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: August 20, 2024
Inspection Number: 2024-1519-0006
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 30, 31, 2024 and August 1, 2, 7, 8, 12, 13, 14, 15, 19, 20, 2024

The following intake(s) were inspected:

- Intake: #00120518, #00120997, #00121101, #00121495 - Complaint related to resident care and services and medication administration
- Intake: #00121615 - Complaint related to resident care and services
- Intake: #00122459 - Complaint related to resident care and services
- Intake: #00120809 - Related to resident to resident physical abuse
- Intake: #00122563 -Related to resident to resident physical abuse

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 written plan of care was set out providing clear directions to staff and others who provide direct care a resident.

Sources: Resident health records, observations and interviews with a Personal Support Worker, a Registered Nurse, a Registered Practical Nurse, and a Manager of Resident Care.
[000807]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care

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.

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

Sources: Resident health records, interview with a Manager of Resident Care.
[720483]

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

Sources: Resident health records, interview with a Manager of Resident Care.
[720483]

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

Sources: Resident health records, interview with a Manager of Resident Care.
[720483]

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

Sources: Resident health records, interviews with a Manager of Resident Care and a Nurse Practitioner.
[720483]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (8)
Plan of care
s. 6 (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Sources: Resident health records, interview with a Registered Practical Nurse and a Personal Support Worker.
[720483]

WRITTEN NOTIFICATION: Administration of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Sources: Resident health records, interview with a Registered Practical Nurse and a

Personal Support Worker.
[720483]