Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 8, 2020	2020_621755_0020	008722-20, 010011-20, 014853-20, 016713-20, 018486-20, 018567-20, 020501-20, 020588-20	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

MANON NIGHBOR (755), ANANDRAJ NATARAJAN (573)

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 26, 27, 28, 29, 30, November 2, 3, 4, 5, 6, 9, 10, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 2020.

The following logs were completed in the Critical Incident System Inspection:
Log #020588-20, Critical Incident (CI) #3025-000032-20; log #020501-20, CI #3025-000033-20; log #018486-20, CI #3025-000025-20; log #014853-20, CI #3025-000018-20; log#008722-20, CI #3025-000005-20; log#018567-20, CI #3025-000026-20 related to falls.
Log #010011-20, CI #3025-000006-20 related to missing resident.
Log #016713-20; CI #3025-000021-20 related to allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Director of Clinical Practice, Manager of Resident Care, Physiotherapist (PT), Occupational Therapist (OT), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW) and resident.

During the course of the inspection, the inspector reviewed resident's health care records, relevant policy and procedures, Fall Program Inspection document, observed resident's environment and interviewed staff and resident.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff collaborate with physiotherapy in the assessment of a resident, so that their assessments are integrated and consistent with and complement each other related to fall prevention interventions.

The resident fell numerous times in a span of three months prior to fracturing their hip. A physiotherapy referral was included as an intervention in multiple post fall assessments, during this period of time.
On those specific dates, the Manager of Resident Care indicated that referrals to physiotherapy were not completed and the Physiotherapist confirmed they did not receive any referrals related to the resident's falls during this time period.

Sources:
Resident's progress notes, Scott Fall Risk Screening Tools and Post-Fall Huddles. Interviews with Manager of Resident's Care and Physiotherapist. [s. 6. (4) (a)]

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 staff collaborate with physiotherapy in the assessment of residents, so that their assessments are integrated and consistent with and complement each other related to fall prevention interventions, to be implemented voluntarily.

Issued on this 8th day of December, 2020

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

Original report signed by the inspector.