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

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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 27, 2015	2015_225126_0016	O-001776-15	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

LINDA HARKINS (126)

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): April 21, 22, 2015

During the course of the inspection, the inspector(s) spoke with the CEO, the Chief Nursing Officer, the Chief Operating Officer, the RAI Coordinator,several Registered Nurses and several Registered Practical Nurses.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition

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

1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that plan of care was setting out clear directions related to funeral arrangements.

Resident #01 health care record was reviewed. It was noted on the admission summary sheet that Resident #01 body was to be discharged to Beechwood Military Cimetary. On the "Release of deceased patient/resident" sheet, it was documented that the body was released to Basic Funeral on a specific date in December 2012. The "Release of deceased patient/resident" sheet was not signed either by the nursing staff or by the director of the funeral home, it only documented the name of the resident, the name of the funeral home and the date and time the body was released to the funeral home.

Discussion held with Nurse #100 and she indicated that at that time, she was working as a Registered Practical Nurse and she would have not been the one that released the body. She indicated she does not remember who was working at that time. The nursing schedule was reviewed for that specific day and the Registered Nurse no longer works in the home.

Discussion held with Nurse #101 and she indicated that she was the Full Time Registered Nurse on evening shift on that specific day in December 2012, as she

remembered bringing the body of Resident #01 to the morgue but was not the one who release the body. Both Nurses indicated that when a body is release that there is a process in place and they are required to complete and signed the document called "Release of deceased patient/resident sheet". [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given an explanation of the plan of care.

In August 2007, Resident #02 gave the Power of Attorney (POA) for Personal care to the two children (#1-#2) which the children had the authority to Act jointly and severally. This POA was then granted Notorial Seal of Office in September 2007.

Resident #02 health care record was reviewed for the period of November 2014 - January 9, 2015. It was documented in the progress notes that the resident condition changed. POA #1 was notified and was kept informed of the resident deterioration. POA #2 was not informed of the changed of condition or of the deterioration of Resident # 2 during that period. It was documented that when Resident #02 passed away on evening on a specific date in January 2015, POA #2 was not informed of Resident #02 passing until the next morning.

Discussion with Nursing S# 103, indicated that she was communicating the change in the resident condition to POA #1 and was assuming that POA #1 was sharing the information with POA #2. She also indicated that when they are two POAs, she only communicate with one.

Discussion with the Chief Nursing Officer, who indicated that at this time the home does not have a policy related to the communication of information to the POA. [s. 6. (12)]

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Issued on this 27th day of May, 2015

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

Original report signed by the inspector.