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
Aug 27, 2021	2021_912117_0001	004168-21, 010936-21, 011047-21	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

LYNE DUCHESNE (117)

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 9, 10, 11, 12, 16 and 17, 2021

The following intakes were completed as part of this critical incident inspection:

- Log # 004168-21: A critical incident (#M622-000008-21) related to alleged staff to resident abuse

- Log # 010936-21: A critical incident (#M622-000019-21) related improper treatment of a resident that results in harm or risk of harm to a resident.

- Log # 011047-21: A critical incident (#M622-000020-21) related to alleged staff to resident neglect

It is noted that Inspector Cheryl Leach #719340 participated in the inspection as an observer.

During the course of the inspection, the inspector(s) spoke with Program Managers for Resident Care and Personal Care, Maintenance Supervisor, Environmental Services Manager, Infection Control and Prevention (IPAC) Lead, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), several Dietary Aides, several Housekeeping staff members, an Activity Aide as well as to several residents.

During the course of the inspection, the inspector(s) reviewed several residents health care records, observed the provision of resident care and services, observed several lunch time meal services, observed infection control practices and reviewed the infection control program, observed resident rooms and common areas, reviewed air temperature monitoring records, and reviewed licensee investigation documents.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **3 WN(s)**
- **3 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. (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 :

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

A resident's plan of care identified that the resident required 1-staff assistance with transfers, toileting, and bathing.The plan indicated that the resident was to have a bath on a specific day of the week.

In March 2021, a resident required toileting assistance. A PSW told the resident that they were not going to assist the resident with their transfer and toileting needs. The resident was not physically able to self-transfer and was not toileted by the PSW. Later in the day, the resident reported to an RN that they had not been offered their scheduled bath as per their plan of care.

Two RNs spoke with the resident regarding their lack of bath. During the discussion, the resident reported that the PSW had refused to provide toileting and transfer assistance earlier that same day. Both RNs reported having spoken with the PSW regarding the resident’s care needs. The PSW said that the resident had refused their bath and did not acknowledge any issues with the resident’s toileting and transfer needs.

As per interviews with both RNs and a Program Manager, the resident had never refused a bath. As per the home’s internal investigation, the PSW did not provide the resident with their toileting, transferring and bath care. As such the resident was at risk of harm as they did not receive their care as set out in their plan of care.

Sources: Interview with resident, two RNs and Program Manager, Resident health care record, plan of care, Critical Incident Report and licensee internal investigation [s. 6. (7)]

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 care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

On August 9 and 10, 2021, a review of the home's air temperature monitoring system was done. The Maintenance Supervisor informed the inspector that the home has a central air conditioning system. The home started to monitor and document the air temperatures as of June 1, 2021 in the following locations:
- two resident bedrooms, in different parts of the home,
- in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor
- at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night

As such, there was a potential risk to residents of being impacted by elevated temperatures within the home as air temperatures were not monitored and documented as per legislated requirements between May 15 and June 1, 2021.

Sources: Interview Maintenance Supervisor, temperature documentation [s. 21. (2) 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 temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, in one resident common area on every floor of the home, which may include a lounge, dining area, or corridor and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident is offered a minimum of three meals daily.

In July 2021, a Dietary Aide noted that the lunch meal for a resident had not been offered to the resident. A PSW indicated that the resident had a late breakfast and the lunch time meal was not offered to them.

A Program Manager said that the resident did not receive their lunch time meal on that day in July 2021. As such, the resident was put at nutritional risk by not having been offered their lunch time meal.

Sources: Resident health care record, Licensee internal investigation, Interivew with a Program Manager, Critical Incident Report [s. 71. (3) (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 each resident is offered a minimum of three meals daily, to be implemented voluntarily.

Issued on this 31st day of August, 2021

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

Original report signed by the inspector.