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 31, 2018	2018_730593_0019	025210-18, 027076-18	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

GILLIAN CHAMBERLIN (593)

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): November 26, 28 - 29, December 3 - 4, 24, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Program Manager, Registered Nursing Staff, Personal Support Workers (PSW), residents and family members.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, reviewed video footage and reviewed licensee policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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	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. 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 actions taken with respect to resident #001 under, O. Reg 48. (1) 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions; including assessments, reassessments, interventions and the residents responses to interventions, are documented.

A critical incident (CIS) was submitted to the Director, detailing alleged neglect toward resident #001. The CIS described the incident: resident #001's family member approached the Administrator indicating that neglect toward resident #001 had resulted in an additional hospitalization admission for resident #001. The CIS further indicated that the resident was sent to hospital for a complication from a previous procedure received in hospital.

Resident #001 was admitted to the hospital, for a specific procedure. The resident returned with a specific wound as a result of the procedure. Approximately four weeks later, resident #001 was admitted to the hospital due to a complication to the specific wound resulting from the procedure. The resident returned from the hospital, with new orders for specific medications and wound care.

Resident #001's medication administration record (MAR) was reviewed for a three month period. There were two orders documented specifically related to wound treatments.

The first order was ordered to be completed every second day or PRN (as needed). The MAR documentation did not indicate that the treatment was completed at least every two days as per the order.

The second order was to be completed daily for a two week period. During this two week period, this treatment was not documented as completed on five of the days in this two week period. The MAR did not indicate that the treatment was completed daily as per the order.

Inspector #593 reviewed the progress notes for resident #001, there were no progress notes related to the wound treatments that were not completed as above and or an explanation as to why the treatments were not completed as per the orders.

During an interview with Inspector #593, December 4, 2018, RN #100 indicated that for the first order, this order was completed daily and sometimes more than daily as needed. The RN added that it was likely that the treatment was completed but not documented as

often as the treatment was completed.

During an interview with Inspector #593, December 24, 2018. Program Manager (PM) #101 indicated that for the first order, often resident #001 was absent from the home or would refuse to have the treatment completed. Regarding the second order, PM #101 indicated that it was likely that this treatment was completed daily as resident #001 was less resistive to care around this time, however not always documented when the treatment was completed. PM #101 further indicated that it was the expectation of the home that if the treatment was unable to be completed that there should be a documented progress note to indicate why. PM #101 added that they reviewed resident #001's progress notes and could not find any entries related to either order. [s. 30. (2)]

Issued on this 15th day of January, 2019

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

Original report signed by the inspector.