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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 14, 2018	2018_583117_0017	030423-18	Resident Quality Inspection

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

LYNE DUCHESNE (117), JANET MCPARLAND (142), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 26, 27, 28 and 29, 2018

It is noted that the following inspections were conducted concurrently with the Resident Quality Inspection and included in this inspection report:

- Log # 009298-18 : complaint related to allged resident abuse and neglect as well as the home's medication management system
- Log # 028563-18 : critical Incident (M622-000036-18) related to a resident fall and transfer to hospital with injury
- Log # 030339-18 : critical incident (M622-000042-18) related to a resident fall and transfer to hospital with injury

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Directors of Care (DOC), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Registered Dietitian (RD), several Dietary Aides, an external Skin and Wound Care Consultant from KDS Services, the Manager of Activities and Volunteers, the Resident Council Chair, the Family Council Co-Chair as well as several family members.

In addition, during the course of the inspection, the inspectors reviewed several resident health care records, observed the provision of resident care and services, observed the provision of several lunch meal services, observed resident rooms, tub/shower rooms as well as resident common areas, observed the provision medication administration, reviewed the medication management system, internal incident reports, medication incident reports, reviewed the home's policy P&P # 335.10 "Least Restraint", reviewed date September 2018, as well as Resident and Family Council Meeting Minutes from January 2018 to October 2018.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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	Légende 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Resident #014 is identified as having a pressure ulcer and is on the home's Skin and Wound Care Program. The pressure ulcer was noted on a specified day in 2018 and is still present. The resident was seen by an external consultant in regards to the pressure ulcer wound care treatment.

On a specified day in 2018, 14 days after the pressure ulcer was noted, an external consultant ordered a dressing for the resident's pressure ulcer. The order was that the pressure ulcer be cleansed with normal saline and a dressing was to be applied. This dressing change was to be done every 3 days and as needed (PRN).

Twenty-eight (28) days later, the same external consultant ordered that a specialized wound treatment was to be done twice per week, to be done at the same time as the previously ordered dressing change. Only trained registered staff were to do the treatment. RN #100 and RPN #017 received this training. The treatment was discontinued on a specified day in 2018, twenty-eight (28) days after the specialized

treatment was ordered.

A review of the resident's health care record, including the Medication Administration Record (MAR), was conducted. The dressing change is noted to have been done as per the treatment order when initially ordered on a specified day in 2018. The MAR also tracks the specialized wound treatment and dressing change. It is noted that the specialized wound treatment and dressing changes were done on three specified days during this 28-day treatment period by RN #100. There is no other documentation indicating that the pressure ulcer treatment and dressings were provided twice weekly/ every three days, to Resident #014 as per the treatment and dressing orders.

On November 26, 2018, RN #100 said that they and RPN #107, had received training from the external consultant on how to do the specialized wound treatment. RN #100 said that they had applied the treatment as per MAR documentation on the three identified days in 2018. RN #100 said that the other specified treatment days most likely occurred when they were not working. On November 27, 2018, RPN #107 said that they had received training on how to apply the specialized wound treatment to resident #014's wound. However, since the training, they had not provided treatments to resident #014's wound. RPN #017 said that they were not informed of the need to do resident #014's wound treatment when RN #100 was not available to do so.

As such, resident #014 did not receive the specialized wound treatment and pressure ulcer dressing change as ordered during a specified 28-day period in 2018. [s. 50. (2) (b) (ii)]

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has dining and snack service that includes monitoring of all residents during meals.

Resident # 013 was admitted to the home with several diagnosis. The resident is independent and eats three meals independently in their bedroom. Resident #008 is on a regular texture diet. The resident indicated that in the past, on one occasion, a piece a food was stuck in his/her throat.

On a specified day in 2018, resident#008 was observed to be eating lunch in the bedroom with the door close and no staff were within close vicinity.

Discussion held with Personal Support Worker (PSW) #101 who indicated that resident #008 requested to have the door of the bedroom closed. PSW #101 was aware that the bedroom's door shall be left open for monitoring. PSW #101 had been feeding other resident in another hallway.

Discussion held with Registered Nurse (RN) #100 indicated that when resident are having their meals in the bedroom that the bedroom door shall be left open and staff are to stay within proximity to monitor resident that eat in their bedroom.

Resident #008 was not monitored during lunch of a specified day in 2018. [s. 73. (1) 4.]

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 that the home has dining and snack service that includes monitoring of all residents during meals, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #006 was admitted to the home in 2018 and has multiple diagnoses. On a specified day in 2018, Inspector #142 observed resident sitting in their wheelchair with a front closing lap belt applied.

In review of the resident's health record it was noted that on a specified day in 2018, the physician wrote an order for a front closure lap belt for safety. Resident #006's current plan of care indicated the use of the wheelchair lap belt as a restraint. Interventions included apply belt when up in wheelchair and tilt to reposition resident every two hours, check resident hourly and reposition every 2 hours as per facility protocol and document on flow sheet. RNs #111 and #118 both indicated to Inspector #142 that the lap belt for resident #006 was considered a restraint. During an interview with PSW #117, they indicated to Inspector #142 that they document on the restraint and repositioning monitoring form the application, monitoring and removal of resident #006's restraint and repositioning of the resident.

Inspector #142 reviewed the restraint monitoring forms for a 12-day period and it was noted that there was no documentation for repositioning on various shifts for 11 identified days. There was no documentation on various shifts for 6 identified days related to the resident's response to the restraint. Further, there was no documentation on various shifts for 8 identified days related to monitoring, application and removal of the lap belt restraint.

Inspector #142 and RN #111 reviewed the restraint monitoring forms for resident #006 for an identified month and noted the lack of documentation related to application, removal, resident response and repositioning.

Upon further review of the resident's health record, it was also noted that there was no documentation to support the reassessment and effectiveness of the restraining by a member of the registered nursing staff at least every eight hours. In an interview with RNs #118 and #119, both indicated that it is the home's expectation that the registered staff document in the Medication Administration Record (MAR) the reassessment and effectiveness of the restraining. In reviewing the identified MAR with RN #118, they indicated that there was no documentation regarding the reassessment and effectiveness of the restraining.

In an interview with the Manager of Personal Care, Inspector #142 and Manager of Personal Care reviewed the restraint and repositioning monitoring form for the identified month in 2018 and agreed that for resident #006 the application, monitoring, resident's response and repositioning and release of the lap belt was not documented for the above identified days. The Manager of Personal Care, further indicated that it is the expectation that registered staff document on the MAR every shift the reassessment and effectiveness of the restraining.

In an interview with RNs #118 and #119, both indicated that it is the home's expectation that the registered staff document in the Medication Administration Record (MAR) the reassessment and effectiveness of the restraining. In reviewing the identified monthly MAR with RN #118, they indicated that there was no documentation regarding the reassessment and effectiveness of the restraining. [s. 110. (7)]

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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy,

the licensee is required to ensure that the policy (b) is complied with.

As per O.Reg. 109. (a) Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with, (a) use of physical devices. The licensee's policy # 335.10 "Least Restraint", last revised September 2018, identifies the following:

PASD Monitoring
1. Obtain and document consent or refusal on consent form.
2. Initiate the Restraint Monitoring Form. Please note this is the same form sued for restraint monitoring.
3. Complete the monitoring form using the appropriate key and response.
4. The resident and the PASD must be checked at least hourly to confirm that the device is properly positioned and that circulation to the skin is adequate, that skin is intact, that breathing is unimpaired, and that the resident is not severely agitated.
5. The PASD must be released and the resident repositioned at least every 2 hours.

Resident #014 was identified as being at risk of falls on a specified day in 2018. The resident's plan of care identified that as a fall prevention intervention, the resident had a personal assistance services device (PASD) attached to their wheelchair. The PASD was ordered on a specified day in 2018. The resident's power of attorney (POA) consented to the use of the PASD. The PASD use was subsequently implemented.

Four months later, on a specified day in 2018, resident #021 was found on the floor of their room. The resident had fallen out of their wheelchair; the PASD device was undone. Resident #021 was assessed and transferred to hospital for further assessment. The resident was diagnosed with an injury.

A review of the resident's health care record, was conducted including Resident #021's Restraint/PASD/Repositioning Monitoring Form for the wheelchair PASD in use at the time of the resident's fall and injury. It was noted that during the 12 days prior to, and including the day of the resident fall and injury, there is no documentation for 10 of the12 days related to the application, monitoring, repositioning and removal of the wheelchair PASD. There is no documentation of the resident's response to the use of the PASD. Notes from RPN #123, who assessed the resident post fall, notes that resident #021 had been seen by RPN #123 to have their PASD in place approximately one hour prior to the fall.

On November 28, 2018, RN #100, PSW #115 and #116 said to the inspector that prior to resident #021's injury, the resident was known to be able to undo their PASD and that the resident did on occasion try to self-transfer out of their wheelchair. PSW # 115 and #116 said that they regularly provide care to the resident. When they do so, they do apply the PASD as per the resident's plan of care and monitor the resident as the resident is able to undo the PASD. They also said that they have to document the application, monitoring, removal and the resident's response to the use of the
PASD on the Restraint/PASD/Repositioning Monitoring Form. This form was introduced in a specified month in 2018, replacing a previous form. PSW #115 and #116 had no comments as to why there were gaps in the Restraint/PASD/Repositioning Monitoring Form documentation related to the use of resident #021's PASD. The home's DOC # 110 said to the inspector that it is the home's expectation that the non-registered staff document the application, monitoring, repositioning and removal of the resident #021's PASD as per the home's Least Restraint policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented

Resident #014 identified is as having a pressure ulcer and is on the home's Skin and Wound Care Program. The pressure ulcer was noted on a specified day in 2018 and is still present. The resident was seen by the Registered Dietitian in regards to the pressure ulcer wound care treatment.

On a specified day in 2018, the Registered Dietitian ordered a dietary supplement to be given at breakfast and at lunch. A review of two monthly medication administration records (MAR) indicate that the dietary supplement is to be mixed with either apple sauce or yogourt. One of the MARs indicates that the resident did not receive the prescribed dietary supplement on one specified morning and during the lunch time meal of 13 other days. The other MAR indicates that the resident did not receive the prescribed dietary supplement on one morning and during the lunch time meal of 16 other days.

Resident #014 was observed to receive the dietary supplement during two lunch time meal services and to consume the dietary supplement. Resident #014 said to the inspector that they regularly receive and consume the prescribed nutritional supplement.

As per dietary aide #105, the nutritional supplement is prepared by the home's dietary services department and provided to resident #014 during the specified meal service. RPN #104 as well as DOC #109 and #110 said that it is the registered staff's responsibility to ensure that the resident consumes the prescribed dietary supplement, as per the MAR order and to document this in the MAR.

As such, the Registered Dietitian's order a nutritional supplement to be provided twice daily to resident #014 was not assessed as being administered by registered staff and was not documented for 14 doses in a specified month and for 17 doses during another specified month in 2018. [s. 30. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #022 has multiple diagnoses. Inspector #142 reviewed the physician orders for a specified month in 2018 and noted that seven (7) identified medication were prescribed for the resident to be taken at a specified time.

On a specified day in 2018, an incident report was completed for resident #022 which identified that multiple medications were not given at the specified time and the medications were found in the medication cart.

Resident #022 was not administered the seven (7) identified medication that were prescribed to be taken at the specified time.
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Resident #022's health record was reviewed and there was no evidence of any adverse effects to the resident as a result of the medication incident.

On November 28, 2018 during an interview with the Director of Care, they reviewed the medication incident report with Inspector #142 and acknowledged that resident #022 was not administered their medications on a specified day, as specified by the prescriber. [s. 131. (2)]

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Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 3rd day of January, 2019

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

Original report signed by the inspector.