



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**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**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4^{ième} étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2013	2013_193150_0028	O-000471- 13 /O- 000826-13	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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection



The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 8, 9, 10, 2013

During this inspection, the inspector did 2 critical incidents inspections: log# O-000826-13, O-000471-13.

During the course of the inspection, the inspector(s) spoke with the Chief of Resident Care, Director of Community Outreach, Registered Nurse(RN), Registered Practical Nurse(RPN), Occupation Therapist, Personal Support Worker(PSW), Resident Assessment Instrument Coordinator, Special Approach Personal Support Worker(PSW) and the resident.

During the course of the inspection, the inspector(s) reviewed the residents' health records, the internal incident reports, the home's "Fall Prevention policies Caring for residents with responsive behaviours #NSG-B-130 revised 2009-06", "Fall Management policy #Gen-CL-1550 revised 2011", observed resident care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).

(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :



1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c8. s.6 (10)(b) in that the home did not ensure that the plan of care related to the resident's toileting needs were evaluated post fracture.(log #000471-13).

1- The resident #001 upon admission was identified at high risk for falls.

2- On a specific date in June 2013, the resident #001 had a fall and sustained a fracture and returned to the home.

3- The staff #S102 states that the resident's toileting routine was more independent before his injury and the resident was incontinent after the return from hospital.

4- The resident #001 had several falls without injury during a two week period in July 2013.

5- The staff #S103 states that the resident's fall trends indicated that some of the falls were related to toileting needs. The resident is known to transfers self unaided by either staff or walker. The resident will not ask for help or ring the call bell as per interviewed staff.

6- In June 2013, the multidisciplinary care plan indicates in section history of falls that the resident fell attempting to transfer from wheelchair to toilet.

7- The resident's #001 care plan indicates that the "resident refuses, assistance with transfers and should be assisted however transfers self unaided by either staff or walker, will not ask for help or ring the call bell". This intervention only relates to transfer interventions.

8-No fall interventions were identified related to toileting.

9- The resident #001 care plan does not include any toileting interventions considering that incontinence is a contributing factor to the falls. [s. 6. (10) (b)]



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

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

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 resident is reassessed and the plan of care reviewed and revised when the care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

Issued on this 28th day of October, 2013

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