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
Nov 24, 2021	2021_593573_0025	007776-21, 011349-21, 011721-21, 012258-21, 012938-21, 013912-21, 014119-21, 015843-21, 016296-21, 016769-21	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

ANANDRAJ NATARAJAN (573), EMILY PRIOR (732)

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): November 10, 12, and 16 -19, 2021

The Following logs were completed in this Critical Incident System (CIS) inspection:

(i) Log #011349-21 and Log #013912-21 were related to staff to resident alleged physical abuse.

(ii) Log #011721-21, Log #012258-21 and Log #014119-21 were related to resident to resident alleged physical abuse.

(iii) Log #007776-21 and Log # 016769-21 related to the fall incident that caused injury to the residents.

(iv) Log #015843-21 related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Nursing, the Director of Clinical Practice, the Manager(s) of Resident Care Services, Manager of Infection Prevention and Control, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Administrative Assistants.

During the course of the inspection, the inspector(s) reviewed the resident health care records, and other pertinent documents. The inspector(s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
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	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. (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 that the written plan of care for the resident set out clear directions to the staff regarding the resident’s physical behaviours.

A resident’s clinical records identified that the resident had responsive behaviors, including the physical behaviour towards other residents. Resident’s progress notes documentation indicated multiple incidents in which the resident exhibited physical responsive behaviour towards other residents. A review of the resident’s written plan of care in place did not identify the resident’s physical responsive behaviour towards other residents. The lack of clear direction in the resident’s plan of care for their responsive behaviours, places potential risk of harm to the residents.

Sources: The resident’s written plan of care, and interview with the RN and other staff. [s. 6. (1) (c)]

Issued on this 15th day of December, 2021

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

Original report signed by the inspector.