Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2021	2021_902622_0008	015635-21, 016368-21	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

HEATH HEFFERNAN (622)

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): November 8, 9, 10, 12, 16, 17, 18, 19, 2021

The following inspections were completed:

Complaint intake log #016368-21 and 015635-21- related to alleged physical, verbal abuse and resident care and services.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Managers of Resident Care, the Collaborative Practice Leader, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and the residents.

Also during the course of the inspection, the inspector reviewed nursing staff schedules, applicable complaint documents including video surveillance, the licensee's investigation documents, resident health records, the licensee's policy and procedure related to; Resident Abuse and Neglect - revised October 14, 2021, Concerns, Complaints, Compliments and Recommendations - September 5, 2018, and made observations of staff to resident interaction and resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	Légende 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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

The Ministry of Long-Term Care received a complaint alleging that staff were not following a resident's plan of care, and as a result had fallen.

On a date in September 2021, video surveillance showed directions posted in a resident's room for staff to follow related to the safe height of a specific piece of equipment. A Personal Support Worker (PSW) was observed not following the directions that were posted in the resident's room.

A review of the plan of care indicated that the resident's specific equipment was to be kept at a safe height for resident transfers.

The PSW stated that on the date in September 2021, they had lowered the resident's specific equipment lower than the plan of care directed.

The Manager of Resident Care stated that the direction for the height of the specific equipment posted in the resident's room, had been put in place by the Occupational Therapist and staff were to follow that direction as part of the plan of care.

On a date in August 2021, video surveillance showed the resident sliding from the side of the bed. The resident's assistive device was not within their reach at the open side of their bed.

A review of the plan of care for the resident which was in place at the time of the video surveillance in August 2021, indicated that their assistive device was to be in place at the open side of their bed.

On a date in October 2021, video surveillance showed the resident ambulating in their room, their assistive device was not within their reach.

A review of the resident's plan of care indicated that, the resident's assistive device was always to be within reach and used when up.

The Collaborative Practice Leader Registered Nurse (RN), reviewed the video surveillance from August and October 2021 and stated that the resident's assistive device was not within their reach on either date as directed in their plan of care.

Failing to follow the falls prevention plan of care, may result in risk of harm to the resident.

Sources: Video surveillance, resident health records and PSW and other staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the home received written complaints concerning the care of a resident, the long-term care home immediately forwarded it to the Director.

On dates in October and November 2021, the long-term care home received emails with concerns about staff not following a resident's plan of care.

The Manager of Resident Care stated that the specific complaints from October and November 2021, related to the resident's plan of care were not forwarded to the Director.

Sources: the licensee's email records, the Manager of Resident Care, and other staff. [s. 22. (1)]

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 every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: 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 an allegation of staff to a resident abuse was immediately reported to the Director.

According to O. Reg. 79/10, s. 2 (1)., the definition of "physical abuse" means,
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

The Manager of Resident Care received an email alleging that on a date in September 2021, video surveillance showed a Personal Support Worker (PSW) physically abuse a resident.

A review of the Ministry of Long-Term Care online critical incident submissions indicated that there were no critical incidents submitted related to the specific allegation of PSW to resident physical abuse on or after the date in September 2021.

The Manager of Resident Care, stated that they had not reported the allegation of PSW to resident physical abuse to the Director, that was reported to them on the date in September 2021.

Sources: the licensee's complaint documentation, video surveillance, the Manager of Resident Care, and other staff. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that abuse of a resident by staff that resulted in a risk of harm to the resident, occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 6th day of January, 2022

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

Original report signed by the inspector.