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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

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_0012	013970-16	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): July 4, 5 and 6, 2016

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

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that resident # 001's Substitute Decision Maker (SDM) was provided with the opportunity to participate fully in the development and the implementation of the plan of care.

On July 5, 2016, Inspector #126 interviewed the informant regarding the concerns with the Home. The informant indicated that on an a specific afternoon of March 2016, resident # 001 had visitor during the day and that they left the home for a few hours. When they returned to the home a few hours later, resident # 001's condition has changed. The informant indicated that the family was not informed of the change of the resident's condition.

In the progress notes of that specific date in March 2016, resident # 001 was assessed by Registered Practical Nurse (RPN) # 101. RPN #101 documented that the resident's condition has changed and that he/she notified the Physician and Registered Nurse (RN)# 102.

On July 6, 2016, interview held with RPN # 101, indicated that she has assessed resident # 001 at the end of the day shift. She indicated that resident # 001 was alone in the room, was calm and in no distress. RPN # 101 indicated that resident # 001's condition has changed and that he/she notified the physician. RPN #101 indicated that they usually notify the family if there is a new order and did not call the family as she assumed that RN # 102 was going to contact them.

On July 6, 2016, interview held with RN # 102 , indicated that she cannot recall contacting the family regarding the change in condition of resident # 001 and wanted to review her notes. The next day, discussion held with RN # 102 indicated that after reviewing the notes he/she indicated that the family was not contacted. RN # 102 indicated that family are to be contacted when there is a change in the resident's condition and new order are received.

The SDM were not provided with the opportunity to participate fully in the development and the implementation of the plan of care [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

In reviewing the plan of care of resident # 001, it was noted in the Medical Directives dated November 2011, form # 345:11, that the nurse is to inform the physician if there is a change in condition in the resident and if a specific treatment is given.

On a specific day of March 2016, it was documented in the daily report that resident # 001's condition changed. There is no documentation that the physician was informed of the change in the resident's condition.

Discussion held with Resident Care Manager #105 indicated that the expectation in the Medical Directive is that the physician be informed of the change in resident's condition.

The physician was not informed of resident's # 001 change in condition. [s.6. (7)]

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.