Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 28, 2011	2011_117_8595_28Jan093814	Critical Incident Log # O-000175

Licensee/Titulaire

The Perley and Rideau Veterans Health Centre
1750 Russell Rd
Ottawa, ON

Long-Term Care Home/Foyer de soins de longue durée

The Perley and Rideau Veterans Health Centre
1750 Russell Rd
Ottawa, ON

Name of Inspector(s)/Nom de l'inspecteur(s)

Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

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Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a critical incident inspection related to the fall and transfer to hospital of a resident.

During the course of the inspection, the inspector spoke with the home's Chief Executive Office, to a Registered Nurse, to a Registered Practical Nurse, to a Personal Support Worker, to the resident, and to a family member of the identified resident.

During the course of the inspection, the inspector reviewed the resident's health care record, observed a resident and examined the identified resident's wheelchair, chair alarm, lap belt, bed alarm, side rails and posey mat.

The following Inspection Protocols were during this inspection:

- Falls Prevention
- Minimizing Restraints

Findings of Non-Compliance were found during this inspection.

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

1. The resident is identified as being at high risk for falls. He/She fell on January 18 2011. He/She was assessed post fall to need PASDs (positioning aids safety devices). A lap belt, which he /she can release, and a chair alarm were added to his/her wheelchair post fall.

2. On January 28, 2011 at 11:15 am , it was observed by the MOHLTC inspector that the resident did not have his/her wheelchair lap belt applied around his/her waist as identified in his/her plan of care. The lap belt buckle ends were clipped together. The lap belt was behind the resident's back.

3. The wheelchair chair alarm is connected to the lap belt buckle. In the occurrence noted above, the resident did not have his/her lap belt applied and therefore did not have his/her chair alarm applied as identified in his/her plan of care.

4. The Personal Support Worker who was providing direct care to the resident told the MOHLTC inspector on January 28, 2011, that her/she did not apply the wheelchair lap belt and chair alarm, as identified in the resident's plan of care that morning.

Inspector ID #:	# 117

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 31, 2010