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

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

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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
Mar 28, 2018	2018_683126_0002	029181-17	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): January 26, 27, 29, February 20, 27, 28, March 1, 2, 5, 7, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident Care, the residents and the family member.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the right of resident #001 to receive visits from Family Member (FM) #100 and consult in private with FM #100 without interference was fully respected and promoted.

Resident #001 was admitted to the home on a specific date in September 2017. Conditions of visitation were issued less than one month after resident #001's admission that prohibited Family Member (FM) #100 from entering Garry J Armstrong and its surrounding grounds and appurtenances and was effective for 1 year.

Review of a copy of resident's Power of Attorney (POA) document, dated a specific date in January 2017 indicated that in the event of any legal incapacity on the part of resident #001, the Attorneys for Personal Care (APC)(FM #101 and FM #103, jointly and severally) are authorized to make decisions regarding personal care including health care, nutrition, shelter, clothing, hygiene, safety and cessation or continuation of measure may be artificially prolonged and to give and refuse consent to treatment which the Health Care Consent Act, 1996 applies. The POA document does not state that the APCs are authorized to choose or restrict visitors.

The Administrator indicated that on a specific date in November 2017, FM #100 presented to the Home and was repeatedly asked and invited to enter the Home and meet with the Administrator to have a conversation. As per the Administrator, FM#100 informed them that he/she had papers which would allow him/her to enter the home but was unable to produce these documents at that time.

In December 2017, the Administrator met with APCs, FM #102 and FM #103 and advised

them that they could not restrict FM #100 from visiting resident #001and they understood. They discussed the need to schedule visits to respect conditions directives between FM #100 and FM #102 #103.

On a specific date in January 2018, the Administrator contacted FM #100 regarding placing the conditions of visitation on hold to allow visits with resident #001. The meeting was to review the code of conduct and some conditions associated with resident #001 receiving the visits of FM #100. FM #100 refused the meeting.

Resident #001's progress notes were reviewed for the period of two months and the following were noted:

On a specific date of December 2017, it is documented in the progress notes that FM #100 left a voice mail message to Program Manager of Resident Care (PMORC) #104, indicating that the Home was breaking the law by not accepting visitation to resident #001. The Administrator was informed of FM #100's voice mail message.

On a specific date in January 2018, it is documented in the progress notes that FM #100 returned the Administrator's call to make the necessary arrangements to have the conditions of visitation placed on hold for a short period to let FM #100 enter the home and to facilitate a conversation between them. FM #100 asked if he/she could bring someone and the Administrator agreed. FM #100 indicated that he/she would not be coming in, that the conditions of visitation was illegal and would not be discriminated against. The Administrator advised FM #100 that the conversation was intended to be helpful in understanding what behaviors were expected and acceptable during visitation with resident #001.

On a specific date in January 2018, it is documented in the progress notes that Registered Nurse (RN) #105 contacted APC FM #101 and indicated that FM #100 was not capable of taking resident #001 outside of the building for different reasons. APC FM #101 also indicated that they felt that if visits were allowed they would adjust but they felt that FM #100 was upsetting resident #001 and gets the resident agitated and difficult to settle.

On a specific date in January 2018, it is documented in the progress notes that the Administrator organized a telephone call with resident #001 and FM #100, noting that resident #002 refused to talk to FM #100. The phone call left resident #001 agitated and upset.

On a specific date in January 2018, it was documented in the progress notes that the Administrator discussed with FM #101 regarding the request of FM #100 to visit resident #001 and have a phone in the room. FM #101, indicated that it would not be in resident #001's best health and safety interest to receive phone calls or visits from FM #100.

It is documented in the progress notes that resident #001 has tried to use the phone on three occasions in January 2018, wanting to talk to FM #100 and APC FM #103. Resident #001 was very upset that APC FM #101 was not allowing any external phone calls to be made.

On a specific date in January 2018, the Administrator returned the call to FM #100 who wanted to speak to resident #001 and resident #002. As per FM #100 he/she was informed by the Administrator that he/she does not have permission to call resident #001 and #002 given the agitation exhibited by resident #001 on that specific date of January 2018 during the phone call with FM #100.

Discussion held with the Administrator who indicated to Inspector # 126 that since December, 2017, FM #100 has been invited on several occasions to come in and discuss a plan for visitation with resident #001.

Discussion held with FM #100 who indicated that conditions of visitation were not legal, that there has been no visits with resident #001 and the Home has not allowed resident #001 to have a telephone in the room, which would be paid for by FM #100.

Resident #001 expressed to nursing staff on the unit on several occasions wanting to receive visits from FM #100 and wanting to speak on the phone to FM #100.

On a specific day in March 2018, Inspector #126 received information from the Administrator in that the licensee plans to send a letter to FM #100 regarding visitations with resident #001 and resident #002, in the next few days. In the letter, the licensee stipulates specific conditions for planned visitations that are to occur three times per week between resident #001, resident #002 and FM #100.

The POA does not authorize the appointed attorneys to make decisions about resident #001 right to receive visitors of his or her choice and consult in private with any person without interference. Because the safety concerns expressed by the licensee are not sufficient justification to fully restrict resident #001 from receiving visits from FM #100, the

licensee has failed to ensure resident #001's right to receive visitors of her or his choice and consult without interference has not been fully respected and promoted.

Issued on this 28th day of March, 2018

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

Original report signed by the inspector.