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
Mar 4, 2019	2019_617148_0005	029315-17, 029472-17, 006266-18, 006348-18, 006583-18, 010782-18, 026799-18, 030262-18, 031999-18	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

AMANDA NIXON (148), EMILY BROOKS (732)

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): January 31, February 1, 4-8 and 11, 2019

The following critical incident reports (CIR) were included in this inspection: CIR #M622-000062-17 (Log 029315-17); CIR #M622-000068-17 (Log 029472-17); CIR #M622-000011-18 (Log 006266-18); CIR #M622-000012-18 (Log 006348-18); CIR #M622-000013-18 (Log 006583-18); CIR #M622-000020-18 (Log 010782-18); CIR #M622-000041-18 (Log 030262-18); CIR #M622-000047-18 (Log 032999-18); and CIR #M622-000033-18 (Log 026799-18).

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Program Manager of Resident Care, Program Manager of Personal Care, RAI Coordinator, Rehabilitation Assistant, Administrative Assistant, Program Manager of Clinical Quality Improvement (CQI), Pharmacy Representative, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

In addition, the Inspectors reviewed health care records and policies related to the medication management system and falls prevention program.The Inspectors observed resident care environments including bedrooms and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 :

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A Critical Incident Report was submitted to the Director on a specified date describing that resident #005 had a fall from bed. The health care record demonstrated that after the fall, the resident was referred to and assessed by the Rehabilitation Assistant at which time two fall mats were put in place at the bedside. The plan of care was not updated to reflect the use of two fall mats.

During observations of the resident on February 4, 2019, Inspector #148 observed resident #005 in bed resting, with one fall mat in place at the resident's bedside. In discussion with the Rehabilitation Assistant #111, the inventory maintained by the rehabilitation department indicated that the resident was to have two fall mats. Interviews with nursing staff and review of the health care record could not demonstrate when the resident's second fall mat was removed or when the resident's need for such intervention was reassessed.

The plan of care, as it relates to the implementation of fall mats, was not based on an assessment of the resident.
(Log 006266-18)

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date, resident #006 was found on the floor at bedside at a specified hour. RN #119 responded to the fall and assessed the resident; no injury was noted. Later in

the day, RN #105 was informed that the resident had fallen approximately five hours prior to the resident being found.

The plan of care for resident #006 described the resident at risk of falls with interventions including the requirement for staff to regularly check the resident. The Program Manager of Personal Care indicated that all residents are to be checked hourly and this was the requirement for resident #006.

It was determined through staff interview and review of the home's investigation that PSW #117 and RPN #118, who were responsible for the care of resident #006, did not complete regular resident checks; including the one hour checks planned for resident #006.

The licensee failed to ensure that resident #006 was provided with the care as set out in the plan of care, specifically as it relates to monitoring of the resident during an identified shift.
(Log 026799-18)

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 ensure that the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the plan of care is provided to the resident as specified in the plan, 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 :

The licensee failed to ensure that a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, the Program Manager of Personal Care submitted a Critical Incident Report to the Director. The CIR described that eleven days prior, resident #006 was found on the floor at bedside at a specified hour. Later in the day, RN #105 was informed that the resident had fallen approximately five hours prior to the resident being found. The progress note written by RN #105 on the same date, indicated that the Program Manager of Personal Care was informed of the alleged time of the resident's fall and subsequent time of discovery of the resident.

The Program Manager of Personal Care began an investigation based on the complaint made by the resident's family that the resident was not monitored for approximately five hours. During an interview with the Program Manager of Personal Care and as indicated by the CIR, the home conducted investigative meetings with PSW #117, five days after the fall. In addition, the investigation included a review of video footage, as available. In discussion with the Program Manager of Personal Care, it was indicated that the licensee had reasonable grounds to suspect neglect may have occurred, however, a report to the Director was not made until eleven days later.

The license failed to immediately report the alleged neglect of resident #006 to the Director.
(Log 026799-18)

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 ensure that a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that when a resident has fallen, a post fall assessment was conducted, using a clinically appropriate instrument that was specifically designed for falls.

The licensee submitted a Critical Incident Report stating that resident #009 had an un-witnessed fall at the bed side. The resident was assessed and monitored, and when symptoms of an injury presented, the resident was sent to hospital for further assessment. The resident was diagnosed with a specified injury.

In an interview, RPN #108, and RN #105, stated that a resident was to have a post fall huddle form filled out after every fall as their post fall assessment. RN #105 stated that the assessment can be found in the resident's health care record.

The Manager of Personal Care informed the Inspector that a resident should be assessed after every fall, and that at the time of the fall, staff were to use a post fall huddle form as their post fall assessment. The Manager of Personal Care gave Inspector #732 a document entitled Appendix D: Post Fall Screen for Resident/Environmental Factors, and confirmed that this was the form known as the post fall huddle form, and was to be filled out after every fall.

Inspector #732 and the Manager of Personal Care reviewed resident #009's health care record for a post fall huddle form. Inspector #732 and the Manager of Personal Care were unable to locate the form. The Manager of Personal Care indicated that the post fall huddle form must not have been completed for resident #009. Therefore, the licensee has failed to ensure that resident #009 received a post fall assessment using the home's post fall huddle form.
(Log 010782-18)

WN #4: 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 :

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

The licensee submitted a Critical Incident Report indicating that resident #003 was involved in a medication incident. On a specified date, resident #003 was complaining of pain for which the resident was sent to hospital. The CIR indicated that in preparation for the resident's transfer to hospital, it was noticed that resident #003 had not received a prescribed medication for six weeks due to a transcription error. The home's investigation into the medication incident determined no harm had come to the resident related to the transcription error.

A progress note written by RN #115, indicated that the resident had returned from an appointment with a physician's order for a medication. The resident's attending physician was contacted and the order was processed in accordance with the home's medication management practices at the time. Inspector #732 reviewed the transcribed physician's order written by RN #115 on the Physician's Digiorder sheet, whereby, the RN had written the prescribed medication order in a specified way.

Inspector #732 reviewed resident #003 Medication Administration Record (MAR) with Program Manager of CQI . Program Manager CQI confirmed the first and last dose administered to the resident. Program Manager of CQI confirmed that resident #003's original prescription for their medication was for five months, and that resident #003 only received the medication for two months.

Inspector #732 reviewed documentation from a meeting held with RN #115 and management regarding this incident, whereby, RN #115 recognized that a medication transcription error had occurred.

The licensee has failed to ensure that resident #003 received a medication as prescribed for a full five months.
(Log 030262-18)

Issued on this 4th day of March, 2019

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

Original report signed by the inspector.