

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: February 3, 2025
Inspection Number: 2025-1519-0002
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 21, 22, 23 and 24, 2025.

The following intake(s) were inspected:

- Intake: #00135005 / Critical Incident System (CIS) report 3025-000158-24 was related to an allegation of staff to resident abuse.
- Intake: #00136972 / CIS report 3025-000005-25 was related to an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

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

- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Administration

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

Non-compliance with: O. Reg. 246/22, s. 123 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to comply with their medication management system policies and procedures in that the as needed (PRN) medication procedure was not followed.

In accordance with O. Reg. 246/22 s.11 (1) (b), the licensee was required to ensure their written policies and procedures ensured the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's Policy and Procedure for as needed (PRN) Medication Administration and Documentation, stated:

- To ensure that PRN medications are administered appropriately, and all required assessments and documentation are completed.
- Nursing staff assess the resident to determine the need for a PRN medication and document an assessment in the progress notes.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

- Properly document on the medication administration record the time, dose and reason the medication was given.
- Assess and document the resident's response to the PRN medication.
- The re-assessment timeframe should be determined based on medication and indication for use, 1-2 hours is reasonable to determine effect.

Specifically, the licensee has failed to comply with their medication management system policies and procedures in that a resident was ordered a medication to be administered PRN. A Registered Practical Nurse (RPN) assessed and documented that the resident required the administration of the PRN medication. They signed for its administration on the electronic medication administration record (eMAR). The PRN medication was administered by a different RPN who did not assess the resident to determine the need for its administration, did not prepare the medication and did not sign for its administration.

After the PRN medication was given, the RPN who assessed the need for its administration received an order to administer a different medication immediately (STAT). They documented the assessed need for administering the STAT medication, prepared it and signed for its administration on the eMAR. The STAT medication was administered by the RPN who administered the PRN medication. This RPN did not re-assess the resident for the effectiveness of the first medication (the PRN), and they did not assess the need to administer the STAT medication, did not prepare it, and they did not document regarding its administration. This was against the home's policy for the administration of PRN medications.

Sources: Review of a resident's health records, licensee investigation notes and the home's Policy and Procedure for PRN Medication Administration and Documentation, and interview with the Resident Care Manager.