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
Oct 7, 2021	2021_785732_0009	022094-20, 002987-21, 003645-21, 003759-21, 006595-21	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

EMILY PRIOR (732), MEGAN MACPHAIL (551)

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): April 12 to 16, 19 to 23, and 26 to 30, 2021; May 4 and 5, 2021; and June 2, 7, and 8, 2021.

The following logs were completed during this Complaint inspection:

log #003759-21 and log #003645-21 (CI #3025-000011-21) related to falls prevention, alleged resident to resident abuse, and responsive behaviours;

log #002987-21 related to air temperature, personal support services, and recreation and social activities;

log #022094-20 related to discharge and accommodation fees; and

log #006595-21 (CI #3025-000002-21) related to falls prevention.

During the inspection, the inspector(s) observed the provision of care and services to residents, resident environments, resident to resident interactions, and staff to resident interactions.The inspector(s) also reviewed resident health care records, relevant policies and procedures, and maintenance documents.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing, a Manager of Resident Care, the Manager of Property Services/Materials Management/Laundry, the Admissions Coordinator, the Collaborative Practice Leader, a Physiotherapist, a Recreation Therapist, a Recreation Programmer, a Placement Coordinator from the Local Health Integration Network (LHIN), a Registered Nurse (RN), a Registered Practical Nurse (RPN), and a Personal Support Worker (PSW). The inspector(s) also spoke with a Physician and Social Worker from the Royal Ottawa Hospital (ROH).

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours
Safe and Secure Home

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	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 O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that contact was maintained with a resident who was on an absence in order to determine when the resident would be returning to the home.

A resident of the home was admitted to hospital.

When the resident was ready to be discharged back to the home, there was a discharge planning meeting with the staff of the hospital, the home, and the resident's SDM. The home declined to take the resident back stating they were unable to accommodate the staffing requirement to maintain the resident's isolation, as was required in Directive #3 at the time, and the resident remained in hospital.

Due to the COVID-19 pandemic, the resident was not discharged from the home when their set number of days of leave were reached, and the resident's SDM continued to pay a basic accommodation rate of $62.18 daily, or $1891.31 monthly.

Approximately five months after they had been admitted to hospital, the resident's SDM asked the home to have the resident discharged.

After the discharge planning meeting, there was no evidence of communication from the home to the resident's SDM, and the SDM was not given an opportunity to determine when the resident would be returning to the home.

Sources: Resident health care record and interviews with staff and resident's SDM. (551) [s. 141. (1)]

Issued on this 7th day of October, 2021

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

Original report signed by the inspector.