CPR. She/he proceeded to the nursing station, obtained a stethoscope and returned to resident #001. Charge Nurse #111 auscultated resident #001’s chest and indicated to those staff present that she/he did not hear a heartbeat nor was the resident breathing. Charge Nurse #111 did not initiate CPR.

The staff requested permission to transfer resident #001 back to his/her room at which

point Charge Nurse #111 said to leave the resident in the chair and she/he would contact the coroner. Charge Nurse #111 then left resident #001 with the staff members and returned to the nursing station. Charge Nurse #111 checked the resident’s health care record and found the resident’s advance directives that indicated that resident #001 was a level 4 thus requiring CPR and immediate transfer to an acute care hospital. Charge Nurse #111 returned to resident #001 and indicated to staff present that although the resident had level 4 advance directives, CPR was futile. Charge Nurse #111 indicated to Inspector #161 that the incident had occurred at least 20 minutes prior and that by the time that she/he arrived at the scene, it was too late to start CPR.

On April 4, 2016, discussion held with the Manager of the resident care area where resident #001 had resided. The Manager indicated to Inspector #161 that when the Charge Nurse #111 determined that the resident did not have a pulse and was not breathing, the resident’s Advance Directives Level 4 should have been immediately initiated; CPR should have been performed and an ambulance called to transfer the resident to an acute care facility. This was confirmed by the home’s Chief Nursing Officer.

In summary, on a specific date in March 2016 resident #001 choked in the dining room. Abdominal thrusts were performed multiple times to no avail. The resident was determined to have deceased. The resident’ s Advance Directives Level 4 were not followed; CPR was not performed nor an ambulance called for the immediate transfer of resident #001 to an acute care facility. [s. 6. (2)]

Additional Required Actions:

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

Issued on this 15th day of April, 2016

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN SMID (161)
Inspection No. / No de l'inspection :	2016_384161_0011
Log No. / Registre no:	007975-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 15, 2016
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

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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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Order / Ordre :

1. Conduct a root cause analyses with the personnel that were involved in this sentinel event.

2. Review the assessment and the provision of emergency care when a resident's wishes/preferences cannot be ascertained at the time of the incident; and how Advance Directives are used to support decision making during the care planning process, when there is a matter of seconds when dealing with an emergency. This may involve the participation of an ethicist and may require the home to review and revise their Advance Directives policy and procedures.

3. Educate all registered nursing staff related to rapid decision making when wishes of a resident/SDM regarding a known condition are unknown or unclear; or when an emergency unrelated to that condition occurs. This includes education to all registered nursing staff on the revised Advance Directives policy and procedures.

4. Measure the uptake and demonstrate the acquired knowledge, identify deficits and retrain as needed. Monitor on-going compliance as determined by the Chief Nursing Officer.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on the needs and the preferences of resident #001.

On a specific date in March 2016 the home's Chief Nursing Officer notified the Director that a sudden, unexpected death had occurred at dinner in a dining room that involved resident #001. On that same date in March 2016 a Critical

Incident Report (CIR) was submitted to the Director which provided additional information regarding this incident and the report was updated as required.

On April 1, 4, 5, 2016, an on-site inspection was conducted by MOHLTC Compliance Inspector #161. Resident #001's health care records were reviewed. The resident was admitted to the home on a specific date in early 2014 with multiple medical diagnoses. On the day of admission, resident #001's Substitute Decision Maker (SDM) signed the home's Advance Directives document and indicated a Level 4 on behalf of the resident. The home defines Level 4 as: in the event of a sudden witnessed collapse, cardiopulmonary resuscitation (CPR) would be attempted by the staff at the home and an ambulance would be called immediately for transfer of a resident to an acute care hospital for treatment. The Advance Directives document is supported by the home's policy and procedure titled "Advance Directives #Gen-CL-1618" last revised 2011.07.22.

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According to RPN #108, he/she was approached by FNA #106 and PSW #107 who were visibly upset and indicated to him/her to come urgently to the dining room. He/she ran to the dining room and observed resident #001 slumped in the chair and noted that on the resident's dinner plate there were some vegetables, gravy but no meat. RPN #108 immediately thought that resident #001 had choked. RPN #108 performed a finger sweep of the resident's mouth which retrieved some vegetables; and started performing abdominal thrusts while calling out to staff to summon a registered nurse. RPN #108 recalled that an RPN and Charge Nurse #111 arrived on the scene. RPN #108 continued performing abdominal thrusts while Charge Nurse #111 assessed the resident. The Charge Nurse #111 indicated to RPN #108 that resident #001 was not breathing, did not have a pulse and left without informing RPN #108 where she/he was going. RPN #108 continued to perform abdominal thrusts on resident #001. Charge Nurse #111 returned to resident #001 and told RPN #108 that the resident had level 4 advance directives however it was too late to perform CPR because resident #001 had not been breathing nor had a pulse for a long time, and that CPR was futile. Upon hearing this information from Charge Nurse #111, RPN #108 indicated to Inspector #161 that he/she stopped performing abdominal thrusts. RPN #108 did not perform CPR nor did any other staff member in attendance at the scene.

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On April 4, 2016, discussion held with the Manager of the resident care area where resident #001 had resided. The Manager indicated to Inspector #161 that when the Charge Nurse #111 determined that the resident did not have a pulse and was not breathing, the resident's Advance Directives Level 4 should have been immediately initiated; CPR should have been performed and an ambulance called to transfer the resident to an acute care facility. This was confirmed by the home's Chief Nursing Officer.

In summary, on a specific date in March 2016 resident #001 choked in the dining room. Abdominal thrusts were performed multiple times to no avail. The resident was determined to have deceased. The resident' s Advance Directives Level 4 were not followed; CPR was not performed nor an ambulance called for the immediate transfer of resident #001 to an acute care facility. [s. 6. (2)]
(161)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de sions de longue durée
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
Inspection de sions de longue durée
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 15th day of April, 2016

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