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

Division des foyers de soins de longue durée
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
Aug 10, 2016	2016_384161_0036	017321-16 X 019210-16 X 019219-16 X 019045-16 X 020040-16	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 August 3, 4, 5, 8, 2016.

During the course of the inspection, the inspector(s) conducted five critical incident system inspections as follows:
- two critical incident reports the home submitted related to allegations of resident to resident abuse,
- two critical incident reports the home submitted related to allegations of staff to resident abuse,
- one critical incident report the home submitted related to an allegation of staff to resident neglect.

During the course of the inspection, the inspector(s) reviewed the five critical incident reports the home had submitted, reviewed the identified residents health care records, home's investigation notes and the homes policy and procedure titled "Abuse of Residents - GEN-AD-1022" last revised 2014-12-15.

During the course of the inspection, the inspector(s) spoke with identified residents, Personal Support Workers, Personal Support Worker Supervisor, Registered Nursing Staff, Special Approach Personal Support Worker, several Managers of Resident Care, Director Nursing Operations, Chief Nursing Officer

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #005 was not neglected by Personal Support Worker #110.

As per O. Reg. 79/10, s.5. "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In 2016 resident #005 was admitted to the home with multiple medical diagnoses. The resident required the assistance of two people for positioning in bed, transferring, toileting, and the assistance of one person for personal hygiene, eating and drinking.

Personal Support Worker (PSW) #110 was assigned to the provision of care and services to resident #005 on two consecutive dates in July 2016 from 0700 hours to 1500 hours. Registered nursing staff on duty on those specified dates in July 2016, observed that from 0700 hours until approximately 1100 hours, PSW #110 did not go into the room of resident #005 to offer nor provide any care and services as described above; nor was breakfast or any beverages offered or provided by PSW #110 during those hours. On the second consecutive date in July 2016, PSW #110's pattern of inaction was reported to PSW Supervisor #106. The home immediately initiated an investigation which included a review of resident #005's point of care documentation for the above dates and times, as well as video surveillance taken in the corridor of the residents' home area. Two days later, on a specified date in July 2016 PSW #110 indicated to PSW Supervisor #106 and the Manager of Resident Care #111, that on the dates and times indicated above, she did not go into the room of resident #005 to offer nor provide any care and services as described above; nor did she offer nor provide resident #005 with breakfast or any beverages. On the same date that PSW #110 was interviewed in July 2016, the home concluded their investigation and PSW #110 was disciplined for her pattern of inaction.

On August 8, 2016 during a review by Inspector #161 of resident #005's point of care documentation for the above dates and times, PSW Supervisor #106 and Manager of Resident Care #111 confirmed that PSW #110 had failed to provide care and services to resident #005 on two consecutive dates in July 2016 between the hours of 0700 and approximately 1100. [s. 19. (1)]

Issued on this 10th day of August, 2016

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

Original report signed by the inspector.