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
May 24, 2022	2022_973573_0008	016028-21, 016322-21, 019027-21, 019043-21, 020325-21, 000721-22	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

ANANDRAJ NATARAJAN (573), JANET MCPARLAND (142)

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): March 15 - 18, 21 - 25, and 28, 2022

The Following logs were completed in this Critical Incident System (CIS) inspection:

- Log (s)#016028-21 and #016322-2, were related to injury to the resident with unknown cause.
- Log #019043-21, related to staff to resident alleged emotional abuse.
- Log #019027-21, related to improper care of a resident that resulted in harm to the resident.
- Log #020325-21, related to a medication incident.
- Log #000721-22, related to resident to resident alleged physical abuse.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSW), Housekeeping staff, Registered Practical Nurses (RPN), Registered Nurses (RN), the Program Manager of Resident Care (PMRC), the Program Manager of Personal Care (PMPC) and the Administrator.

During the course of the inspection, the inspector(s) reviewed the critical incident reports, the resident health care records and other pertinent documents. The inspector(s) observed residents, resident home areas and infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

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

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

- **1 WN(s)**
- **0 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was administered to the resident in accordance with directions for use specified by the prescriber.

A resident was prescribed for a pain medication with specified frequency when needed for pain. The resident's health record was reviewed, and interviews were conducted with the resident and registered staff. It was noted that the resident, exhibited pain daily and received medication with specified frequency as needed.

On a day in December 2021 the resident requested pain medication from the RN. Shortly thereafter, the resident asked a staff member if they could inquire with the RN if the resident could have their pain medication. In an interview with the RN, they indicated that they did not administer the pain medication when the resident requested it. The resident was administered their pain medication approximately one hour after requesting it.

Sources: the resident's health record, interviews with the RN and the staff member. [s. 131. (2)]

Issued on this 26th day of May, 2022

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

Original report signed by the inspector.