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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2018	2018_730593_0012	022682-18	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

GILLIAN CHAMBERLIN (593)

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): August 28 - 30, September 4, 2018.

During the course of the inspection, the inspector(s) spoke with the Director of Clinical Practice, Manager of Resident Care, Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The inspector observed the provision of care and services to residents, staff to resident interactions, residents' environment, resident health care records, reviewed staff training records, complaint correspondence and licensee policies.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Reporting and Complaints

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of an unexpected or sudden death.

Resident #001 was admitted to the long-term care home. They were admitted following a hospital stay. The residents discharge date was scheduled for approximately three weeks after their admission date.

Resident #001 had multiple goals to work towards during their three week stay at the home. At the time of the incident, resident #001 had met all of their documented goals.

The day before their discharge date, resident #001 became unwell and was monitored throughout the night. Early the next morning, the resident had low blood pressure and was assessed by the physician as a result. The resident was sent to hospital and died later that morning in hospital.

During an interview with Inspector #593, August 30, 2018, RN #103 reported that the death of resident #001 was a shock to them as the resident was doing well with their rehabilitation and at the start of their evening shift, the day before the resident died, they were told at handover that resident #001 was doing well. Resident #001 first became unwell on RN #103's shift however when RN #103 finished their shift, resident #001 seemed to be feeling better.

During an interview with Inspector #593, August 30, 2018, RN #102 reported that resident #001 was doing really well with their rehabilitation and a discharge date had been set.

During an interview with Inspector #593, August 28, 2018, Director of Clinical Practice #100 reported that resident #001 was admitted to the home with specific goals to achieve before discharge. The resident had met their goals, had a discharge plan in place, was doing well and then suffered a medical event the night before they were due to be discharged.

Resident #001 was due to be discharged from the home as they had met their rehabilitation goals and as reported by staff, doing well. Unfortunately resident #001 suffered a medical event and passed away. This death was unexpected, however was not reported to the Director. [s. 107. (1) 2.]

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Issued on this 27th day of September, 2018

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

Original report signed by the inspector.