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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2019	2019_730593_0027	009259-19, 014421-19, 015447-19	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

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): August 26 - 29, September 3 - 6, 9, 16 - 19, 2019.

CIS Log #014421-19 (M622-000033-19) was inspected related to alleged neglect of a resident.
CIS Log #015447-19 (M6222-000038-19) and CIS Log #009259-19 (M622-000015-19) were inspected related to alleged improper/incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Manager of Clinical Care, Rehabilitation Assistant, Registered Nursing Staff (RNs), Personal Support Workers (PSWs) and residents.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met when resident #001 was being restrained by a physical device under section 31 of the Act, that the residents condition was reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the residents condition or circumstances.

A critical incident report (CIS) was submitted to the Ministry of Long-Term Care (MLTC) reporting an incident of improper/incompetent treatment of resident #001. It was reported in the CIS that resident #001 was found in another resident's room, they had slid down their wheelchair and become caught on the physical device. There was redness noted on the resident's body but no other injuries sustained.

A review of the licensee policy: Least Restraint, no: 335.10, revision date September 2018, documented the following:

Procedure- Initiation of Restraint

7. Fax the physician order to Pharmacy so that the restraint order will appear on the MAR and the quarterly medication review.
17. The resident's condition is reassessed, and the effectiveness of the restraining is evaluated every 8 hours by a member of the registered staff. These interventions are documented on the MAR.

A review of resident #001's plan of care found the following:

• Physicians order, March 2019- physical device for safety.
• Physicians order, March 2019- change to physical device for safety.

A review of the Medication Administration Records (MAR), found the following:

• March - April 2019- No entry related to a physical device.

A review of the electronic Medication Administration Records (eMAR), found the following:

• April 2019- No entry related to a physical device.
• May 2019- Physical device when up for safety. Eight-hour monitoring by a member of the registered nursing staff began after the incident of alleged improper/incompetent treatment.

During an interview with Inspector #593, August 29, 2019, RN #102 indicated that the physical device for resident #001 was not added to the eMAR until after the incident. RN #102 indicated that it could have been missed when the home switched to electronic MAR's in April, 2019 however when reviewing the paper MAR for March and April, 2019, the physical device was not documented. RN #102 said that PSW's are checking this restraint hourly however if it is not included on the MAR or eMAR, it is unlikely that registered nursing staff are completing the eight-hourly evaluation.

During an interview with Inspector #593, September 3, 2019, Manager of Personal Care indicated that when a restraint is initiated, the physicians order is faxed to the pharmacy by a member of the registered nursing staff who was on duty when the restraint was initiated. The Manager of Personal Care indicated that they were unsure how this error went unnoticed for more than four weeks and whether it was a pharmacy or a nursing issue.

As such, the licensee has failed to ensure that resident #001 was reassessed and the effectiveness of the restraining evaluated by a member of the registered nursing staff, at least every eight hours. [s. 110. (2) 6.]

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 ensuring that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.