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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2016	2016_380593_0014	011766-16, 006345-16, 004652-16, 004498-16, 000466-16, 036089-15	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

GILLIAN CHAMBERLIN (593)

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): May 9-13, 16-17, 2016.

Six Critical Incidents were inspected during the inspection. Including logs #011766-16, #006345-16, #004498-16 related to falls, #004652-16 related to resident neglect, #000466-16 related to resident to resident abuse and #036089-15 related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Manager of Clinical Services, Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The Inspector observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

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

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 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. (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. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan [log #004652-16].

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding a reported complaint of resident neglect. A private care provider for resident #003, reported that for a period of time on a particular day, care was not provided to resident #003.

The home received a written complaint from resident #003's private care provider alleging neglect of resident #003 for a period on a particular day, 2016. A summary of the written complaint was as follows:

Walking into resident #003's room yesterday was as if I hadn't even left from the morning, everything was as I left it. Resident #003's clothes were set out for them and laid over the back of a chair, at 1630 hours, they were still in their nightgown and clothes were untouched. I opened a new bag of briefs, placing most of them inside the cupboard but leaving four out on top, these four were still in place. I brought in several hand towels and wash clothes and placed them on the railing, ready to be used throughout the day, none of them had been used. I am certain resident #003 was in my opinion, neglected.

PSW Manager #101 reviewed the video surveillance which captured the entrance to resident #003's room. The following is a timeline of events occurring February 11, 2016:

0712 hours- staff member peeked in room

0810 hours- private care provider arrived

0820 hours- PSW #100 entered room, signed log and left room

1000 hours- Private care provider leaves

1030 hours- RPN provided medications

1033 hours- PSW #100 entered room, signed log and left room

1300 hours- RPN provided medications

1421 hours- PSW #100 entered room, signed log and left room

1452 hours- Juice delivered by other PSW

1538 hours- towels dropped in door of room by evening PSW

1551 hours- RPN provided medications

1621 hours- Visitor entered and left at 16:23

1630 hours- Private care provider arrived

During an interview with Inspector #593, May 11, 2016, PSW Manager #101, reported that PSW #100 was assigned to resident #003 for the day shift. #101 confirmed that they completed the investigation of the complaint received documenting alleged neglect. #101 reported that the outcome of the investigation was that for a period of time on a particular day, care was not provided and a meal was not provided to resident #003. #101 further added that PSW #100 was late to the unit that morning as it was not their regular assignment and because of this, they missed the morning report. The private care provider usually leaves in the morning and comes back in the afternoon, with care being provided by the staff of the home during this time.

During an interview with Inspector #593, May 12, 2016, PSW #100 reported that they were not very familiar with that particular home area and usually they would check the Kardex however did not that day. When they checked on resident #003, they saw that

the resident had a private care provider and assumed it was for the entire day. At lunch time, they were told to sit in the dining room to assist with feeding residents and that their residents staying in their rooms, would be fed also. PSW #100 reported that they checked on the resident several times and saw that they were sleeping and as the home area had some residents on isolation precautions, they thought that resident #003 was one of these residents and that was why they were sleeping in bed for the day.

A review of resident #003's care plan in place February 11, 2016, found that for ADLs, resident #013 required extensive assistance by staff. For mobility and walking, resident #003 required extensive assistance by staff in their room and total dependence on staff for mobility on and off the unit. [s. 6. (7)]

2. The licensee has failed to ensure that resident #009 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective [log #004498-16].

A Critical Incident (CI) was submitted to the MOHLTC related to an incident where resident #009 fell and was then admitted to hospital due to an injury sustained during the fall.

A review of resident #009's health care record, found that the resident was a high falls risk with a history of falls including multiple falls that occurred over a period of approximately 12 months. The Fall Risk Screening tool was not completed for any of the falls.

A review of resident #009's care plan at the time of the most recent fall, found several interventions documented related to managing falls risk. Care plans in place prior to this dated January, 2015, April, 2015, July, 2015 and October, 2015; had the same interventions documented related to managing falls risk.

During an interview with Inspector #593, May 17, 2016, RN #105 reported that if a resident was a frequent faller, the interventions would be reviewed and this may involve a referral to the Occupational Therapist (OT) or the Physiotherapist (PT). This could involve application of a physical device eg. seatbelt to assist with fall prevention. Regarding resident #009, the RN reported that resident #009 was a frequent faller and they were pretty sure that they completed OT referrals for this resident.

A review of resident #009's health care record, found no PT assessments related to falls

and the only OT assessment related to falls was completed after the fall occurring January, 2016.

After an interview with Inspector #593, May 19, 2016, Manager of Clinical Services #104 reported via email that there was no re-assessment of resident #009 related to falls interventions including referral and assessment by OT or PT.

Review of the home's policy titled "Fall Prevention Program- GEN-CL-1550, NSG-F-550" last revised July 2011, documented that in addition to the completion of a risk management report, all falls will be investigated and analyzed using the Fall Risk Screening Tool. Nursing staff will open a new Fall Risk Screening Tool following each fall, which must be completed within 72 hours. They will consult with members of the interdisciplinary team as needed, and will notify team members by email if a resident needs to be reassessed following a fall. The full time RN will monitor the number of falls occurring and following the third fall; will notify the Fall Prevention Team via email that a team assessment is required. [s. 6. (10) (b)]

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 ensuring that the care set out in the plan of care is provided to all residents as per the plan and all residents are reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective, specifically related to falls interventions but not limited to, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director [log #000466-16].

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of resident to resident physical abuse occurring January, 2016. It was reported that a loud verbal exchange occurred between residents #005 and #006, with resident #006 pushing resident #005 from their room. Resident #005 landed in the hallway hitting their head on the floor, resulting in an injury to their face.

The after-hours pager was contacted, however the incident actually occurred nearly 24 hours earlier than when the incident was reported to the Director.

During an interview with Inspector #593, May 13, 2016, Manager of Clinical Services #102 reported that the homes internal reporting process after-hours is that all staff are to report to the registered nursing staff, it is then the registered nursing staffs responsibility to complete a risk management report and inform the administrator on call. The administrator on call is then to report the incident to the Director. #102 reported that the registered nursing staff did immediately inform the administrator on call however they were unsure why the administrator on call did not then immediately report the incident to the Director.

A review of the home's policy titled "Abuse of Residents- GEN-AD-1022" last revised December, 2014, documented that reporting incidents of abuse or neglect after hours, staff must report the incident to a supervisory staff member. Supervisory staff will notify the administrator on call. The administrator on call must inform the MOHLTC immediately. [s. 24. (1)]

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 ensuring that the policy "Abuse of Residents- GEN-AD-1022" is complied, specifically "reporting incidents of abuse or neglect", ensuring that all suspicions of abuse by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident is immediately reported to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Policy- "Fall Prevention Program- GEN-CL-1550, NSG-F-550" is complied with. This is a required program in the regulations under r. 48. (1) every licensee of a long-term care home shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home [log #011766-16].

A review of the home's policy titled "Fall Prevention Program- GEN-CL-1550, NSG-F-550" last revised July 2011, documented that in addition to the completion of a risk management report, all falls will be investigated and analyzed using the Fall Risk Screening Tool. Nursing staff will open a new Fall Risk Screening Tool following each fall, which must be completed within 72 hours.

A Critical Incident (CI) was submitted to the MOHLTC related to an incident where resident #007 fell and was then admitted to hospital due to an injury sustained during the fall.

A review of resident #007's health care record, found no initiated or completed Fall Risk Screening Tools related to this fall or an earlier fall sustained by the resident.

During an interview with Inspector #593, May 18, 2016, Manager of Clinical Services #102 reported a Fall Risk Assessment is not necessarily completed after every fall, when advised that it was documented in the home's policy, #102 reported that the assessment should have been completed for resident #007. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that Policy- "Fall Prevention Program- GEN-CL-1550, NSG-F-550" is complied with [log #006345-16].

A review of the home's policy titled "Fall Prevention Program- GEN-CL-1550, NSG-F-550" last revised July 2011, documented that in addition to the completion of a risk management report, all falls will be investigated and analyzed using the Fall Risk Screening Tool. Nursing staff will open a new Fall Risk Screening Tool following each fall, which must be completed within 72 hours.

A Critical Incident (CI) was submitted to the MOHLTC related to an incident where resident #008 fell and was then admitted to hospital due to a change in condition contributing to the fall.

A review of resident #008's health care record, found no initiated or completed Fall Risk Screening Tools related to this fall or a later fall sustained by the resident.

During an interview with Inspector #593, May 18, 2016, Manager of Clinical Services #102 reported a Fall Risk Assessment is not necessarily completed after every fall, when advised that it was documented in the home's policy, #102 reported that the assessment should have been completed for resident #008. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that Policy- "Fall Prevention Program- GEN-CL-1550, NSG-F-550" is complied with [log #004498-16].

A review of the home's policy titled "Fall Prevention Program- GEN-CL-1550, NSG-F-550" last revised July 2011, documented that in addition to the completion of a risk

management report, all falls will be investigated and analyzed using the Fall Risk Screening Tool. Nursing staff will open a new Fall Risk Screening Tool following each fall, which must be completed within 72 hours.

A Critical Incident (CI) was submitted to the MOHLTC related to an incident where resident #009 fell and was then admitted to hospital due to an injury sustained during the fall.

A review of resident #009's health care record, found no initiated or completed Fall Risk Screening Tools related to this fall. Furthermore, the resident had multiple falls over the past 12 months and there was no Fall Risk Screening Tool completed for any of these falls.

During an interview with Inspector #593, May 19, 2016, Manager of Clinical Services #104 reported that they were unsure about the home's policy regarding post falls assessment however confirmed that this was not completed for each of the nine falls sustained by resident #009. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee has failed to ensure that Policy- "The Medication Pass- 3-6" is complied with. This is a required policy in the regulations under r. 114. (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home [log #036089-15].

A review of the home's policy "The Medication Pass- 3-6", dated January 2014, found that the procedure for administering medications includes- document on MAR (medication administration record) in proper space for each medication administered or document by code if medication not given.

A CI was submitted to the MOHLTC related to an incident of alleged staff to resident physical abuse. It was reported that RN #103 was witnessed to physically abuse resident #004.

It was documented in the home's investigation records that RN #103 requested RPN #106 to administer a PRN to resident #004 to assist in managing behaviours. RPN #106 was hesitant to do so as they had just administered the resident's regular medications. The RPN gave the PRN medication to RN #103 who administered the drugs to resident #004.

A review of resident #004's MAR, found no documentation related to the administration of a PRN on this day.

During an interview with Inspector #593, May 13, 2016, RPN #106 reported that RN #103 requested the RPN to administer a PRN to resident #004 as they were very loud and excited. RPN #106 reported that they refused as they were not the one dealing with the situation but they did give the PRN medications to the RN, who administered the drugs to resident #004. RPN #106 further reported that the RN should have documented the administration of the PRN as they were the one who administered the drug.

During an interview with Inspector #593, May 17, 2016, Manager of Clinical Services #102 reported that RN #103 should have documented the administration of the PRN to resident #004. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, being 21 days [log #004652-16].

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of staff to resident neglect. It was reported by resident #003's private care giver that no care was provided to resident #003 for a period of approximately six and a half hours.

The CI was reviewed by the CIATT team with a request to the home to amend the CI with the outcome of the investigation. The CI was not amended until 54 days after the CI was first submitted to the Director.

During an interview with Inspector #593, May 13, 2016, Manager of Clinical Services #102 reported that they submitted the initial CI as the regular manager was on vacation. When they returned from vacation, they handed the incident over to the regular manager and it was their responsibility to amend the CI with the outcome.

A review of the home's policy titled "Abuse of Residents- GEN-AD-1022" last revised December 2014, documented that reporting incidents of abuse or neglect, the manager or administrator on call must complete a MOHLTC online critical incident system (CIS) form within 10 business days. [s. 104. (1) 4.]

2. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, being 21 days [log #036089-15].

A CI was submitted to the MOHLTC related to an incident of alleged staff to resident verbal abuse. It was reported that RN #103 was witnessed to physically abuse resident #004.

The CI was reviewed by the CIATT team with a request to the home to amend the CI with the outcome of the investigation. The CI was not amended until more than three months after the CI was first submitted to the Director.

During an interview with Inspector #593, May 13, 2016, Manager of Clinical Services #102 reported that the incident occurred in their home area however they were away and another manager submitted the CI. This incident has been ongoing and they have no reason as to why the CI was amended late other than it got away from them.

A review of the home's policy titled "Abuse of Residents- GEN-AD-1022" last revised December 2014, documented that reporting incidents of abuse or neglect, the manager or administrator on call must complete a MOHLTC online critical incident system (CIS) form within 10 business days. [s. 104. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when informing the Director of an incident under subsection (1), (3) or (3.1), shall, within 10 days of becoming aware of the incident, make a report in writing to the Director setting out the outcome or current status of the individual involved in the incident and the long-term actions planned to correct the situation and prevent recurrence [log #011766-16].

A Critical Incident (CI) was submitted to the MOHLTC related to an incident where resident #007 fell and was then admitted to hospital due to an injury sustained during the fall.

At the time of submission, the CI did not include the outcome or current status of the individual involved or the long-terms actions to prevent re-occurrence. The CI was not amended with this information until 35 days after the CI was first submitted to the Director.

During an interview with Inspector #593, May 13, 2016, Manager of Clinical Services #102 reported that there was no reason that the CI was amended late. [s. 107. (4) 4. ii.]

Issued on this 6th day of June, 2016

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

Original report signed by the inspector.