Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Feb 9, 2018	2017_658178_0019	018207-17	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

SUSAN LUI (178)

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): December 6, 7, 8, 11, 12, 13, 18, 19, 20, 21, 2017.

**The following Critical Incident Logs were inspected concurrently with this Complaint inspection:
023229-17 and 028151-17, regarding improper/incompetent treatment of a resident that results in harm or risk to a resident.**

**During the course of the inspection, the inspector(s) spoke with personal support workers (PSWs), registered nurses (RNs), registered practical nurses (RPNs), Program Manager of Resident Care, Program Manager of Personal Care, Program Manager of Recreation, Administrator, Trainer, a private companion, and a resident.
During the course of the inspection, the inspector also observed residents and resident care, observed staff to resident interactions, reviewed resident health records, employee training records, home policies and procedures, and documentation related to the home’s investigations into the above critical incidents.**

**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.

- **2 WN(s)**
- **2 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. 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. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.

An identified Critical incident Report (CIR), which is submitted by the home, indicated

that on an identified date, resident #007 informed staff that the resident was experiencing discomfort in an identified body part as a result of performing an activity of daily living (ADL) with the assistance of one staff member rather than two as the resident required.

Review of resident #007's health record indicated that the resident requires assistance with all ADLs. Review of the ADL Assistance plan of care in place on the day of the incident, indicated that resident #007 required assistance from two staff on all shifts for positioning. Resident #007's progress notes on the day of the incident, indicated that the resident complained of discomfort in an identified site as a result of being positioned by only one staff while being assisted with an identified ADL that day.

During an interview with Inspector #178 on December 20, 2017, resident #007 indicated that two staff are required to provide the resident with the identified ADL.

During an interview with inspector #178 on December 18, 2017, PSW #115 indicated that on one occasion the PSW repositioned and assisted resident #007 with an identified ADL without the assistance of another staff member. PSW #115 indicated awareness that the resident's plan of care called for two staff to assist with positioning and the identified ADL, however the resident was anxious to receive the ADL assistance. A second PSW was not immediately available to assist with the care, so PSW #115 repositioned the resident and provided the ADL assistance independently. PSW #115 indicated that the resident did not report experiencing any pain while the ADL assistance was provided.

During an interview with inspector #178 on December 18, 2017, the Program Manager of Personal Care indicated that the home had investigated the incident, and determined that the PSW had failed to follow the resident's plan of care by providing the identified ADL assistance alone, rather than waiting for a second staff member for assistance. The resident was not found to be injured as a result of the incident. (023229-17)

It is noted that a Director's Order related to LTCHA s. 6 (7) Plan of Care was issued to the City of Ottawa on July 19, 2017 as part of a Director Referral under Inspection # 2017_620126_0004, made in accordance with s. 152, paragraph 4 of the Long-Term Care Homes Act, 2007 (LTCHA). The Director's Order compliance due date was December 1, 2017. It is noted that the above finding of non-compliance issued under LTCHA s. 6 (7) occurred prior to the December 1, 2017 compliance due date. [s. 6. (7)]

2. The licensee failed to ensure that the plan of care for resident #005 was reviewed and

revised when the resident's care needs changed.

Inspector #178 reviewed the health record of resident #005 as part of a complaint inspection involving an allegation of staff to resident abuse or rough care. Review of the health record indicated that resident #005 was admitted to the long-term care home with numerous medical diagnoses, and passed away from complications of those conditions on an identified date. Resident #005 was capable of making care decisions. The resident's End of Life Wishes Form, signed by resident #005 on an identified date, indicated the resident's wishes with regards to end of life care.

Review of resident #005's physician progress note written on the day of the resident's death, indicated that the resident had chosen not to follow recommendations for treatment. Review of resident #005's progress notes on the same day, indicated that the when the resident ceased to breathe, the instructions indicated in the resident's End of Life Wishes Form were not followed.

During an interview with Inspector #178 on December 8, 2017, RN # 123 indicated that resident #005 ‘s death had not been unexpected because the resident had chosen to not follow advice regarding medical treatment, and the resident's condition was declining. RN #123 further indicated that he/she had spoken to resident #005 about the resident's condition and risk of death approximately a month before the resident died, and the resident's response indicated that the resident may have changed his/her mind regarding wishes related to end of life care. This conversation was not documented in the resident's health record.

During an interview with inspector #178 on December 11, 2017, RPN #122 indicated that on the day that resident #005 ceased to breathe, the measures recorded in resident #005's End of Life Wishes Form were not followed. RPN #122 indicated that he/she was aware of resident #005's documented wishes on the End of Life Wishes Form, and could not provide a reason as to why these measures were not followed when resident #005 ceased to breathe.

During an interview with Inspector #178 on December 18, 2017, the home's Administrator indicated that at the time of resident #005's death, the wishes recorded on the resident's End of Life Wishes Form were not followed by staff. The Administrator indicated that RN #123 indicated to her that in the last few weeks of the resident's life, the resident had chosen to refuse treatment and the resident made statements indicating

that the resident's end of life wishes may have changed from what was recorded on the resident's End of Life Wishes Form. The Administrator indicated that this was not documented in the resident's record and that there is no evidence to indicate that staff reviewed and revised the End of Life Wishes Form with the resident in response to the resident's recent expressions of a change of end of life wishes. The Administrator indicated that if a resident's end of life wishes changed, the resident's plan of care and the End of Life Wishes Form should be reviewed and revised in accordance with those expressed wishes.
(018207-17) [s. 6. (10) (b)]

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 the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 used safe positioning devices or techniques when assisting resident #009.

Review of an identified CIR, which is submitted by the home, indicated that an allegation was made that on an identified date, resident #009 was repositioned in bed improperly by a PSW.

During an interview with Inspector #178 on December 8, 2017, informant #124 indicated that on an identified date, PSW #103 repositioned resident #009 in the bed improperly by grasping the resident in an identified body area and pulling the resident lower in the bed. The informant indicated that the resident yelled the word “ouch” when this happened.

During an interview with Inspector #178 on December 19, 2017, PSW #103 indicated that on an identified date, he/she repositioned resident #009 in the bed by grasping the resident in an identified body area and pulling the resident down lower in the bed. PSW #103 indicated that he/she would not normally reposition a resident in bed using this method. PSW #103 indicated that he/she would normally reposition a resident in bed using the soaker pad with a second person to assist, however in this case the soaker pad was not properly positioned underneath the resident.

During an interview with Inspector #178 on December 18, 2017, the Program Manager for Personal Care indicated that PSW #103 improperly repositioned resident #009 in bed by grasping the resident in an identified body area to reposition the resident in bed.

(023229-17) [s. 36.]

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 staff use safe positioning devices or techniques when assisting resident #009, to be implemented voluntarily.

Issued on this 21st day of February, 2018

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

Original report signed by the inspector.