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: April 10, 2024	
Inspection Number: 2024-1617-0001	
Inspection Type: Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature** Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2024.05.07 10:03:20 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7, 8, 12, 13, 14, 2024

The following intake(s) were inspected:
• Intake: #00100177, #00104089 and #00101379 were related to a fall which resulted in a significant change in health condition
• Intake: #00104002 Alleged staff to resident physical and emotional abuse

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 # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to revise the written plan of care when the care set out in the plan was no longer necessary.

Rationale and Summary

On a specific date, a resident experienced a fall which resulted in a change in their health condition and mobility status.

A review of the resident's written plan of care revealed the resident's plan of care was reviewed after the fall. It was noted that the resident's risk of falls was identified as a focus which included an intervention.

On three different dates during the inspection, Inspector observed the resident, it was noted on each occasion the intervention was not in place.

When interviewed two Personal Support Workers (PSW) stated the intervention was no longer used. A Registered Nurse (RN) also stated the intervention was no longer in place and reported that it is regular practice that if an intervention was no longer used than it was removed from the written plan of care.
When interviewed The Program Manager of Resident Care confirmed that if the resident no longer required the intervention the written plan of care should have been updated to reflect the change in interventions.

As such, the resident's written plan of care was not reassessed.

Sources: Resident health records, observations, interviews with registered staff, personal support workers and the Program Manager of Resident Care.

[720483]