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: October 25, 2024
Inspection Number: 2024-1617-0007
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 from October 23 to 25, 2024.

The following intakes were inspected:

Intake: #00124248 related to an allegation of staff to resident neglect related to resident care and support services.
Intake: #00126972 related to an allegation of resident-to-resident verbal abuse.
Intake: #00127850 related to an allegation of resident-to-resident physical abuse.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 (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 transfers and continence care set out in the plan of care was provided to a resident as specified in their plan.

On multiple occasions during a specified period of time, a resident was not transferred to their wheelchair and back to their bed or provided continence care, as specified in their plan.

Sources: Resident health care records review, shift report book review for the resident's unit and interview with Program Manager for Personal Care.

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (1) 2.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are

developed to meet the needs of residents with responsive behaviours:
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

The licensee has failed to ensure that there were written strategies, including techniques and interventions, to prevent, minimize or respond to a resident's ongoing responsive behaviours which increased in frequency in the last few months.

Sources: Record reviews and interviews with Behavioral Support Ontario Lead.