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
Sep 14, 2017	2017_658178_0012	007811-17	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

SUSAN LUI (178)

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 12, 19, 20, 21, 24, 25, 26, 2017.

During the course of the inspection, the inspector(s) spoke with the Program Manager of Resident Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers PSW).

During the course of this inspection, the inspector also observed residents and resident care, reviewed residents' health care records and policies related to the home's prevention of abuse program.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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 has failed to ensure that their written policy that promotes zero tolerance

of abuse and neglect of residents is complied with.

The licensee's written policy titled "Abuse", #750.65, last revised June 2017, states under the section titled "Practice":
Residents will not be subjected to any form of physical, emotional, sexual, verbal or financial abuse or neglect from other residents, families, volunteers or employees. (For definitions please see Appendix A).
Appendix A of the licensee's Abuse policy defines sexual abuse as follows:
(a) Any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or a staff member, or
(b) Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

O. Reg 79/10, s. 2. (1) defines sexual abuse as:
(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or
(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Review of an identified Critical Incident Report (CIR) indicated that on an identified date, a PSW found a resident's room door barricaded with a wheelchair. When the PSW and an RPN entered the room, they found Resident #001 entirely naked, and Resident #002 naked from the waist down. Resident #001 was sitting on the bed, and Resident #002 was sitting facing Resident #001 with his/her legs around Resident #001's waist. The CIR, which was submitted by the licensee, indicated that both residents are moderately cognitively impaired, and do not have the capacity to consent to sexual behaviour. The CIR indicated that Resident #001 was upset, stating that the apartment was paid for. When staff attempted to assist Resident #002 from the bed, Resident #001 pushed and hit at the staff member's hands and attempted to bite the staff member's forearm. The residents were separated, assessed for injury, Resident #002 was transferred to hospital for assessment, and one to one supervision was initiated for Resident #001.

Review of Resident #001's health record indicated that the resident was assessed to have a Cognitive Performance Scale of 3/6, and a history of wandering behaviour.

Resident #001 did not have any history of sexually inappropriate or sexually disinhibited behaviour prior to this incident. Resident #001 ambulates independently.

Review of Resident #002's health record indicated that the resident was cognitively impaired, and had a past history of wandering, mood/relationship problems, verbally abusive as well as socially and sexually inappropriate behaviours. Resident #002 ambulates using a wheelchair.

On July 19, 2017, RN #100 indicated to Inspector #178 that some time ago, Resident #001 had been discovered with Resident #002 in a resident room, and both residents were naked from the waist down. As a result, Resident #001 was sent out for a psychiatric evaluation, and had only recently returned to the unit.

On July 20, 2017, PSW #102 indicated to Inspector #178 that on an identified date, she found Resident #001 and Resident #002 together in a co-resident's bed. Both residents were naked from the waist down, and Resident #002 had his/her legs wrapped around the waist of Resident #001. PSW #102 indicated that Resident #001 was agitated, and made statements which indicated that the resident thought he/she was a young adult in his/her apartment, and that the resident believed that the staff were police officers arriving to separate the resident from the resident's friend. PSW #102 indicated that Resident #002's cognition is very impaired and that he/she would not have been able to understand what was happening.

On July 21, 2017, RN #109 indicated to inspector #178 that Resident #002 had exhibited sexually inappropriate or flirtatious behavior in the past, but the resident's cognitive impairment has progressed in the past year, and by the time of this incident, the resident had ceased exhibiting those behaviours.

The licensee failed to ensure that their written policy that promotes zero tolerance of abuse and neglect of residents was complied with, in that Resident #001 and Resident #002, two residents who were incapable of consenting to sexual activity, were not protected from non-consensual sexual behaviour from each other.

Non compliance with section 20 (1) was previously issued in Inspection #2017_620126_0004 (A1), dated August 9, 2017, and a VPC was issued. Non compliance with section 20 (1) was also referenced in Inspection #2017_620126_0004 (A1) as evidence of non-compliance with section 19 (1), the duty to protect residents from abuse. As a result, Compliance Order #002 and Director Referral #001 were

issued.

(007811-17) [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 that home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 3rd day of October, 2017

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

Original report signed by the inspector.