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 10, 2024
Inspection Number: 2024-1617-0006
Inspection Type: Critical Incident
Licensee: City of Ottawa
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 5, 6, 9, 10, 2024

The following intake(s) were inspected:

- Intake: #00121945 related to a complaint of alleged neglect.
- Intake: #00123772 related to alleged resident-to-resident physical abuse.
- Intake: #00124649 related to alleged staff to resident physical abuse.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Care Plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, in particular as it pertained to the use of a resident safety device. On several dates, the inspector and staff members observed the resident to be without the safety device that was specified in their care plan, and that was acknowledged by staff to be required.

Sources: Resident record review, observations, and staff interviews.

WRITTEN NOTIFICATION: Infection Prevention and Control

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 has failed to ensure staff follow the Infection Prevention and Control (IPAC) standard issued by the Director for hand hygiene before and after resident contact, particularly during a medication preparation and administration episode where a staff member failed to perform hand hygiene.

Sources: Observations, staff interview, IPAC Standard for Long Term Care Homes, April 2022.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to acknowledge the receipt of a complaint within 10 business days. The licensee did not notify the complainant of the receipt of their complaint, and given a delay in the investigation, when a reasonable resolution may be expected by providing a follow-up response that meets the requirements of the regulations.

Sources: Resident record review, staff interviews.