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

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Original Public Report

Report Issue Date August 9, 2022
Inspection Number **2022_1519_0003**
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
The Perley and Rideau Veterans' Health Centre
1750 Russell Road Ottawa ON K1G 5Z6

Long-Term Care Home and City
The Perley and Rideau Veterans' Health Centre
1750 Russell Road Ottawa ON K1G 5Z6

Lead Inspector
ANANDRAJ (ANDY) NATARAJAN #573

Inspector Digital Signature
Anandraj Natarajan
Digitally signed by Anandraj Natarajan
Date: 2022.08.11 14:51:49 -04'00'

Additional Inspector(s)
Mark McGill (733)
Lisa Cummings (756)
Karen Buness (720483)

Inspector(s) #740811, 740814, 741823 and 740785 were present during the inspection as an observer.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 27- 30, 2022, July 4- 8, 11-15 and 18, 2022.

The following intake(s) were inspected:

- Intake 000338-22 Complaint related to a resident elopement.
- Intake 019389-21 Critical Incident Report (CIR) related to allegations of staff to resident physical abuse.

- Intake 019955-21 CIR related to allegations of resident to resident physical abuse.
- Intake 001300-22 CIR related to a fall with injury and significant health change.
- Intake 001956-22 CIR related to a resident injury of unknown cause.
- Intake 005245-22 CIR related to allegations of staff to resident sexual abuse.
- Intake 005559-22 CIR related to allegations of resident to resident physical abuse.
- Intake 005593-22 CIR related to a fall with injury and significant health change.
- Intake 005718-22 CIR related to a fall with injury and significant health change.
- Intake 007627-22 CIR related to medication incident.
- Intake 007278-22 CIR related to a fall with injury and significant health change.
- Intake 007641-22 CIR related to allegations of staff to resident physical abuse.
- Intake 008374-22 CIR related to allegations of visitor to resident financial abuse.
- Intake 008523-22 CIR related to a fall with injury and significant health change.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 s. 140 (6)

A resident was observed with a tube of medicated cream on their bedside table that was supplied by the licensee's pharmacy provider. The resident had a physician's order for this medicated cream, but it did not indicate that it could be self-administered.

The Manager of Resident Care confirmed the physician's order did not indicate the resident could have the medicated cream at their bedside. The Manager of Resident Care had the medicated cream removed from the resident's room the same day and requested a review of the physician's order.

Sources: Observations in the resident room, physician orders, and interviews with the Manager of Resident Care.

Date Remedy Implemented: July 8, 2022

[756]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.102 (2) b

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff related to routine practices and additional precautions.

Rationale and Summary:
During an observation of the residents' unit that was declared on a respiratory outbreak, a recreation staff and an essential care giver observed within proximity to the residents with no eye protection (goggles or face shield). The inspector observed a housekeeping staff exit the residents' room, not wearing their eye protection. In the resident's room, the inspector observed PSW staff with no gown within two meters to the resident with droplet and contact precautions. Failing to participate in the implementation of the IPAC program increases the risk of disease transmission among the residents, staff, and others.

Sources: Inspector observations, licensee's memo related to mandatory eye protection dated June 10, 2022, interview with the Infection Prevention and Control Program Lead and other staff interviews.

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WRITTEN NOTIFICATION [FALL PREVENTION AND MANAGEMENT]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 48 (1) (1)

The licensee has failed to comply with the program for assessing and transferring the resident after they sustained a fall.

Rationale and Summary

In accordance with O. Reg. 79 /10 s. 48 (1) (1), the licensee is required to ensure there is a falls prevention and management program in place, and in accordance with O. Reg 79/10 s. 8 (1) (b), the licensee must ensure the program is complied with.

Specifically, staff did not comply with the policy “Fall Prevention Program” dated December 3, 2021. This policy stated that a resident who falls should receive an assessment post-fall, and if the resident was on the floor, the assessment would be conducted on the floor prior to a transfer using a mechanical lift.

On a day in January 2022, PSW staff stated they found the resident on the floor beside their bed. The PSW stated they assisted the resident from the floor to the bed by themselves and without the use of a mechanical lift. Once the resident was in bed, the PSW stated they reported to the RPN. When interviewed, the RPN stated they were informed the resident was experiencing pain to their limb, however they were not informed the resident experienced a fall. The RPN stated they did not conduct a post-fall assessment as a result.

The Manager of Resident Care confirmed that the resident was transferred prior to an assessment by a registered staff and the resident was transferred without the use of a mechanical lift which was not in compliance with their policy.

The resident was transferred to hospital the following shift and was diagnosed with an injury and that resulted in significant change in their health status.

Sources: Resident healthcare record, Falls Prevention Program (revised December 3, 2021), interviews with the PSW, the RPN and the Manager of Resident Care.

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