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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 18, 2015	2015_362138_0017	O-001563-15, O-001626-15, O-001909-15, O-001996-15, O-002133-15	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

Long-Term Care Home/Foyer de soins de longue durée

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD OTTAWA ON K1N 5M2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 26, 27, and 29, 2015

Additional offsite inspection activities occurred on May 27 and 28, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager Resident Care (RNs/RPNs), the Manager of Resident Care (PSWs), the Social Worker, Registered Nurses (RNs), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), and Residents.

The inspector also reviewed several Critical Incident Reports, reviewed several health care records, reviewed the home's policy related to abuse and to falls management, reviewed internal investigative documents, reviewed partial components of employee files

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

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 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 failed to comply with section 6(7) of the Act in that the care set out in the plan of care was not provided to the resident as specified in the plan.

The home submitted a Critical Incident Report to the Ministry of Health and Long Term Care outlining that Resident #005 was not transferred properly from the resident's bed to the resident's wheelchair on a date in April 2015.

The inspector reviewed Resident #005's plan of care that was in effect at the time of the incident and noted that the resident was to be transferred in the evening in a two staff side by side transfer. RN #101 stated that a staff transfer of a resident requires resident participation and clarified that a two person transfer is not a two person lift. Lifting of a resident for a transfer is only completed with the aid of a mechanical lift and never solely by staff.

The inspector spoke to Resident #005 regarding the incident in April 2015. The resident stated to the inspector that s/he had felt pain during the transfer and was upset once the transfer was completed because of the pain.

The inspector spoke with the two staff members involved in the incident, PSW #102 and PSW#103. PSW #102 stated to the inspector that she and her co worker, PSW #103, attempted to transfer Resident #005 in a side by side transfer but the resident would not weight bear. PSW #102 further stated that she and her co worker completed a staff lift of the resident instead. PSW #102 confirmed that the resident was upset when the lift was completed but did not voice any pain. The inspector spoke with PSW #103 who also stated that the resident was being transferred in a side by side transfer but the resident did not participate in the transfer resulting in him and PSW #102 completing a lift to transfer the resident from the bed to the wheelchair. PSW #103 stated that the resident was very upset once the transfer was completed.

The inspector spoke with the Manager of Resident Care (PSWs) who stated that the incident had been investigated by the home and that the home had delivered disciplinary actions to both PSW #102 and PSW #103 for failure to properly transfer Resident #005. (Log # O-001996-15) [s. 6. (7)]

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 residents transfers are completed as directed by the residents' plan of care, to be implemented voluntarily.

WN #2: 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 comply with section 8(1)(b) of the regulation in that where the licensee is required 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 is complied with.

In accordance with this section and sections 30.(1), 48.(1)1., 48.(2)(a) and (b), and 49.(1)(2)and (3), the licensee is required to have a falls prevention and management program that includes relevant policies, procedures, and protocols and provides for methods to reduce the risk and monitor outcomes.

During the course of the inspection, Inspector #138 reviewed a Critical Incident Report that outlined Resident #001 sustained a fall on a date in May 2015 with a transfer to hospital related to injuries. The inspector reviewed the resident's health care record and noted that the resident was returned to the home on several days later.

The inspector spoke with the unit RN #100, regarding Resident #001 and the home's falls prevention and management program. The RN stated that after Resident #001's fall the home should have completed a Risk Assessment for Falls Tool, known as a RAFT or FRAT, for the resident's fall and that the Falls Prevention Program Binder would outline this information. The inspector and RN #100 reviewed this binder and no information was found regarding Resident #001's fall. RN #100 also verified Resident #001's health care record and was unable to find any documentation to suggest that a Risk Assessment for Falls Tool had been completed for the fall that had occurred.

The inspector reviewed the home's policy "Falls Prevention Program: Resident Assessment for Falls Tool(RAFT) revised September 2013 and noted that the policy stated that a RAFT would be completed by the registered staff after a resident fall when there was an injury requiring hospitalization.
(Log #O-002133-15) [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, 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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The following non compliance is additional information for section 19(1) of the Act under Compliance Order 001, Inspection # 2015_286547_0002, dated April 7, 2015, and with a compliance due date of June 30, 2015.

The licensee failed to comply with section 20(1) of the Act in that the written policy in place to promote tolerance of abuse and neglect of residents was not complied with.

The home submitted a Critical Incident Report to the Ministry of Health and Long Term Care outlining that Resident #002 was abused by PSW #106 on a date in January 2015 in which PRN #104 witnessed PSW #106 emotionally abuse Resident #002 in the hallway outside the resident’s room.

The inspector spoke with the Manager of Resident Care (PSWs) who stated that the incident was investigated and PSW #106 was terminated as a result of the incident.

The inspector spoke with the RPN #104 who witnessed the incident. RPN #104 stated that she had witnessed the incident and had intervened to ensure resident safety. RPN #104 stated the PSW #106 continued to work the rest of the shift although RPN #104 had held a conversation with PSW #106 indicating that PSW #106’s actions with Resident #002 was abuse. Despite recognizing the incident of abuse that had occurred, RPN #106 did not further report the incident until several hours later when she made a report to the charge RN. RPN #106 stated to the inspector that she realizes that she should have made a report to the charge RN at the time of the incident and should not have waited.

The inspector spoke with the charge RN #105 who confirmed that she had not been made aware of the incident involving PSW #106 and Resident #002 until several hours after the incident occurred. RN #105 stated that the incident should have been reported earlier but that once she was aware she took immediate action including informing the

manager on call who is responsible to report the incident to the Ministry of Health and Long Term Care.

The inspector reviewed the home's policy on abuse as provided by the Manager of Resident Care (PSWs) and noted that the policy directs any suspicion or allegation of resident abuse to be reported immediately to the Charge Nurse who will then take further action including the notification of appropriate others who will then report the incident to The Ministry of Health and Long Term Care.

The home did not follow its abuse policy in the incident that occurred in January 2015 between Resident #002 and PSW #106 in that PRN #104 did not immediately report witnessed abuse to the Charge Nurse, RN #106.
(Log #O-001563-15) [s. 20. (1)]

Issued on this 18th day of June, 2015

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

Original report signed by the inspector.