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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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, 5, 6, 7, 12, 2011	2011_029134_0007	Complaint

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 Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physio Assistant (PTA), Physiotherapist, RAI Coordinator, Advanced Practice Nurse, a family member and the resident.

During the course of the inspection, the inspector(s) conducted two complaint inspections related to log # O-001591-11 and # O-001886-11.

During the course of the inspection the inspector reviewed the residents' health records and observed one resident's transfers.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Personal Support Services

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 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 comply with section 36 of the O. Reg. 79/10, in that staff did not use safe transferring and positioning techniques when assisting one identified resident.

The identified resident's care plan specifies resident is a 2 person transfer for all transfers. The interventions listed in the care plan are as follows: 1. allow resident to do as much of the transfer by self, 2. resident is able to transfer, stand and pivot, 3. allow sufficient time to do the transfer, 4. don't rush. There is also an entry in the care plan that indicates the resident can stand and pivot and is able to walk with walker assisted by one person.

The identified resident's transfer from chair to toilet was observed by the inspector during the inspection. Three staff members were assisting the resident to the toilet. The resident became resistive, agitated and uncooperative. Staff proceeded with the transfer and there was a need to completely support the resident's weight before being able to sit the resident on the commode chair. The transferring technique used was unsafe placing the resident and staff members at risk.

During the inspection the identified resident was observed to be reclined in own wheelchair. The resident's lower legs were not supported properly. Staff members interviewed indicated that when this resident is reclined the foot rests do not support the lower legs. Safe positioning technique was not used when resident was tilted in own wheelchair on September 28, 2011.

(Log # O-001591-11)

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 staff assesses the resident's behavior and ability to follow instruction prior to transferring and ensure staff is provided with alternate safe transfer and positioning techniques based on the resident's behavior at the time of being assisted, to be implemented voluntarily.

Issued on this 7th day of October, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, LTCH Inspector #134