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: May 24, 2024	
Inspection Number: 2024-1617-0002	
Inspection Type: Critical Incident	
Licensee: City of Ottawa	
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa	
Lead Inspector Severn Brown (740785)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23, 24, 25, 26, 30, 2024 and May 1, 2024

The following intake(s) were inspected:

- Intake: #00112095 - IL-0124371-AH/M622-000018-24 – Resident to resident abuse
- Intake: #00113457 - M622-000026-24 - Fall of resident resulting in injury with change in condition.

The following Inspection Protocols were used during this inspection:

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 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that a resident's plan of care set out clear direction for staff and others who provide care to the resident.

Rationale and summary
A resident's care plan and kardex both stated that the resident was to have hourly checks for safety. On record review with a Personal Support Worker (PSW), they confirmed that the resident had hourly safety checks documented in their kardex but was was unaware of this requirement. Another PSW on the resident's unit stated they were unaware that the resident required hourly safety checks. Program Manager-Resident Care stated that the resident does not require hourly safety

checks at this point but confirmed that the resident's care plan still specified that they be performed.

By not ensuring that resident's plan of care set out clear direction for staff and other, the resident was put at risk of not being provided consistent care and monitoring.

Sources:
The Resident's care plan and kardex;
Interviews with two PSWs, and the Program Manager-Resident Care.

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that staff complied with the home's infection prevention and control (IPAC) program related to units on respiratory outbreaks.

Rationale and summary
Per the IPAC Standard for Long-Term Care Homes, section 9.1 (f), the licensee shall ensure Routine Practices and Additional Precautions are followed in the IPAC program related to additional personal protective equipment (PPE) requirements.

The IPAC Nurse stated that the third floor was on a COVID outbreak and all staff must wear masks and eye protection while working in any area of the unit. During the inspection, multiple staff members were observed without masks while working on the third floor unit. Multiple staff members were observed without masks while in the nursing station and out in the hallway interacting with residents.

By not ensuring that staff were wearing masks and eye protection as part of the home's IPAC program, resident's were put at risk of contracting a communicable disease.

Sources:
Observations on third floor;
Interview with the IPAC Nurse.

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