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
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: March 16, 2023

Inspection Number: 2023-1617-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: City of Ottawa

Long Term Care Home and City: Garry J. Armstrong Home, Ottawa

Lead Inspector	**Inspector Digital Signature**
Lisa Cummings (756)	Lisa Cummings Digitally signed by Lisa Cummings Date: 2023.03.27 14:00:29 -04'00'

Additional Inspector(s)
Severn Brown (740785)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7, 8, 9, 13, 14, 15, 16, 21, 22, 2023.

The following intake(s) were inspected:
• Intake #00009308: (M622-000055-22) regarding an allegation of improper care
• Intake #00014910 and #00017494: Complaints regarding an injury and personal care and services
• Intake #00015060: (M622-000069-22) related to an allegation of financial abuse
• Intake #00015087: A follow-up for a compliance order regarding the falls prevention and management program
• Intake #00018055: (M622-000001-23) related to a written complaint with an allegation of verbal abuse and personal care and services.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #01 from Inspection #2022-1617-0001 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Lisa

Cummings (756)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee has failed to ensure that safe transferring techniques were used when assisting a resident.

Rationale and Summary
A resident was assessed to have an injury and an investigation was initiated by the Program Manager of Personal Care which identified the use of a mechanical lift as the possible cause.

Two Personal Support Workers (PSW) acknowledged they had used a specific type of mechanical lift when assisting the resident but stated this lift was used months before the bruising occurred. A Registered Nurse (RN) stated that residents must be assessed by a physiotherapist to use this type of mechanical lift for transfers and confirmed the resident had not received this assessment and the type of mechanical lift should not have been used when assisting them.

The Program Manager of Personal Care stated further interviews with staff identified the mechanical lift had been used more recently to assist the resident and the pattern of injury suggested the mechanical

lift sling could have been the cause.

Sources: Resident healthcare record, Lifting & Transferring Residents policy, interviews with PSWs, an RN, and the Program Manager of Personal Care.

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