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

Original Public Report

Report Issue Date: December 14, 2023

Inspection Number: 2023-1519-0009

Inspection Type:
Complaint
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	**Inspector Digital Signature**
Dee Colborne (000721)	Diana (Dee) Colborne Digitally signed by Diana (Dee) Colborne Date: 2023.12.18 14:42:46 -05'00'

Additional Inspector(s)
Jessica Nguyen (000729)
Margaret Beamish (000723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 14, 15, 16, 17, 20, 21, 22, 2023

The following intake(s) were inspected:

- Intake: #00097844- Resident to resident alleged physical abuse.
- Intake: #00098166- Complaint regarding a bed refusal.
- Intake: #00100316- Staff to resident alleged neglect.
- Intake: #00100615-Unwitnessed fall of a resident resulting in an injury.
- Intake: #00100891-Staff to resident alleged neglect.
- Intake: #00101160-Controlled substances discrepancy.

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The following intake(s) were completed in this inspection:

- Intake: #00100248 and intake: #00101296, were all related to falls.
- Intake: #00101165, intake: #00100368, intake: #00099622, intake: #0010069, were all related to controlled substance medication.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 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 ensure that the home's policy to promote zero tolerance

of abuse and neglect was complied with when a staff member did not immediately report an allegation of improper care of resident.

Rationale and Summary:

A review of the licensee's investigation file noted that a staff member was aware of allegations of improper care towards a resident when the resident stated to them that another staff member frequently did not return to the resident's room to provide care to them. The resident also stated that they no longer wished for a certain staff member to provide care to them. The staff member did not report the allegations to the home immediately resulting in the incident not being reported to the Ministry of Long-Term Care until a few days later.

Manager of Resident Care acknowledged that staff member should have reported the allegations of improper care immediately to registered staff as per the home's policy when the resident had first reported it to them.

Failing to ensure the home's policy to promote zero tolerance of abuse and neglect was complied with, may delay the investigation, placing residents at risk of harm.

Sources: Critical Incident Report, licensee investigation file, and interview with Manager of Resident Care .

[000723]

WRITTEN NOTIFICATION: Authorization for Admission to a Home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)
Authorization for admission to a home

Licensee consideration and approval
s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

The licensee has failed to comply with FTLCA section s. 51 (7) b whereby the licensee refused an applicant's admission to the home based on reasons that are not permitted in the legislation.

Rationale and Summary:

Review of the applicants admission package, identified that the applicant was a crisis admission and has not smoked for a period of time and was a calm and quiet person that did well in a structured environment and very co-operative.

Interview with the Admission Coordinator confirmed that applicant was refused admission because of smoking risk and certain health issues. They also confirmed they were aware of the legislative requirements and that the homes reason for refusal did not meet the legislation for refusal. They confirmed the home did have a responsive behaviour program with BSO support.

Interview with the Director of Care, (DOC) confirmed that the applicant was refused admission via letter on a specified date in 2023, based on their history of smoking as well as certain health issues. The home felt they would pose a risk to residents and staff as they feel applicants have the freedom to restart smoking. Another reason

was their staff not having the ability in dealing with certain health issues.

Withholding approval of applicant's admission to the home was based on reasons that were not permitted in the legislation.

Sources: Applicants application, Interviews with DOC and Admissions Coordinator.

[000721]

WRITTEN NOTIFICATION: Binding on Licenses- COVID-19 Directives-Masking

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated and effective on November 7, 2023 when masking requirements were not followed by staff.

Rationale and Summary:

In accordance with the Minister's Directive: COVID -19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated and effective on November 7, 2023;

licensees are required to ensure that the masking requirements as set out in this guidance document are followed. As one of the key defenses against the transmission of respiratory viruses, homes
must ensure that all staff, students, volunteers and support workers comply with applicable masking requirements at all times. Masks are required to be worn in all resident areas indoors.

During the inspection, several inspectors, observed on several separate occasions, staff were not wearing masks in resident areas of the home.

Review of the home's communication to staff, indicate that staff are to wear masks only on resident home units. Masking is required in all other areas of the home when a point of risk assessment determines it necessary.
Review of the homes policy regarding masking is not specific but states the home will follow guidelines as per the Provincial infectious Diseases Advisory Committee (PIDAC), Ottawa Public health, Ministry of LTC, The Chief Medical Officer and Accreditation Canada and that the Perley will meet the expected standard of care.

Interviews with the Director of Care (DOC) and the IPAC lead both confirmed that masks are to only be worn on resident units and not any other resident areas of the home.
Interviews with several staff, all confirmed they should have had their masks on.

Failure to comply with the masking requirements for masks to be worn on all resident areas indoors, places the residents at risk of transmission of infectious diseases.

Sources: Observations on specified dates in November 2023; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance

document for long-term care homes in Ontario; Homes IPAC policy; Interviews with the DOC, IPAC lead and other staff.
[000721]

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that all controlled substances that were to be destroyed and disposed were stored safely and securely within the home, until the destruction and disposal occurred.

Rationale and Summary:

On a specified date, during the destruction process on a resident unit , it was noted that the destruction box was overflowing and the contents of the box were easily assessible. An RPN compared the contents of the destruction box to the destruction logs on a resident unit and noted the following five discrepancies:

- one empty hydromorphone card placed in destruction box on a specified date, which was missing 5.5 mg

- one hydromorphone card with the wrong count, placed in destruction box on a specified date, which was missing 1.5 mg
- one hydromorphone card with the wrong count, placed in destruction box on a specified date, which was missing 6.0 mg
- one hydromorphone card that was placed in destruction box on a specified date, which was not found in destruction box and was missing 4.75 mg
- one empty hydromorphone card placed in destruction box on a specified date, which was missing 1.25 mg

This totaled 19 mg of hydromorphone that was never found and remains unaccounted for. The RPN immediately reported the discrepancies to Manager of Resident Care.

Review of the internal investigation notes stated that Manager of Resident Care and RPN checked all destruction boxes in the building after discrepancies on a specific resident unit were noted and all three destruction boxes in the specified resident unit were so full that narcotic cards were easily assessible and could be pulled out of the opening.

Policy: Destruction and Disposal of Narcotic and Controlled Medications. Last reviewed June 30, 2023, indicates that any narcotic or controlled substance to be destroyed or disposed of has to be securely stored in a "one-way access" double locked box in the medication room, only accessible to nursing staff.

During an interview with an RPN, it was confirmed that on a specified date in November 2023, the destruction box on a specified resident unit was found to be overflowing, the door to the box was not properly closed and the controlled substances inside were easily assessible. An RPN confirmed the five discrepancies found during the destruction process, this included two empty hydromorphone cards, two hydromorphone cards with the wrong count and one hydromorphone

card missing from the destruction box, totaling 19 mg of hydromorphone that was never found and remains unaccounted for. The RPN believes that all narcotics were properly counted, double signed, and placed into the destruction box by the staff on the specified days, but because the destruction box was so full, they were easily assessible after.

By not ensuring that the controlled substances that were to be destroyed and disposed of were stored safely and securely within the home, actual controlled substances went missing.

Sources: Internal investigation notes, Policy: Destruction and Disposal of Narcotic and Controlled Medications. Last reviewed June 30, 2023, and Interview with RPN.

[000729]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
A) Educate all PSW staff working on a specified resident home area including full-time, part-time and casual basis staff on resident and staff hand hygiene requirements during meal service, including requirements of staff to support

residents with performing hand hygiene prior to meals, as per evidence based best practice standards.
B) Perform weekly audits, alternating meals (e.g. breakfast, lunch and supper), on hand hygiene during meal service. Audits are to be conducted until consistent compliance to the Infection Prevention and Control program related to hand hygiene is demonstrated.
C) Take corrective actions to address staff non-compliance related to hand hygiene as identified in the audits.
D) Written records of A, B and C shall be maintained until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard issued by the Director with respect to infection prevention and control measures for hand hygiene.

The home failed to ensure residents were supported to perform hand hygiene prior to receiving a meal, as part of the IPAC program, was followed by staff during meal service in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes September 2023" (IPAC Standard).

Specifically, residents did not receive support from staff in the dining room of a specified resident home area with hand hygiene prior to a lunch meal as required in the Hand Hygiene Program requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary:
On a specified day in November 2023, during the lunch hour Inspector #000723 observed lunch service in the dining room of a specified resident home area. A total of twenty-three residents were observed entering the dining room either

independently or with the assistance of staff. Out of the twenty-three residents, it was observed that staff either prompted or provided assistance to four residents with performing hand hygiene prior to their meal. Two residents were observed entering the dining room independently at 1210 hours self-propelling in their wheelchairs touching the wheels with their hands. Both residents did not receive cueing or assistance with hand hygiene prior to receiving their meals, which consisted of two handheld main choices of either a hamburger or a chicken salad sandwich. A total of nineteen residents were observed to not receive hand hygiene prior to being served their meals.

In an interview, a PSW stated that residents should be supported to perform hand hygiene prior to meals. The PSW did not know if all residents had received hand hygiene prior to this meal service. IPAC Lead and IPAC Employee Health Consultant both acknowledged that residents should be supported or cued by staff to perform hand hygiene prior to meals.

As such, a lack of hand hygiene increases the risk of disease transmission amongst residents and staff.

Sources: observation on a specified date in November 2023 and interviews with PSW, IPAC Lead and IPAC Employee Health Consultant.

[000723]

This order must be complied with by January 31, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.