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: March 27, 2024

Inspection Number: 2024-1519-0001

Inspection Type:
Critical Incident
Follow up

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**
Dee Colborne (000721)	Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2024.03.27 15:09:51 -04'00'

Additional Inspector(s)
Gabriella Kuilder (000726)
Gurpreet Gill (705004)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 22, 23, 26, 27, 28, 29, 2024 and March 1, 4, 5, 2024

The following intake(s) were inspected:

- Intake: #00094693 - COVID 19 Outbreak
- Intake: #00096202 - Rhinovirus Outbreak
- Intake: #00103662 - ARI/COVID 19 Outbreak
- Intake: #00104203 - Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b)
- Intake: #00105845 - Unresponsive episode for a resident
- Intake: #00106418 - Alleged physical abuse of a resident to resident

- Intake: #00107619 - Fall of resident resulting in an injury
- Intake: #00108389 - Alleged physical abuse of a resident by a staff
- Intake: #00108748 - Complainant with concerns regarding a resident
- Intake: #00108920 - Alleged physical abuse of resident by staff

Inspector #000858 was present in an observer role during this inspection.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1519-0009 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Dee Colborne (000721)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

On a specified date in January 2024, an incident of alleged resident to resident physical abuse occurred. A resident was seated quietly at the dining table. A Personal Support Worker (PSW) who was assigned one to one duties for a resident decided to help serve drinks to other residents in the dining area. During this time the resident was calling out from their dining table. This triggered another resident to approach that resident and strike them. Staff immediately intervened and redirected the resident back to their table.

A review of a memo sent to registered staff by Manager of Resident Care (MRC) on a specified date in December 2023, indicated one to one staffing was implemented for a resident due to their physical responsive behaviors towards other residents.

The memo indicated at the start of each shift registered staff are to review one to one staff's duties and care direction for the resident. The memo indicated all staff assigned to one to one duties are to sign a designated log sheet acknowledging they have read and understood the assignment duties prior providing care to the resident.

Additionally, the memo states "Eyes must be on the resident at all times when out of their room, resident is unpredictable and can appear calm and then will strike out at co-residents. Please redirect away from co-residents — especially those that are verbally responsive. If resident is in their room, please ensure that you are situated

outside room. 1-1 for resident must be covered while on break."

It was noted on a specified date in January 2024, a PSW signed a log sheet acknowledging they read and understood, one to one assignment duties and care requirements for the resident.

During, interview with a PSW, they indicated they were provided with information related to duties when assigned to one to one for the resident by the registered staff at the beginning of the shift.
The PSW stated they left the resident seated at their dining table with their spouse and went to help distribute drinks to other residents during supper service. The PSW indicated they felt it would be acceptable to leave the resident unattended as another PSW was seated at the resident's dining table assisting another resident with eating.

During an interview with a Registered Practical Nurse (RPN), they indicated on a specified date in January, 2024, that they provided a PSW with direction to not to leave the resident unattended during their shift, and that the PSW reviewed the document outlining one to one duties for the resident. They believed the PSW left the resident unattended during supper service to retrieve a drink, and this was when the altercation occurred.

During an interview with the Manager of Resident Care (MRC), they indicated on a specified date in January 2024, at the time of the alleged physical abuse by a resident towards another resident, that the PSW was in the area where the resident was seated having dinner. However, the PSW was completing another task leaving the resident unattended. The MRC indicated they understood that the PSW was informed of the one to one duties and responsibilities for the resident by the registered staff at the beginning of the shift.

By failing to comply with the care set out in the plan of care for the resident specific to one to one supervision by assigned staff lead to an incident that resulted in an increased risk of injury and harm to other residents.

Sources
CIR-#2023-3025-000006-24, interview with an RPN, PSW, MRC , review of plan of care, review care acknowledgement sign off log
[000726]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to comply with the home's policy related to Resident Abuse and Neglect (revised December 5, 2023), specifically the immediate reporting of allegation of physical abuse.

Rationale and Summary:
On a specified date in February 2024, a Critical Incident report was submitted by the home to the Director regarding an allegation of staff to resident physical abuse that occurred on a specified date in February 2024.

The home's policy related to Resident Abuse and Neglect (revised December 5, 2023) states "staff members will notify their immediate supervisor immediately, and either the supervisor or staff will report directly to the MOLTC via the Critical Incident Reporting system or Toll-Free ACTION line".

Investigation notes created by the PSW Supervisor regarding interview with an RPN indicated a resident reported an allegation of physical abuse by a PSW on a specified date in January 2024. Notes indicated the RPN choose to speak with the PSW regarding the allegation as the resident stated the incident could have been an accident.

During an interview with the RPN, they indicated allegation of abuse by the PSW was reported to them prior to a specified date in February 2024. They acknowledged they made a "mistake" in not immediately reporting.

During an interview with the Manager of Resident Care (MRC) they indicated that during the investigation it was identified the RPN did not immediately report allegation of physical abuse made by a resident towards a PSW. The RPN was required to complete a review of the home's policy regarding the duty to report any allegations of abuse to the Director.

Failure to report any alleged physical abuse to the director immediately may cause delay in ensuring the resident is safe and that appropriate follow up occurs.

Sources: Investigation notes, interview with MRC, RPN , Policy: Resident Abuse and Neglect (revised December 5, 2023), Critical incident report

[000726]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #003 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 any alleged abuse of a resident by anyone is immediately reported to the Director.

Rationale and Summary:

A Critical Incident Report (CIR), was submitted by the home on a specified date in February 2024 to the Director and stated that the incident of alleged staff to resident physical abuse occurred on a specified date in February 2024. This incident was not immediately reported to the Director.

Review of resident progress notes indicated that the resident claimed they were slapped in the face by a PSW around suppertime on a specified date in February 2024. This was reported to an RN on a specified date in February 2024. A physical assessment was performed at the time and no noted physical injuries were found, but the resident was upset by it. Further progress notes, dated on a specified date in February 2024 from the PSW supervisor states that they received a phone call from the resident's spouse stating that the resident informed them they were slapped in the face last evening around supper time by a PSW wearing a specific garment of clothing. The PSW supervisor met with the resident on a specified date and time in February 2024 to get further details, where the resident stated they were slapped

by a PSW wearing a specific garment of clothing just before supper on the evening of a specified date in February 2024.

Review of the homes investigation notes stated that they discussed and educated the RN on the Ministry reporting requirements on a specified date in February 2024.

During an Interview conducted on a specified date and time in March 2024 with an RN, they confirmed that the resident reported the alleged physical abuse on a specified date and time in February 2024 and they did not report this to management or report it to the Director. They confirmed the PSW Supervisor educated them on the Ministry reporting requirements.

Interview with the PSW Supervisor on a specified date and time in March 2024 confirmed the home reported the incident a day late as the RN did not follow the homes process on reporting any alleged abuse, and should have reported it on a specified date in February 2024.

Failure to report any alleged physical abuse immediately to the Director may cause delay in ensuring the resident is safe and that appropriate follow up occurs.

Sources: Critical Incident report, Resident progress notes, homes investigation notes, interview with RN, PSW Supervisor and other staff.

[000721]

WRITTEN NOTIFICATION: Hand Hygiene

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

In accordance with the O'Reg 246/22 ,that all homes shall comply with any standard or protocol, particularly the Infection prevention and Control (IPAC) Standard, the licensee was required to ensure that Routine Precautions are followed in the IPAC program, including ensuring staff perform hand hygiene at the four moments of hand hygiene, specifically that registered staff perform hand hygiene in between residents receiving their medications.

Rationale and Summary:
On a specified date and time in February 2024 at 1158 hours on a specified resident area, the inspector observed an RPN enter the dining room and proceed with administering medications to the residents without performing hand hygiene in between each of them. Inspector noted the RPN check a resident's blood sugar at the dining table and when the RPN returned they disposed of the equipment used to check the residents blood sugar and proceeded to then get the medications ready for the next resident and did not perform hand hygiene. At a specified time, the RPN prepared medications for another resident and placed it in applesauce and went over to a resident, touched them on the shoulder and then spoon fed the medication to the resident. They proceeded to get the next residents medication ready without preforming hand hygiene.

During an interview with the RPN on a specified date and time in February 2024, the RPN confirmed that they only perform hand hygiene when they first come into the dining room and they don't do it again as all the residents are in a common area so they do not need to perform hand hygiene between every resident.

Interview with the IPAC Manager on a specified date and time confirmed that the home's expectation for RPNs' performing medication pass, is that if they come in contact with the medications or the residents, they are to perform hand hygiene in between each resident. They confirmed if you are handing out medications, you should have clean hands while doing so.

Failure to perform hand hygiene in between residents' medication pass, increases the risk for transmission of disease.

Sources: inspector observations, interviews with RPN and IPAC Manager [000721]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that drugs are stored in a secure and locked medication cart.

Rationale and Summary:
On a specified date in February 2024, during the inspector's initial tour of the home on a resident home area, inspector 000721 observed a medication cart at a specified time in the hallway in front of a resident's room with the lock engaged and secure, but noted the bottom drawer was not closed. The inspector was able to

completely open the drawer and have access to all the medication bottles in the bottom of the cart. The narcotic drawer was also in this drawer but was found locked and secured. There were no registered staff around the cart.

Interview with the RPN confirmed that the lock mechanism was engaged and secure but that the bottom drawer of the medication cart was open and not secure.

Failure to ensure the medication cart drawers are secure and locked, increases the risk for residents to be able to access medications that are not prescribed for them and cause possible injury.

Sources: Inspector 000721 observations, interview with an RPN.
[000721]

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