Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Mar 20, 2013	2013_203126_0010	O-000030,000026,000161-13	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

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

This inspection was conducted on the following date(s): March 14-15, 2013

During the course of the inspection, the inspector(s) spoke with the Chief Executor Officer, the Chief Resident Care (Long Term Care), One Program Manager, several registered and non registered nursing staff and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records and policies related to fall management program and prevention of abuse.

Three Critical Incidents were reviewed during this inspection.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, C.8 S3.(1) 2. in that a resident Right's to be protected from physical abuse(physical force by a resident that causes physical injury to another resident) from a co-resident was not fully respected and promoted:
On a specific date in February 2013, a resident pushed to the floor by a co-Resident. This fall resulted in an injury to the resident. [s. 3. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.8.(1) b in that the home did not comply with the fall prevention program policy and procedure by not completing a fall risk screening tool post fall.

Between October 2012 and March 2013, an identified resident experienced several falls. The post fall assessment was not conducted using the Fall Risk Screening Tool as per the Fall Prevention Program Policy and procedure. (GEN-CL-1550, NSG-F-550)

March 14, 2013, interview held with the unit day shift Registered Nurse regarding the identified resident. The Registered Nurse indicated that the post assessment fall is documented in the progress note and that was not aware of the Fall Risk Screening Tool in MDS.

A resident fell in February 2013. The post fall assessment was not conducted using the Fall Risk Screening Tool as per the Fall Prevention Program Policy and procedure.

The Fall Prevention Program Policy and Procedure was reviewed and requires that that " All residents who have fallen are assessed, and where the condition and circumstances of the resident requires, a post fall assessment will be conducted using the Fall Risk Screening Tool." [s. 8. (1)]

2. The licensee has failed to comply with O.Reg 79/10 s. 8. (1) b in that the home did not comply with the Policy and Procedure Abuse of Residents (GEN-AD-1022).

On a specific date in January 2013, a Personal Support Worker(PSW) witnessed another PSW roughly shove an identified resident onto the bed resulting in an injury. The PSW who witnessed the incident informed a Registered Nurse the following day.The Director of Resident Care, was informed by internal courier several days after the incident.

The PSW and the RN did not comply with the Policy and Procedure Abuse of Residents (GEN-AD-1022) in that they did not immediately report the incident of abuse as per procedure, reporting incident of abuse /neglect, that requires that "staff

must report the incident directly to Ministry of Health and Long Term Care and/or immediately notify supervisory staff member.Supervisory staff member will notify manager immediately. [s. 8. (1)]

Issued on this 20th day of March, 2013

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