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: February 7, 2024	
Inspection Number: 2023-1519-0010	
Inspection Type: Critical Incident	
Licensee: The Perley and Rideau Veterans' Health Centre	
Long Term Care Home and City: The Perley and Rideau Veterans' Health Centre, Ottawa	
Lead Inspector Pamela Finnikin (720492)	**Inspector Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2024.03.05 09:30:28 -05'00'
Additional Inspector(s) Martin Orr (000747)	

INSPECTION SUMMARY

The following intakes were completed in this Critical Incident (CI) inspection:

The inspection occurred onsite on the following date(s): January 3-5, 8-11, 2024

- Intake: #00101386, CI #3025-000117-23 – Alleged financial abuse of resident
- Intake: #00101927, CI #3025-000118-23; Intake: #00101934, CI #3025-000120; Intake: #00104699, CI #3025-000137-23 – Alleged resident to resident physical abuse
- Intake: #00101935, CI #3025-000119-23; Intake: #00102874, CI #3025-000127-23 – Alleged resident to resident sexual abuse
- Intake: #00102394, CI #3025-000123-23 – Alleged staff to resident neglect
- Intake: #00102509, CI #3025-000124-23 – Alleged staff to resident emotional abuse

- Intake: #00103159, CI #3025-000128-23 – Fall of resident resulting in injury and transfer to hospital

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

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 care set out in a resident's plan of care was documented as required.

Rationale and Summary

The resident had an incident of physical aggression towards another resident in December 2023 and required 1:1 (one to one observation) and behaviour mapping as implemented interventions.

Review of Point Click Care (PCC) progress notes confirmed that the Resident Care Manager initiated 1:1 (one to one observation) for the resident in December 2023 starting on the evening shift and that behaviour mapping was initiated in December 2023 by a Registered Practical Nurse (RPN).

The Behaviour Mapping Procedure states that dates are to be added to the Behaviour Mapping Tool (paper document) on all three shifts for five days and signed by the Personal Support Workers (PSW's), and that RPNs are to ensure PSW's document on the Behaviour Mapping tool every shift and sign the order in the TAR (Treatment Administration Record) in PCC.

Review of the resident's behaviour mapping tool indicated that documentation was initiated in December 2023, one day after Behaviour Mapping was ordered by the RPN and that on three shifts, documentation was not completed as required by PSW's.

An RPN confirmed that behaviour mapping was not completed by 1:1 staff according to the Behaviour Mapping Procedure for the resident. The RPN's are required to check that the PSW's have signed the hourly behaviour mapping tool on their shift prior to signing off on the order in PCC, and on three shifts, this was not completed according to procedure.

Failure to immediately initiate behaviour mapping and document on the tool on all shifts for a resident by 1:1 PSW's put the resident at risk for inaccurate outcomes and analysis of the implemented interventions.

Sources: The resident's clinical health records, Behaviour Mapping Procedure, interviews with an RPN, a manager and others.

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WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

#1

On a date in November 2023, a Registered Nurse (RN) documented in a resident's chart a witnessed incident of alleged sexual abuse towards another resident.

A Critical Incident Report (CIR) was submitted to the Director in November 2023 on the following day shift and stated that the incident of alleged sexual abuse occurred on the night shift. The witnessed incident was not immediately reported to the Director.

An interview with an RN confirmed that the Admin on call was notified by telephone during the night shift as per the home's internal protocol.

An interview with a Manager of Resident Care confirmed that the CIR was submitted for the first time on the day shift in November 2023.

Failure to make mandatory reports to the Director may increase risk of negative interactions between residents.

Sources: Resident's progress notes, CIR, and interviews with an RN, Manager of Resident Care and others.

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#2

On a date in November 2023, an incident of alleged emotional abuse by a Personal Support Worker (PSW) to a resident was witnessed by a Recreation Therapist (RT).

Critical Incident Report (CIR) was submitted in November 2023 to the director and stated that the incident of alleged staff to resident emotional abuse occurred 5 days earlier in November 2023. This witnessed incident was not immediately reported to the Director.

In an interview with an RT, they confirmed they reported the incident to the charge Registered Nurse (RN) on the date of the incident in November 2023 and then to their supervisor three days later in November 2023.

An interview with an RN confirmed that they did not report the incident of abuse

immediately in November 2023 and that they received training on the prevention of abuse and neglect, and were aware of the reporting obligations.

The Manager of Resident Care was notified in November 2023, and confirmed in an interview that they did not report the incident of alleged emotional abuse to the Director until two days after being notified in November 2023.

Failure to make mandatory reports to the Director may increase risk of negative interactions between residents.

Sources: Review of the resident's health care records, CIR and interviews with RT, RN, and Manager of Resident Care.

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