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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 1, 2017	2017_617148_0025	016508-17, 016556-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

AMANDA NIXON (148)

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 27 and 28, 2017

This complaint inspection was initially reported as an alleged resident abuse, there was also an associated critical incident report submitted to the Director by the licensee related to an improper transfer.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Manager of Resident Care, Registered Nursing staff and Personal Support Workers (PSW).

The Inspector also observed the identified resident's environment and reviewed the resident's health care record.

The following Inspection Protocols were used during this inspection:
Personal Support Services
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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Resident #001 was assessed to require a two person side by side transfer during the day shift. The resident's kardex, used to inform direct care staff of the resident's requirements, indicates that the wheelchair is to be positioned and locked then the resident is to be assisted with the transfer from bed to wheelchair. The health care record indicates the resident is not always able to follow directions, requires extensive assistance for bed mobility and can be known to be resistive to care.

On the morning of a specified date, the resident was provided with care in bed by PSW #101. PSW #101 indicates that after morning care the resident was transferred from the bed to his/her wheelchair, the PSW indicates that PSW #102 assisted with the transfer. After the transfer PSW #101 continued to finish care at which time the resident was calling out and becoming agitated. It was at this time that PSW #101 observed that the resident's extremity was not properly positioned; the resident sustained an injury as a result. Statements from PSW #102 indicate that she did not participate in the transfer of this resident on the morning specified.

The resident was not provided with a safe transfer on the specified morning as described. [s. 36.]

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.