Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2017	2017_683126_0013	017480-17	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

LINDA HARKINS (126)

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): September 20, 21, 22, 2017

During this complaint inspection a Critical Incident (CI) related to an allegation of physical abuse was reviewed.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Resident Care Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) , a family member and the resident.

During the course of this inspection, the Inspector observed care and services provided to the resident, reviewed the resident health care record, reviewed the "Unit daily record" and reviewed the staffing schedule for two specific staff members.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if a person has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

On a specified date in July 2017, resident #001 called a family member and informed them that Personal Support Worker (PSW) #100, the one that he/she had an incident with, in the past, was no longer working in the home. Resident #001 indicated that PSW #100 was fired from the home for abusing another resident. After the telephone conversation with resident #001, the family member contacted the Action-Line to report the allegation of physical abuse to resident #001 from PSW #100. In the previous month, resident #001 had told the family member, that PSW #100 had poked his/her on the shoulder after he/she told PSW #100 to go away and that he/she didn't want him bathing him/her.

On September 20, 2017, resident #001 indicated to Inspector #126 that PSW #100 came in the room at the beginning of the evening shift and said "I'm giving you a shower and I am putting you to bed". As per the resident, PSW #100 was shaking his/her finger at him/her in front of his/her face and he/she then poked him/her on the left shoulder with

two fingers. Resident #001 indicated that he/she had bruising on the front of the shoulder on the soft tissue area a couple of days later. Resident #001 indicated that he/she told PSW #100 that he/she would not bathe him/her, or put him/her to bed, and told him/her to get out of the room. Resident #001 indicated that he/she followed PSW #100 out of the room and went to the nursing station and told Registered Nurse #101 about the incident.

Resident #001 indicated that the incident must have occurred on Thursday as it was Doctor's Day and the Day Charge RN #101 was still on the unit. Furthermore, resident #001 indicated that in the past he/she was getting a shower on Monday and Thursday and that now these shower/bath days have changed. Resident #001 indicated to Inspector #126 that he/she cannot remember the exact date that the incident occurred.

RN #101 did not report immediately the allegation of physical abuse to the Director when it occurred.

A Written Notification is issued as the Licensee was served with a Compliance Order from the Director on July 19, 2017 with a compliance due date of December 1, 2017. [s. 24. (1)]

Issued on this 2nd day of October, 2017

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

Original report signed by the inspector.