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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 22, 2013	2013_193150_0029	O-000920-13	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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): October 29, 30, 2013

During the course of the inspection, the inspector(s) spoke with the Chief of Resident Care, Director of Resident Care, Pharmacist, Registered Nurse, Registered Practical Nurse, Personal Support Worker.

During the course of the inspection, the inspector(s) reviewed the resident's health care records, Inter-Hospital Patient Transfer Records, Hospital Integrated Progress Notes, Hospital Medical Consultation reports, Hospital Discharge Summary report, Medication Reconciliation policies #7-2, dated 06/10, #10-8 dated 03/09, Medication Pass #3-7 dated 02/12, Hours of Medication Administration #3-9 dated 02/12, Pharmacy Service Agreement May 2012.

The following Inspection Protocols were used during this inspection:
Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 as failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.19, Duty to protect. The licensee specifically failed to comply with the following subsection: s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure residents are not neglected by the licensee or staff. 2007, c.8, s.19 (1).

Ontario Regulation 79/10, made under the Long-Term Care Homes Act, 2007, defines "neglect" as 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.

The following occurrences demonstrate a pattern of inaction that jeopardized the health, safety and well- being of resident #001.

Resident #001 had a known history of respiratory problem.

On an identified date in September 2013, the resident was transferred to hospital.

On an identified date in September 2013 on evening, the resident returned from the The Ottawa Hospital (TOH) to the same resident care unit, at the Perley Rideau Veteran Health Center (PRVHC).

The hospital "Inter Hospital patient transfer record", the "Hospital integrated progress notes", two Hospital medical consults from medicine and respiratory physicians and the Hospital Medication Administration Records were included in the information transfer package provided to the unit staff upon return of the resident from the hospital.

The home's progress notes and Internal Post Critical Incident debrief were reviewed by inspector #150. It indicates the following:

On an identified date in September 2013, RN S#108 progress notes documented Resident #001 returned from hospital on evening "skin assessment was done and the resident alert, no respiratory distress and twitching observed, vital signs stable as per RPN's report. "

The PRVHC Medication Administration Records (MAR) was reviewed by inspector

#150. It indicated that a narcotic medication was ordered 4 times a day by the physician on call during the evening of the resident's return from the hospital in September 2013.

The PRVHC MAR sheet documented that the narcotic medication was administered for the first time to the resident upon the resident's return from the hospital and a second dose administered later.

On an identified date in September 2013, on evening, a PSW informed the RPN that the resident was less responsive than usual.

On the next day, in the morning, 2 Personal Support Worker (PSW) and 2 Registered Practical Nurses (RPN) went in to do care and found the resident to be "completely unresponsive". The RPN S#103 informed RN S#104 of resident #001 status.

On the same morning, RPN S#103 progress notes documented "resident is completely unresponsive to voice, touch or pain, 06h00 meds held due to unresponsiveness, RN updated".

On the same morning, RN S#104 at 06h05 assessed the resident #001, progress notes documented at 06h30: "change of condition data: resident was seen at the start of the shift and appeared to be breathing with O2 running at 4l/min via N/P. No labored breathing. Did not wake at that time. RPN reported that the resident was unresponsive during the care given. Action: saw the resident at 06h05, and spoke to her although she still appeared to be sleeping. Response: the resident moves the arms a little and her breathing changed as though aware of writer. Will discuss with day shift as to direction of care."

On the same morning at 0745, Day RN paged the DOC and direction given to call 911 as the resident was unresponsive. The resident was transferred to the hospital.

Two days later in September 2013, the home was notified that the resident had passed away in the hospital.

On October 30, 2013, inspector #150 interviewed RN S#104. The RN confirmed to be covering the unit on an identified date in September 2013 during the night shift. The RN stated that the RN was called around 05h00 by the unit RPN S#103 informing the

RN that the resident was not responding. The RN came to the unit and assessed the resident and concluded that the resident was responding to stimuli such as opening the eyes and vital signs were stable.

2. On October 29, 2013, the Pharmacist on duty S#100 was interviewed by inspector #150. The pharmacist stated that the resident returned from the hospital on an identified date in September 2013 at 17h00. The Pharmacist was informed by the RN that some paperwork was sent with the resident. The pharmacist stated that the documentation received was incomplete and missing the discharge summary. The pharmacist stated that she was not aware of the no narcotics noted for this resident and did not mention it to the physician on call.

The Pharmacist on duty S#100 stated that the medication reconciliation was done by using the Hospital Medication Administration Records Sheet (MARS) and comparing with the PRVHC MARS of the resident prior to the transfer to the hospital. It was noted that there was 2 medications missing in the reconciliation, including a narcotic.

The pharmacist on duty S#100 noted that hospital' MARS indicated that the resident was not receiving any narcotic medication during the admission at the hospital but received an analgesic medication po, prn on a regular basis and had received 1 dose of an identified medication (an opioid substitute) prn on an identified date in September 2013.

The pharmacist on duty S#100 stated that the physician on call that evening was contacted to discuss the discrepancy related to the reconciliation and the use of an identified medication in the hospital. The physician on call approved the consolidated chart orders including a narcotic 4 times a day as per prior prescription.

The pharmacist on duty S#100, documented in the progress notes on an identified date in September 2013 "Advised of resident return from hospital in the evening. Spoke with the nurse who would try to track down the discharge summary, notes or prescriptions. No diagnoses indicated on transfer paperwork".

The TOH "Intergrated progress notes" which were included in the Hospital transfer package were provided and reviewed by the inspector #150. Under Issues section the following is noted, the resident's diagnosis, "no narcotic".
However the TOH Hospital Integrated progress notes indicating "no narcotic" was not

communicated to the physician.

3. The TOH fax copy of the resident's "Discharge Summary" was reviewed by inspector #150. The fax copy was dated as sent on "an identified date in September 2013 at 05h49 pm" from the hospital to the PRVHC unit".

The hospital Discharge Summary indicates that "the narcotics were discontinued given that likely contribution to the patient's respiratory problems."

On October 29, 2013, the Director of Resident Care S#105 was interviewed and stated that the Discharge Summary sent to the home to the PRVHC unit identified the date and time in September 2013 at 5h49 pm, was picked-up in the fax machine by the RPN at 22h30, the RPN S#101 showed it to the RN S#108, did not read it and put it in the Doctor's Nursing communication binder.

As per interview with the Director of Resident Care S#105, she stated that the evening RPN S#101 and RN S#108 did not inform the night RN S#104 of the fax received from the TOH related to the Discharge Summary of the resident #001.

The content of the Discharge Summary received on evening shift was not communicated to the night registered staff, the pharmacist or the physician on call.

On October 30, 2013, the Night RN S#104 was interviewed and stated that the RN was not informed of the resident's return from the hospital and not informed of the fax that was sent from the hospital.

No PRVHC registered nursing staff read the Hospital Discharge Summary in which the physician's recommendation noted was "narcotics were discontinued given there likely contribution to the patient's respiratory problem.

The above evidence demonstrates a pattern of inaction related the following:

1- failed to review of Hospital Information upon the return of the resident from the hospital by the pharmacist and Registered Staff on an identified date in September 2013.

2- No documentation noted on evening and night shift on the resident's assessment

related to the narcotic response and effectiveness administered on a identified dates in September 2013.

3- No documentation noted related to the PSW observation that the resident was "less responsive than usual"on an identified date in September 2013 at 23h03 communicated to the registered staff and no further assessment documented.

4- Failed to take appropriate actions in response to the narcotic medication adverse reaction on identified dates in September 2013.

5- The critical incident investigation noted no documentation noted that registered staff assessed the resident #001 on night shift until 5am on an identified date in September 2013.

6- Significant delay in responding to the resident's deteriorating clinical condition from the time where the resident was identified by the RPN S#103 to be non-responsive on an identified date in September 2013 at 05h02 to the time where the RN S#104 came to assess the resident at 06h05.

7- Staff on day shift called 911 and the resident was transferred to the hospital. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 26th day of November, 2013

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

CAROLE BARIL

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

Ministére 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) :	CAROLE BARIL (150)
Inspection No. / No de l'inspection :	2013_193150_0029
Log No. / Registre no:	O-000920-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 22, 2013
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 :	Akos Hoffer

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:

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

Ministére 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

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 ensure actions are taken to protect residents from neglect, when the residents care needs following admission to hospital require prompt and appropriate interventions, to mitigate risks to their health, safety and well being. This plan must include:

1- revision of hospital to Long-Term Care home communication protocols,

2- revision of internal communication protocols between Nursing, Pharmacist and Medical Services related to the residents' diagnosis and identified health concerns;

3- revision of medication administration, monitoring and documentation of psychotropic medications protocol upon readmission to the Long-Term care home.

4- staff education related to the implementation of all the revised protocols.

This plan must be submitted in writing to Inspector Carole Baril at 347 Preston Street, 4th, Ottawa ON K1S #H4 or by fax at 1-613-569-9670 on or before December 2, 2013.

Grounds / Motifs :

1. 1. The licensee as failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.19, Duty to protect. The licensee specifically failed to comply with the following subsection:

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

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by the physician on call during the evening of the resident's return from the hospital in September 2013.

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On the same morning, RPN S#103 progress notes documented "resident is completely unresponsive to voice, touch or pain, 06h00 meds held due to unresponsiveness, RN updated".

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3- No documentation noted related to the PSW observation that the resident was "less responsive than usual"on an identified date in September 2013 at 23h03 communicated to the registered staff and no further assessment documented.

4- Failed to take appropriate actions in response to the narcotic medication adverse reaction on identified dates in September 2013.

5- The critical incident investigation noted no documentation noted that registered staff assessed the resident #001 on night shift until 5am on an identified date in September 2013.

6- Significant delay in responding to the resident's deteriorating clinical condition from the time where the resident was identified by the RPN S#103 to be non-responsive on an identified date in September 2013 at 05h02 to the time where the RN S#104 came to assess the resident at 06h05.

7. Staff on day shift called 911 and the resident was transferred to the hospital.
[s. 19. (1)]
(150)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

REVIEW/APPEAL INFORMATION

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 Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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 Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

Ministére 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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of November, 2013

Signature of Inspector / Signature de l'inspecteur : CAROL BARIL

Name of Inspector / Nom de l'inspecteur : CAROLE BARIL

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