Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 30, 2020	2020_785732_0020	002319-20, 002342-20, 005449-20, 005722-20, 015400-20, 016170-20, 018117-20	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

EMILY BROOKS (732), ANANDRAJ NATARAJAN (573)

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): October 2, 5, 6, 8, 9, 13, 15, and 19, 2020 off site; and October 7 and 14, 2020 on site.

The following intakes were inspected during this Critical Incident System Inspection (CIS):

Log #018117-20 (Critical Incident (CI) #M622-000027-20), log #016170-20 (CI #M622-000023-20), and log #005449-20 (CI #M622-000010-20) related to falls prevention and management.

Log #015400-20 (CI #M622-000021-20) related to safe transfers.

Log #005722-20 (CI #M622-000023-20) related to alleged resident to resident abuse.

Log #002342-20 (CI #M622-000006-20) related to alleged staff to resident abuse

Log #002319-20 (CI #M622-000005-20) related to alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Personal Care, a Clinical Quality Team Registered Nurse, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

In addition, the inspector(s) observed the provision of care and services to residents; and reviewed Critical Incident Reports, health care records, relevant policies and procedures, and investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident related to their responsive behaviours.

A resident was admitted to the Long-Term Care Home, and from admission to October of 2020, the resident had exhibited responsive behaviours towards staff and residents, experienced suicidal ideation, was sent to hospital for behaviours, and was followed by Behavioural Supports Ontario staff and The Royal Ottawa Geriatric Psychiatry team.

The Manager of Personal Care, a Clinical Quality Team RN , an RN, an RPN, and a PSW were all aware the resident exhibited responsive behaviours and described to Inspector #732 interventions to be used when the resident exhibited such behaviours. Despite this, Inspector #732 was unable to locate a written plan of care that reflected the planned care for the resident’s responsive behaviours, and this was confirmed by the Manager of Personal Care.

Sources: Resident's plan of care, progress notes, and admission assessments; and interviews with the Manager of Personal Care, the Clinical Quality Team RN, the RN , the RPN, the PSW, and other staff. [s. 6. (1) (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 to ensure that there is a written plan of care that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the Fall Assessment policy and procedure included in the required falls prevention and management program was complied with for a resident.

O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury and O. Reg. 79/10 s.30(1) requires that this program include relevant policies, procedures and protocols to reduce risk and monitor outcomes.

Specifically, an RPN did not comply with the licensee's policy and procedure "Fall Assessment, No: 315.08". The policy indicated that when a fall occurred, registered staff are to complete an Incident Report and Falls - Post Falls Assessment.

The Manager of Personal Care explained that the above assessments should be completed immediately after the fall.

A resident experienced a fall. An Incident Report was completed the next day, and a Falls – Post Falls Assessment was completed two days later; both by the same RPN. The RPN confirmed that the above assessments should be completed on the day a fall occurs and acknowledged that they had been completed at a later date.

Sources: Resident's progress notes; Fall Assessment policy and procedure (No: 315.08, revised June 2019); Falls – Post Fall Assessment; Incident Report; and interviews with Manager of Personal Care, the RPN, and other staff. [s. 8. (1) (a),s. 8. (1) (b)]

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 the Fall Assessment policy and procedure is complied with, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to ensure that the improper/incompetent treatment of a resident by two PSW's was immediately reported to the Director.

A resident was being transferred by a lift from their bed to their mobility device by two PSW's and slipped out of their sling, ending up on the floor. The resident sustained injuries, requiring transfer to hospital.

The Manager of Personal Care reported the incident to the Director the next day.

Sources: Critical Incident System report; resident's progress notes and incident report; and interview with the Manager of Personal Care and the RN. [s. 24. (1)]

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by another resident had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

A review of the Critical Incident System report indicated that the allegations of a resident to resident sexual abuse incident was not immediately reported to the Ministry of Long-Term Care (MLTC) Director.

An RN stated to Inspector #573 that the RPN on the unit failed to report the incident immediately and they were made aware of the incident on the next day. Furthermore, the RN acknowledged that the allegations of the sexual abuse incident was not immediately reported to the MLTC.

Sources: Critical Incident System report, resident's progress notes, and an interview with the RN, and other staff. [s. 24. (1)]

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 the improper/incompetent treatment of a resident and any reasonable grounds to suspect that abuse of a resident has occurred, is immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that two PSW's used safe transferring techniques when assisting a resident from their bed to their mobility device.

A resident was being transferred from their bed to their mobility device with the use of a lift by two PSW's. During the transfer, the resident slipped out of the sling and landed on the floor. The resident sustained injuries, was sent to hospital, and required treatment.

Both staff members indicated that the sling remained attached to the lift when the resident fell, and that they were unsure how the resident slipped from the sling.

Investigation by the Manager of Personal Care determined improper treatment resulting in resident harm occurred. They explained that it was never determined how the resident slipped out of the sling as what the staff described did not match how the resident was found. They also indicated that the slings have plastic bones to support the head and both staff members admitted they did not apply them, or use them, when transferring the resident.

Sources: Critical Incident System report; resident’s progress notes and plan of care; investigation notes; and interviews with Manager of Personal Care, and the PSW's. [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was assessed using an assessment form when the resident's pain was not relieved by initial interventions.

A resident had a fall in which they experienced pain that required medication. The resident continued to experience pain up until their transfer to hospital three days later, where they were diagnosed with injuries and required surgery.

The licensee's Pain Assessment Policy described a specific assessment form to be used when a resident experiences unrelieved pain. An RPN stated they did not initiate this assessment form after the resident's fall.

The Manager of Personal Care told Inspector #732 that a pain assessment should have been completed on the resident and confirmed that there were no records of the assessment form being completed.

Sources: Resident's progress notes and care record; interviews with Manager of Personal Care, the RPN, and other staff; and Assessment: Pain P&P, No: 315.18 [s. 52. (2)]

Issued on this 2nd day of November, 2020

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

Original report signed by the inspector.