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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Public Report

Report Issue Date: April 16, 2025
Inspection Number: 2025-1617-0004
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): April 8, 9, 10, 14, 15, 2025

The following intake(s) were inspected:

- Intake: #00142298 - Alleged resident to resident physical abuse resulting in injury.
- Intake: #00144040 - Alleged staff to resident neglect.
- Intake: #00144226 - Alleged staff to resident physical abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
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 the care set out in the plan of care is provided to the resident as specified in the plan.

Specifically, on a day in March, 2025, the licensee failed to provide a treatment when the resident expressed a symptom and upon assessment. During an interview with a staff member, they confirmed that there was a delay in treatment resulting in agitation and responsive behaviours of a resident.

Sources: Resident record review and an interview with staff.

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse by a staff member.
Physical abuse is defined by O. Reg. 246/22 s. 2 (1) as the use of physical force by anyone other than a resident that causes physical injury or pain.
On a day in March, 2025, a resident arrived to a floor looking for a nurse when a staff member physically pushed a resident. As a result, the resident suffered an injury. During an interview with

a staff member, they confirmed that physical abuse was founded during their internal investigation.

Sources: The Critical Incident (CI), the home's internal investigation file and an interview with a staff member.