Ontario

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 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
Jul 12, 2019	2019_809733_0014	025959-18, 003626-19, 009982-19	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

MARK MCGILL (733), GILLIAN CHAMBERLIN (593)

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): June 20, 21, 24, 25, 26, 27, 28, July 2, 3, 2019.

Log 025959-18 (CIS: M622-000034-18) is related to alleged staff to resident neglect.
Log 003626-19 (CIS: M622-000004-19) is related to a fall.
Log 009982-19 is related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Program Manager, Clinical Quality Improvement, the Manager of Personal Care, the Manager of Resident Care, Registered Nurses, Personal Support Workers.

The inspectors also reviewed residents health care records, reviewed policies and procedures and spoke with residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Where the licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, the licensee has failed in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Resident #001 was bleeding related to an urinary tract infection and was not assessed nor did they have their continence brief changed for a period of approximately three hours on a specified date in 2018.

In an interview with Inspector #733, Program Manager #100 indicated that Resident #001 was not changed for a period of time from 1330 hours until around 1700 as they wanted the nurse to see the blood. A review of the homes investigation notes indicates that the resident's brief was checked and was dry at 1345 hours and indicates that the resident was not changed until 1710 hours.

According to PSW #105, they informed RPN #107 on two occasions that Resident #001 was bleeding and that they wanted the nurse to see. On the first occasion, RPN #107 indicated that this was not unusual for the resident. Resident #001 was offered to be changed by PSW #105 but they refused as again, they wanted the nurse to assess. PSW #105 went back to RPN #107 who stated that they "were like that, don't worry about it." Further, according to RN #106, the fact that the resident wanted to be assessed was not passed onto them by RPN #107.

Later that day, when RN #103 started their shift around 1500 hours, the fact that Resident #001 was bleeding and required to be assessed was not brought to their attention at shift report, according to RN #103. In addition, since RN #103 was late arriving to their shift on a specified date, they did not complete shift report with all staff including PSWs but rather with the RN only. RN #103 indicated that the first time they were informed of the bleeding was at 1640 hours. When RN #103 was informed of the bleeding they did not immediately assess the resident as they were busy with another matter. According to RN #103, the resident was assessed shortly after 1700 hours and was then changed by PSW #105 at that time.

Staff involved in the residents care failed to collaborate with each other to ensure that assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and compliment each other, to be implemented voluntarily.

Issued on this 12th day of July, 2019

[redacted]

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

Original report signed by the inspector.