Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 11, 12, 15, 16, 17, 18, 19, 2012	2012_199161_0002	Critical Incident

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

Long-Term Care Home/Foyer de soins de longue durée

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager Resident Care, Manager Hospitality Services, RAI Co-ordinator, a Registered Nurse, Registered Practical Nurse, two Personal Support Workers and a Resident.

During the course of the inspection, the inspector(s) reviewed the health records of Resident #001, #002, #003, three Critical Incident Reports, policies and procedures related to Abuse, Least Restraint, Falls Prevention Program, Resident Assessment for Falls Tool and observed residents.

During the course of the inspection, the inspector(s) conducted three Critical Incident inspections: Log # O-002708-11, O-000284-12, O-000289-12.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 19(1) in that the home did not protect a resident from neglect by two staff members.

Ontario Regulation 79/10 made under the Long Term Care Homes Act 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

In December 2011, the Manager of Resident Care submitted a report of an incident via the Critical Incident System, which had occurred at the home on a date in November 2011.

According to the Manager Resident Care and the Manager Hospitality Services during an interview with the inspector on October 11, 2012, the following incident occurred on a date in November 2011 which culminated in disciplinary action towards two staff members.

On a date in November 2011 there was an argument between a Food Service Attendant (FSA) and a Registered Practical Nurse (RPN) which resulted in Resident # 001 not receiving her/ his dinner at mealtime.

According to the Manager Resident Care, and the Manager Hospitality Services, on a date in November 2011, Resident #001 declined the meal choices for dinner and requested an egg sandwich to be provided in her/his room. The RPN in turn, informed the FSA of Resident #001's request. The FSA refused the RPN's request for an egg sandwich to believing that the RPN was ordering the egg sandwich for herself and not for Resident #001. An argument ensued. The RPN indicated that because of the argument, she told the FSA to bring Resident #001 the egg sandwich in her/his room as per Resident # 001's request. The RPN went for her dinner break. The FSA plated the egg sandwich and left it on the counter in the dining room rather than bringing the sandwich to Resident #001 in her/ his room. The FSA indicated she was aware that Resident #001 had not received her/his dinner as the egg sandwich had been left on the counter. The FSA indicated she was aware that Resident #001 had not received any other food. The FSA indicated that she placed the egg sandwich which had been sitting at room temperature for at least 1.5 hours, on the snack cart. The FSA did not inform any staff members that the egg sandwich was intended for Resident #001. The RPN returned from dinner and did not follow up to ensure that Resident # 001 received the egg sandwich. Approximately 1.5 hours after dinner, a Personal Support Worker was informed by Resident # 001 that she/he was hungry and she/he had not been provided her/his dinner. The Personal Support Worker promptly provided Resident #001 with a meal.

The RPN and FSA received disciplinary action as a result of their negligent conduct towards Resident # 001. (Log #O-002708-11)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to comply with O. Reg. 79/10 s. 49(2) in that when a resident has fallen, the resident did not have a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

In February 2012 the Manager, Resident Care submitted a report of an incident which occurred at the home on a date in February 2012. The incident involved Resident #002 who fell and sustained a fractured left clavicle.

A review of Resident #002's health record revealed that she/he did not have a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls.

On October 11, 2012 the Manager, Resident Care indicated to the inspector that Resident #002 did not have a post-fall assessment because the home had not yet implemented a clinically appropriate assessment instrument that is specifically designed for falls.(Log # O-000289-12)

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s.96(e) in that the homes written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations.

On October 11, 2012 the Manager, Resident Care of the home provided the inspector with a copy of the home's written policy and procedure # 750.65 "Abuse."

A review of the home's written policy and procedure # 750.65 "Abuse" does not identify the training and retraining requirements for all staff including:
i. training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
ii. situations that may lead to abuse and neglect and how to avoid such situations. (Log #O-002708-11)

The licensee failed to comply with O. Reg 79/10 s.96(c) in that the homes written policy to promote zero tolerance of abuse and neglect of residents does not identify measures and strategies to prevent abuse and neglect.

On October 11, 2012 the Manager, Resident Care of the home provided the inspector with a copy of the home's written policy and procedure # 750.65 "Abuse."

A review of the home's written policy and procedure # 750.65 "Abuse" does not identify measures and strategies to prevent abuse and neglect. (Log #O-002708-11)

The licensee failed to comply with O. Reg 79/10 s.96(b) in that the home's written policy to promote zero tolerance of abuse and neglect of residents does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate.

On October 11, 2012 the Manager, Resident Care of the home provided the inspector with a copy of the home's written policy and procedure # 750.65 "Abuse."

A review of the home's written policy and procedure # 750.65 "Abuse" does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. (Log #O-002708-11)

The licensee failed to comply with O. Reg 79/10 s.96(a) in that the home's written policy to promote zero tolerance of abuse and neglect of residents does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

On October 11, 2012 the Manager, Resident Care of the home provided the inspector with a copy of the home's written policy and procedure # 750.65 "Abuse."

A review of the home's written policy and procedure # 750.65 "Abuse" does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. (Log #O-002708-11)

On October 11, 2012 the Administrator and the Manager, Resident Care verified and told the inspector that Policy and Procedure # 750.65 "Abuse" (Revision date July 2012) was the home's most recent policy/procedure.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s.97(2) in that a resident's Substitute Decision Maker was not notified of the results of a neglect investigation immediately upon the completion.

On a date in November 2011 an incident of staff to resident #001 neglect occurred. The Manager, Resident Care was informed of the incident in December 2011. An investigation was conducted by the Manager, Resident Care and the Manager, Hospitality Services.

On October 11, 2012 the Manager, Resident Services indicated to the inspector that their investigation was completed shortly after the incident was brought to their attention and that she had not realized that she was required to notify Resident # 001's Substitute Decision Maker of the results of their investigation. (Log #O-002708-11)

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 104(1)4 in that in making a report to the Director under subsection 23 (2) of the Act, the licensee did not include in writing with respect to an incident of neglect by staff that led to the report, the long-term actions planned to correct the situation and prevent recurrence.

In December 2011, the Manager of Resident Care submitted a report of an incident via the Critical Incident System, which had occurred at the home on a date in November 2011.

According to the Manager Resident Care and the Manager Hospitality Services during an interview with the inspector on October 11, 2012, the following incident occurred on a date in November 2011 which culminated in disciplinary action towards two staff members.

On a date in November 2011 there was an argument between a Food Service Attendant (FSA) and a Registered Practical Nurse (RPN) which resulted in Resident # 001 not receiving her/ his dinner at mealtime.
According to the Manager Resident Care, and the Manager Hospitality Services, on a date in November 2011, Resident #001 declined the meal choices for dinner and requested an egg sandwich to be provided in her/his room. The RPN in turn, informed the FSA of Resident #001's request. The FSA refused the RPN's request for an egg sandwich to believing that the RPN was ordering the egg sandwich for herself and not for Resident #001. An argument ensued. The RPN indicated that because of the argument, she told the FSA to bring Resident #001 the egg sandwich in her/his room as per Resident # 001's request. The RPN went for her dinner break. The FSA plated the egg sandwich and left it on the counter in the dining room rather than bringing the sandwich to Resident #001 in her/ his room. The FSA indicated she was aware that Resident #001 had not received her/his dinner as the egg sandwich had been left on the counter. The FSA indicated she was aware that Resident #001 had not received any other food. The FSA indicated that she placed the egg sandwich which had been sitting at room temperature for at least 1.5 hours, on the snack cart. The FSA did not inform any staff members that the egg sandwich was intended for Resident #001. The RPN returned from dinner and did not follow up to ensure that Resident # 001 received the egg sandwich. Approximately 1.5 hours after dinner, a Personal Support Worker was informed by Resident # 001 that she/he was hungry and she/he had not been provided her/his dinner. The Personal Support Worker promptly provided Resident #001 with a meal.

The RPN and FSA received disciplinary action as a result of their negligent conduct towards Resident # 001.

The report #M622-000061-11 does not include in writing, the long-term actions planned to correct the situation and prevent recurrence. (Log #O-002708-11)

The licensee failed to comply with O. Reg 79/10 s. 104(1)1 in that in making a report to the Director under subsection 23 (2) of the Act, the licensee did not include in writing with respect to an incident of neglect by staff that led to the report, the date and time of the incident.

In December 2011, the Manager of Resident Care submitted a report of an incident via the Critical Incident System, which had occurred at the home on a date in November 2011.

According to the Manager Resident Care and the Manager Hospitality Services during an interview with the inspector on October 11, 2012, the following incident occurred on a date in November 2011 which culminated in disciplinary action towards two staff members.

On a date in November 2011 there was an argument between a Food Service Attendant (FSA) and a Registered Practical Nurse (RPN) which resulted in Resident # 001 not receiving her/ his dinner at mealtime.
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The RPN and FSA received disciplinary action as a result of their negligent conduct towards Resident # 001.

The report #M622-000061-11 does not include in writing, the date and time of the incident. (Log #O-002708-11)

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.20(2)(b) in that the home's written policy to promote zero tolerance of abuse and neglect of residents does not clearly set out what constitutes abuse and neglect.

On October 11, 2012 the Manager, Resident Care of the home provided the inspector with a copy of the home's written policy and procedure # 750.65 "Abuse."

A review of the home's written policy and procedure # 750.65 "Abuse" does not clearly set out what constitutes physical, emotional, verbal, sexual abuse nor neglect.

Issued on this 19th day of October, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs