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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 9, 2014	2014_225126_0011	O-000218-14, O-000255-14	Complaint

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

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

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 3 and 8, 2014

During the course of the inspection, the inspector(s) spoke with the Chief Resident Care, the Director of Resident Care, the Manager of Resident Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Worker(PSW) and several residents.

During the course of the inspection, the inspector(s) reviewed several health care records, reviewed the following policies: NSG-M 1220/GEN-CL-1220 Medication transcription, Administration control and documentation, GEN-CL-1550-NSG-F-550 Fall Prevention Program and GEN-CL-1700 Power Mobility-Electric Wheelchair and scooter use and observed care and services provided to residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Nutrition and Hydration

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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S. O. 2007, c.8 s.24. (1)(4). in that the licensee did not immediately report to the Director an incident which the resident reported misappropriation of money.

As indicated by the resident health care record and a Critical Incident Report on a specific day in April 2011, Resident #1 reported that he/she was missing $80.00 dollars in his/her wallet.

The Director was informed of the incident described above, through the Critical Incident System April 19, 2011. The Director was not informed immediately of the resident misappropriation of money. [s. 24. (1)]

WN #2: 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 79/10 s. 30. (2) in that the licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were are documented.

In the progress notes of the morning of a specific day in April 2011, it is noted that resident #1 fell and the physician was contacted at that time. The physician ordered neuro vitals signs to be done for the next 48 hours and to apply ice pack. The resident neuro vitals signs were documented at that time in the progress note. Inspector # 126 reviewed resident's #1 health care record and did not find any further documentation related to the neuro and vitals signs.

Discussion held with the Director of Resident Care(CC) and the Manager of Resident Care (SD) indicated that the nursing staff are required to use the Neurological Flow Sheet for documentation. The protocol frequency is written on the Flow Sheet. Vitals signs and Neuro checks were to be done every 15 minutes x 1 hour, every 30 minutes x 1 hour and every 1 hour x 4 hours and every 4 hours x 24 hours and to progress along this time schedule ONLY if signs are stable.

The Director Residents Services reviewed resident #1 health care record and did not find any Neurological Flow Sheet in the record. [s. 30. (2)]

WN #3: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.107 (3), whereby the licensee did not ensure that an injury of person that resulted in transfer to hospital was reported within one business day to the Director.

As indicated by the resident health care record and Critical Incident Report, Resident #1 was found lying on the floor in the doorway of the room on a specific day of April 2011.

The Director was informed of the incident described above, through the Critical Incident System May 6, 2011. The Director was not informed within one business day of an injury that resulted in transfer to hospital.

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was applied. [s. 107. (3)]

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

---

Issued on this 9th day of April, 2014

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

LINDA HARKINS Inspector #126