**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

**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 Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 11, 2016 | 2016_287548_0002 | 035671-15, O-002100-15, O-002161-15, O-001959-15 | Critical Incident System |

### 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

RUZICA SUBOTIC-HOWELL (548)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): January 6, 8,11,12 and 13, 2016**

**An unannounced inspection was conducted for Critical incident reports#: M622-000014-15,M622-000021-15, M622-000028-15 and M622-000061-15.**

**During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Managers of Resident Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Health Care Aides (HCAs) and Trainer-Education.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**

**During the course of this inspection, Non-Compliances were issued.**
**2 WN(s)**
**1 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the care set out in the plan of care for resident #015 is provided to the resident as specified in the plan.

The home submitted critical incident report#: M622-000028-15 on specified day in May, 2015. The resident alleged staff member to resident abuse, resident left on the toilet for a long time and the door to the toilet left open while being toileted.

Inspector #548 reviewed the resident's #15 health care record.

The resident #015 requires assistance with activities of daily living and diminished eyesight. On a specified day in January, 2016 inspector#548 conducted an interview with resident #015, at the time the resident became lost in the conversation and did not answer the inspector’s questions.

On January 12, 2016 Manager of Resident Care #116 provided to inspector the resident’s care plan and her investigative notes.

The care plan specifies that the resident is to be assisted with two persons to the toilet and one staff member is to remain with the resident and to “supervise”.

On January 13, 2016 during an interview HCA#121 indicated that he is aware that the resident requires two-person assistance for her toileting needs. He indicated that he has left the resident with the call bell within reach and returned in a short period of time to attend to her after helping another resident. HCA#121 indicated that this is a practice on the unit and was not aware that the resident required supervision with one staff member as he has not read the care plans for a while. Furthermore, he indicated that he was not certain resident #015 would recall on how to use the call bell on a consistent basis due to the resident's cognitive impairment.

Review of the home’s investigative notes disclose that a HCA assisted the resident to the toilet, informed the resident where the call bell was and left the resident unattended to find another staff member to assist with the resident’s#015 care.

On January 13,2016 during an interview Manager of resident care #116 confirmed that the HCA was aware of the resident's needs and provisions in the care plan related to supervision while being toileted however, left the resident #015 unsupervised.

From the review of the investigative notes and staff interviews it was inconclusive the amount of time the resident was left unattended. The home investigation concluded there was no staff to resident abuse and the Manager of resident care #116 confirmed during her interview that the plan of care was not followed. [s. 6. (7)]

***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 resident #15 is provided the care set out in the plan of care, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that drugs are stored in an area or medication cart that is secure and locked.

On January 8, 2016 at approximately 1240 hours on the seventh floor dining room during meal service inspector #548 observed a container of prescription eye drops to be left on the medication cart unattended with residents, health care aides and a visitor present. It was observed that RPN#111 was administering medications to a resident approximately 5-7 feet away from the cart. During an interview the RPN#111 indicated that she knows drugs are not to be left unattended and secured the eye drops in the medication cart.

On January 11, 2016 at 0820 hours on the seventh floor the inspector #548 observed RPN#111 administer medications to three residents #010,#011,#012. It was observed that RPN#111 prepared medications from the medication cart for resident #010 outside the resident's room in the hallway. RPN#111 left a drug Valporic acid syrup on top of the cart and entered the resident's room. In the presence of inspector #548 RPN#111 proceeded to administer the resident's medications while her back was turned and the cart out of eyesight. During the medication administration it was observed by inspector #548 co-residents' mobilizing to and from their rooms and a member of the housekeeping staff in another resident's room across from the medication cart. While the inspector and RPN#111 were in the resident's room it was observed by inspector #548 that a prescription drug was left on the bedside table. During an interview RPN#111 indicated that the resident is not cognitively aware to administer the medication and the medication is only to be administered by registered nursing staff and is to be secured in the medication cart.

On January 11, 2016 on the seventh floor RN#119 indicated that she was not aware that drugs were left at the bedside and on the cart unattended. She indicated there are residents that mobilized around the unit and for their safety all drugs are to be secured.

On January, 2015 during an interview Manager of Resident Care #112 indicated that registered nursing staff are to follow the College of Nurses of Ontario Standards of Practice for Medication Administration. [s. 129. (1) (a)]

**Issued on this 11th day of February, 2016**

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

**Original report signed by the inspector.**