

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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Report Date(s) / Date(s) du apport

Aug 5, 2016

Inspection No / No de l'inspection

2016_200148_0025

Log # / Registre no

014410-16 AND 018967-16 Type of Inspection / Genre d'inspection

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection



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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): August 2, 3 and 4, 2016

This inspection included two critical incident reports, one related to a fall that caused injury to a resident resulting in a significant change in health status and a second related to a missing resident with injury.

During the course of the inspection, the inspector(s) spoke with Chief Nursing Officer, Administrative assistant, Director of Nursing Operations, Director of Support Services, two Managers of Resident Care, Building Maintenance Worker, Registered Nurses, Registered Practical Nurses, Nursing Clerks and residents.

The Inspector reviewed resident health care records, risk management reports and door security information including a quick report of door alarms as it relates to the incident of a missing resident. In addition, the Inspector also observed residents and the door security system.

The following Inspection Protocols were used during this inspection: Falls Prevention
Safe and Secure Home

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

- 1 WN(s)
- 1 VPC(s)
- 0 CO(s)
- 0 DR(s)
- 0 WAO(s)



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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

- s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
- (a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants:



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1. The licensee has failed to ensure that procedures are developed and implemented to ensure that, electrical and non-electrical equipment are kept in good repair.

The Perley and Rideau Veterans' Health Centre is a 450 bed home. Among other building areas, it includes three long-term care resident units known as Gatieau, Ottawa and Rideau.

A Critical Incident Report was sent to the Director (MOHLTC), indicating that resident #001 left the home on a specified date, through the Rideau 1 North exterior door (Rideau main door). The resident was later found and brought back to the home with minor injuries.

As part of the inspection of this incident, Inspector #148 observed the Rideau main door. In accordance with section 9 of O.Regulation 79/10, doors leading to the outside of the home must be kept closed and locked, equipped with a door access control system that is kept on at all times, and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door

On August 3, 2016, the Inspector tested the door alarm for the Rideau main door. At 0926 hours the Inspector opened the Rideau main door and at 0929 hours an audible alarm was activated at the door. The Inspector observed the resident-staff communication system console located at the Rideau 1 North nurses' station. The console did not have a visual or audible alert of the activated door alarm. The nursing clerks for both the Rideau 1 North and South units, who were present at the time of the test, reported that the Rideau 1 North door alarm signals to a panel located on Rideau 2 South.

On August 4, 2016, the Inspector spoke with the home's Director of Support Services who indicated that each of the three unit exterior doors are connected to the resident-staff communication system on the unit with which the exterior door is located. Specifically, the Rideau main door alarm would be connected to the Rideau 1 North nurses' station console. She described the wall mounted panel on Rideau 2 South, which was primarily for exterior doors in the Perley (Centre Block).

On August 4, 2016, the Inspector observed the Rideau main door in the company of the



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home's Building Maintenance Worker (BMW). Due to issues discovered when attempting to activate the door alarm (see below), the door alarm was activated by the forced entry alarm by opening the side panel door. The Inspector and BMW observed the resident-staff communication system console located at the Rideau 1 North nurses' station. The console did not have a visual or audible alert of the activated door alarm. The Rideau main door audible alarm was not connected to the resident-staff communication and response system nor was it connected to the audio visual enunciator that is connected to the nurses' station nearest to the door.

During two tests on August 4, 2016, in the company of the BMW, the alarm of the Rideau main door could not be engaged after more than five minutes of having held open the door. It was discovered by the BMW that the door alarm could not activate due to the positioning of the magnetic lock. The BMW completed a readjustment of the magnetic lock, after which, the Rideau main door alarm was in working condition.

On August 4, 2016, the Inspector spoke with the Director of Support Services, who indicated that although there are monthly audits in place to monitor the resident-staff communication system there are no procedures in place to ensure that the door security equipment is kept in good repair, including that alarms are in working condition and that alarms are connected to the resident-staff communication system or enunciator at the nearest nurses' station. [s. 90. (2) (a)]

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 procedures are developed and implemented to ensure that, electrical and non-electrical equipment, specifically door security equipment are kept in good repair, to be implemented voluntarily.



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Issued on this 5th day of August, 2016

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

Original report signed by the inspector.