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 # / No de registre	Type of Inspection / Genre d'inspection
Mar 23, 2018	2018_619550_0002	026472-17, 027199-17, 001793-18	Complaint

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

JOANNE HENRIE (550), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 9, 12, 13, 14 and 15, 2018.

This Complaint and Critical Incident Inspection is related to a complaint regarding allegations of abuse to residents and a critical incident the home submitted related to the allegations of neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), the Director of Community Outreach and Programing, the interim Manager of Resident Care, the Coordinator of RecreationTherapists, two Recreation Therapists, the Therapeutic Recreation and Creative Arts and several Registered Practical Nurses (RPN).

In addition, the inspectors reviewed resident health care records, a critical incident report (CIR), internal investigation files, policies related to concerns and complaints and abuse of residents.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care for resident #003 was not provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director describing an incident of improper/incompetent treatment of a resident. The CIR indicated that resident #003's care needs were not met appropriately by the staff members.

Inspector #592 reviewed resident #003's health care records. The health care records indicated that resident #003 was admitted with several medical conditions.

According to the written plan of care in place at the time of the incident, resident #003 was identified as having multiple responsive behaviours, incontinence issues, weight issues and required assistance for meals. Interventions were identified to mitigate the behaviours and assist the resident with the identified problems.

Inspector #592 requested and was provided with the home's investigation report. The investigation report included the home's action plan, several interviews, Point of Care documentation and documentation by the PSW supervisor when they viewed the video footage. Inspector reviewed the interviews conducted by the PSW Supervisor. One of the interviews was done with PSW #104 who was the PSW working with PSW #105 who was assigned to resident #003 the day of the incident. An email was also forwarded to the PSW Supervisor by PSW #104 describing the proceedings of the shift, the day on which the incident occurred. The documentation on the email was reviewed by the Inspector which indicated that at a specific period of the day, on the date the incident occurred, PSW#105 reported to PSW #104 that resident #003 had refused to get out of bed and since both PSWs were new on the unit, they were unsure if this was regular behaviour for this resident. PSW #104 told PSW #105 that if the resident says "no", it means "no" and not to force the resident. PSW #104 documented that at a certain period of the day, a visitor (who was later identified as a member of resident #003's family) was observed in the resident's room giving the resident something to eat. The documentation further indicated that towards the end of the shift, PSW #104 and #105 were approached by staff #102 who asked them if resident #003 had had something to eat and if the resident's care had been provided. PSW #105 informed staff #102 that the resident had refused the care and had eaten something in the room while the resident's family member was present. Staff #102 responded by telling both PSWs that their approach was possibly wrong and requested if they could give the resident something to eat.

The documentation submitted to the PSW supervisor by PSW #105 was reviewed by inspector #592. PSW #105 who was the PSW assigned to resident #003 the date of the incident went to resident #003's room at the beginning of the shift to provide care to the resident. At that time, resident #003 refused all care and was exhibiting responsive

behaviours. The documentation further indicated that PSW #105 approached resident #003 several times but the resident was still refusing care. PSW #104 provided resident #003 with a meal tray which the resident refused. PSW #105 provided another meal tray to the resident later on and tried to assist the resident to eat and to provide care but again the resident refused. Because resident #003 was exhibiting responsive behaviours, PSW #105 left the resident's room without providing any care to the resident. PSW #105 had documented being approached at the end of the shift by staff #102 who was questioning why care had not been provided to resident #003. PSW #105 went into resident #003's room with staff #102 and although the resident was still resisting care, PSW #105 had been able to perform part of the care.

Inspector #592 reviewed the notes taken by the PSW supervisor when they viewed the home's video footage. There were six entries documented related to resident #003 for the shift in question on the day of the incident as follows:

-Five hours and forty-five minutes after the start of the shift, resident #003's call bell was answered by PSW #104.
-Six hours and twenty minutes into the shift, PSW #105 brought a meal tray to resident #003.
-Six hours and fifty minutes into the shift, resident #003 had a visitor.
-Seven hours and twenty minutes into the shift, resident #003's visitor was leaving the unit.
-Eight hours and fifteen minutes into the shift, staff #102 came from the dining room with snack and fluids.
-Eight hours and twenty minutes into the shift, PSW #105 entered the room of resident #003 accompanied by staff #102.

The video was not viewed by the inspector.

A review of the documentation completed by PSW #105 in the Daily Flow Sheets (DFS) regarding the care provided to resident #003 on the day of the incident was done by Inspector #592. The documentation indicated that resident #003 refused care and assistance. Furthermore, the documentation in the DFS indicated the resident exhibited some responsive behaviours, was incontinent and had consumed a specific amount of liquids and food.

On February 14, 2018, in an interview the DON indicated to Inspector #592 that the home had immediately conducted an internal investigation upon becoming aware of the

incident. The DON further indicated that following the staff interviews, documentation and viewing of the video footage, it was determined that resident #003's care needs were not appropriately met by the staff members. The care of the resident that was documented in Point of Care (POC) was not provided to the resident that day. The DON further indicated that usually the PSWs are to return later when a resident refuses care and if still unsuccessful, PSWs are to report this to the nurse and get some assistance. The DON indicated that following the outcome of the home's internal investigation, it was determined that the care set out in the plan of care for resident #003 was not provided to the resident as specified in the plan. [s. 6. (7)]

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 to ensure that care is provided to residents as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home:
• was investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, has the

investigation commenced immediately

A complaint was submitted through the Action Line reporting three incidents of alleged sexual abuse which occurred on three different dates. One incident was directed towards one resident by staff #103 and two incidents were directed towards another resident by staff #103.

Inspector #550 reviewed the home's internal investigation report related to the third reported incident. It was documented that the incident was witnessed by staff #102 and reported to the on-call supervisor for that day, staff #100. There was no documentation indicating that an investigation had started at that time.

During an interview, staff #100 indicated to inspector #550 to having met with staff #102 at this employee's request the day the incident occurred. Staff #102 verbally reported to them having witnessed staff #103 to be touching resident #002 inappropriately earlier that day. The employee further informed staff #100 that it was not the first time staff #103 was reported for inappropriately touching residents. Staff #100 indicated to the inspector that staff #102 was anxious about the safety of this resident and frustrated that the behaviour of inappropriate touching appeared to be continuing despite previously reporting inappropriate behaviours done by this employee. Staff #100 indicated not being sure if the reported incident was a behaviour of a sexual nature or not, referring that it was a gray area. Staff #100 informed inspector #550 that an investigation was not started at the time the incident was reported nor had staff #103 been spoken to.

The investigation was conducted two days later by the Recreation Therapist Coordinator.

As evidenced above, the incident of alleged behaviour of a sexual nature to resident #002 by staff #103 was not immediately investigated. [s. 101. (1) 1.]

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response been made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

A complaint was submitted through the Action Line reporting three incidents of alleged

sexual abuse which occurred on three different dates. One incident was directed towards one resident by staff #103 and two incidents were directed towards another resident by staff #103. It was later determined, through the home's investigation that the incidents were not incidents of sexual abuse therefore they were treated as complaints.

This finding is specifically related to the third incident of alleged sexual abuse between staff #103 and resident #002.

During an interview, staff #102 indicated to inspector #550 having reported this incident of alleged sexual abuse by staff #103 towards resident #002, to the on-call supervisor for that day, staff #100. Staff #102 indicated having discussed the incident with the Director of Community Outreach and Programing and the Recreation Therapists Coordinator but was never provided with a response to the complaint. Staff #102 indicated having requested a response to the complaint, to the Director of Community Outreach and Programming and the Recreation Therapists Coordinator, more specifically wanting to know what actions had been taken in regards to the complaint. Staff #102 was told verbally by the Director of Community Outreach and Programing and the Recreation Therapists Coordinator that they were taking care of it and staff #103 had been spoken to. At no time was staff #102 informed that the licensee had determined that the incident was not an incident of sexual abuse and the reasons why they had made this determination.

During an interview, the Recreation Therapists Coordinator indicated to the inspector that during a meeting, staff #102 was informed that the complaint was being looked into, that the Director of Community Outreach and Programming and themself had spoken to staff #103. The Recreation Therapists Coordinator further informed staff #102 that no other information could be shared with them due to the HR confidentiality process. The Director of Community Outreach and Programming confirmed to inspector #550 that no other information or response was provided to staff #102 in regards to the complaint brought forward regarding staff #103.

As evidenced, the licensee did not provide staff #102 with a response indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

3. This finding is specifically related to the second incident of alleged sexual abuse between staff #103 and resident #001.

It was reported that staff #103 was observed to be inappropriately touching resident #001.

Inspector #592 requested and was provided with the home's investigation report. A document titled " Work Related Feedback" was reviewed by the inspector. Under "Nature of Concern/Positive Feedback", it was documented that staff #102 had reported witnessing staff #103 inappropriately touching resident #001. The document indicated that a follow-up was done with staff #103 by staff #101 following the reporting of this incident.

During an interview, staff #102 indicated to inspector #592 to having reported the incident immediately after it occurred to the Recreation Therapists Coordinator and was later informed by the same that staff #101 would follow-up with staff #103. Staff #102 indicated not having received any feedback or response following the concerns that were brought forward to the managers even after sharing with them their concerned for resident #001 and other residents' safety.

In an interview the Director of Community Outreach and Programming indicated to Inspector #592 that the incident was not treated as an incident of alleged sexual abuse but rather a behaviour issue, therefore the incident had been treated as a complaint. The Director of Community Outreach and Programming further indicated that they did not recall the specific date of the complaint nor when the investigation took place. Following the investigation, a verbal response was provided to staff #102. The Director of Community Outreach and Programming did not recall what information was provided to staff #102 as a response. The Director of Community Outreach and Programming confirmed that staff #102 was not informed that they believed the complaint to be unfounded and the reason for the belief. [s. 101. (1) 3.]

4. This finding is specifically related to the first incident of alleged sexual abuse between staff #103 and resident #001.

It was reported that staff #103 was observed acting inappropriately with resident #001.

Staff #102 described the incident of inappropriate behaviour to inspector #592 indicating that this incident was reported to the Director of Community Outreach and Programing by telephone, immediately after staff #102 witnessed the incident. Staff #102 met with the Director of Community Outreach and Programing the following work day and was told that a follow-up would be done. Staff #102 further indicated meeting with the Recreation

Therapists Coordinator whereby was informed that a follow-up had been done. No details regarding the follow up was provided to staff #102.

In an interview the Recreation Therapists Coordinator indicated to inspector #592 that they were asked by their manager to do the follow-up on this incident. The Recreation Therapists Coordinator further indicated that they provided a verbal response to staff #102 after the follow-up had been completed. The Recreational Therapists Coordinator indicated that they did not have any documentation on the response provided to staff #102 therefore was not able to tell the inspector what had been provided to staff #102.

In an interview with the Director of Community Outreach and Programming, they indicated to inspector #592 that they never thought this incident to be an incident of sexual abuse and it was treated as a behavioural issue from staff #103. The incident was therefore treated as a complaint. Following the investigation, a verbal response was provided to staff #102 but the Director did not recall what was said as they did not have any documentation related to the response. The Director of Community Outreach and Programming confirmed to inspector #592 that they did not provide staff #102 with a response explaining what they had done to resolve the complaint or that they believed the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

5. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt as follows;
(2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for
actions to be taken and any follow-up action required
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

A complaint was received through the Action Line reporting three incidents of alleged sexual abuse between staff and residents which occurred on three separate dates. The complaint was followed by a written description of the events from the complainant.

It was reported that on the first incident, staff #103 was acting inappropriately with

resident #001.

Inspector #592 requested and was provided with the home's investigation report. The report contained a document titled "Staff #103-Complaint from (specified month and year) which was reviewed by the inspector. The date the incident occurred was documented as an approximate date. The documentation was describing an incident that was reported by staff #102 where this employee had witnessed staff #103 acting inappropriately with resident #001. It was also documented that the Recreation Therapists Coordinator had done a follow-up with staff #103 following the reporting of the incident.

On February 12, 2018, in an interview with inspector #592 staff #102 described the first incident as documented above and indicated having immediately reported the incident to the Director of Community Outreach and Programming by telephone. Staff #102 indicated to having met with the Director of Community Outreach and Programming two days later and was told that a follow-up would be done. Staff #102 further indicated they were later informed verbally by the Recreation Therapists Coordinator that a follow-up to the incident had been done.

On February 13, 2018, in an interview with the Recreation Therapists Coordinator who indicated to inspector #592 that they had been asked by the Director of Community Outreach and Programming to do a follow-up regarding the incident described above. The Recreation Therapists Coordinator indicated that they did a follow-up to the incident but was not able to provide the inspector with the exact date on which the incident occurred and the date the incident was investigated upon as they did not document this information. The Recreation Therapists Coordinator further indicated that a verbal response was provided to staff #102 but had not documented this.

In an interview the Director of Community Outreach and Programming indicated to inspector #592 that they did not recall the specific date the incident was reported to them or when the investigation took place as this was not documented. The Director further indicated that following the investigation, that a verbal response was provided to staff #102 however that there was no documentation of this response.

It was determined through a review of the investigation file and interviews with the Recreation Therapist Coordinator and the Director of Community Outreach that the licensee did not have a documented record of the first incident indicating:
-the date the incident occurred and,

-every date on which any response was provided to the complainant and a description of the response. [s. 101. (2)]

6. A complaint was received through the Action Line reporting three incidents of alleged sexual abuse between staff and residents which occurred on three separate dates. The complaint was followed by a written description of the events from the complainant.

It was reported that on the second incident, staff #103 was inappropriately touching resident #001.

Inspector #592 requested and was provided with the home's investigation report. The report contained a document titled " Work Related Feedback" which was dated on a specific date. Under "Nature of Concern/Positive Feedback", it was documented that an incident had been reported by staff member #102, who had witnessed staff #103 inappropriately touching resident #001 on a specific body part. The document indicated that a follow-up was done with staff #103 by staff #101 following the reporting of the second incident.

In an interview staff #102 indicated to inspector #592 that the incident was immediately reported to the Recreation Therapists Coordinator by leaving a voice message followed by a discussion. Staff #102 was told by the Recreation Therapists Coordinator that staff #101 would do a follow-up with staff #103. Staff #102 indicated that no response was provided regarding the concerns that were brought forward to the managers' attention although staff #102 had expressed being afraid for the safety of residents and staffs to the Recreation Therapists Coordinator and the Director of Community Outreach Programming.

In an interview staff #101 indicated to inspector #592 that the incident occurred as described above and having been asked to do the follow-up by the Recreation Therapists Coordinator. Staff #101 further indicated not recalling the exact date that the incident was reported but that a meeting was held with staff #103 possibly within a few days after the incident had been reported. Staff #101 confirmed that the date on the document "Work Related Feedback" was the date that the document was completed but was unsure when the meeting with staff #103 had occurred. Staff #101 indicated that the follow-up of the outcome with staff #102 had possibly been done by the supervisors but was unsure as there was no documentation.

In an interview the Director of Community Outreach and Programming indicated to

Inspector #592 that the incident occurred as described above and that the incident was not treated as an incident of alleged sexual abuse but rather a behaviour issue, therefore the incident had been treated as a complaint. The Director of Community Outreach and Programming indicated that they did not recall the specific date of the complaint nor when the investigation took place as they did not have any documentation related to this complaint. The Director further indicated that following the investigation, responses provided to staff #102 were done verbally, therefore could not provide any documentation of the responses provided to the complainant and the description of the responses.

It was determined through a review of the investigation file and interviews with staff #101 and the Director of Community Outreach Programming that the licensee did not have a documented record of the second incident indicating:
-the date the second incident occurred and,
-every date on which any response was provided to the complainant and a description of the response. [s. 101. (2)]

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 to ensure that where a written or verbal complaint made to the licensee or a staff member alleges harm or risk of harm to one or more residents an investigation commences immediately; for every verbal or written complaint regarding the care of a resident or operation of the home, a response indicating what the licensee has done to resolve the complaint, or that the licensee believes the complaint to be unfounded and the reasons for the belief is provided to the complainant; and a documented record is kept in the home that includes, the nature of each verbal or written complaint, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

An incident of improper care to a resident was reported to the Director through the after-hours pager followed by the submission of Critical Incident Report (CIR). It was reported that resident #003 was found by a staff member in bed, care had not been provided and a small plastic cup containing medication had been left at the resident's bedside and the medication had not been taken.

Staff #102 who reported the incident was interviewed by inspector #550 and indicated having found a small plastic cup containing medication in it. Staff #102 indicated having reported this observation to RPN #106.

Inspector #550 reviewed the Medication Administration Record (MAR) for resident #003 for the day of the incident. It was documented that the resident was to receive a specified medication at a specific time, during the shift in question. The inspector noted that this medication was signed as having been administered at a specific time by RPN #107. There was a note on the MAR indicating some directives for administration.

Inspector #550 interviewed RPN #107. The RPN indicated to the inspector that when they went to administer the medication to resident #003, the resident told the RPN to leave the medication cup on the bedside table and that they would take them later. The RPN indicated having left the medication at bedside as per the resident's instructions and signed the administration in the MAR. RPN indicated having forgotten to return later to make sure the resident had taken the medication. The RPN further explained not being familiar with resident #003 and thought it was "ok" to leave the medication with the resident.

The Interim manager of Resident Care in place at the time of the incident indicated to inspector #550 resident #003 did not receive the specified medication as prescribed by the doctor. [s. 131. (2)]

Issued on this 20th day of April, 2018

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

Original report signed by the inspector.