Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2013	2012_203126_0010	O-000874-12,001055,001155-12	Critical Incident System

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road, OTTAWA, ON, K1G-5Z6

Long-Term Care Home/Foyer de soins de longue durée

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 10, 11, 12, 13, 14, 17 and 18, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Resident Care, the Directors of care and the nursing staff.

During the course of the inspection, the inspector(s) reviewed the residents health care record and observed care and services given to residents.

The purpose if this inspection is to conduct ~~6~~ 7 Critical Incidents inspections. The following CI were reviewed:

Log # O-000874-12
Log # O-001055-12
Log # O-001155-12
Log # O-001479-12
Log # O-002390-12
Log # O-002395-12
Log #O-002428-12

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Falls Prevention

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 30. (2) in that the home did not take any actions with respect to a resident under a program, including assessments, reassessments interventions and the residents responses to interventions were documented.

In December 2011, resident #5 had several abdominal x-ray done, one of the abdominal x-ray, revealed that the resident had " A large fecaloma persist in the rectum consistent with fecal impaction". No action was documented in the progress notes from the physician or the nursing staff related the abdominal x-ray done in December 2011. No assessment, reassessment interventions or resident's response to interventions were documented in the resident health care record(hard copy and point click care were reviewed). Log #O-001479-12 [s. 30. (2)]

2. In February 2012, resident #2 was prescribed a pain medication at bed time for one week. On a specific date in April 2012, the Psychogeriatric Team noted that the pain medication was not administered to the resident between the period of March 2012 and that specific date in April 2012. There was no documentation in the health care record (hard copy and/or point click care) that the pain medication was assessed, reassessed. Log # O-001055-12 [s. 30. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Regs 79/10 s.107. (2) in that the home did not report immediately an incident of unexpected death after normal business hours using the Ministry method for the after hours emergency contact.

On a specific date in December 2012, Resident #7 died unexpectedly. The Home did notify the Ottawa Service Area via email that same day but did not immediately notified the Director using the Ministry's method of after hours emergency contact. Log # O-002395-12 [s. 107. (2)]

Issued on this 7th day of January, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

LHarkins