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
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Original Public Report

Report Issue Date: May 27, 2024	
Inspection Number: 2024-1519-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Perley and Rideau Veterans' Health Centre	
Long Term Care Home and City: The Perley and Rideau Veterans' Health Centre, Ottawa	
Lead Inspector Saba Wardak (000732)	Inspector Digital Signature
Additional Inspector(s) Severn Brown (740785)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-9, 13-17, 2024.

The following intake(s) were inspected:

- Intake: #00115529 - Proactive Compliance Inspection (PCI)

The following Inspection Protocols were used during this inspection:

Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management

Pain Management
Prevention of Abuse and Neglect
Quality Improvement
Resident Care and Support Services
Residents' and Family Councils
Residents' Rights and Choices
Safe and Secure Home
Skin and Wound Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a resident's care plan provided clear direction related to the resident's safety checks.

Rationale and Summary
A resident's care plan stated that the resident is to be assessed at specified times of

the night by a registered staff member. Resident's safety round sheets, however, indicated the resident was checked by a Personal Support Worker (PSW) on these specified times. Manager, Resident Care #120 stated that it is not necessary for a registered staff member to perform the checks and it is appropriate for the checks to be completed by a PSW.

Manager, Resident Care #120 corrected the care plan to indicate that the checks could be performed by a PSW.

Sources:
Resident's care plan and safety rounding sheets;
Interview with Manager, Resident Care #120.

[740785]

Date Remedy Implemented: May 16, 2024

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that doors leading to a non-residential area were

kept closed and locked when not in use.

Rationale and Summary
On a specified day, doors leading to non-residential area behind the nursing station on two separate units were observed propped open without any staff members supervising the area. On a separate occasion, the door leading to a non-residential area behind the nursing station on a different unit was also observed propped open without any staff members supervising the area. These doors on all units lead to non-residential areas and are potentially accessible to residents.

Per Manager, Resident Care #120, the doors leading to non-residential areas behind the nursing station must be kept closed and locked. Director of Care (DOC) #100 also confirmed that these doors must be kept closed and locked.

By not ensuring that the doors on all units leading to non-residential areas were kept closed and locked, residents were put at risk of unsupervised access and potential injury or entrapment.

Sources:
Observations of nursing stations on various units;
Interviews with Manager, Resident Care #120 and DOC #100.

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