Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 11, 2014	2014_198117_0004	O-000082-14	Resident Quality Inspection

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

LYNE DUCHESNE (117), LINDA HARKINS (126), RENA BOWEN (549), SUSAN WENDT (546)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): February 3, 4, 5, 6, 7 and 10, 2014

It is noted that a Critical Incident inspection log # O-001048-13 was also conducted during this Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with Administrator, two Managers of Resident Care Services (MRCS), Manager of Hospitality Services, Manager of Recreation/Leisure and Volunteer Services, Facilities Supervisor, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Food Service Manager, RAI-Coordinator, several dietary aides, several housekeeping aides, restorative care coordinator, physiotherapist, several administrative clerks, several resident family members, several residents, the Co-chair of the Residents' Council and the President of the Family Council.

During the course of the inspection, the inspector(s) reviewed several residents' health care records; observed the February 3, 2104 lunch time meal service on 3rd floor unit; observed medication pass on February 7, 2014 on 5th floor; examined several resident rooms, bathrooms and resident common areas; examined non-residential areas such as kitchen serveries, tub/shower rooms, medication rooms, clean and soiled utility rooms; reviewed the home's Resident Admission Package; reviewed the home's Infection Control Program, Medication Administration Program and the home's Preventative Maintenance Program; reviewed the Therapy Equipment Chargeable Items list; reviewed minutes of the Residents and Family Councils meetings as well as the Food Committee minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, s.15 (2)

(c) in that the licensee did not ensure the home, furnishings and equipment are maintained in good state of repair.

The home has three elevators, two elevators are used by the residents and the public, one elevator is used by staff with access only with a swipe card. During the tour of the home on February 3, 2014, it was noted that the two elevators are used by the public and the residents have numerous small and large chips of wood broken off from the wood panels on the inside of the elevators.

February 3, 2014, on the 3rd floor, numerous resident room doors were found to have chips of wood missing in the lower part of the doors, the lower part of the wall in the corridor between rooms #220 and #223 has noticeable marks and pieces of gyp-rock missing.

The walls at the end of the corridors where noticeably discoloured around the alcohol hand rub dispensers on all floors.

February 4th, 2014, in room #223, the resident's bathroom door on the inside had the finish removed from the mid to bottom of the door.

February 4th, 2014, in room #220 had a piece of unfinished wood screwed to the corner of the wall at the entrance to the resident's room. This room also had a piece of damaged wood screwed to the wall of the resident's room; this piece of wood was damaged. Large splinters on the piece of discoloured wood are accessible to residents.

February 5th, 2014, in room #300 had a piece of unfinished wood screwed to the corner of the wall at the entrance to the resident's room.

February 6th, 2014, Inspector #549 was informed by the Facilities Manager that the pieces of wood were screwed to the corner of the walls due to the wall being damaged.

Inspector #549 discussed the disrepairs with the Facilities Manager on February 6, 2013. The Facilities Manager indicated to Inspector #549 that he was aware of the need for the repairs on 2nd and 3rd floors but that he did not have a plan in place to complete them. In regard to the elevators, the Facilities Manager stated that he is getting quotes for repairs but did not give any timelines for the repairs.

February 7, 2014, several of the three unit carts used by the care staff for disposal of soiled laundry and garbage are either missing the step lever to open the tops of the bins or the levers are not working.

Inspector #549 discussed the disrepairs of the laundry carts with the Hospitality Manager who stated she was just notified of the broken and missing levers on the laundry carts. The Hospitality Manager stated she will put a plan together to replace and repair the laundry carts. [s. 15. (2) (c)]

2. The resident-staff communication and response system (the system) in room #300 both the system by the bed and the resident's washroom were activated by Inspector #117 on February 4th. The system did activate but could not be deactivated at the point of service unless the pull cord was pushed back into the console on the wall and then the deactivation button pushed. Staff member S112 indicated the malfunction of the consoles in room #300 was an ongoing issue.

The Maintenance department was notified February 4th of the malfunction through the home's Parks Building Grounds Operations Maintenance program (PBGOM). The request was also written in the Long Term Care Planner.
February 6th, 2014 @ 10:30 am Inspector #549 interviewed staff member S112 who stated the system in resident's washroom in room #300 was repaired February 5th. Inspector # 549 activated the system in resident's washroom in room 300 with staff member S112 present. The system could not be deactivated at the point of service without pushing the cord back into the console on the wall then pushing the deactivation button. Staff member S112 indicated to Inspector #549 the system was functioning properly February 5th as maintenance had repaired it.
February 6th @ 10:40 am PBGOM was notified again, the system was repaired once more. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment, specifically resident elevators, walls and doors of the 2nd and 3rd floor resident home areas, resident communication and response system and the laundry/utility carts are maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 17 (1) (a) in that resident's communication and response system was not accessible by resident #509 and #570.

February 4th, inspector #126 noted that the resident's communication and response system (the system) console cord was not accessible to the resident #570. The resident stated to inspector #126 that the console cord was not easily accessible when he was in bed.

February 4th, inspector #117 noted that the system console cord was caught under the bedside dresser and was not accessible to resident #509. The resident stated to inspector #117 that this was frequent occurrence and that he had to repeatedly free the cord to ensure accessibility when in bed. [s. 17. (1) (a)]

2. The licensee has failed to comply with O.Reg.79/10, s.17(1) (f) in that the resident-staff communication and response system did not clearly indicate when activated where the signal is coming from.

The communication and response system (the system) for this home works by pulling a cord in the resident's room or bathroom. The pull cord comes from the console on the wall. Once the pull cord is activated there is a light outside of the resident's room that will light up indicating the source. There is also a signal sent to the PSWs pager. To deactivate the system, the health care staff need to push the deactivation button on the console, on the wall.

February 3, 2014 Inspector #117 tested the system on the 2nd floor in Room #223. The system did not activate the light outside of the resident's room, make an audible sound or activate the PSWs pager.

February 4, 2014, Inspector #549 tested the system on the 7th floor in Room #700. The system did not activate the light outside of the resident's room, make an audible sound or activate the PSWs pager. The unit RPN stated the resident is not capable of using the system so no one knew it was not functioning.

Staff were not aware of the malfunction of the system until it was brought to their attention by Inspector #117 and #549. The system was repaired within 24 hours of notification to maintenance. [s. 17. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident- staff communication and response system console cords are accessible to residents at all times and clearly indicates when activated, where the signal is coming from, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10 s. 44 in that equipment and devices were not readily available at the home to meet the nursing and personal care needs of residents.

Resident #515 is identified as being at high risk for falls. The resident's plan of care identified that nursing staff had approached the resident's family to purchase a tab/bed alarm for the resident as a fall risk intervention. The resident was observed to have a tab/bed alarm applied to his/her wheelchair. Staff member S#122 stated to inspector #117 on February 7, 2014, that when residents are identified as requiring tab/bed alarms as a fall prevention intervention, resident families are approached and asked to purchase the device as the home does not provide them. Inspector #117 spoke with the home's Administrator on February 7, 2014 and confirmed that the home does not provide tab/bed alarms. These devices are to be purchased by residents families / legal substitute decision makers as fall risk interventions.

February 10, 2014, the home's restorative care coordinator confirmed to inspector #117 that resident families are asked to purchase tab/bed alarm as a fall risk intervention. The home does not provide these devices to the residents. The restorative care coordinator stated that the home currently has 3 tab/alarms in the physiotherapy room. These tab/bed alarms were purchased by other families/residents and when no longer required were donated to the home. The donated tab/bed alarms are used temporarily for residents as a fall risk intervention until the families/residents purchase their own tab/bed alarms.

The home does not provide tab/bed alarms, devices identified as being needed to meet residents nursing and personal care needs. [s. 44.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that equipment and devices, specifically tab/bed alarms, are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10, s. 107 (3.1) (b) in that the licensee did not report an injury that resulted in a significant change in a resident's health condition to the Director, no later than 3 business days after the occurrence of the incident

On a specific day in October 2013, resident #4949 sustained a fall. A head to toe assessment was completed by the evening unit RPN and there appeared to be no signs of injury at the time and therefore no treatment was required.

Four days later, in October 2013, resident #4949 was noted to have a significant change in condition. The unit RN notified the attending physician who ordered the resident transferred to hospital for further assessment. The resident was diagnosed with an injury and a respiratory infection and was admitted to hospital.

The Critical Incident report was submitted to the Director, 7 days after the resident was transferred to hospital. [log # O-001048-13] [s. 107. (3.1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any injury that resulted in a significant change in a resident's health condition, is to be reported to the Director, no later than 3 business days after the occurrence of the incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes

Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.

2. A change of 7.5 per cent of body weight, or more, over three months.

3. A change of 10 per cent of body weight, or more, over 6 months.

4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 69 in that the licensee did not ensure that resident with a weight change of 7.5 per cent or more, was not assessed using an interdisciplinary approach, that actions were not taken and outcomes were not evaluated.

Resident #580 weight in December, 2013, was 62.3 kg and the January 2014, weight was 55.9 kg. As of February 6, 2014, resident #580's health care record was reviewed by inspector #126 and no documentation was found related to the 6. 4 kg weight loss.

Discussion with S#123 on February 6, 2014, who stated to inspector #126 that Resident #580 was eating well and was not aware that resident #580 had lost 6.4 kg in the last month.

February 6, 2014, the Food Services Supervisor (FSS) stated to inspector #126 that significant changes are flagged and interventions are initiated. The FSS reviewed resident #580's health care record with Inspector #126 and no documentation was found related to resident's weight loss for the period of December 2013 and January 2014.

February 7, 2013, Inspector #126 reviewed the Registered Dietitian's "significant weight change binder" and no documentation was found related to the resident #580 weight loss. [s. 69.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s.131. (1) in that medications used by resident #570 have not been prescribed for the resident.

February 7, 2014, inspector #126 walked by resident #570's room and noted a bottle of mineral supplement and a bottle of vitamin on the computer table.

Resident #570 stated to inspector #126 that he/she takes the medications when he/she feels he/she requires them. Resident # 570 is alert, oriented and capable of making his/her own care decisions. At the time of the inspection, no wandering residents were observed on this unit.

Discussion with the staff member S105, who stated to inspector #126 that the home has a policy related to medication self administration and that there should be an order for self administering medication on the resident's Medication Administration Record Sheet(MARS).

Resident #570 MARS dated January 2014 was reviewed and it was noted that the resident can keep Acetaminophen 500 mg at bedside for self-administration. The mineral supplement and Vitamin were not prescribed for Resident #570 self administration. [s. 131. (1)]

Issued on this 11th day of February, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs	
Lyne Duchesne #117	Susan Wendt #546
Rena Bowen #549	Linda Harkins #126.