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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2018	2018_593573_0007	005674-18	Resident Quality Inspection

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

ANANDRAJ NATARAJAN (573), GILLIAN CHAMBERLIN (593), JESSICA LAPENSEE (133), MICHELLE EDWARDS (655), PAULA MACDONALD (138), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): April 04, 05, 06, 09, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, and May 01, 2018.

The following Critical Incident, Complaint and Follow up inspections were conducted concurrently during this Resident Quality Inspection:

Critical Incident Logs #012824-17, 013837-17, 019787-17, 02272-17, 024555-17, 027614-17, 028367-17, and 029495-17, related to alleged incidents of resident to

resident physical abuse.
Logs #025531-17 and 025967-17, related to alleged incidents of staff to resident abuse.
Logs #017707-17, 026063-17 and 029632-17, related to fall incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.
Logs #027376-17, 027411-17 and 029493-17, related to medication incidents.
Logs #006018-18 and 004675-18, related to Disease Outbreak.
Log #023275-17, related to alleged resident to resident sexual abuse.
Log #009525-17, related to missing resident lesser than three hours.

Complaint Log #018330-17, related to resident care and services.

Follow up Log #028626-17, related the use of bed rails.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer, Director of Nursing (DON), Director of Support Services (DSS), Director of Clinical Practice, Managers of Resident Care (MRC), Manager of Infection Prevention and Control, Manager of Support Services, Personal Support Worker Supervisors, Food Service Supervisors, Housekeeping Lead, RAI Coordinator, Registered Dietitian (RD), Psycho geriatric Nurse, Registered Nurses (RN), Wound Care Champion, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food and Nutrition Aides, Housekeeping Aides, the Chair of the Family and Friends Council, the Resident Care Liaison, Recreation therapist, the President of the Community Resident's Council, the President of the Veterans Resident's Council, a Volunteer for the Veterans Resident's Council, Family Members, and Residents.

During the course of the inspection, the inspector(s) completed a tour of resident areas, observed medication storage areas, observed meal and snack services, observed medication administration, observed residents' bed systems, reviewed medication incident documentation, reviewed Community and Veteran Resident's Councils meeting minutes, reviewed resident health records, reviewed staff training records, reviewed home's menu cycle, reviewed a supervisor's report, reviewed wheelchair cleaning documentation, reviewed bed system inventory documents, reviewed relevant home policies, protocol and procedures, reviewed critical incident reports and documents related to the licensee's investigation into the identified alleged incidents of abuse.

In addition Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2017_625133_0018	133

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10, s. 48(1), the licensee was required to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, is developed and implemented in the home.

Under the Skin and Wound Care program, as per O.Reg. 79/10 s. 50 (2)(b), every licensee of a LTCH shall ensure that a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Specifically, staff did not comply with the licensee's policy titled Skin and Wound Care Program (unnumbered), dated February 2007, revision dates February 2018, April 11, 2018, which is part of the Licensee's Skin and Wound Care program. The licensee's policy titled Skin and Wound Care Program indicates under the heading "Procedure", that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds will have a weekly wound assessment completed by the registered nursing staff using the Weekly Wound Assessment tool under the assessment tab in Point Click Care (PCC).

(i) Review of resident #023's present plan of care indicated that the resident had a wound on a specified body part. Review of resident #023's Treatment Administration Records for specified months in 2018, indicated that until a specified date in 2018, the resident

dressing to the wound, which was to be changed twice weekly following the resident's bath. On April 18, 2018, Inspector #178 reviewed resident #023's assessment records on the home's electronic software program, Point Click Care (PCC), for four specified months in 2018. Only one Weekly Wound Assessment tool of the wound could be located during this period. The one Weekly Wound Assessment tool was completed on an identified date in 2018 and it indicated the wound at an identified stage. The resident's record contained some documentation of assessments of the wound in the resident's progress notes and three Head to Toe Skin Assessments done in 2018, however no documentation was present to indicate that Weekly Wound Assessments were completed as per the licensee's above mentioned policy titled Skin and Wound Care Program.

During an interview with Inspector #178 on April 18, 2018, RPN #124, indicated that residents' wounds are to be reassessed and documented at least weekly by registered nursing staff, using the Weekly Wound Assessment Beta Jones tool on PCC.

On April 23, 2018, the Director of Clinical Practice indicated to Inspector #178 that in this case staff did not follow the home's Skin and Wound Care Program policy, in that they did not assess and document resident #023's wound weekly using the Weekly Wound Assessment tool on PCC.

(ii) Review of resident #032's health record indicated that the resident had a wound on a specified body part. Resident #032's current plan of care indicated that the resident is at risk for impaired skin integrity related to incontinence product and positioning. Resident #032's Treatment Administration Records for specified months in 2018 indicated that the resident had a wound on a specific body part, which requires a dressing change once weekly.

Inspector #178 reviewed resident #032's assessment records on PCC. Review of the resident's Weekly Wound Assessments on PCC for four specified months in 2018, indicated that no Weekly Wound Assessment tools were completed in 2018. The most recent Weekly Wound Assessment tool documenting resident #032's wound was completed on a specified month in 2017. Some assessments of the wound were documented in resident #032's progress notes, but not in the Weekly Wound Assessment tool on PCC, as per the licensee's policy titled Skin and Wound Care Program.

On April 18, 2018, Inspector #178 observed RPN #123 change the dressing to the resident #032's wound. RPN #123 indicated to Inspector #178 that the resident's wound

should be assessed and documented weekly, using the Weekly Wound Assessments too on PCC. RPN #123 measured resident #032's wound and documented a description of the wound in resident #032's progress notes, but did not complete an assessment of the wound using the Weekly Wound Assessment tool as per the licensee's policy Skin and Wound Care Program. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, that the plan was complied with.

In accordance with s. 87 (1) of the Long-term Care Homes Act, 2007, every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including measures for dealing with emergencies.

In accordance with s. 230 (2) of Ontario Regulation 79/10, the emergency plans for the home are to be writing; and as per s. 230 (4), the emergency plans are to provide for situations involving in a missing resident.

Specifically, the licensee's emergency plan for situations involving a missing resident, as described in the policy titled "Emergency Measures, Code Yellow (search for a Missing Resident) (last revised December 09, 2017), was not complied with.

In the licensee's "Emergency Measures, Code Yellow" policy, it was indicated that where a resident's whereabouts is unaccounted for, up to two staff members are to search all rooms on the resident's unit. It is further indicated that when deemed appropriate and early in the search (maximum. 20 minutes), the Search Coordinator will ask Reception to make the following announcement three times: "full name of resident, please return to unit, room number". As per the above-noted policy, if the resident does not return to the unit within five minutes of the announcement, the Search Coordinator will ask Reception to make the following announcement three times: "Code Yellow, Full name of resident, unit, room number" (within 25 minutes of the search). Then, the staff are to proceed with stage II of the Code Yellow protocol, an internal Facility Wide search then Stage III, an external search of the home's grounds. In the policy, it is indicated that when stage II is initiated, a picture of the missing resident is to be emailed to "all users" with a brief description of the resident and a subject line that indicates "missing resident".

A Critical Incident Report (CIR), was submitted to the Director, related to a missing resident. The incident involved resident #074. According to the CIR, resident #074 went

missing on a specified date in 2017.

During an interview on April 26, 2018, PSW #162 recalled the above-described incident. According to PSW #162, resident #074, at the time of the incident, was known to wander. PSW #074 recalled that on a specified date, resident #074 went missing sometime in the morning, around breakfast time.

According to the licensee's internal investigation notes, resident #074 was seen by staff on the resident's unit at 0715 hours that morning. It is further indicated that at 0800 hours, when PSW #162 had conducted routine rounds, resident #074 was not found to be in their room. According to the investigation notes, it was shortly thereafter that RPN #165 on the same unit asked PSW #162 if they had seen resident #074. At that time, a search was initiated.

During an interview on April 27, 2018, RPN #165, indicated to Inspector #655 that RN #164 led the search for resident #074 when the resident had gone missing. During the same interview, RPN #165 was unable to recall whether the "Code Yellow" plan had been activated at the time of the incident. RPN #165 further indicated to Inspector #655 that when a "Code Yellow" is activated, all staff in the home receive a photo of the missing resident so that they know who to look for. RPN #165 could not recall for how long the resident had been missing.

During an interview April 26, 2018, RN #164 indicated to Inspector #655 that, at the time of the incident, resident #074 was known to wander in the corridors. At the same time, RN #164 indicated that when resident #074 wandered, the resident could not find their way back to the resident's home unit. RN #164 was aware of the Code Yellow policy and described it to the inspector. During the same interview RN #164 indicated that Housekeeping Lead #161 had seen resident #074 outside that day but had not notified the staff on the unit.

During an interview on April 27, 2018, Housekeeping Lead #161 indicated to Inspector #655 that they had seen resident #074 outside sometime in the morning. Housekeeping lead #161 indicated to Inspector #655 that when they had seen the resident, they had not been aware that the resident was missing. Housekeeping lead #161 indicated to Inspector #655 normally, when there is a missing resident, a code yellow is called and an email is sent with a photo of the missing resident. During the same interview, Housekeeping lead #161 indicated that they asked a colleague to monitor the resident who remained outside after they returned to the home. Some time later, the colleague

notified Housekeeping lead #161 that resident #074 was no longer on the home property, after which time Housekeeping lead #161 notified the nurse on resident #074's unit. The nurse accompanied Housekeeping lead #161 outside to retrieve the resident at that time. According to the internal investigation notes, the nurse on the resident's unit was notified by Housekeeping Lead #161 at 0851 hours.

According to the CIR, the resident was retrieved and returned back to the home at 0900 hours.

According to the internal investigation notes, resident #074 also spoke staff/security (commissioners) on the way out of the building.

During an interview, Manager of Resident Care (MRC) #121 indicated that when a resident goes missing, the "Code Yellow" protocol is expected to be followed. According to MRC #121, an announcement is expected to be made related to the activation of a "Code Yellow" within 25 minutes of identifying the resident as missing. At the time of the interview, MRC #121 was unable to speak to whether a "Code Yellow" had been activated when resident #074 went missing on May 13, 2017.

Manager of Resident Care #121 spoke with Manager of Resident Care #108 before confirming that on May 13, 2017, resident #074 was missing for approximately one hour. At the same time, it was confirmed that the "Code Yellow" protocol was expected to be activated at the time; it was confirmed by Manager of Resident Care #121 and #108 that it was not.

The licensee's failed to ensure that the emergency plan for situations involving a missing resident, as described in the policy titled "Emergency Measures, Code Yellow (search for a Missing Resident) (last revised December 09, 2017), was complied with. (Log #009525

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulation requires the licensee of a long term care home to institute or otherwise put in place any plan, policy, protocol, procedure, strategy, or system; that the plan, policy, protocol, procedure, strategy, or system, are complied with, to be implemented voluntarily.

WN #2: 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 failed to ensure that any person who has reasonable grounds to suspect that any abuse of a resident by anyone has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg 79/10 s.2 (1), "Physical Abuse" means the use of physical force by a resident that causes physical injury to another resident.

The licensee submitted Critical Incident Report (CIR) involving physical abuse by

resident #043 to resident #053 in which resident #053 suffered an injury on a specified date and time. This CIR outlined that the abuse occurred the previous day.

The home's risk management report for the abuse incident described above was reviewed. The risk management report verified that the abuse occurred on a specified date and time but further described that the injury to resident #053 was identified later the same day at a specified hours.

The health care record for resident #053 was reviewed. It was noted in a progress note dated the same day of the abuse incident at a specified hours that the nurse in charge, RN #120, notified the police, notified the manager on call, and left a message on the cell phone of Manager of Resident Care (MRC) #108. It was noted that there was no indication in resident #053's health care record that the Director was made aware of this incident of abuse at this time.

Discussion was held with MRC #121 regarding this Critical Incident Report. The MRC stated that the incident of abuse was reported by the nurse after hours to MRC #108, however this manager had not been designated to be on call and had not responded. MRC #121 stated that it is the responsibility of the designated manager on call to report abuse but because the designated manager on call was not notified, the incident had not been reported until the following day when the CIR was submitted.

As such, the licensee failed to ensure that any person who had reasonable grounds to suspect the abuse of resident #053 that occurred on a specified date and time, reported it immediately to the Director. (Log #027614-17) [s. 24. (1)]

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

As per O. Reg. 79/10, s.5, "Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents

Inspector #178 interviewed RPN #109 on April 20, 2018. RPN #109 indicated that on a specified date in 2017, resident #062 indicated that the PSW who regularly works nights

had refused to assist resident #062 to the toilet that morning, dislikes the resident, and this morning turned off the call bell and closed the resident's door, without meeting the resident's needs. RPN #109 also indicated that resident #062 indicated that the night staff member dressed the resident that morning, when the resident requested not to be dressed. RPN #109 reported this information to the acting (A) Manager of Resident Care (MRC) #132 and to the PSW Supervisor by sending them an email on a specified date. Further, RPN #109 indicated that RPN #109 also told the (A) MRC #132 this information verbally on the same day. RPN #109 did not contact either the (A) MRC #132 or the PSW Supervisor to ensure they received RPN #109's email detailing resident #062's allegations. RPN #109 indicated that the home's policy to promote zero tolerance of abuse and neglect requires that staff report alleged abuse or neglect to their supervisor, and that the managers or RN ensures it is reported to the Ministry of Health and Long term Care (MOHLTC).

On April 20, 2018, Inspector #178 interviewed the staff member who was acting (A) MRC #132 on resident #062's unit during the period around the incident date. The (A) MRC indicated that they were not immediately aware of the email from RPN #109 reporting resident #109's complaints regarding the night PSW. The (A) MRC indicated that RPN #109's email was not flagged as urgent and was not recognized as requiring the (A) MRC's immediate attention, and therefore was not immediately noticed by the (A) MRC. Further, (A) MRC #132 indicated no memory of being told verbally by RPN #109 about resident #062's complaints about the night PSW. The (A) MRC indicated that the first knowledge they had of resident #062's complaints was when they received a complaint letter from the resident's family on a specified date. The (A) MRC indicated that after receiving the family's letter of complaint, the (A) MRC spoke to RPN #109, who then reported resident #062's allegation that the night PSW refused to toilet the resident, dressed the resident when the resident did not want to be dressed, and shut off the call bell and closed the door without meeting the resident's needs when the resident rang for assistance. After receiving the letter of complaint from resident #062's family, the (A) MRC immediately initiated an investigation into the resident's allegations, and reported resident #062's allegations to the Director under the LTCHA.

In conclusion, the licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm occurred, immediately reported the suspicion and the information upon which it was based to the Director under the LTCHA. (Log #025967-17) [s. 24. (1)]

3. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with O.Reg 79/10 s.2(1), "Sexual Abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report (CIR) regarding an alleged resident to resident sexual abuse incident was submitted to the Director on a specified date, which was six days after the occurrence of the incident.

Inspector #573 reviewed CIR which indicated that on a specified date, resident #071's Substitute Decision Maker reported to former Manager of Resident Care (MRC) #172 regarding an alleged sexual incident between resident #070 and resident #071. The CIR indicated that the home immediately initiated an investigation and immediate actions were taken to monitor both the residents as the result of the incident.

On April 26, 2018, Inspector #573 spoke with home's psycho geriatric RN #167, who stated that next day after the incident, resident #071 was assessed for cognitive testing. RN #167 stated that it was confirmed through various cognitive testing assessments that resident #071 had severe cognitive deficits. Further, RN #167 indicated that resident #071 does not have the capacity to understand nor consent to touching of a sexual nature.

On April 26, 2018, Inspector #573 spoke with the home's Director of Nursing, who indicated that the incident on a specified date, resident to resident alleged sexual abuse was not immediately reported to the Director by the former MRC.(Log #023275- 17) [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

On April 10, 2018, Inspector #178 observed the narcotic drawers in the medication cart on unit Ottawa Two West. Inside the narcotic drawer holding the non-scheduled controlled medications, the inspector observed along with various controlled medications, a small clear plastic bag holding a gold wedding band. The plastic bag was labelled with a resident's name, and dated. Inspector #178 interviewed RPN #101 who indicated that only controlled drugs should be present in the narcotic drawer. [s. 129. (1) (a)]

2. On April 12, 2018, Inspector #178 observed the narcotic drawers on the medication cart on Ottawa Two East. Inside the drawer, along with narcotics and controlled medications, the inspector observed an envelope labelled with a resident's name containing five dollars, a set of key that RPN #110 identified as the RNs keys, a gold band in a bag labelled with a resident's name, a key labelled with a resident name and room number, and a bottle of test solution for the glucose testing machines.

Inspector #178 interviewed RPN #101 who indicated that only medications should be stored in the narcotic drawers, but that the home does not have another locked area to store items for safe keeping therefore staff keep personal items on the medication cart. .

During an interview with Inspector #178 on April 13, 2018, Manager of Resident Care #108 indicated that only drugs or drug related items should be stored in the narcotic drawers. [s. 129. (1) (a)]

3. On April 04, 2018, Inspector(s) touring the home observed the following medication storage concerns:

-on the counter in the locked tub room on Gatineau Two South, Inspector #178 observed a plastic bin containing multiple prescription creams and lotions, labelled with residents' names.
-in the locked tub rooms on Ottawa Two East and Ottawa Two West, Inspector #593 observed prescription lotions and creams labelled with residents' names, stored in an unlocked cupboard.
-in the locked Rideau Two North tub room, Inspector #573 observed a white caddy containing prescription topical creams labelled with residents' names.
-in the unlocked room of resident #031, Inspector #573 observed a tube of prescription topical gel labelled with the resident's name, stored on top of the bedside table.

On April 12, 2018, Inspector #178 further observed:

-on the counter in the locked specified unit's tub room, a plastic bin containing prescription topical gel for resident #034, prescription shampoo and prescription topical ointment for resident #055, prescription topical cream for resident #056, prescription topical gel for resident #057, prescription shampoo and lotion for resident #058.
-inside an unlocked cabinet in the locked tub room on a specified unit, two prescription topical creams and two prescription lotion for resident #059, prescription topical gel for

resident #009, one prescription topical cream for resident #060, one prescription topical cream for resident #061.
-in the unlocked room of resident #031, prescription topical gel and one prescription lotion on bedside table.

On April 13, 2018, RPN #109 indicated to Inspector #178 that resident #031 is not capable of self-applying prescription topical gel or prescribed lotion, and that these items should not be stored in the resident's room. RPN #109 indicated that the gel and lotion had been removed earlier that day from resident #031's room and were currently in the locked medication room, accessible only to the RN and RPN. RPN #109 indicated that the PSWs apply prescription topical gel and prescribed lotion for resident #031, and the PSWs will be provided with the gel and lotion in the morning, and during the day they should store them in the locked cabinet in the tub room until they are returned to the medication room.

On April 10, 2018, RPN #103 indicated to Inspector #178 that PSWs apply prescription topical creams and lotions to residents. RPN #103 indicated that the prescription topical creams and lotions that PSWs apply are stored in the tub room in a locked cabinet to which PSWs carry the key.

On April 13, 2018, the Director of Nursing (DON) indicated to Inspector #178 that PSWs apply medicated creams and ointments after receiving instruction regarding how to do so. The DON indicated that the medicated creams and ointments are to be stored in a locked cabinet in the locked tub rooms, with the key to the cabinet hung on the side of the cabinet. The DON indicated that registered nursing staff, PSWs and housekeeping staff all have access to the locked tub rooms. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance a) to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and b) that is secure and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of home's infection prevention and control program.

On April 20, 2018, in Gatineau 1 South Tub room #1009, the Inspector observed nail care equipment within the "nail tools" drawer, in the three drawer cart located to the side of the bathtub. There were two nail clippers and a nail nipper. The nail care equipment was not labelled with a resident's name. It was also noted that there was two bottles of 70% isopropyl alcohol in the "nail tools" drawer.

PSW #148 indicated that the nail care equipment in the tub room was used for all residents. The PSW indicated that most residents had a nail clipper in their bedroom, however, they were not good quality and therefore they preferred to use the nail care equipment in the tub room as it was of better quality. The PSW indicated that before using the nail care equipment, they would wipe it with an alcohol swab (70% isopropyl alcohol). The PSW indicated that after using the nail care equipment, they would soak it in the alcohol (70% isopropyl alcohol) for five to ten minutes, sometimes longer.

PSW #153 indicated that the nail care equipment in the tub room was used for residents when they came in for a bath. The PSW indicated that after using the nail care equipment, they would soak it in the alcohol (70% isopropyl alcohol) for 15 - 20 minutes. The PSW indicated that the clippers were for fingernails and the nippers were for thick toe nails. The PSW indicated that residents had a nail clipper, attached to a small care caddy, in their bedrooms. The PSW indicated that it was difficult to carry the care caddy around and properly position the resident to allow for the provision of nail care.

The Provincial Infectious Diseases Advisory Committee's (PIDAC) best practices document titled "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, 3rd Edition", dated May 2013, outlines

how shared nail tools are to be processed after use. As per the PIDAC best practices document, 60 - 95% isopropyl alcohol is classified as a low level disinfectant. Low level disinfectants are only suitable for disinfecting non-critical equipment, after the equipment has been cleaned, with a required contact time of ten minutes. Fingernail care equipment used for multiple residents is classified as semi-critical equipment. Between uses, semi-critical equipment requires cleaning followed by high level disinfection. Foot care equipment is classified as critical equipment. Between uses, critical equipment requires cleaning, followed by sterilization. The process described by PSW #153 and #148 did not meet established best practices for the reprocessing of fingernail care equipment used on multiple residents, or the requirement for the reprocessing of foot care equipment. Pre cleaning was not a part of the described process. High level disinfection or sterilization was not a part of the described process, as 70% isopropyl alcohol is classified as a low level disinfectant only.

On April 24, 2018, the Inspector met with the Manager of Infection Prevention and Control Program to discuss the shared nail care equipment in the Gatineau 1 South tub room. The Manager indicated that they had not been aware that there was any sharing of nail care equipment between residents. The Manager indicated that there was no relevant policy as it was not supposed to be occurring.

On April 24, 2018, the Inspector met with Manager of Resident Care (MRC) #121 to discuss the shared nail care equipment in the Gatineau 1 South tub room. The MRC indicated that PSWs were expected to use the residents' dedicated nail care equipment, and this was related to infection prevention and control. The MRC indicated that they thought the "nail tools" carts had been removed from the tub rooms in 2017.

On April 26, 2018, the Inspector met with the Director of Nursing (DON) to discuss the shared nail care equipment in the Gatineau 1 South tub room. The DON indicated that it was their expectation that the care caddies with nail clippers attached had been removed from the residents' bedrooms at least two years ago. The DON indicated that the "nail tools" carts were supposed to have been removed from the tub rooms in 2017, to ensure that there was no shared nail care equipment as this was an infection prevention and control issue. The DON confirmed that it was the expectation that only a resident's dedicated nail care equipment, located in the resident's bedroom, be used for that resident.

As such, the licensee has failed to ensure that PSW #148 and #153 participate in the home's infection prevention and control program, specifically related to the use of

residents' nail care equipment. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the home's infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #068 was provided to the resident as specified in the plan.

On April 05, 2018, at 1214 hours during the lunch service, Inspector #593 observed RPN #143 provide a specified consistency thickened fluid to resident #068. Later, during the same lunch service, a PSW in orientation was observed to provide the same specified consistency thickened fluid to resident #068 upon instruction by RPN #143.

During an interview with Inspector #593, on April 05, 2018, with the PSW in orientation, the PSW reported that they were unsure about the thickened fluids for this resident, which at this time, RPN #143 interrupted and said that resident #068 received a specified consistency thickened fluids.

A review of the dietary binder located in the unit's kitchen, found that resident #068 was on a different specified thickened fluids.

On April 10, 2018, at 1221 hours during the lunch service, Inspector #593 observed PSW

#144 provide a specified consistency thickened fluids to resident #068.

During an interview with Inspector #593 on April 10, 2018, PSW #144 reported that resident #068 received thickened fluids as they would cough if given regular fluids. At this time, PSW #144 checked with PSW #145 who reported that the resident did not receive fully thickened fluids, they received different specified thickened fluids.

During an interview with Inspector #593 on April 10, 2018, PSW #145 reported that they were aware that resident #068 was supposed to receive a different specified thickened fluids, but they don't have access to that specified consistency thickened fluids for resident #068.

A review of resident #068's documented care plan, found that resident #068 had difficulty in swallowing related to a specific diagnosis and was to receive a specific consistency thickened fluids.

During an interview with Inspector #593, on April 17, 2018, Registered Dietitian (RD) #146 reported that they provide commercially prepared specified thickened fluids in the home and they either dilute or thicken it to make different specified consistency fluids. All staff have been educated on this process. The RD further added that the thickened fluid directions for resident #068 have not changed and the staff should be following the resident's plan of care. [s. 6. (7)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device, if the restraining of the resident was included in the resident's plan of care.

On April 06 and 13, 2018, resident #037 was observed seated in a wheelchair with a front closing lap belt. On April 13, 2018, two separate occasions when PSW #116 and Inspector #573 requested resident #037 to undo this front closing lap belt, resident #037 could not undo the front closing lap belt.

On April 13, 2018, during an interview, PSW #116 stated that the front closing lap belt is used for resident #037's safety while in the wheelchair to prevent falls. Further PSW #116 stated that resident was cognitively and physically incapable of removing the front closing lap belt at all times.

Resident #037's heath care records including current written plan of care were reviewed by Inspector #573, and there was no documentation that indicated resident #037 required a wheelchair front closing lap belt as a restraint.

On April 13, 2018, Inspector #573 spoke with RN #127, who stated that if resident #037 was not able to undo the lap belt, then the use of wheelchair lap belt will be considered as restraint. Further, RN #127 indicated that resident #037 will be reassessed for the use of wheelchair lap belt restraint by the registered nursing staff. [s. 31. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that only residents of the long term care home are members of the Residents' Council.

The Perley and Rideau Veterans' Health Centre has two separate and distinct Residents' Councils, one being the Veteran Residents' Council for the residents of the home who are veterans. The Veteran Residents' Council is comprised of various members including three members who are not residents of the home.

Posted minutes of the Veteran Residents' Council for the time period of May 2017 to February 2018 were reviewed and it was noted that each set of minutes contained an attendance list which included the positions of Family Member, Secretary, and Legion Representative.

A discussion was held with a resident member of the Veteran Residents' Council, resident #049, and this resident confirmed that the individuals who hold the positions of Family Member, Secretary, and Legion Representative regularly attended the Veteran Residents' Council meetings. Resident #049 also confirmed that the individuals who hold the positions of Family Member, Secretary, and Legion Representative are not residents of the home.

A discussion was held with the person assigned to assist the Veteran Residents' Council, volunteer #118, and this person confirmed that the positions of Family Member, Secretary, and Legion Representative were included in the Veteran Residents' Council and also confirmed that the individuals in those positions were not residents of the home.

As such, the licensee has failed to ensure that only residents of the home are members of the Veteran Residents' Council. [s. 56. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #070's Substitute Decision Maker (SDM) was notified within 12 hours upon becoming aware of any other alleged suspected or witnessed incident of abuse or neglect of resident #070.

On an identified date Critical Incident Report (CIR) was submitted to the Director, indicating resident #071's Substitute Decision Maker (SDM) reported to former Manager of Resident Care #172 an alleged sexual incident between resident #070 and resident #071.

Inspector #573 reviewed CIR and was unable to locate any documentation indicating that resident #070's Substitute Decision Maker was notified of the alleged sexual incident between resident #070 and resident #071.

Inspector #573 reviewed resident #070's health care records, which identified that resident had a delegated SDM for health/financial care. Review of resident #070's progress notes indicated that three days after the incident, resident #070's SDM was notified of the alleged sexual incident.

On April 26, 2018, Inspector #573 spoke with the home's Director of Nursing, who indicated that resident #070's SDM was not notified within 12 hours upon becoming aware of the alleged sexual abuse incident of resident #070.(Log #023275- 17) [s. 97. (1) (b)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of an outbreak of a communicable disease as defined in the Health Protection and Promotion Act.

On April 24, 2018, Inspector #133 met with the Manager of Infection Prevention and Control Program to review two Critical Incident Reports (CIR) that they had submitted to inform the Director of an outbreak of a communicable disease. CIR #C595-000007-18 was related to an outbreak of Acute Respiratory Illness on the Ottawa 1 West unit, which was declared by Ottawa Public Health on February 12, 2018. The Director was not immediately informed of the outbreak. The Director was informed of the outbreak one day later, on February 13, 2018. CIR #C595-000013-18 was related to an outbreak of Acute Respiratory Illness on the Rideau 2 North unit, which was declared by Ottawa Public Health on March 03, 2018. The Director was not immediately informed of the outbreak. The Director was informed of the outbreak one day later, on March 04, 2018. The Manager of the Infection Prevention and Control Program confirmed that the Director was not informed of the two outbreaks on the respective days that they were declared. (Logs #006018-18 and 004675-18) [s. 107. (1) 5.]

Issued on this 25th day of May, 2018

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

Original report signed by the inspector.