



**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
prévues le Loi de 2007 les
foyers de soins de longue**

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
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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 22, 23, Mar 6, 7, 8, 9, 14, 2012	2012_044161_0014	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

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with a Program Manager and Registered staff.

During the course of the inspection, the inspector(s) reviewed the health care records of three identified residents salient email correspondence; observed an identified resident as well as expiry dates on the nutritional supplements stored in the resident's room and in the storage room.

It is noted that three complaint inspections were conducted during the course of this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 subsections:
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 comply with section 6(7) of the LTCH Act 2007, in that the care set out in the plan of care was not provided to two residents as specified in the plan.
2. An identified resident Physician's Orders dated January 10 – April 8, 2012 indicates that the resident is to receive oxygen via nasal prongs at 2L/mins prn.
3. According to the progress notes of February 2, 2012 @ 15:30, staff checked the oxygen tank and discovered that it was empty. The resident was wearing oxygen nasal prongs which were attached to the oxygen tank. (log # O-002571-11)
4. An identified resident's plan of care of July 2011 indicates that a bed alarm is required when the resident is in bed.
5. In August 2011 the bed alarm was not turned on when the resident was in bed.
6. In August 2011 a Resident Assistant indicated to a Program Manager that she/he had not turned the bed alarm on. (Log # O-002345-11)

Issued on this 14th day of March, 2012



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

Katherine Snid