

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: September 26, 2024

Inspection Number: 2024-1519-0007

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): September 19, 20, 23, 24, and 25, 2024

The following intake(s) were inspected:

- Intake: #00122665/ Critical Incident System (CIS) Report 3025-000089-24- an incident related to resident to resident physical abuse.
- Intake: #00124787 a complaint related to concerns about the care of a resident.
- Intake: #00125440 a complaint regarding concerns about the care of a resident.
- Intake: #00125612/ Critical Incident System (CIS) Report 3025-000110-24 an incident related to resident to resident physical abuse.

The following intakes were completed in this inspection:

• Intake: #00126408/ Critical Incident System (CIS) Report 3025-000114- 24-related to a written complaint received about the care concerns of a resident.



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- Intake: #00126674 a complaint related to concerns about the care of a resident.
- Intake: #00127061 a complaint related to concerns about the care of a resident.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Recreational and Social Activities

## **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 (9) 1.

Plan of care

- s. 6 (9) The licensee shall ensure that the following are documented:
- 1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the bed mobility set out in the plan of care was documented.



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A resident's plan of care directed staff to reposition the resident at 0200 hours and 0600 hours. A review of documentation records over two separate dates did not show documentation for the repositioning provided by a PSW.

Sources: Resident's electronic medical record and documentation records, interview with PSW.

#### WRITTEN NOTIFICATION: Skin and Wound

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

- s. 55 (2) Every licensee of a long-term care home shall ensure that,
- (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
- (iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee has failed to ensure that a resident's altered skin integrity was reassessed at least weekly by an authorized person.

A resident was assessed to have a wound on a specified date. A review of the medical records showed that wound assessment was not completed weekly over a 24 day period.

Sources: Resident health care records, assessment records, and interview with a nurse.



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### WRITTEN NOTIFICATION: Drugs Administration

NC #003 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 re-

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.

The physician order directs staff to administer a medication at a specified time. The electronic Medical Administration Record (eMAR) showed that medication was not administered at the specified time on two separate dates.

Sources: Physician's order and a resident's eMAR from a specified month.