Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: December 2, 2022	
Inspection Number: 2022-1617-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: City of Ottawa	
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa	
Lead Inspector Lisa Cummings (756)	**Inspector Digital Signature**
Additional Inspector(s) Sarah Stephens (740823) Severn Brown (740785)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 12, 13, 17-21, 24, 25, 28, 2022, with October 25 and 28, 2022 conducted off-site.

The following intake(s) were completed during this inspection:
- Intake #00005436, a complaint related to food and meal assistance, weight loss, personal care, mobility aids, and visitation.
- Intake #00001329 (CIS #M622-000025-22), Intake #00001944 (CIS #M622-000032-22), Intake #00004881 (CIS #M622-000016-22), Intake #00005196 (CIS #M622-000019-22), Intake #00005859 (CIS #M622-000021-22), Intake #00007243 (CIS #M622-000015-22), and Intake #00008000 (CIS #M622-000049-22) were related to falls that caused injury and required a transfer to hospital.
- Intake #00002379 (CIS #M622-000035-22), Intake #00005503 (CIS #M622-000036-22), Intake #00006314 (CIS #M622-000039-22), and Intake #00008020 (CIS #M622-000050-22) related to allegations of resident to resident abuse.
- Intake #00005201 (CIS #M622-000018-22) related to an unexpected death.
- Intake #00006355 (CIS #M622-000006-22) related to transfer and positioning techniques.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' Rights and Choices
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care that set out clear directions for a resident regarding fall risk and mobility requirements.

Rationale and Summary:
The resident had a history of falls and had a Falls Risk assessment completed. The assessment determined the resident was at a very high risk but this was not reflected in the plan of care.

The resident experienced four falls and was transferred to hospital with an injury after the final fall.

The care plan indicated the resident's ambulation and transfer status. However, the Kardex directed staff to remind the resident to use a mobility device but it did not identify the level of assistance required regarding transferring or ambulating.

A PSW stated that the Kardex is used to obtain information about providing care for a resident. Further, an RN stated that as the resident's mobility level decreased, a mobility device became required. The resident's care plan and kardex did not identify the use of this mobility device.

The plan of care lacked clear direction for staff relating to the resident's fall risk and specific mobility

needs.

Lack of clear direction about fall risk and mobility requirements increased the risk for injury.

Sources:
Resident care plan and Kardex, fall risk assessment, and interviews with a PSW and an RN.

[740823]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 58 (4) (b)

Non-compliance with: O. Reg. 246/22 *s. 58 (4) b.*

The licensee has failed to ensure that the developed strategy of one-to-one supervision, with the Personal Support Worker (PSW) staying close to the resident, was implemented.

Rationale and Summary
A Manager stated that the one-to-one PSW for the resident must always remain close enough to intervene if the resident begins to display responsive behaviours towards another resident. Interviews with the Manager and a PSW indicated that the resident had unpredictable behaviours and required constant close supervision to ensure the safety of other residents. The resident's care plan indicated that they must have a one-to-one PSW at all times when awake.

The resident had an altercation with another resident causing injury to the other resident. A Registered Practical Nurse stated that the one-to-one PSW for the resident was not able to intervene on that date as they were not directly by the side of the resident at the time of the altercation. Further, on three separate dates, the one-to-one PSW for the resident was observed to be at the other end of the hallway from the resident, to be several metres away from the resident assisting with the feeding of another resident and was across the dining room from the resident. In these three observations, the one-to-one PSW assigned to the resident was at too great a distance to intervene immediately if the resident began to display responsive behaviours towards other residents.

There is potential increased risk of altercation if a staff member cannot intervene immediately when the

resident begins to display responsive behaviours.

Sources:
Observations of the resident, resident plan of care, and interviews with a Manager, a PSW & an RPN.

[740785]

COMPLIANCE ORDER CO #01 Falls Prevention and Management

NC #03 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O.REG 246/22, s. 53 (1) 1.

The licensee shall:
1. Perform weekly audits of resident health care records on the specified unit over a four week period to ensure that staff are following the licensee's Falls Prevention Program and policies with regard to:
-Performing a Fall Risk assessment on all residents on admission to the unit and updating the 24 hour care plan.
-Complete a Post Fall assessment after every resident fall, using the licensee's Post Fall assessment tool.
-Review/update the care plan after every fall, as per the licensee's Falls Prevention Program.

2. Take corrective actions to address staff non-compliance to the licensee's falls prevention policies identified in the audits. Maintain a record of audits and corrective actions taken.

A written record must be kept of everything required under this compliance order.

Grounds
The licensee has failed to ensure that the Falls Prevention Program and Falls Assessment policy was complied with for a resident.

In accordance with O.REG 246/22, s. 53 (1) (1.), the licensee is required to ensure there is a Falls Prevention and Management Program in place, and in accordance with O.REG 246/22, s. 11 (1) (b.), the licensee must ensure the program is complied with.

A resident was identified as being at risk for falls during admission. According to the Falls assessment policy, within 24 hours of admission, a Fall Risk assessment should be completed and documented on the 24-hour care plan. The resident's 24-hour care plan indicated a risk for falls, but a Fall Risk assessment was not completed on admission and fall risk was not addressed in the resident's care plan.

The resident experienced a fall and a Fall Risk assessment was completed indicating the resident was at a very high risk of falls. Fall risk was not identified in the care plan or Kardex. According to the Falls Assessment Policy, after a fall, Registered Staff will develop and update the care plan in consultation with the interdisciplinary team and update the Kardex.

On another date, the resident had a neurological flowsheet commenced with hourly assessments. There was no documentation or additional assessments in the resident's health care record on this date. Progress notes from the following shift indicated the resident experienced a fall. The RPN working that shift stated they could not recall if the resident experienced a fall but confirmed that a head injury routine would have only been started in the event of fall.

A Manager confirmed that the policy is expected to be followed in the event of a fall and fall risk should be included in the care plan.

The resident experienced two further falls, resulting in an injury that required transfer to hospital. The resident later passed away due to the injury.

According to the Falls Assessment Policy, when a fall has occurred, registered staff will perform and document a physical assessment of the resident, complete an incident note, complete a Post Falls Assessment, develop and update the care plan in consultation with the interdisciplinary team and update the Kardex.

Failure to implement fall prevention policy requirements and lack of documentation heightened the risk for falls and injury.

Sources:
24-hour care plan, resident's progress notes, care plan, and Kardex, Neurological flow sheet, Physician progress notes, Falls prevention program (November 2021), Falls assessment policy (May 2022), and interviews with an RPN and a Manager.

[740823]

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Long-Term Care Inspections Branch

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This order must be complied with by January 20, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.