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
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Original Public Report

Report Issue Date: September 19, 2023	
Inspection Number: 2023-1617-0004	
Inspection Type: Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa	
Lead Inspector Saba Wardak (000732)	**Inspector Digital Signature** Saba Wardak Digitally signed by Saba Wardak Date: 2023.09.19 14:45:03 -04'00'
Additional Inspector(s) Pamela Finnikin (720492) Gabriella Kuilder (000726)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 28, 29, 30, 31, 2023 and September 1, 5, 2023

The following intake(s) were inspected:

- Intake: #00090721 (CI# M622-000033-23) related to resident-to-resident verbal abuse and responsive behaviours.
- Intake: #00092314 (CI #M622-000036-23) related to resident-to-resident sexual abuse.
- Intake: #00092907 (CI #M622-000039-23) related to alleged staff to resident physical abuse.
- Intake: #00094003 (CI #M622-000041-23) related to alleged staff to resident verbal abuse.
- Intake: #00094831 (CI #M622-000046-23) related to fall resulting in injury and significant change in condition.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Rationale and Summary

On a specified date at a specified time, a resident attempted to self-transfer, resulting in a fall. Registered staff as well as DOC confirmed that this resident had instructions in place to decrease their risk of injury related to falls. This information is included in the Kardex, which reflects the resident's care plan and is accessible to all direct care staff. Registered staff confirmed that staff failed to ensure that the instructions in the Kardex were followed, after the resident was transferred to bed prior to the incident.

The resident sustained an injury as a result of the fall. Failure to ensure that the instructions in the plan of care were followed, placed the resident at an increased risk of injury.

Sources
Resident's care plan, Unusual Occurrence Report, Post-Fall assessment report, interviews with DOC and other staff.

[000732]