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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 24, 2024	
Original Report Issue Date: May 8, 2024	
Inspection Number: 2024-1519-0002 (A1)	
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	
Amended By Megan MacPhail (551)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to:
Add April 26, 2024, as a date when the onsite inspection occurred.

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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 Margaret Beamish (000723)	Additional Inspector(s) Megan MacPhail (551)
Amended By Megan MacPhail (551)	Inspector who Amended Digital Signature

AMENDED INSPECTION SUMMARY

This report has been amended to:
Add April 26, 2024, as a date when the onsite inspection occurred.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 11-12, 2024, April 15-19, 2024, and April 23-26, 2024

The following intakes were completed in this complaint inspection:

- Intake #00110721 was related to alleged improper / incompetent care of a resident.
- Intake #00111228 was related to a bed refusal.
- Intake #00111383 was related to Infection Prevention and Control (IPAC) management.
- Intakes #00110939, #00111367, #00114243 were related to plan of care and medication administration for a resident.

The following intakes were completed in this critical incident (CI) inspection:

- Intake #00110582 and Intake #00111891 were related to alleged resident to resident physical abuse.
- Intake #00110747 was related to a COVID 19 outbreak.

Inspectors #000858 and #000810 were present as observers during this inspection.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Admission, Absences and Discharge

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to the application of two prescribed treatments.

A) Rationale and Summary:
On a certain date, the application of a prescribed treatment on a resident was ordered to be done for a specified amount of times per week for a specified time period.

The application of the specified prescribed treatment and other prescribed treatments was recorded by the registered nursing staff on the eTAR, and the tasks were delegated to the Personal Support Workers (PSWs).

As per the eTAR for a specified month, the treatment began on a specified date, and the application of the prescribed treatment was scheduled for a specified time on specified days of the week.

On a specified date, an order was written stating that application of the prescribed treatment could be decreased in frequency per week for a specified time period. As per the eTAR for a specified month, the treatment began on a specified date, and the application of the prescribed treatment was scheduled for a specified time on different specified days of the week.

The order for the application of the prescribed treatment for a specified number of times per week was not discontinued, and in two specified months, the treatment was applied to the resident at an increased frequency per week than ordered. As per the eTARs for two different specified months, the order for the application of the prescribed treatment was changed to a different frequency per week. The prescribed treatment was discontinued on a specified date after.

The Unit Manager stated that the order for the application of the prescribed treatment should have been maintained at a specified frequency per week or decreased to a specified frequency per week. It should not have been increased to to a specified frequency per weeks during a specified two month time period.

The treatment with the prescribed treatment was applied to a resident at a frequency that was greater than ordered for two specified months.

Sources: Review of a resident's health care record and interview with Unit Manager. [551]

B) Rationale and Summary:
On a specified date, the application of a prescribed treatment to a resident was ordered to be applied for a specified number of times per day.

As per the eTAR for a specified month, the application of the prescribed treatment

was scheduled for two specified times per day.

The order for the application of of the prescribed treatment was discontinued on a specified date.

On a specified date, a PSW stated that they applied the prescribed treatment to the resident at a certain time of day, and on a different date, another PSW stated that they applied the prescribed treatment at a different time of day, and they intended to apply it that same day after the prescribed treatment had already been discontinued.

The resident continued to have the prescribed treatment applied to them after the order was discontinued.

Sources: Review of a resident's health care record and interviews with two PSWs. [551]

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
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 FLTCA 2021 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. Specifically, the licensee withheld an applicant's application for admission citing the staff of the home lacked the nursing expertise.

Rationale and Summary:
A review of the letter provided to an applicant from a specified date, stated that the home withheld approval of admission because the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements. The letter further stated that the home's decision was based on the applicant having a history of mental health issues and a specified diagnosis. The letter then stated that the home did not have the mental health supports required for residents under the age of 65 years or the expertise to care for anyone with the specified diagnosis.

A review of the application package, including the international Resident Assessment Instrument (interRAI) completed on a specified date, showed that the applicant had a history of mental health issues at a specified age, but none since. The application also showed that the applicant did not currently have any diagnoses related to mental health and had the specified diagnosis.

In an interview, the Director of Care (DOC) stated that the applicant was refused admission as there were no mental health supports in the system for residents under 65 years of age, and because the applicant would no longer receive community supports for the specified diagnosis once they were admitted to long-term care. Additionally, the DOC stated that the staff in the home did not have knowledge about caring for individuals with the specified diagnosis, but that the

home had previously reached out to other community resources to help support staff education on diagnoses that they were unfamiliar with.

As such, withholding approval of the applicant's admission to the home was based on reasons that were not permitted within the legislation.

Sources: An applicant's application, applicant refusal letter, and interview with DOC. [000723]

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The licensee has failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber related to the administration of a specified medication on a specified date.

Rationale and Summary:
On a specified date, a resident was ordered a medication at a specified dose for at a specified time per day for a certain number of days. As per the eMAR from a specified month, an initial dose was administered on a specified date at a specified time of day, and other doses were administered at a different time of day during a

specified time period after the initial dose. As per the eMAR from the next month, the last dose was administered on a specified date.

The Unit Manager reviewed the eMAR from a specified month and could not find an indication that a dose of the medication was administered on a specified date, as prescribed.

The resident was being treated for a suspected infection, and they did not receive a dose of the medication as ordered.

Sources: Review of a resident's health care record and interview with Unit Manager. [551]