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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2016	2016_287548_0001	035761-15	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): on January 4, 5,6,8 and 11, 2016

to conduct an unannounced complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care #112 and #115, Registered Nurse (RN), Manager of Environmental Services,Health Care Aides (HCAs)and Dietitian.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

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. 6. Plan of care

Specifically failed to comply with the following:

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented: food and fluid

intake, repositioning and bathing, the provision of the care set out in the plan of care.

The licensee's written documentation; Nutrition Intake Flow Sheet, Repositioning Schedule and Bath Schedule-6th Floor communicates the provision of care set out in the plan of care for resident #010.

The resident #010 had multiple diagnosis. The resident #010 was hospitalized on a specified day in November, 2015 and returned to the home on a specified day in December, 2015. Several days later was transferred to hospital on a specified day in December, 2015, the resident #010 subsequently passed away while in hospital.

The resident #010 required total assistance with one staff member and specific assistive devices for nutrition and hydration needs. The resident #010 was seen by the dietitian on a specified day in November, 2015 and was assigned a high nutritional risk as the resident required total assistance for meals,encouragement to eat and presented with fatigue. The resident #010 required a nosey cup to assist with the administration of fluids.

The Inspector #548 reviewed the resident's #010 health care record.

The resident's #010 current care plan was provided to inspector #548 by the Manager of Resident Care #112.

The Inspector #548 reviewed the care plan. The care plan specified the amount of nutrition and hydration intake on a daily basis specific to the resident's needs. The care plan directed staff to encourage the intake of water.

The home's process to document resident intake includes the daily record of both food and fluid per meal and nourishment on the Nutrition Intake Flow sheet form. On January 5, 2016 during an interview HCA#114 confirmed resident intake and refusal for both fluids and food are to be documented on the flow sheet. RN#113 and HCA#114 both indicated that when a resident's intake is not sufficient the HCAs are expected to communicate this to the registered nursing staff, for the specific nourishment and meal. RN #113 indicated that registered nursing staff are to document in the progress notes when the resident intake is not sufficient and consult the dietitian as required. Both staff members indicated the resident's #010 family member assisted with feeding the resident for meals.

The home's Nutrition Intake Flow Sheet is for the recording of resident intake on a daily basis and is arranged for the documentation of the amount of intake or refusal for food and fluid for each nourishment and meal. The flow sheet specifies the documentation of afternoon nourishment to include the amount of solid and fluid taken, for supper to record the amount of solids, juice, milk, water and other intake and for the evening nourishment the amount of solid and fluid.

The Inspector #548 reviewed the progress notes and Nutrition Intake Flow sheet form for specified days in November, 2015 to a specified day in December, 2015. There is no record on the Nutrition Intake Flow Sheet of resident's #010 intake for nourishment and meals for: two days in November,2015 for afternoon nourishment and supper, two days for afternoon nourishment and one day for afternoon and evening nourishment and supper. As well, in December 2015 there is no record for lunch on one day and no record of morning, afternoon and evening nourishment and supper for two days.

On January 8, 2015 during an interview Manger of Resident Care #115 confirmed the home's process to document fluid and food intake. She indicated the resident's #010 food and fluid intake is to be completed by the HCA on the flow sheet for the actual amount of intake. In addition, should the resident's #010 refuse to take in any nourishment or their planned meals that the HCAs are to directly report this to a registered nursing staff member.

2. The resident's #010 current care plan was provided to the inspector #548 by the Manager of Resident Care on January 4, 2016.

Inspector #548 reviewed the resident's #010 care plan. The care plan specified the frequency of repositioning the resident while in bed or in the wheelchair and the time frame to assist the resident to rise and retire.

During an interview with RN #113 and HCA #114 they both indicated that the resident was known to need to be repositioned q2hours or when necessary while in bed and in the tilt wheelchair. Both indicated that there is a form specific for the documentation each time a resident is repositioned. Both indicated resident #010 had a usual routine of when to get out of bed and be placed in the wheelchair and when to retire.

The Inspector #548 reviewed the resident's #010 health care record.

The Inspector #548 reviewed the document titled: Repositioning Schedule dated

December 2015. The form guides HCAs to document when a resident has been repositioned- whether in bed and/or chair, the position of the resident and turning time and, to initial once this is completed. Upon review, there is no record of the repositioning on four specific days and timeframes on the form. The HCA#114 indicated all care related to repositioning is to be completed on the flow sheet. Both staff interviewed could not confirm the resident #010 was repositioned during the times where there is no record of repositioning.

The Inspector reviewed the progress notes for a specified period of time in November, 2015 to a specified date in December, 2015. Review of the progress note entries during this period of time indicated the resident remained in bed however there is no record on the flow sheet the resident #010 was repositioned.

The licensee failed to ensure the documentation of the provision of care to reposition resident #010 was completed for specific dates and time periods. [s. 6. (9) 1.]

3. Resident #010 requires total assistance with bathing. Inspector #548 reviewed resident's #010 health care record.

The resident's #010 current care plan was provided to the inspector#548 by the Manager of Resident Care on January 4, 2016. Inspector #548 reviewed the care plan.

On January 5, 2016 during an interview RN#113 and HCA#114 both indicated that each resident is scheduled for the twice weekly bath/shower/bed bath. RN#113 indicated that the resident #010 was scheduled for a bath on Wednesday during the day and a shower on Friday evening each week. Both staff indicated that the home's process is to document that the resident received a bath.

The Inspector #548 reviewed the bath schedule titled: Bath Schedule-6th Floor document. It specifies the scheduled time for bathing to be provided. Both RN#113 and HCA#114 indicated completed baths/shower are documented on the home's flow sheet and it is communicated if the bath is not provided and documented that the bath/shower did not take place. The schedule indicated the resident #010 is to receive a shower/bath on specified days and evenings.

The Inspector #548 reviewed the homes flow sheet titled: MDS Monitoring Observation Record-Bath Record for November and December 2015. The form guides HCAs to initial the type of care provided to the resident. Review of the document indicated there was no

record that the resident received a bath/shower on three separate occasions on the scheduled days in November, 2015 and December, 2015.

On January 6, 2016 during an interview the Manager of Resident Care #115 indicated that when a bath/shower is completed there must be documentation on the flow sheet. In addition, if there was a reason for the omission it would be charted in the progress notes by the registered nursing staff. There was no record in the progress notes pertaining to whether the baths/showers were given and staff interviewed could not confirm that the baths/showers were provided.

As such, the licensee failed to ensure the provisions of the care set out in the plan of care are documented for resident #010. [s. 6. (9) 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 the provision of care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.