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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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 15, 2021	2021_902622_0007	013799-21, 013856-21	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

HEATH HEFFERNAN (622), ANANDRAJ NATARAJAN (573)

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): November 8, 9, 10, 12, 16, 17, 18, 19, 2021

The following inspections were completed:

Complaint intake log #013799-21 and 013856-21 - related to resident care and services.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Manager of Resident Care, Personal Support Worker (PSW) Supervisors, Material Management/ Laundry Supervisor, Infection Prevention and Control Manager, Registered Nurse (RN), Registered Practical Nurses (RPNs), Occupational Therapist, Personal Support Workers (PSWs), a Housekeeper and the residents.

Also during the course of the inspection, the inspector reviewed nursing staff schedules, applicable complaint documents including video surveillance, the licensee's investigation documents, resident health records, the licensee's policy and procedure related to: Personal Protective Equipment (PPE) - revised September 15, 2021, Concerns, Complaints, Compliments and Recommendations - September 5, 2018, and made observations of resident care and services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for dressing, bed mobility and positioning was provided to a resident as specified in the plan.

Inspector #622 reviewed ten separate video surveillance clips from a resident's room. All ten video surveillance clips showed staff rolling and repositioning the resident alone.

The plan of care stated that the resident required extensive assistance of two staff for specific care tasks.

A Personal Support Worker (PSW) viewed all ten video surveillance clips and said that, the staff members seen performing care alone for the resident on each of the video surveillance clips, were not following the plan of care as they did not use two staff for the resident's specific care tasks.

Failing to follow the resident's mobility and positioning plan of care may result in risk of harm to the resident.

Sources: video surveillance clips, resident health records, PSW and other staff. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints concerning the care of a resident were immediately forwarded it to the Director.

The Manager of Resident Care received an email that indicated concern with care issues related to a resident. The email indicated that video surveillance clips from a resident's room showed staff not following the infection prevention and control policy.

A second email sent to the Manager of Resident Care indicated that video surveillance clips from a resident's room showed PSWs were not following the residents plan of care related to using two staff for specific care tasks.

The Manager of Resident Care stated that, the complaints they received related to the staff not following the infection prevention and control policy in a resident's room, and PSWs not following the residents plan of care related to using two staff for specific care tasks, had not been forwarded to the Ministry of Long-Term Care.

Sources: complaint documentation, the licensee's investigation documents, resident health records, the Manager of Resident Care, and other staff. [s. 22. (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 every licensee of a long-term care home who receives a written complaint concerning the care of a resident, or the operation of the long-term care home, shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the Infection Prevention and Control program.

According to the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 86 (1)., every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home.

The licensee's Personal Protective Equipment (PPE) policy and procedure stated that supervisors were to ensure that employees properly use PPE. Gloves were to be used as a protective barrier when contacting bodily fluids and surgical masks were always to be worn when entering the facility.

A review of three video surveillance clips taken in a resident's room during a one-month period, showed a Personal Support Worker (PSW) performing specific resident care without wearing gloves. The videos also showed a housekeeper with their mask below their nose and a PSW wearing their mask under their chin.

The Infection Prevention and Control Manager/RN viewed the three video surveillance

clips and stated that the PSW should have been wearing gloves to perform the specific care to the resident. Furthermore, the housekeeper and the PSW were not wearing their masks appropriately as the masks were always to cover the chin and nose.

Sources: video surveillance clips, resident health records, complaint documentation, the licensee's investigation documents, the licensee's Personal Protective Equipment (PPE) policy and procedure, the Infection Prevention and Control Manager/RN and other staff. [s. 229. (4)] (622)

2. This non-compliance was noted during concurrent inspection #2021_593573_0025.

During a lunch meal service, the inspector observed two Personal Support Workers (PSWs) assist with the residents' feeding and did not perform their hand hygiene nor wash their hands between the care. Furthermore, the staff failed to assist the residents to clean their hands before and after meals.

Failing to participate in the implementation of the Infection Prevention and Control program may result in the spread of infection, and risk of harm to the residents and staff.

Sources: Direct observations, interview with the Manager of Infection Prevention and Control and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the infection, prevention and control program, to be implemented voluntarily.

Issued on this 6th day of January, 2022

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

Original report signed by the inspector.