Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2019	2019_730593_0030	014325-19	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), MARK MCGILL (733)

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): August 26 - 29, September 3 - 6, 9, 16 - 19, 2019.

Complaint log #014325-19 was inspected related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Manager of Environmental Services, Facilities Supervisor, Registered Nursing Staff, Personal Support Workers (PSWs), housekeeping and family members.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment and reviewed resident health care records, investigation records and licensee policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
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	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 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 has failed to ensure that the care set out in the plan of care was provided to resident #001 as per the plan.

A complaint was received through the Action Line by a family member of resident #001. It was alleged that when another family member was visiting resident #001, they found the resident covered in urine, along with the floor and bed linens. At the time of the incident, two PSWs were also in the room providing care to resident #001.

A review of resident #001's documented care plan, found the following:

• Toileting- at night, resident #001 will be checked if they are incontinent of urine on the first and last round, if awake offer the urinal and remove it when the resident has voided to prevent spills.

A timeline from video surveillance provided by the licensee shows the following:

0600 hours- PSW #103 enters room.

0603 hours- PSW #103 leaves room and re-enters with supplies.

0605 hours- PSW #103 leaves room.

0811 hours- PSWs #104 and #105 enter room and discover resident #001 wet with urine, the bed and the floor are also wet with urine.

0822 hours- Family member of resident #001 enters room. RN #106 enters room.

During an interview with Inspector #593, September 17, 2019, PSW #103 indicated that resident #001 is not toileted during the night shift as they use a urinal, the care that is provided during the night shift includes changing the brief if the resident has been incontinent as well as emptying and cleaning the urinal if the resident has voided. PSW #103 indicated that they need to empty the urinal when it has been full as the resident sometimes spills the contents and when resident #001 voids, it is usually a large volume. PSW #103 indicated that the last time that they check on resident #001 is during last rounds which is usually around 0645 hours, indicating that this is more of a safety check and they don't need to check the urianl at this time, they just need to check that the resident is still in bed.

During an interview with Inspector #593, September 9, 2019, PSW #105 indicated that they were the regular day shift PSW for resident #001. PSW #105 indicated that when

they entered resident #001's room at 0811 hours, the resident was wet all over with urine, and the pull up (incontinence product) was also soaked through.

During an Interview with Inspector #593, September 16, 2019, RN #106 indicated that when they entered resident #001's room two PSWs were transferring resident #001 to the washroom. RN #106 said that the bed was soaked, the floor was soaked and that it was not a regular wetness, it was like someone had poured urine onto the mat. RN #106 was not sure how long the resident was left like that but indicated that there was no odour, so unlikely for very long.

During an interview with Inspector #593, September 19, 2019, Manager of Resident Care indicated that last rounds on night shift were completed right before day shift started at 0700 hours. The Manager of Resident Care also indicated that the expectation of last rounds was to check each resident and change those residents who required to be changed.

As such, the licensee has failed to ensure that the care for resident #001 was provided as per the plan of care related to toileting, as resident #001 was not checked at last rounds by the night shift staff which is the expectation of the home and documented in the resident's plan of care. [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 ensuring that the care set out in the plan of care is provided to resident #001 as per the plan, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.