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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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 29, 2015	2015_225126_0017	O-000793-14, O-001465-15, O-001501-15, O-001796-15	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

LINDA HARKINS (126)

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): April 23, 24, 2015

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Nursing Chief Officer, several Registered Nurses, several Registered Practical Nurses, several Home Support Worker and several residents.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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 abuse of a resident by anyone was immediately reported to the Director.

On a specific date of July 2015, after supper, Dietary Aid staff S# 101 was in the kitchen and heard residents yelling. S# 101 responded and observed Resident #01 grabbing Resident #02 right wrist and would not let go. Registered Practical Nurse S# 100 intervened and redirected both residents. Resident #02 sustained a skin tear to the right wrist and the surrounding area was observed to be slightly bruised. S# 100 notified the Registered Nurse (RN) S# 102, left a voice mail to the Power of Attorney and notified Resident Care Manager S# 103 via email.

Inspector # 126 interviewed Resident Care Manager S# 103 on April 23, 2015. She indicated that following the incident, RN S#102 contacted Resident Care Manager S# 104 (who was covering for S# 103 at that time) and that it was decided not to contact the police as there was no intent to harm Resident #02. Resident #01 had responsive behaviors and would try and hold on to people as they are walking around. Upon her return on a specific date in July 2015, S# 103 became aware of the incident and in reviewing the documentation related to that incident, submitted a Critical Incident that same day for resident to resident abuse that resulted in a physical injury.
Abuse of a resident was not immediately reported to the Director and was reported 4 days after the incidents. [s. 24. (1)]

WN #2: 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/Faits saillants :

1. The licensee has failed to ensure that appropriate police force was notified of the incident that occurred on July 24, 2015.

On a specific date in July 2015, after supper, Dietary Aid staff S# 101 was in the kitchen and heard residents yelling. S# 101 responded and observed Resident #01 grabbing Resident #02 right wrist and would not let go. Registered Practical Nurse S# 100 intervened and redirected both residents. Resident #02 sustained a skin tear to the right wrist and the surrounding area was observed to be slightly bruised. S# 100 notified the Registered Nurse (RN) S# 102, left a voice mail to the Power of Attorney and notified Resident Care Manager S# 103 via email.

Inspector # 126 interviewed Resident Care Manager S# 103 on April 23, 2015. She indicated that following the incident, RN S#102 contacted Resident Care Manager S# 104 (who was covering for S# 103 at that time) and that it was decided not to contact the police as there was no intent to harm Resident #02. Resident # 01 had responsive behaviors and would try and hold on to people as they are walking around. [s. 98.]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.