Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Sep 22, 23, 28, 29, 30, Oct 4, 6, 7, 12, 2011 | 2011_029134_0008 | Critical Incident |

**Licensee/Titulaire de permis**

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

**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**

COLETTE ASSELIN (134)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DOC), Registered practical Nurse (RPN) and Personal Support workers (PSW).**

**During the course of the inspection, the inspector(s) conducted two critical incident inspections log # O-001898-11 and # O-001027-11.**

**During the course of the inspection the inspector reviewed the residents' progress notes and plan of care as well as the home's security system in place on the unit.**

**The following Inspection Protocols were used during this inspection:**

**Dignity, Choice and Privacy**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 subsections:**

**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 failed to comply with s. 6 (7) of the Long Term Care Home Act, 2007, in that the resident was not monitored every 30 minutes as per care set out in resident's care plan.

One identified resident with a diagnosis of dementia left the secure unit without anyone noticing. There is an entry in the care plan dated June 1, 2011 staff is to monitor whereabouts every 30 minutes.

The DOC, reported that staff giving out snacks on August 19, 2011 did not see the resident in own room at 19:30. Staff did not check the unit for the resident's location at that time and did not report it to the RPN on duty.

On August 19, 2011 at 20:00, there is a chart entry in the progress notes indicating "staff had not seen the resident in a while and when RPN went to the resident's room to administer medication at 20:00, the resident was missing". A search was initiated.

The resident had left the secure unit, had exited the home and was found approximately .05 km from the home. There were no injuries.

Monitoring every 30 minutes did not occur on the evening shift of August 19, 2011

(log # O-001898-11)

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following subsections:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.**
**2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.**
**3. A missing or unaccounted for controlled substance.**
**4. An injury in respect of which a person is taken to hospital.**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. The Licensee failed to comply with section 107 (3)(1) of the O. Reg. 79/10, in that the Director was not informed within one business day of an incident involving a resident who went missing for less then three hours.

One identified with a diagnosis of dementia left the secure unit without anyone noticing. At 20:00 when the RPN noted that the resident was absent, a search was initiated. The resident was found outside on the street by a family visitor who reported the whereabouts.

The resident had left the secure unit, had exited the home and was found approximately .05 km from the home. The resident was not injured.

The incident was reported to the Ministry of Health and Long Term Care office via Critical Incident System (CIS), seven days after the incident occurred.

(log # O-001898-11)

**Issued on this 7th day of October, 2011**

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

Colette Cassell, LTCH Inspector #134