Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 11, 2011	2011_126_8595_11jan102209	Follow up to critical incident Log # O-000047

Licensee/Titulaire

The Perley and Rideau Veterans Health Centre
1750 Russell Rd
Ottawa, ON
613-526-7172

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

The Perley and Rideau Veterans Health Centre
1750 Russell Rd
Ottawa, ON
613-526-7172

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

Linda Harkins Inspector #126

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up to a critical incident inspection for potential/actual abuse, neglect.

During the course of the inspection, the inspector spoke with: the Chief Executive Officer, the Program Manager of the unit, the Day Charge Nurse, the Resident Aid and the resident.

During the course of the inspection, the inspector reviewed the resident's health care record.

The following Inspection Protocols were used in part or in whole during this inspection:
Dignity, choice and privacy
Prevention of Abuse, Neglect and Retaliation

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN

NON- COMPLIANCE / (Non-respectés)	
Definitions/Définitions **WN** – Written Notifications/Avis écrit **VPC** – Voluntary Plan of Correction/Plan de redressement volontaire **DR** – Director Referral/Régisseur envoyé **CO** – Compliance Order/Ordres de conformité **WAO** – Work and Activity Order/Ordres: travaux et acivités	
The following constitutes written notification of non-compliance undetr paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007,S.O. 2007, c. 8, s. 23(1) Every licensee of a long-term care home shall ensure that,

(b) appropriate action is taken in response to every such incident; and

Findings:

1) The evening of December 27, 2010, a resident, reported to a Resident Aid (RA) that she/he was threatened by another (RA).
2) The email correspondence to the Program Manager(PM) dated December 27, 2010, the Registered Nurse(RN) reported that the resident stated "she is clever" and "I've been thrown against the wall".

3) Program Manager on call was not informed immediately of the incident. The unit (PM) the unit became aware of the incident of abuse on December 29, 2010, upon her return from holidays.
4) A full physical assessment of the resident was not documented in the progress note.
5) The Physician was not notified of the incident of abuse
6) The Power of Attorney was not notified immediately of the incident of abuse.
7) The Police was not informed of the incident abuse as of January 10, 2011

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WN #2: The Licensee has failed to comply with O.Reg. 79/10, s. 97.(1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,

(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

Findings:

1) No documentation in progress note informing the resident's Power of Attorney of the incident of abuse of December 27, 2010.
2) The (RN) sent an email to her (PM) on December 27, 2010 and no indication or documentation in the email that the Power of Attorney was notified of the incident of abuse.
3) The (PM) confirmed that the (POA) was notified on December 30, 2011.

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WN #3: The Licensee has failed to comply with O. Reg. 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:

1) The incident of abuse occurred on December 27, 2010 and the Police was not yet contacted as of January 10, 2011.

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WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1) The evening of December 27, 2010, a resident, reported to a (RA) that he/she was threatened by another (RA).
2) The evening of December 27, 2010, a resident reported to (RN) that the (RA) was clever and that he/she was thrown against the wall.
3) The email correspondence to the (PM) dated December 27, 2010, the (RN) wrote that the resident stated that he/she was afraid of his care giver (RA) and did not feel safe.

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Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. L Hawkins
Title: Date:	Date of Report: (if different from date(s) of inspection). May 10, 2011