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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 4, 2023	
Inspection Number: 2023-1617-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: City of Ottawa	
Long-Term Care Home and City: Garry J. Armstrong Home, Ottawa	
Lead Inspector Marko Punzalan (742406)	**Inspector Digital Signature** Marko Punzalan Digitally signed by Marko Punzalan Date: 2023.07.10 12:00:45 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 1, 2, 5, 6, 8, 9, 12, 13, 14, 2023

The following intake(s) were inspected:

Intake: #00084087 - Complaint /concerns related to care and services to the resident.
Intake: #00020970 – M622-000011-23 – Fall of a resident resulting in a significant change in health status.
Intake: #00021704 – M622-000012-23 - Improper care resulted in the risk of harm to the resident's health status
Intake: #00021974 – M622-000013-23 - Improper care resulted in the risk of harm to the resident's health status
Intake: #00084739 – M622-000018-23 – Alleged financial abuse of a resident.
Intake: #00088937 – M622-000028-23- Fall of a resident resulting in a significant change in health status.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, 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.

Rationale and Summary
A resident was transferred by PSW and should be transferred by two staff and to use a mechanical lift. Left ankle swelling was found on the same day. The resident was sent to the hospital where they were diagnosed with left ankle fracture. A review of the transfer plan of care stated that the resident transferring procedure always required two staff using a mechanical lift.

In an interview with PSW, the resident plan of care should always be transferred by two staff using a mechanical lift.

In an interview with RPN, the plan of care for the resident clearly stated that the transferring and positioning of the resident always required two staff.

In an interview with the Program Manager for Personal Care (PMPC), the resident plan of care for transferring and positioning required two staff, the camera footage revealed that the resident was transferred by one staff only.

The transfer plan of care for the resident was not being followed at the time when they sustained injuries that resulted in a left ankle fracture.

Sources
Review of clinical records for a resident interview with RPN and PSW and PMPC.
[742406]

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the resident plan of care was documented.

Rationale and Summary:
The resident plan of care stated that staff was to monitor the resident every hour and document it in their health care records.
A review of the resident's health record of hourly visual checks confirmed that there was missing documentation.
During an interview, RPN indicated that PSW should have documented every hour of observation in residents' flow sheets.
During an interview, the Program Manager for Personal Care (PMPC) that staff should be documenting the every-hour visual checks on residents' flow sheets.

Therefore, the provision of care set out for the resident plan of care regarding monitoring every hour was not documented.
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Sources: Healthcare records and interviews with RPN and the Program Manager for Personal Care. [742406]

WRITTEN NOTIFICATION: Reporting certain matters to Directors

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)

The licensee has failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the residents has occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
A Critical Incident System (CIS) report # M622-000013-23 was submitted to the Director related to the improper transfer or positioning of the resident by PSW. The incident occurred on the evening of February 26, 2023, and was reported four days late to the director.

The Program Manager for Personal Care (PMPC) indicated that incidents should be reported on time, and they did not follow the proper process of reporting. Furthermore, the PMPC, indicated that the improper transfer or positioning incident was not immediately reported to the Director.

Sources: Critical Incident report # M66-000013-23 and interview with the Program Manager for Personal Care (PMPC)
[742406]

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