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
Jul 13, 2017	2017_620126_0005	031811-16, 034948-16, 000637-17, 001545-17, 002308-17, 002386-17, 004435-17	Critical Incident System

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

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): March 13, 14, 15,16, 17, 20, 21, 22, 23, and 28, 2017

During this inspection the following logs were inspected;
Log # 031811-16: allegation of abuse to a resident
Log # 034948-16: allegation of abuse to a resident
Log # 000637-17: allegation of abuse to a resident
Log # 001545-17: incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status
Log # 002308-17: allegation of abuse to resident
Log # 002386-17: allegation of abuse to a resident
Log # 004435-17: allegation of abuse to a resident

During the course of the inspection, the inspector(s) spoke with identified residents and their Substitute Decision Maker (SDM), Personal Support Workers (PSW) , Registered Practical Nurses (RPN), Registered Nurses (RN), Administrative Assistants, the Program Manager of Personal Care (PMOPC), the Program Manager of Resident Care (PMORC) and the home's Acting Administrator.

During the course of this inspection, the inspector observed care and services given to the identified residents, reviewed the staff education history reports, reviewed the criminal reference checks, reviewed the health care record of the identified residents and reviewed the licensee's policies and procedures titled: "Abuse" -750.65 revision date September 2016.

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

During the course of this inspection, Non-Compliances were issued.

2 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. 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 licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of resident was complied with:

Log # 000637-17
The licensee's "Abuse Policy" -750.65 last revised September 2016 requires staff under the section:
"Practice:
The Homes are committed to zero tolerance of abuse or neglect to our residents. The Residents bill of rights entitles all residents in City Homes to receive care of the highest standard, to be treated with dignity and respect and to live in an environment that is free from threats, fear and injustice.

Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect from the other residents, families, volunteers or employees. (For definition please see appendix A)

Violation of any aspect of this policy with lead to disciplinary action up to and including dismissal."

As per O. Reg 79/10, section. 2. (1) (a) "defines emotional abuse"as:
"(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

A Critical Incident (CI) was submitted to Ministry of Health and Long-Term Care (MOHLTC) in January 2017 for physical abuse staff to resident. The incident occurred on

a specific day in January 2017. MOHLTC Director was notified the same day of the incident.

According to the CI report, on a specific day in January 2017, Personal Support Worker (PSW) #100 was seen holding on to Resident #007 and pulling him/her as he/she was holding tight onto the fire door in the corridor. Resident # 006 told PSW #100 to stop and was walking with his/her walker towards him. Then, PSW #100 pushed resident #006 on the right shoulder. Due to the impact, resident #006 hit his/her shoulder on the wall. Resident #006 did not sustained any injury from the incident and was angry at PSW #100.

Resident # 006 was admitted to the home in 2016 with several diagnoses. Resident #006 was ambulating with a walker and was known to exhibit responsive behaviors such as thinking resident # 007 was his/her spouse on occasion.

Resident #007 was admitted to the home in 2016 with several diagnoses. Resident #007 often misidentifies resident #006 thinking he/she was his/her spouse. At the time of the incident, resident # 007 was under close monitoring with one on one by PSW #100 for exhibiting responsive behaviors. The one on one monitoring was implemented to prevent the escalation of these inappropriate behaviors.

Activity Staff(AS) #106, wrote a statement describing the incident of that specific day in January 2017. As she was coming out of the elevator, she heard someone arguing and saw PSW #100 and resident #007. She asked PSW #100 what he was doing. She observed PSW #100 pushing resident # 007 who was trying to fight back. She documented that she felt that PSW#100 was using excessive force. RPN #105 came out of the medication room and said let go. Resident #006 was walking toward PSW #100 and then PSW #100 pushed resident #006. Inspector #126 was unable to interview AS #106 as she was on a leave of absence.

On March 28, 2017, during an interview, RPN #105 indicated to Inspector #126, via telephone, that she was in the medication room at the time, when she overheard a female staff saying "what are you doing" in a loud voice. She came out of the medication room and observed PSW #100 pulling the hand of resident #007, trying to get him/her away from the fire door. She indicated that resident #006 was beside resident #007 and that PSW #100 pushed resident #006 on the right shoulder and the resident hit the wall with his/her left shoulder. Resident #006 did not fall to the floor and did not sustained any injury. RPN #105 immediately requested that PSW #100 move away from the residents

and that he/she goes to the Living Room.

On March 28, 2017, during an interview, PMORC indicated to Inspector #126, that once the investigation was completed, PSW #100 was terminated for contravention with the City's Long-Term- Care Abuse Policy and the City's Code of Conduct.

The licensee failed to comply with the Abuse Policy when resident #006 was subjected to emotional abuse by PSW #100. [s. 20. (1)]

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 staff comply with the Abuse Policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if a person has reasonable grounds to suspect that Improper or Incompetent treatment of care of a resident that resulted in harm immediately report the suspicion to the Director.

Log # 004435-17

A Critical Incident (CI) was submitted to Ministry of Health and Long-Term Care (MOHLTC) on a specific day of February 2017 for "Improper or Incompetent treatment of a resident that results in harm or risk to a resident". According to the CI report, the incident occurred on that specific day of February 2017, when resident #002 "returned from the hair dresser with new scratch marks on forehead, and both cheeks. No bleeding noted. Residents face was clear from any scratch marks prior to hair dressing appointment. Home showed and discussed scratches with hair dresser. Hairdresser stated that the resident was resistive towards her and scratches occurred when resident lifted her/his hand up to stop the hair treatment".

On that specific day of February 2017, resident #002 returned to the unit around 1250 hours. Registered Nurse(RN) #102 documented in the progress notes that resident #002 had two scratch marks on the forehead and two scratch marks on the right and left cheeks about 2 centimetres long. RN #102, documented that resident #002 did not have any scratch marks prior to the hair dressing appointment. RN #102 indicated that she informed the hair dresser that she would notify the Manager about resident #002's scratches to the face. RN #102 sent an email to Acting Administrator and to the PMORC on that same day, describing concerns related to resident #002's new scratches to his/her face.

On March 23, 2017, during an interview, the PMORC indicated to Inspector #126, that the incident was not immediately reported to the Director. The PMORC indicated that the Critical Incident (CI) report was submitted the next day, after the incident.

On March 23, 2017, during an interview, the Acting Administrator, indicated to Inspector #126 that the incident was not immediately reported to the Director. The Acting Administrator indicated that the CI report was sent to the Director the next day, after the incident.

The Incident of that specific day in February 2017 was not immediately reported to the Director [s. 24. (1)]

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Issued on this 21st day of August, 2017

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

Original report signed by the inspector.