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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Public Report

Report Issue Date: September 4, 2025
Inspection Number: 2025-1617-0007
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 on the following date(s): August 29, 2025 and September 2, 3, 4, 2025

The following intake(s) were inspected:

- Intake: #00153460 - (CIS #M622-000051-25) related to improper/Incompetent care of a resident by a staff resulting in injury.
- Intake: #00154604 - (CIS #M622-000054-25) related to a fall of a resident resulting in injury.

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

Resident Care and Support Services
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 (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 a resident as specified in the plan.

According to the resident's care plan, following a recent fall that resulted in injury, the resident was to use a mobility device for ambulation due to change in health condition and an identified safety measure was implemented.

A day in August 2025, the resident was ambulating assisted by a staff member without the mobility device when a fall occurred. Another staff member reported that they had assisted the resident with ambulation without the mobility device since the most recent fall.

The resident was observed on multiple occasions seated in their wheelchair without the identified safety measure in place.

Sources: Inspector's observations, progress notes, care plan and interviews with two staff members.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that a resident's specified assessments to be completed every shift as set out in the plan of care, was documented.

Specifically, during an identified period of time, scheduled specified assessments completed were not consistently documented on multiple occasions, as per care plan.

Sources: Assessment record, electronic medication administration record (eMAR), plan of care, and progress notes. Interview with a staff member.

WRITTEN NOTIFICATION: Personal Assistance Services Device

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 36 (3)
PASDs that limit or inhibit movement
s. 36 (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

The licensee has failed to ensure that the use of a specified Personal Assistance Services Device (PASD) for a resident during mealtimes was included in the resident's plan of care.

On two different occasions in an identified care area, the specified PASD was

observed in place. The resident's plan of care did not identify the use of the specified PASD. A staff member stated that the specified PASD was routinely applied during the care to manage the resident's responsive behaviours.

Sources: Inspector's observations, resident's plan of care and interview with a staff member.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a staff member used safe transferring techniques when assisting a resident.

Progress notes indicated that a resident had a change in health condition. The care plan specified that the resident required a two-person pivot assist for all transfers. However, the home's internal investigation revealed that a staff member conducted the transfer without the assistance of a second staff member, which was subsequently confirmed by the staff member.

Sources: Progress notes, plan of care, the home's investigation notes. Interview with a staff member.