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

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Original Public Report

Report Issue Date: November 10, 2023
Inspection Number: 2023-1617-0005
Inspection Type: Complaint Critical Incident
Licensee: City of Ottawa
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa

Lead Inspector	**Inspector Digital Signature**
Margaret Beamish (000723)	Margaret E Beamish Digitally signed by Margaret E Beamish Date: 2023.11.14 10:35:11 -05'00'

Additional Inspector(s)
Julienne NgoNloga (502)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 23, 25, 26, 27, 30, 31, 2023 and November 1, 2023.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00098648 was related to alleged staff to resident abuse.
- Intake: #00098714 was related to a verbal complaint regarding meal service.
- Intake: #00099239 was related to a fall with injury resulting in a significant change in condition.

The following intakes were completed in this complaint inspection:

- Intake: #00098709 was related to alleged staff to resident abuse.
- Intake: #00093117 was related to a bed refusal challenge.

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

Admission, Absences and Discharge
Falls Prevention and Management

Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect

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 (10) (b)

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised at any other time when care set out in the plan was no longer necessary.

Rationale and Summary:
The home's Registered Dietitian (RD) documented on a certain date, that the hospital's Speech Language Pathologist (SLP) recommended a texture modified diet and thickened fluids. A physician's order confirmed the diet on the same day.

On a certain date, Inspector #502 observed the resident's breakfast which included beverages at regular consistency and a meal which did not meet the requirements of the resident's diet order.

In interviews, two Personal Support Workers (PSW) indicated that when they followed the diet order, the resident did not accept the meal. A Registered Practical Nurse (RPN) indicated that the resident was not compliant with the diet order, but they had not referred the resident to the RD for reassessment.

By not reassessing the resident's dietary needs, there is a potential risk that the resident's care needs for a texture modified diet and thickened fluids were not met.

Sources: Inspector #502's observation, review of a resident's health record, and staff interviews. [502]

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

Rationale and Summary:
On a certain date, a resident was exhibiting physically responsive behaviours during care and was physically abused by a staff member which resulted in pain.

The resident's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments and behaviour observation flowsheets over several months, indicated that the resident was identified as exhibiting physically responsive behaviours, including resistance to care. These assessments and flowsheets also showed that these behaviours worsened prior to the incident of abuse.

In an interview, a PSW indicated that providing the resident with their favourite food or beverage either before care or as an incentive to comply with care was an effective intervention to help reduce responsive behaviours during care. A Behaviour Supports Ontario staff member (BSO) identified several triggers for the resident's physically responsive behaviours. BSO stated that they did not recommend staff using food or beverages as an intervention to help reduce responsive behaviours during care.

In an interview, another PSW indicated that they were not aware of these interventions and stated that they would look at the resident's care plan and kardex to know which interventions were in place for their responsive behaviours. The resident's care plan and kardex that were in place prior to the incident of abuse did not contain the identified triggers and interventions identified by BSO and a PSW.

As such, the resident was at risk of harm when staff did not collaborate with each other in the development and implementation of strategies and identification of triggers for the resident's physically responsive behaviours.

Sources: a resident’s care plan, kardex, progress notes, RAI-MDS assessments, MDS Monitoring and Observation Record - 30 day Behaviour Observation Tools; interviews with staff. [000723]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from physical abuse by a staff member.

Rationale and Summary:
Physical abuse is defined by O. Reg. 246/22 s. 2 (1) as the use of physical force by anyone other than a resident that causes physical injury or pain.

On a certain date, a resident exhibited physically responsive behaviours towards a staff member during care and the staff member hit the resident. The resident complained of pain following the incident and was transferred to hospital for further assessment.

In an interview, the staff member stated they were aware that the resident had a history of physically responsive behaviours. The staff member acknowledged that on a certain date, they had hit the resident instead of stopping and reapproaching when the resident started displaying physically responsive behaviours during care. Program Manager of Personal Care (PMPC) acknowledged that the staff to resident physical abuse was confirmed during the home's internal investigation.

As such, the resident was not protected from physical abuse when a staff member physically abused them when they displayed responsive behaviours during care.

Sources: a resident's progress notes, the home's internal investigation file, interviews with staff. [000723]

WRITTEN NOTIFICATION: Licensee consideration and approval

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (7) (b)

The licensee has failed to comply with FTLCA section s. 51 (7) b whereby the licensee refused an applicant's admission to the home based on reasons that are not permitted in the legislation.

Specifically, the licensee withheld an applicant's application for admission citing the staff of the home lacked the nursing expertise.

Rationale and Summary:
A review of a complaint letter showed that an applicant's application for admission in the home was withheld.

A review of their application package, and the Behavioural Assessment Tool, indicated that the applicant had a specific diagnosis with repetitive behaviours. If the applicant's repetitive behaviours were not acknowledged and provided reassurance then the applicant would become upset and restless with inability to settle.

Interventions were in place for managing the applicant's repetitive behaviours.

A review of a written notice from a certain date, that was sent to the applicant's Substitute Decision Maker (SDM) revealed that the applicant's application for admission to the home was withheld. The written notice stated that staff of the home lacked the nursing expertise necessary to meet the applicant's requirements. The written notice stated the applicant suffered from a specified diagnosis, and the home did not have access to psychiatry services unless they have been diagnosed with major neurocognitive disorders that were specifically age related.

Interview with a Registered Nurse (RN) revealed that the home had a Behaviour Support Program (BSO) and staff of the home were trained in the areas of responsive behaviours of residents. Furthermore, the home had a process in place to transfer the resident to hospital when they require further assessment or treatment.

As such, the reason provided to support a lack of nursing expertise and withhold the applicant's application for admission in the home did not meet the requirement of this provision.

Sources: Admission package, an applicant's behavioural assessment, staff interview. [502]

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (b)

The licensee has failed to ensure that when the home withheld approval for admission, they gave an applicant a written notice setting out (b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant’s condition and requirements for care.

Rationale and Summary:
A written notice showed that on a certain date, the home withheld an applicant’s application for admission due to lack of nursing expertise.

The written notice outlined the applicant's diagnosis and the requirement to access psychogeriatric service. The written notice failed to provide a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care identified on the applicant's admission package.

Interview with PMPC acknowledged that the letter did not provide a detailed explanation as outlined in the legislation.

As such, the written notice sent to the applicant by the home failed to meet the requirements of this provision.

Sources: Written notice and staff interview. [502]

WRITTEN NOTIFICATION: Written notice if licensee withholds approval

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 51 (9) (c)

The licensee has failed to ensure that when the home withheld approval for admission, that they provided an applicant with a written notice setting out (c) an explanation of how the supporting facts justify the decision to withhold approval.

Rationale and Summary:
A written notice showed that on a certain date, the home withheld an applicant's application for admission due to lack of nursing expertise.

The written notice outlined the applicant's diagnosis and the requirement to access psychogeriatric service. The written notice failed to provide an explanation as to how the supporting facts that included access to psychiatric services justified the decision to withhold approval as the applicant's behavioural assessment did not identify the need of psychiatric services.

Interview with Program Manager for Personal Care acknowledged that the written notice sent to the applicant's Substitute Decision Maker (SDM) did not provide an explanation of how the supporting facts justified the decision to withhold approval.

As such, the written notice sent by the home to the SDM failed to meet the requirements of this

provision.

Sources: Written notice and staff interview. [502]

WRITTEN NOTIFICATION: Behaviours and altercations

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 60 (a)

The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours.

Rationale and Summary:
On a certain date, a resident exhibited physically responsive behaviours towards a staff member during care.

A review of the resident's RAI-MDS assessments from a certain time period, showed that the resident's physically responsive behaviours were coded as increasing in frequency each quarter.

The resident's behaviour observation flowsheets from from a certain time period, indicated that the resident was exhibiting physically responsive behaviours daily on a certain shift.

A review of the resident's written plan of care in place at the time of the incident did not identify the triggers for the resident's physically responsive behaviours, and no interventions for managing the resident's physically responsive behaviours were documented.

A PSW, stated that they were aware of the resident's physically responsive behaviours and had reported them to registered nursing staff prior to the incident and was told to document them in the resident's behaviour observation flowsheets.

An RN stated that registered nursing staff were expected to review the behaviour observation flowsheets at the end of each month and take corrective action and revise the care plan.

The Infection Prevention and Control (IPAC) Lead/BSO Liaison stated that the resident was known to have a history of physically responsive behaviours but was not referred back to BSO for further assessment until after the incident of abuse.

PMPC acknowledged that the resident's documented increased physically responsive behaviours should have been reassessed.

By not developing and implementing interventions to address the resident's increasing physically responsive behaviours, the resident was placed at risk of harm during care.

Sources: a resident's care plan, kardex, progress notes, RAI-MDS assessments, MDS Monitoring and Observation Record - 30 day Behaviour Observation Tools; interviews with staff. [000723]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (i)

The licensee has failed to ensure that drugs were stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Rationale and Summary:
Inspector #502 observed on a certain date, a medication cup containing two tablets on a resident's bed side table. The resident was resting in bed and staff were not present in the room.

Review of the resident's electronic medication administration record (eMAR) showed that a Registered Practical Nurse (RPN) signed that the medication was given to the resident, but they refused.

In an interview, the RPN indicated that it was a specific medication and they would attempt to administer the medication again. The Program Manager of Resident Care (PMRC) acknowledged that the medication should have been in an area that is secured and locked.

By having the medication in the resident's room unattended, there was potential risk for other residents to have access to medications.

Sources: Inspector #502's observation, a resident's eMAR, staff interviews. [502]

WRITTEN NOTIFICATION: Administration of drugs

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (6)

The licensee has failed to ensure that no resident administered a drug to themself unless the administration had been approved by the prescriber in consultation with the resident.

Rationale and Summary:
On a certain date, Inspector #502 observed that when a resident self-administered their medications, a small yellow tablet fell into a cup containing a hot beverage.

Review of the electronic medication administration record (eMAR) indicated under "self-administration of medication" that the resident may keep and administer their own as needed (PRN) medications which included topical treatments, over the counter (OTC) medications and alternative non-prescription medications. However, the resident's self-administration order did not include scheduled medications. Review of the eMAR showed that the resident's scheduled medication regimen included medications they were not permitted to self-administer.

Interview with an RPN indicated that the resident exhibited responsive behaviours during the medication pass, so they left the medications on the night side table and would check before the end of the shift to see if the resident had taken the medications. The RPN indicated that the resident could take their medications unsupervised, and they have to use a stop and reapproach strategy when the resident resists care by not accepting medications.

By providing the resident with scheduled medications for self-administration, there was a risk that the resident would not have taken their scheduled medications and there was a potential risk that other residents could have access to the medications.

Sources: Inspector #502's observation, a resident's health record review, and staff interview. [502]

WRITTEN NOTIFICATION: Administration of drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (7) (d)

Where a resident of the home may administer a drug to themself under subsection (6), the licensee shall ensure that there are written policies to ensure the residents who administer a drug to themselves understand the necessity for safekeeping of the drug. In accordance with O. Reg. 246/22 s. 11 (1) (b) any policy put in place must be complied with.

Specifically, the licensee has failed to comply with the home's policy titled Resident Self-Administration of Medications #345.07 dated September 2022 stated that if there are noticeable changes between quarterly reviews regarding self-administration of medications, the concerns should be reported to the physician and another Self-Administration of Medications Assessment and Agreement Form should be completed.

Rationale and Summary:
On a certain date, Inspector #502 observed a resident's as needed (PRN) medication on a commode across the room and the door to the resident's room was opened.

Review of the resident's Self-Administration of Medications Assessment and Agreement Form signed by the resident on a certain date, stated under paragraph five that the agreement will be reviewed with the resident every quarter and more often if needed.

In an interview, Program Manager of Resident Care (PMRC) indicated that when the agreement was initially signed the resident refused to use a locked box, as they showed their sense of independence by choosing where in their room they wanted to store the medication and were closing their door to prevent others from accessing their room.

Since a recent incident, which resulted in injury, the resident's care needs have changed. The PMRC #111 indicated that the self-administration of medication form should have been reevaluated.

By not reassessing the resident's capacity to self-administer their medication, there is a potential risk that other residents could access their PRN medication.

Sources: Inspector #502's observation, review of policy Self-Administration of Medications #345.07 (dated September 2022), and staff interview. [502]