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: June 20, 2023

Inspection Number: 2023-1519-0006

Inspection Type:
Critical Incident System

Licensee: The Perley and Rideau Veterans' Health Centre

Long Term Care Home and City: The Perley and Rideau Veterans' Health Centre, Ottawa

Lead Inspector	**Inspector Digital Signature**
Cheryl Leach (719340)	Cheryl Leach Digitally signed by Cheryl Leach Date: 2023.06.20 10:57:30 -04'00'

Additional Inspector(s)
Martin Orr (000747)
Margaret Beamish (000723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 17, 18, 23, 24, 25, 26, 29, 2023

The following intake(s) were inspected:
· Intake #00022845-[CI 3025-000030-23] Alleged misappropriation of resident's funds.
· Intake #00084251-[IL-11438-AH/CI 3025-000034-23] Visitor to resident physical abuse.
· Intake #00084252-[IL-11439-AH/CI 3025-000035-23] Visitor to resident verbal abuse.
· Intake #00084645-[IL-11639-AH/CI 3025-000037-23] Alleged staff to resident physical and sexual abuse.
· Intake #00086911-[IL-12701-AH/CI 3025-000044-23] Resident to resident physical abuse.
· Intake #00087109-[CI 3025-000047-23] related to a fall resulting in an injury and a significant change in condition.

The following intake was completed in this inspection:
· Intake#00083798-[CI 3025-000032-23] related to a fall resulting in an injury and a significant change in condition.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to protect residents from physical abuse by another resident.

Rationale and Summary
Physical abuse is defined by O. Reg. 246/22 s. 2 (1) as the use of physical force by a resident that causes physical injury to another resident.

A resident exhibited physical responsive behaviours towards another resident by striking them. This resulted in an injury to the resident.

A resident exhibited physical responsive behaviours by punching another resident and the resident sustained an injury. Registered Nurse (RN) stated that the resident was emotional and anxious after being punched.

Additionally, a resident exhibited physical responsive behaviours including striking and punching towards residents several other times.

Resident's care plan listed to initiate 1:1 monitoring if required for managing their responsive behaviours which was not implemented for several incidents.

Behaviour mapping sheets were initiated for three incidents which had several missing entries. The home's Behaviour Mapping Procedure stated that behaviour mapping is required for all three shifts for five days on the Behaviour Mapping tool. Manager of Resident Care confirmed that the expectation of staff is to complete this documentation for five days and all three shifts when behaviour mapping is initiated.

The home's Behaviour Mapping Procedure also stated that on the sixth day registered staff will analyze the behaviour mapping tool using the Behaviour Mapping Analysis assessment in Point Click Care. Manager of Resident Care stated that staff would complete this once the behaviour mapping was done. The Behaviour Mapping Analysis for resident was missing for one incident.

The home's Responsive Behaviour Program Policy and Procedure stated that an Antecedent, Behaviour and Consequence (ABC) Huddle with all staff present during the incident is to be completed after a high risk incident. A review of resident's progress notes showed no notes under the titles of ABC Huddle or ABC Review for these incidents. Manager of Resident Care confirmed that the ABC Huddle listed in the home's Responsive Behaviour Program Policy and Procedure would only be documented in the progress notes under the title of ABC Review. There were no ABC Review notes completed for these incidents.

Failure to protect other residents from abuse by a resident placed them at an increased risk of harm.

Sources: risk management assessments, progress notes, care plan, behaviour mapping sheets, Responsive Behaviour Program Policy and Procedure, Behaviour Mapping Procedure, interviews with RN's, Managers of Resident Care and others.

[000723]

WRITTEN NOTIFICATION: Reporting to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 4.

The licensee failed to immediately report the suspicion and the information upon which it is based to the Director regarding misuse or misappropriation of a resident's money.

Rationale and Summary

A review of the licensee's investigation file noted that the alleged incident of misuse or

misappropriation of a resident's money occurred during the evening shift as reported in an email sent to the Manager of Resident Care the following morning. This alleged incident was not reported to the Director immediately as confirmed in an interview with the Manager of Resident Care. Failing to immediately report all allegations of misuse or misappropriation of a resident's money to the Director, places residents at risk of harm.

Sources: Critical Incident Report, licensee investigation file and an interview with the Manager of Resident Care.

[719340]