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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 13, 2016	2016_285126_0013	008178-16, 012358-16, 013955-16, 017102-16, 017640-16, 018450-16, 019924-16	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

LINDA HARKINS (126)

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): July 6,7,8,11,12, 2016

During this inspection, five Critical Incidents related to allegation of abuse and two Critical Incidents related to transfer to hospital were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Manager for Registered Nursing Staff, the Registered Care Manager for Personal Support Worker , Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. Related to Log # 008178-16
The licensee has failed to ensure that care that was set out in the plan of care was provided to resident #001.

Resident #001 was admitted to the home in 2010 with several diagnosis. It is noted in the written Kardex, updated February 4, 2016 that resident # 001 requires a lap belt when sitting in the wheel chair.

On a specific day in March 2016, Personal Support Worker (PSW) # 100 was wheeling resident #001 back to his/her room after a shower, when resident # 001 slid down to the floor which resulted in an injury. After the shower, resident #001's front closure lap belt was not applied to the resident when he/she was sitting in the wheelchair (W/C).

Discussion with Resident Care Manager # 101 who indicated that it was clearly identified that resident # 001 required a front closure lap belt at all time when sitting up in the w/c.

Resident #001's front closure lap belt was not applied by PSW# 100 after a shower as per plan of care and resulted in an injury. [s. 6. (7)]

2. Related to Log # 017102-16
The licensee has failed to ensure that the care set out in the plan of care was provided to resident # 004 as specified in the plan of care.

Resident # 004 was admitted to the home in December 2015 with several diagnosis. Resident # 004's plan of care (no date on copy) indicates under toileting: "Limited assistance, one staff, Will call bell when needs to use toilet". Resident Care Manager (RCM) # 101, indicated that it was the updated version of the plan of care.

On a specific day in June 2016, resident # 004 reported to Registered Nurse (RN) # 106 that Personal Support Worker (PSW) # 105 refused to assist him/her to the toilet because he/she had been toileted twice already and refused to assist with toileting a third time. RN # 106, took resident # 004 to the bathroom to assist with toileting and found that resident was incontinent of stool.

Inspector # 126 interviewed resident # 004 who indicated that if he/she doesn't go to the bathroom when he/she call the bell that he/she can be incontinent.

Toileting Care was not provided to resident # 004 as specified in the plan of care. [s. 6. (7)]

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Issued on this 13th day of July, 2016

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

Original report signed by the inspector.