

#### Ministry of Long-Term Care

Long-Term Care Operations Division Long-Term Care Inspections Branch Ottawa Service Area Office 347 Preston Street, Suite 420 Ottawa ON K1S 3J4 Telephone: 1-877-779-5559 OttawaSAO.moh@ontario.ca

Original	Public	Report

Report Issue Date	August 9, 2022			
-	2022_1519_0001			
Inspection Type				
Critical Incident System	em 🛛 Complaint	Follow-Up	Director Order Follow-up	
□ Proactive Inspection	-	- 1	□ Post-occupancy	
□ Other				
			_	
Licensee The Perley and Rideau Veterans' Health Centre 1750 Russell Road Ottawa ON K1G 5Z6 Long-Term Care Home and City The Perley and Rideau Veterans' Health Centre				
1750 Russell Road Ottawa ON K1G 5Z6				
Lead Inspector Inspector Digital Signature ANANDRAJ (ANDY) NATARAJAN #573				
Additional Inspector(s) Inspector(s) #740811, 740814, 741823 and 740785 were present during the inspection as an observer.				

## **INSPECTION SUMMARY**

The inspection occurred on the following date(s): June 27- 30, 2022, July 4- 8, 11-15 and 18, 2022.

The following intake(s) were inspected:

- Intake 005915-22 and 008825-22 complaints related to allegation of staff to resident physical abuse and concerns related to resident care.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Resident Care and Support Services

### **INSPECTION RESULTS**



# WRITTEN NOTIFICATION [PLAN OF CARE]

# NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 - s.6 (7)

# The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

### **Rationale and Summary**

A review of the plan of care for the resident's toileting care identified instructions to the staff on how to communicate with the resident. The plan of care directed the staff to communicate with positive tone of voice, one person talks, and the steps needed to be simple and direct.

The inspector reviewed video footage dated on a day in May 2022 where two PSW staff assisted with the resident's toileting care. The video footage showed that while providing the toileting care, the PSW failed to communicate with the resident and did not follow the instructions as specified in the plan.

**Sources:** the resident's plan of care, video surveillance, and interview with the staff members. [573]