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: October 9, 2025
Inspection Number: 2025-1617-0008
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): October 7-9, 2025

The following intake(s) were inspected:

- Intake: #00157116 - M622-000058-25- ARI - COVID - Outbreak Declared 05SEPT25 - Finalized 17SEPT25 - Gatineau House.
- Intake: #00157354 - M622-000059-25- Improper/Incompetent treatment or care of resident resulting in injury and hospitalization.
- Intake: #00158077 - M622-000060-25 - Complaint/response - Complainant with concerns regarding resident care.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

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.

Specifically, the licensee has failed to ensure that a Registered Practical Nurse (RPN) used the ordered size of a medical device during the scheduled change of said device. The resident subsequently sustained an injury and required hospitalization from the use of the incorrect size of the medical device.

Sources:
The home's investigation documentation into the incident;
A resident's electronic chart;
Interview with the Program Manager-Resident Care.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee has failed to ensure that medications stored in a medication cart were kept secure and locked.

During the inspection, the inspector observed an unattended and unlocked medication cart on the 6th floor. The nurse using the medication cart was observed returning to the medication cart from a resident's room.

Sources:
Observation of a medication cart on the 6th floor.