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

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347 Preston St., 4th Floor
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
Jun 7, 8, 10, 21, 2011	2011_042148_0010	Critical Incident

Licensee/Titulaire
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(s)
Amanda Nixon (148)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Director of Organizational Performance, Program
Manager for the Gatineau unit, Registered Nursing Staff, Resident Assistants and residents on the Gatineau unit.

During the course of the inspection, the inspector(s) reviewed the health record of an identified resident, the home's investigation notes related to an incident of abuse, the home's Abuse of Residents Policy (#GEN-AD-1022), home records related to abuse training and attendance.

The following Inspection Protocols were used in part or in whole during this inspection:
Prevention of Abuse and Neglect

Findings of Non-Compliance were found during this inspection.

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 activités

The following constitutes written notification of non-compliance under 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. 19. Duty to protect Specifically failed to comply with the following subsections:

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:

1. A Ministry of Health and Long Term Care Inspection was conducted January 2011 related to staff to resident abuse. The following non-compliance were found under the Long Term Care Homes Act:
s. 3(1)1
s. 23(1)(b)
O. Reg 97(1)(a)
O. Reg 98

2. A staff member and Resident Assistant were providing care to an identified resident on the evening of May 28, 2011. The staff member witnessed the Resident Assistant grab the resident's right hand forcing his 3 fingers back, The staff member than witnessed the Resident Assistant grab the resident face squeezing the resident's cheeks hard enough that the resident's mouth was opened. In addition, during the physical abuse described above, the staff member witnessed the Resident Assistant argue with resident using foul language during the care provided.

3. The Resident Assistant involved in the incident on May 28, 2011 was on staff and providing care to residents on May 29, 2011 after Registered Staff were notified of alleged abuse on May 28, 2011.

4. The police force was not notified of the incident of abuse until May 30, 2011.

5. The resident's Substitute Decision Maker was not notified of the incident of abuse until May 30, 2011.

6. The Program Manager on call was not informed immediately of the alleged incident of abuse, as per the home's policy.

7. The licensee did not investigate immediately or protect residents from abuse.

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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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance
Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall
ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings:

1. An incident of staff to resident abuse occurred Saturday May 28, 2011 involving an identified resident and a Resident Assistant.

2. A staff member witnessed the incident of staff to resident abuse on May 28, 2011. The staff member reported the incident of abuse to a Registered Nurse on May 28, 2011. The same staff member reported the incident of abuse to a Registered Nurse, on May 29, 2011.

3. As per the home's Abuse of Residents Policy (#GEN-AD-1022), staff must report the incident of abuse to a supervisory staff member. The supervisory staff are to notify the Administrator on call. Interview with the Gatineau Program Manager confirmed that the Administrator on call on May 28, 2011 was the Program Manager.

4. The Program Manager on call was not informed immediately of the incident. The Gatineau Program Manager became aware of the incident of abuse on Monday May 30, 2011.

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WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act
Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to
the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings:

1. An incident of staff to resident abuse occurred Saturday May 28, 2011 involving an identified resident and a Resident Assistant.

2. A staff member witnessed the incident of staff to resident abuse on May 28, 2011. The staff member reported the incident of abuse to a Registered Nurse on May 28, 2011. The same staff member reported the incident of abuse to a Registered Nurse, on May 29, 2011.

3. The Program Manager on call was not informed immediately of the incident. The Gatineau Program Manager became aware of the incident of abuse on Monday May 30, 2011.

4. The resident's Substitute Decision Maker was not notified of the incident of abuse until May 30, 2011.

5. The police force were not notified of the incident of abuse until May 30, 2011.

6. The Resident Assistant was on staff and providing care to residents on Sunday May 29, 2011 after Registered Staff were notified of alleged incident of abuse on Saturday May 28, 2011.

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WN #4: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration
Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings:

1. An incident of staff to resident abuse occurred Saturday May 28, 2011 involving an identified resident and a Resident Assistant.

2. A staff member witness the incident of staff to resident abuse on May 28, 2011. The staff member reported the incident of abuse to a Registered Nurse on May 28, 2011. The same staff member reported the incident of abuse to a Registered Nurse, on May 29, 2011.

3. The Director was not informed of the incident of abuse until Monday May 30, 2011.

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WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents
Specifically failed to comply with the following subsections:

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
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed

incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings:

1. An incident of staff to resident abuse occurred May 28, 2011 involving an identified resident and a Resident Assistant.

2. A staff member witness the incident of staff to resident abuse on May 28, 2011. The staff member reported the incident of abuse to a Registered Nurse on May 28, 2011. The same staff member reported the incident of abuse to a Registered Nurse, on May 29, 2011.

3. No attempt was made to notify the identified resident's Substitute Decision Maker, until Monday May 30th, 2011.

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WN #6: 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. O. Reg. 79/10, s. 98.

Findings:

1. An incident of staff to resident abuse occurred Saturday May 28, 2011 involving an identified resident and a Resident Assistant.

2. A staff member witness the incident of staff to resident abuse on May 28, 2011. The staff member reported the incident of abuse to a Registered Nurse on May 28, 2011. The same staff member reported the incident of abuse to a Registered Nurse, on May 29, 2011.

3. Police force were not informed of the incident of abuse until Monday May 30, 2011.

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WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights
Specifically failed to comply with the following subsections:
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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings:

1. As it relates to s. 3(1)2: An incident of staff to resident abuse occurred Saturday May 28, 2011, involving an identified resident and a Resident Assistant.

2. A staff member and Resident Assistant were providing care to an identified resident on the evening of May 28, 2011. The staff member witnessed the Resident Assistant grab the resident's right hand forcing his 3 fingers back, The staff member than witnessed the Resident Assistant grab the resident face squeezing the resident's cheeks hard enough that the resident's mouth was opened. In addition, during the physical abuse described above, the staff member witnessed the Resident Assistant argue with resident using foul language during the care provided.

3. Interview on June 8, 2011 with the Gatineau Program Manager, stated that the home's investigation was completed June 3, 2011. The conclusion of the investigation was that the Resident Assistant had physically and verbally abused the identified resident on May 28, 2011.

Inspector ID #:	148

Issued on this 21st day of June, 2011

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.

Amanda Nix RD LTCH Inspector

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

Ministère 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) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2011_042148_0010
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 7, 8, 10, 21, 2011
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 :	GREG FOUGERE

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirements that:
1. the home's policy to promote zero tolerance of abuse is complied with;
2. any alleged, suspected or witnessed abuse of a resident that has resulted in physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident;s health is immediately reported to the resident's Substitute Decision Maker and any other person specified by the resident;
3. any alleged, suspected or witnessed abuse of a resident is immediately reported to the police;
4. abuse of a resident resulting in harm or risk of harm to a resident is immediately reported to the Director.

The plan will include the following to ensure the licensee is compliant with this section by July 31, 2011:
1. Education of all staff related to the requirement to;
   a. take appropriate action in response to alleged, suspected or witnessed incident of abuse of a resident,
   b. immediately report an incident of abuse of a resident resulting in harm or risk of harm to the Director,
   c. immediately report alleged, suspected or witnessed abuse to supervisory staff and manager as per the home's abuse policy and
   d. immediately notify the police force and Substitute Decision Maker as per the requirements under this Act.

The plan is to be submitted to Inspector: Amanda Nixon, Ministry of Health and Long-term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4, Fax 613-569-9670

Grounds / Motifs :

1. 1. A Ministry of Health and Long Term Care Inspection was conducted January 2011 related to staff to resident abuse. The following non-compliance were found under the Long Term Care Homes Act:
s. 3(1)1
s. 23(1)(b)
O. Reg 97(1)(a)
O. Reg 98

2. A staff member and Resident Assistant were providing care to an identified resident on the evening of May 28, 2011. The staff member witnessed the Resident Assistant grab the resident's right hand forcing his 3 fingers back, The staff member than witnessed the Resident Assistant grab the resident face squeezing the resident's cheeks hard enough that the resident's mouth was opened. In addition, during the physical abuse described above, the staff member witnessed the Resident Assistant argue with resident using foul language during the care provided.

3. The Resident Assistant involved in the incident on May 28, 2011 was on staff and providing care to residents on May 29, 2011 after Registered Staff were notified of alleged abuse on May 28, 2011.

4. The police force was not notified of the incident of abuse until May 30, 2011.

5. The resident's Substitute Decision Maker was not notified of the incident of abuse until May 30, 2011.

6. The Program Manager on call was not informed immediately of the alleged incident of abuse, as per the home's policy.

7. The licensee did not investigate immediately or protect residents from abuse. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2011

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

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 Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

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

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

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 21st day of June, 2011

Signature of Inspector / Signature de l'inspecteur : JMcPadend for Amanda Nixon

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

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