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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2019	2019_683126_0028	013947-19, 016041-19, 016686-19, 016970-19, 018683-19	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

LINDA HARKINS (126)

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 24, 25, 28, 29, 30, 31 and November 1, 2019.

During the course of this inspection the following logs were inspected:
Log #013947-19, CI: #C595-000061-19, "Improper/Incompetent treatment of a resident that results in harm or risk to a resident"
Log #016686-19, CI: # C595-000055-19, alleged "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"
Log # 016041, CI: #C595-000054-19, log #016970-19, CI: #C595-000056-19 and log #018683-19,CI: #C595-000061-19 related to "Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status".

During the course of the inspection, the inspector(s) spoke with the Director of Care, two Managers of Resident Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers and several residents.

The Inspector observed the provision of care and services to residents, resident's environment, staff to resident interactions, reviewed the Resident Abuse and Neglect policy reviewed 02/08/2018.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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. Log # 013947-19
The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment of care for resident #001 occurred, was immediately reported to the Director.

On a specific date of July 2019, Resident Care Manager #105 reviewed the camera footage for an incident that occurred on a specific unit. As the camera footage was reviewed, it was observed that on the night shift of that specific date, resident #001 who was sitting in the wheelchair(w/c), was brought in the dining room at 0228h and was left there until the end of breakfast that morning. A Critical Incident was submitted on a specific date of July 2019 as an improper or incompetent treatment of care of a resident that resulted in harm or risk of harm.

Registered Nurse (RN) #106 was interviewed and indicated to Inspector #126 that they completed a skin assessment on resident #001 and pressure injury skin breakdown was observed.

RCM #105 was interviewed and indicated to Inspector #126 that they could not recall why the CI was not immediately reported on that specific date of July 2019.

The licensee as failed to ensure the Director was notified immediately of

improper/incompetent treatment of care for resident #001 that resulted in harm. [s. 24. (1)]

2. Log #016686-19
The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of resident #002 occurred, was immediately reported to the Director.

On a specific date of August 2019, resident #002's care provider reported to Registered Practical Nurse (RPN) #108, that a Personal Support Worker (PSW) who provided care to their spouse during the night shift, hit the left side of his/her trunk and abdomen area.

As they became aware, the licensee conducted an investigation and noted that on that specific night shift, RPN #107, was aware of resident #002's allegation of abuse, staff to resident.

RPN #107 was interviewed via telephone and indicated to Inspector #126, that they were told by resident #002, on that specific night of August 2019 that they were hit by Personal Support Worker (PSW) #108. RPN #107, indicated that they did not notify the Night Supervisor staff regarding resident #002's complaint.

The licensee has failed to ensure the Director was notified immediately of the allegation of abuse, staff to resident. [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 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. 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., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Log # 013947-19
The licensee has failed to ensure that resident #001 who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance tissue load.

On a specific date of July 2019, Resident Care Manager #105 reviewed the camera footage for an incident that occurred on a specific unit. As the camera footage was reviewed, it was observed that on the night shift of that specific night shift, resident #001 was brought in the dining room at 0228h and was left there until the end of breakfast that morning.

The plan of care of resident #001 dated May 2019, indicated that the resident was known to be at risk of pressure skin injury as they required extensive assistance with bed mobility and was known for a history of resolved ulcers. Also, as per the plan of care, when resident #001 was sitting up in the wheelchair, the tilt position device could be used, and the resident could be repositioning every hour and when they were in the sitting position in the w/c the resident required to be repositioned every two hours.

Registered Nurse (RN)#106 indicated that they completed the skin assessment the of that specific date of July 2019 and resident #001 was observed to have pressure injury skin breakdown.

The licensee has failed to ensure that when resident #001 who was the sitting up in the w/c for the period of 0228h until after breakfast was repositioned every 2 hours, which resulted in pressure injury skin breakdown. [s. 50. (2) (d)]

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 shall ensure that, (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated, to be implemented voluntarily.

Issued on this 20th day of November, 2019

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

Original report signed by the inspector.