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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2019	2019_730593_0020	010677-19	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

GILLIAN CHAMBERLIN (593)

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): June 20 - 21, 24 - 27, 2019.

Complaint log #010677-19 was inspected related to allegations of neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Personal Care, Manager of Nursing Care, registered nursing staff, personal support workers, housekeeping staff, residents and family members.

The inspector(s) observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staff schedules and investigation records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
4 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	Légende 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident’s admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return from hospital.

A complaint was received through the Action Line by a family member of resident #001. It was alleged that upon return from hospital, adequate care was not provided to resident #001 which included removal of leads until four days post return to the home. The licensee received a complaint the same day regarding the care provided to resident #001 since return from hospital. The allegations included concerns over leads affixed to resident #001 which were discovered by a family member four days after return from hospital.

A review of resident #001’s documented care plan, found multiple interventions around maintaining continence and maintaining skin integrity.

During an interview with Inspector #593, June 27, 2019, RPN #105 confirmed that they worked the day resident #001 returned from hospital and received resident #001 when they returned from hospital. RPN #105 indicated that they completed vital signs for resident #001 however could not complete the head to toe skin assessment as resident #001 refused. RPN #105 indicated that they did not see any leads as they were unable to remove the resident’s shirt to complete the assessment. When asked about communicating this refusal to the next shift, RPN #105 responded that they wrote it in the communication book but forgot to chart this in a progress note.

A review of the staff communication book found the following entry the day resident #001 returned from hospital:

• Refused changing under shirt and head to toe assessment.

A review of resident #001's progress notes, found no entries related to refusal of the head to toe skin assessment upon return from hospital.

During an interview with Inspector #593, June 24, 2019, Manager of Nursing Services confirmed that a head to toe skin assessment was not completed upon the residents return from hospital. The RPN did not pass this refusal along to the next shift or follow up on this assessment when they were working on the same home area, the following day.

Resident #001 was not provided a head to toe skin assessment upon return from hospital. Initially the resident refused, however this was not adequately communicated to the next shift and therefore no further attempts to complete this assessment were made. As such, the licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return from hospital. (Log #010677-19) [s. 50. (2) (a) (ii)]

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 that every licensee of a long-term care home shall ensure that, (a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, (ii) upon any return of the resident from hospital, to be implemented voluntarily.

WN #2: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented: 1. The provision of care set out in the plan of care.

A complaint was received through the Action Line by a family member of resident #001. It was alleged that upon return from hospital, adequate care was not provided to resident #001 which included bathing.

Resident #001’s health care record was reviewed by Inspector #593. The following was noted:

• Care Plan- BATHING: Shower on Tuesday and Friday morning.
• PSW Flow sheets- week 3 Month two. There was no completed documentation on Friday for bathing.
• PSW Flow sheets- week 3 Month one. There was no completed documentation on Tuesday for bathing.
• PSW Flow sheets- week 4 Month one. There was no completed documentation on Friday for bathing.

During an interview with Inspector #593, June 26, 2019, PSW #103 indicated that they usually showered resident #001 on the Friday. PSW #103 reported that they showered resident #001 on Friday of week three, month two.

During an interview with Inspector #593, June 26, 2019, PSW #104 indicated that resident #001 loved showers and would never refuse showers when offered on dayshift.

During an interview with Inspector #593, June 27, 2019, Manager of Personal Care indicated that if a resident refuses a bath or a shower, this is documented in the daily communication book or in the progress notes. If there is nothing documented about refusals, then it is likely that the bathing occurred but was not documented.

Inspector #593 reviewed resident #001's progress notes and the daily communication binder. There was nothing documented regarding bathing refusals on the dates listed above.

On three occasions, there is no documentation to indicate whether resident #001 was bathed or showered. It is reported by staff that resident #001 usually does not refuse their showers and that they love having their shower. As such, the licensee has failed to ensure that the bathing of resident #001 was documented. (Log #010677-19) [s. 6. (9) 1.]

2. The licensee has failed to ensure that the resident is reassessed, and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary.

A complaint was received through the Action Line by a family member of resident #001. It was alleged that on several occasions when visiting resident #001, adequate care was not provided to resident #001 which included toileting.

A review of resident #001's documented care plan found a specific toileting schedule which included toileting after breakfast, as well as level of assistance and care required for toileting.

Observations by Inspector #593 found the following:

• June 21, 2019- at 0914 hours, resident #001 was observed to be portered out of the dining room post breakfast. The resident was not toileted. A staff member was observed to arrive on the home area and leave with resident #001 via the elevators. At 0957 hours, resident #001 was returned to the home area by the staff member. At 1005 hours, a PSW was observed to take resident #001 to their washroom for toileting.

• June 24, 2019- at 0915 hours, resident #001 was observed to be portered out of the

dining room post breakfast. The resident was not toileted. A staff member was observed to arrive on the home area and leave with resident #001 via the elevators. At 1002 hours, resident #001 was returned to the home area by the staff member. At 1038 hours, resident #001 was seated at the nurses station. The resident was not toileted post breakfast.

During an interview with Inspector #593, June 26, 2019, PSW #104 indicated that resident #001 does not have a toileting schedule, they toilet the resident as needed which is frequently.

During an interview with Inspector #593, June 26, 2019, PSW #103 indicated that resident #001 was toileted before breakfast and then after breakfast they have a regularly scheduled activity and therefore the resident was toileted when they return from their activity.

During an interview with Inspector #593, June 25, 2019, RN #102 indicated that resident #001 does not have a toileting schedule but they are toileted whenever the resident requests to be toileted. After breakfast, resident #001 has a regularly scheduled activity and usually when they return from this activity, they want to use the toilet.

During an interview with inspector #593, June 27, 2019, Manager of Personal Care indicated that it was hard to determine a toileting schedule for resident #001. The resident is able to activate the communication and response system and request to be toileted. Generally, the resident is toileted as per their request as this is something that they can communicate.

Resident #001 has a toileting schedule however as reported by staff, this is generally not followed as the resident is toileted PRN (as needed). As such, the licensee has failed to ensure that resident #001 is reassessed, and the plan of care reviewed and revised when the resident’s care needs change or care set out in the plan is no longer necessary. (Log #010677-19) [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition.

A complaint was received through the Action Line by a family member of resident #001. It was alleged that upon return from hospital, adequate care was not provided to resident #001 which included bathing.

Resident #001’s health care record was reviewed by resident #001. The following was noted:

• Care Plan- BATHING: Shower on Tuesday and Friday morning.
• PSW Flow sheets- week 3 Month two. It was documented on Tuesday, that resident #001 refused bathing.
• PSW Flow sheets- week 4 Month two. It was documented that resident #001 was bathed Friday.
• Progress notes- there was no documentation related to the bathing refusal or any documentation related to re-attempting to bathe resident #001 the following day post refusal.

During an interview with Inspector #593, June 27, 2019, PSW #102 indicated that they were the “Bath PSW” on the Tuesday that the resident refused, which was a 1300 – 2100 hours shift. PSW #102 said that resident #001 refused to get up out of bed and refused to have their shower. When asked if a bath or shower was offered to resident #001 the following day, PSW #102 indicated that this was not the usual practice as each resident has their set bath days and so the next time that resident #001 would have been offered a bath or shower would have been Friday, three days later.

During an interview with Inspector #593, June 25, 2019, RN #103 indicated that resident #001 refused their shower on a Tuesday. When asked if a bath or shower was offered to resident #001 the following day, RN #103 indicated that no, they don't ask again, the way the bath list is set, resident #001 has two showers per week. If they miss the Tuesday, they get a shower on the Friday, so they would just have one shower that week.

During an interview with Inspector #593, June 27, 2019, Manager of Personal Care indicated that if a resident refuses their bath or shower, the practice is that this information is communicated to the next shift requesting that they attempt to bath or shower the resident who refused the previous day. The home's expectation is that they attempt to bath or shower the following day.

Resident #001 refused their shower. No further attempts were made to shower resident #001 until three days later, which was their regularly scheduled shower day. As such, the licensee has failed to ensure that resident #001 was bathed, at a minimum, twice a week by the method of his or her choice. (Log #010677-19) [s. 33. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received fingernail care, including the cutting of fingernails.

A complaint was received through the Action Line by a family member of resident #001. It was alleged that upon return from hospital, adequate care was not provided to resident #001 which included hygiene and grooming.

A review of resident #001's health care record, found the following related to nail care:

• Care Plan- Bathing, shower on Tuesday and Friday morning, trim nails on bath days.

Observations of resident #001 found the following:

• Friday June 21, 2019, 0957 hours- Post shower, nails do not appear to have been trimmed. The nails protrude over the nail bed.
• Tuesday June 25, 2019, 1535 hours- Post shower, nails do not appear to have been trimmed. The nails protrude over the nail bed.
• Thursday June 27, 2019, 0849 hours- nails do not appear to have been trimmed. The nails protrude over the nail bed.

During an interview with Inspector #593, June 26, 2019, PSW #104 indicated that they have showered resident #001 on many occasions. When asked about nail care, PSW #104 indicated that they are not usually comfortable doing this due to difficulty with this resident and so they ask the nurse to trim the resident's nails.

During an interview with Inspector #593, June 27, 2019, PSW #101 indicated that they have showered resident #001 on many occasions as they used to work the 1300 – 2100 hours shift, which is the bath shift for PSWs. When asked about nail care, PSW #101 indicated that this was part of the "bathing package", and when showering resident #001, they would also trim their nails.

During an interview with inspector #593, June 27, 2019, Manager of Personal Care indicated that nail care is usually done with bathing, it is documented on the same flow sheets. If it is noticed between bathing that nails need trimming, any staff would do this. Often, the RN on this unit will trim the resident's nails if they notice that staff are very busy, this may have created some confusion as to who completes this task.

During the inspection, Inspector #593 observed resident #001 with untrimmed nails. It was documented in the care plan that trimming of nails was to be completed on shower days. Post shower, Inspector #593 observed that resident #001's nails had not been trimmed. As such, the licensee has failed to ensure that resident #001 received fingernail care, including the cutting of fingernails. (Log #010677-19) [s. 35. (2)]

Issued on this 11th day of July, 2019

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

Original report signed by the inspector.