Ontario

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 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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2015	2015_193599_0007	O-001679-15	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

HUMPHREY JACQUES (599)

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): March 12 and March 13, 2015

This inspection was in relation to a critical incident Log# O-001679-15

During the course of the inspection, the inspector(s) spoke with Several Personal Support Workers, Registered Nurses. Registered Practical Nurses,Personal Support Worker Supervisor, Director of Care and a Physician.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure there is a written plan of care for each resident that sets out,
(c) Clear directions to staff and others who provide direct care to the resident.

On specific date in October, 2013, Resident #02 sustained a fall and was found lying on the floor in the hallway near Resident's #01 room. In an interview with inspector #599 on a specific date in March, 2015, Registered Practical Nurse S #114 stated that on a specific date in October, 2013, a Dietary Aide informed him that a resident was on the floor in the hallway near resident's #01 room.Registered Practical Nurse S#114 went to assess resident and found Resident #02 lying on the floor in the hallway on his/her back near Resident's #01 room and was restless. Registered Practical Nurse S#114 attempted to assess Resident #02 and stated the resident was "guarding" a specific body part and suspected a fracture of a specific body part. When Registered Nurse S#115 arrived a few minutes later, Registered Practical Nurse S#114 indicated to Registered Nurse S #115 that the Resident #02 should be sent to the hospital for further assessment. Registered Nurse S#115 did not respond to Registered Practical Nurse S#114 and Registered Practical Nurse did not discuss his concern about Resident #02 further with Registered Nurse S#115. The PSW S#113 that was present assisted to transfer the resident to bed and Registered Practical Nurse S #114 continued to complete the medication pass.
Registered Practical Nurse S#114 stated he was concerned about Resident #02 and came back after completing the medication pass to reassess Resident #02. Resident had sustained skin tears on a specific body part and was unable to move a specific body part. Registered Practical Nurse S#114 informed Registered Nurse S #115, based on assessment Resident #02 should be sent to the hospital, Registered Staff S#115 did not acknowledged Registered Practical Nurse S#114 request and continued to complete incident report, risk management for resident to resident abuse and called the police. Registered Practical Nurse S#114 did not follow up on his request to send Resident #02 to hospital. There was no written plan of care set out to give clear directions on how to care for Resident #02 following his/her fall.
Registered Nurse S#115 did not communicate or requested any information about Resident #02 about the assessment completed by Registered Practical Nurse S#114.
In an interview on a specific date in March , 2015, S#112 PSW supervisor informed inspector #599, upon arrival at the scene of the incident, Resident #02 was on the floor in the hallway on his/her back and was in obvious discomfort. Registered Nurse S#115 arrived and assessed resident #02 and requested the PSW to transfer the resident to

bed using a Mediman lift. All staff present told Registered Nurse S#115 that resident #02 was in pain and ordered Tylenol to be given to resident. PSW Supervisor S#112 went to see the resident two to three times and observed Resident #02 appeared to be in discomfort. There were no clear directions from Registered Staff S#115 for the care for Resident #02 following his/her fall

On a specific date in October, 2013, Registered Nurse #116 noted that Resident #02 had sustained a fall and there was no change in the plan of care. Registered Nurse S#116 assessed Resident #02 and identified that the resident had a possible fracture of a specific body part,as resident was in pain. He/she also moaned in pain. Registered Nurse S#116 immediately started the process to transfer Resident #02 to hospital.

On a specific date in March, 2015, in an Interview, the Director of Care informed inspector #599 that the Manager of the Unit G1 is no longer at the Home and was not able to provide specific information regarding the incident. The Director of Care informed inspector #599 that Registered Staff S #115 who was on duty on the day of the incident, was no longer employed at the Home and a report was filed with the College of Nurses of Ontario. The DOC acknowledged that there was not a written plan of care which set out clear directions on how to care for the resident after the fall. [s. 6. (1) (c)]

Issued on this 15th day of May, 2015

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

Original report signed by the inspector.