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: May 24, 2024
Inspection Number: 2024-1617-0003
Inspection Type: Complaint 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: #00111710 -M622-000015-24 - Improper/Incompetent treatment of resident.
- Intake: #00112593 -IL-0124615-AH/M622-000022-24 - Fall of resident resulting in injury.
- Intake: #00113109 -M622-000025-24 - Complainant with concerns regarding resident's recent fall.
- Intake: #00114629 -Complainant with concerns regarding resident's care.

The following Inspection Protocols were used during this inspection:

Medication Management
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management
Restraints / Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that an allegation of neglect was reported immediately to the Director.

Rationale and summary

A Registered Nurse (RN) documented that they called the Manager of Recreation, Leisure, and Volunteers to inform them of being made aware of an allegation of neglect for a resident after being made aware of the allegation. The Manager of Recreation, Leisure, and Volunteers stated they were the on-call manager on the date of the allegation being reported to the home, and were made aware of an incident of alleged neglect against a resident related to a previous fall with change in condition the resident sustained but did not report it to the Ministry of Long-Term Care. Upon review of the Critical Incident (CI) database, no report of an allegation of neglect to the resident was submitted the same day the home was made aware of the allegation. Program Manager-Personal Care stated that the allegation of neglect should have been reported immediately to the Ministry of Long-Term Care. A CI related to the incident of alleged neglect to resident was submitted to the Director several days after the home was made aware of the allegations.

By not ensuring that an allegation of neglect was reported to the Director immediately, the resident was at risk of not being provided all regulatory resources available to them.

Sources

Critical Incident Database;
A resident's electronic chart;
Interviews with Manager of Recreation, Leisure, and Volunteers and the Program Manager-Personal Care.

[740785]

WRITTEN NOTIFICATION: Minimizing Restraints and PASDs Policy

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

The licensee failed to ensure it complied with its policy to minimize restraining of residents. Per FLTCA, 2021 s. 33 (1) (a), the home shall ensure that there is a written policy to minimize the restraining of residents, and per FLTCA, 2021 s. 33 (1) (b), that policy must be complied with.

Rationale and summary
A resident was observed on two occasions by Inspector #740785 during the inspection with a device applied while they were in their wheelchair. A Personal Support Worker (PSW) and RN familiar with the resident both stated that the observed device was applied as a Personal Assistance Service Device (PASD). Upon chart review with a Registered Practical Nurse (RPN), the observed device was not listed in the resident's care plan or kardex. Program Manager-Resident Care also confirmed that the observed device was not listed on the resident's care plan or kardex and stated that it has to be listed on both. Policy 335.10: Minimizing Restraints and Personal Assistance Service Devices (PASDs) stated that PASDs must be listed on a resident's care plan and kardex.

By not ensuring that the resident's PASD was listed on their care plan and kardex, the resident was placed at risk of having inconsistent care related to the use of a

supportive device.

Sources:
Observations of a resident by Inspector #740785;
The resident's care plan and kardex;
Interviews with a PSW, an RPN #108, an RN, and the Program Manager-Resident Care;
Policy 335.10: Minimizing Restraints and Personal Assistance Service Devices (PASDs) last reviewed January 2024.

[740785]

WRITTEN NOTIFICATION: Personal Assistance Service Devices

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (4) 4.
PASDs that limit or inhibit movement
s. 36 (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee failed to ensure that consent was obtained for the use of a Personal Assistance Service Device (PASD) prior to application of the PASD.

Rationale and summary

During the inspection, Inspector #740785 observed a resident in their wheelchair with a Personal Assistance Service Devices (PASD) applied to the resident. Upon chart review, no consent for the PASD was found in the resident's chart. The PSW stated that the device observed applied to the resident was used as a PASD for the resident and that the resident was unable to release themself from the device. Per Policy 335.10: Minimizing Restraints and Personal Assistance Service Devices (PASDs), consent for a PASD must be obtained prior to its use. The Program Manager-Resident Care stated that consent must be obtained prior to the use of any PASD or restraint. On subsequent record review, consent for the resident's PASD was documented the day after the initial observation of the resident.

By not ensuring that consent was obtained for the resident's PASD, the resident's decision makers were not fully informed of the benefits and potential risks of a PASD that limited the resident's movement.

Sources:
Observation of a resident;
The resident's chart;
Policy 335.10: Minimizing Restraints and Persona Assistance Service Devices (PASDs) last reviewed January 2024;
Interviews with a PSW, an RN, and the Program Manager-Resident Care.

[740785]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

The licensee failed to ensure that a final report related to a reported incident of improper care was submitted to the Director within 21 days of the home being made aware of the incident.

Rationale and summary
On a specified date, the Program Manager-Resident Care submitted a Critical Incident (CI) to the Director related to a then alleged incident of improper care for a resident. Per the Ministry of Long-Term Care's Reporting Requirements for LTC Homes, last updated June 2023, the final report for an incident for a report that cannot be immediately completed must be reported to the director within 21 days of the home being made aware of the incident. Upon review of the CI database, the final report related to the incident was not submitted within 21 days of the report being first reported to the Director. Program Manager-Resident Care stated they did not submit a final report for the incident detailed in the CI until after the required 21-day deadline after the initial report to the Director.

Sources:
Review of the Critical Incident Database;
Interview with Program Manager-Resident Care.

[740785]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 119 (7) 6.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response.

The licensee failed to ensure that that staff consistently documented their hourly assessments, reassessment, and monitoring including their response for a resident's applied restraint.

Rationale and summary
The restraint monitoring form for a resident was reviewed for a specific month and gaps in documentation on multiple dates were identified. A PSW stated that residents in restraints must be monitored every hour and that it must be documented in the flowsheets. The Program Manager-Resident Care stated that PSWs are expected to monitor and reassess when residents are in restraints and

must document their monitoring, reassessments, and removal of a restraint, along with the resident's response, on the restraint flowsheets.

By not ensuring that the resident's restraint monitoring was consistently documented in their flowsheet, the resident was placed at risk of not having clear communication to all staff members of their status while in their restraint.

Sources:
Restraint monitoring form for a resident's restraint;
Interviews with a PSW and the Program Manager-Resident Care.

[740785]

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 119 (7) 7.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning.

The licensee failed to ensure that a resident's restraint documentation for their

restraint release and repositioning was documented as required.

Rationale and summary
Inspector #740785 reviewed a resident's restraint monitoring documentation form for a specified month. Multiple gaps in documentation of the resident's restraint release and repositioning were identified. Upon record review with Program Manager-Resident Care, it was confirmed that the release and repositioning of resident was not being documented on the appropriate form. A PSW stated that any restraint must be released, and the resident repositioned every two hours when the restraint is applied. Program Manager-Resident Care stated that any restraint must be released, and the resident repositioned every two hours when the restraint is applied and that the release and repositioning must be documented in on the restraint flowsheet.

By not ensuring that the resident's restraint release and repositioning was consistently documented in their flowsheet, the resident was placed at risk of not having clear communication to all staff members to ensure that the resident is being consistently released from their restraint and repositioned.

Sources:
Form 335.10B for a resident's restraint;
Interviews with a PSW and the Program Manager-Resident Care.

[740785]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee shall:
A) Provide education on all relevant policies for the correct administration of medications to two specific RPNs and an RN;
B) The home shall audit, on a weekly basis for a period of four (4) weeks, a minimum of two morning medication administrations to the resident to ensure they are receiving all regularly scheduled prescribed morning medications. If the two specified RPNs, or RN are to administer any scheduled morning medications to the resident during any weeks of the auditing period, the home shall first audit those listed staff members' morning medication administrations to the resident before auditing other registered nursing staff members until the twice weekly audit requirement is met. If the resident is absent from or ceases to reside in the home during the four week auditing period, the home shall select another resident on the resident's unit to audit;
C) Take corrective action if an audit determines that the resident it is not receiving all medications as scheduled;
D) Keep a written record of all specified requirements in (A), (B), and (C).

Grounds
The licensee failed to ensure that a drug was administered to a resident in accordance to its directions by the prescriber.

On admission a resident had a medication prescribed by their Physician. The Resident's Medication Administration Records showed the specified medication documented as administered by a specific RPN on four occasions, another RPN on two occasions, and an RN on one occasion. During the home's interview with an RPN, conducted by the Program Manager-Resident Care, the RPN stated they never administered the resident's medication as prescribed. During the home's interview with another RPN, conducted by the Program Manager-Resident Care, the RPN stated they documented the resident's medication as administered but did not administer the medication to the resident.

The Program Manager-Resident Care stated that the home's investigation revealed that an RPN documented the medication as administered but did not actually administer the resident's medication on four occasions. The Program Manager-Resident Care further stated their investigation revealed that another RPN documented on two occasions that they administered the resident's medication but did not administer it to the resident on both occasions. The Program Manager-Resident Care finally stated that an RN documented they administered the resident's medication but did not actually administer it on one occasion. The Program Manager-Resident Care stated that the dates the medication was documented as administered were cross-referenced with the resident's medication packaging which found the medication was not administered as the medication doses were found still sealed in its packaging from pharmacy.

By not ensuring that a resident was provided their medication as prescribed, the resident was not provided treatment for a chronic illness and was put at risk of

negative outcomes based on a lack of prescribed treatment.

Sources:
The Resident's chart;
The home's investigation notes;
The home's interview transcripts with two RPNs;
Interview with Program Manager-Resident Care.

[740785]

This order must be complied with by June 28, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.