Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 17, 2023	
Inspection Number: 2023-1519-0008	
Inspection Type: Complaint Critical Incident	
Licensee: The Perley and Rideau Veterans' Health Centre	
Long Term Care Home and City: The Perley and Rideau Veterans' Health Centre, Ottawa	
Lead Inspector Jessica Nguyen (000729)	**Inspector Digital Signature** Jessica Nguyen Digitally signed by Jessica Nguyen Date: 2023.11.08 14:18:31 -05'00'
Additional Inspector(s) Severn Brown (740785) Maryse Lapensee (000727)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 3- 6, 2023 and October 10-11, 2023.

The following intakes were inspected during this complaint inspection:

- Intake: #00095404 related to bathing, clothing/laundry, and ongoing care concerns.
- Intake: #00095850 related to resident care, food and nutrition, rest routines, and concerns with family council.

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake: #00094661/CI# 3025-000082-23, Intake: #00097495/CI#3025-000097-23 and Intake: #00097534/CI#3025-000099-23 were related to a fall with injury resulting in a significant change in condition.
- Intake: #00095334/CI# 3025-000089-23 was related to alleged resident to resident responsive behaviors.
- Intake: #00094670/CI# 3025-000083-23 was related to an incident where a resident sustained an injury of unknown cause that resulted in a significant change in condition.

- Intake: #00095037/CI# 3025-000086-23 was related to alleged staff to resident physical abuse.

The following intakes were completed in this inspection:

- Intake: #00094676/CI# 3025-000084-23, Intake: #00095218/ CI# 3025-000088-23 and Intake: #00097534/CI#3025-000099-23 were related to a fall with injury resulting in a significant change in condition.

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

Resident Care and Support Services
Continence Care
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bedtime and rest routines

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 45

The licensee has failed to ensure that the desired rest routines of a resident were supported.

Rationale and summary
A resident was observed in up in their wheelchair during the course of the inspection. The resident's written care plan states that the resident is to be in bed at a specified time, and the resident was up almost one hour past their specified rest time. A Personal Support Worker (PSW) who was caring for the resident stated that the resident is supposed to be in bed at specified time and that they were unable to

get the resident into bed until past their designated rest time due to other time constraints.

By not ensuring that a resident's specified rest routines were complied with, the resident was put at risk of not being provided optimal comfort and quality of life.

Sources:
Observation of a resident;
The resident's written plan of care;
Interview with a PSW.

[740785]

WRITTEN NOTIFICATION: Food production

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (3) (b)

The licensee has failed to ensure that a food item in the food production system was stored using a method to prevent contamination and food borne illness.

Rationale and summary
A complaint was received regarding the storage of the fluid thickener on the Ottawa 2 West unit of the home. Upon inspection of the fluid thickener storage, the thickener was identified by a Dietary Aide in a container that had been previously used for a different food item and reused to store the fluid thickener. No label identifying the fluid thickener, or an expiry date was present on the container.

The dietary aide stated that dietary aides are responsible for refilling the fluid thickener from a central location in the kitchen in the identified unlabeled container. The Acting Nutrition Manager stated that the fluid thickener should be stored in a labeled container to ensure the product was identified properly.

By not ensuring that the fluid thickener was stored in a labelled container with the product's expiry date, residents who consume thickened fluids are at risk of consuming a product that is potentially contaminated or expired.

Sources:
Observations of the Fluid Thickener storage on Ottawa 2 West;
Interviews with a Dietary Aide and the Acting Nutrition Manager.

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