Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 22, 2020	2020_593573_0002 (A1)	016478-19, 021670-19, 022588-19, 024470-19, 000119-20	Critical Incident System

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

April 17,2020 Home's Administrator requested an extension to the May 30, 2020 compliance due date related to CO #001 s 15 (2) c) - regarding Accommodation Services and balcony doors.
Given the Ontario Health COVID-19 Directives, the request for an extension was approved.
Compliance order CO#001 s. 15 (2) c) has a new compliance due date of September 30, 2020.

Issued on this 22nd day of April, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Inspection Report under *the Long-Term Care Homes Act, 2007*

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
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Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
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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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 20 - 24, 2020.

The Critical Incident System Log(s) #022588-19 and #024470-19 related to resident to resident alleged abuse. Log(s) #021670-19 and #000119-20 related to staff to resident alleged abuse were inspected during this inspection.

Follow up Log #016478-19 - CO #001 from Inspection # 2019_625133_0017 related to water and air infiltration into the home was conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Residents, Personal Support Workers (PSW), Housekeeping staff, Registered Practical Nurses (RPN), Registered Nurses (RN), the Facility Supervisor, the Manager of Hospitality Services, the Program Manager of Personal Care (PMOPC), the Program Manager of Resident Care (PMORC) and the Administrator.

In addition, the inspector reviewed resident health care records, reviewed documents related to water infiltration tracking. The inspector (s) observed the balcony doors and surrounding areas within the 7th, 6th, 3rd and 2nd floor lounges, observed the provision of care and services to residents, staff to resident interactions, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of the original inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

The licensee has failed to comply with Compliance Order (CO) #001 issued as a result of Follow up inspection #2019_625133_0017. The CO report date was November 19, 2019. The CO had a compliance due date of December 21, 2019. The CO was issued pursuant to O. Reg. 79/10, s. 15 (2).

The licensee was ordered to specifically comply with the following items:

1. Permanently rectify the issue of water and air infiltration into the home in the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors.
2. In the area of the 6th floor balcony doors, remediate the damaged and discoloured carpet, the water stained and damaged ceiling areas, and the wall to the right of the doors.
3. Until such time that a permanent solution is found to rectify the issue of water and air infiltration, ensure resident safety by routinely monitoring the areas around the 2nd, 3rd, 6th and 7th floor balcony doors during rain events and/or snow melt. Ensure the 6th floor carpet is cleaned and dried following a water infiltration event. Document the monitoring, as well as all corrective actions and safety measures taken.

The licensee completed section #2 and section #3 of CO #001 from inspection report #2019_625133_0017. The licensee failed to comply section #1 in that the issue of water and air infiltration into the home in the area of the balcony doors on the 6th and 7th floors were not permanently rectified.

On January 21, 2020, Inspector spoke with the Facility Supervisor, who stated that the issue of water and air infiltration into the home in the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors were rectified. The Inspector was informed that the source of the problem was identified, and new commercial balcony doors were installed to permanently rectify the water and air infiltration in the above identified floors.

On January 21, 2020, Inspector #573 observed the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors.

The Inspector observed there was no evidence of water and air infiltration into the home in the area of the balcony doors on the 2nd and 3rd floor.

On the 6th floor, the Inspector observed a saturated blanket which was placed underneath the carpet in front of the balcony door. When the carpet was lifted, Inspector #573 observed standing water on the floor and the water was coming in from underneath the balcony door corners.

On the 7th floor, the Inspector observed a saturated blanket in the area in front of the balcony door, within the lounge. The inspector observed that the floor area in front of the balcony door was wet.

Related to the 7th floor, Inspector spoke with housekeeping staff #115, they indicated that at the beginning of their shift, they will check for any water infiltration at the balcony door. If they noticed the water coming in from the balcony door, they would clean the area and place the blanket in front of the balcony door. Housekeeping staff #115 stated that the water infiltration usually coincided with the rain, nor when the snow melts. Furthermore, they indicated that they had noticed this problem even after the installation of the new balcony door.

Further, related to the 6th floor, on January 21, 2020, Inspector spoke with housekeeping staff #114, they indicated that when they start their shift in the morning, sometimes they will notice accumulated water on the floor in the area of the balcony door. The housekeeper indicated that they would clean the area and place the blanket underneath the carpet in front of the balcony door. Furthermore, the housekeeping staff #114 stated that they will frequently monitor for any water infiltration and document the actions taken in the water infiltration tracking record. The housekeeping staff stated to the inspector that sometimes the blanket will be

saturated and sometimes it will be damp.

On January 21, 2020, Inspector #573 observed the area of the balcony doors on the 6th and 7th floors in the presence of Facility Supervisor, Manager of Hospitality Services and the Administrator. They all agreed with Inspector #573 that there is evidence of water infiltration into the home in the area of the balcony doors on the 6th and 7th floors. Furthermore, the Administrator stated that they will consult with the contractor who installed the new balcony doors to permanently rectify the issue of water infiltration.(Log #016478-19) [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 22nd day of April, 2020 (A1)

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	Amended by LYNE DUCHESNE (117) - (A1)
Inspection No. / No de l’inspection :	2020_593573_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	016478-19, 021670-19, 022588-19, 024470-19, 000119-20 (A1)
Type of Inspection / Genre d’inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 22, 2020(A1)
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Garry J. Armstrong Home 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Sheila Bauer

To City of Ottawa, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_625133_0017, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall be compliant with LTCHA, 2007, s. 15. (2)

1. Identify the primary source of water infiltration and permanently rectify the issue in the area of the balcony doors on the 6th and 7th floors.

2. Until such time that a permanent solution is found to rectify the water infiltration, ensure resident safety by routinely monitoring the areas around the 6th and 7th floor balcony doors during rain events and/or snow melt. Ensure the 6th and 7th floor is cleaned and dried following any water infiltration event. Document the monitoring, as well as all corrective actions and safety measures taken.

Grounds / Motifs :

1. The licensee has failed to ensure that the home is maintained in a safe condition and in a good state of repair.

The licensee has failed to comply with Compliance Order (CO) #001 issued as a result of Follow up inspection #2019_625133_0017. The CO report date was November 19, 2019. The CO had a compliance due date of December 21, 2019. The

CO was issued pursuant to O. Reg. 79/10, s. 15 (2).

The licensee was ordered to specifically comply with the following items:

1. Permanently rectify the issue of water and air infiltration into the home in the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors.
2. In the area of the 6th floor balcony doors, remediate the damaged and discoloured carpet, the water stained and damaged ceiling areas, and the wall to the right of the doors.
3. Until such time that a permanent solution is found to rectify the issue of water and air infiltration, ensure resident safety by routinely monitoring the areas around the 2nd, 3rd, 6th and 7th floor balcony doors during rain events and/or snow melt. Ensure the 6th floor carpet is cleaned and dried following a water infiltration event. Document the monitoring, as well as all corrective actions and safety measures taken.

The licensee completed section #2 and section #3 of CO #001 from inspection report #2019_625133_0017. The licensee failed to comply section #1 in that the issue of water and air infiltration into the home in the area of the balcony doors on the 6th and 7th floors were not permanently rectified.

On January 21, 2020, Inspector spoke with the Facility Supervisor, who stated that the issue of water and air infiltration into the home in the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors were rectified. The Inspector was informed that the source of the problem was identified, and new commercial balcony doors were installed to permanently rectify the water and air infiltration in the above identified floors.

On January 21, 2020, Inspector #573 observed the area of the balcony doors on the 2nd, 3rd, 6th and 7th floors.

The Inspector observed there was no evidence of water and air infiltration into the home in the area of the balcony doors on the 2nd and 3rd floor.

On the 6th floor, the Inspector observed a saturated blanket which was placed underneath the carpet in front of the balcony door. When the carpet was lifted, Inspector #573 observed standing water on the floor and the water was coming in

from underneath the balcony door corners.

On the 7th floor, the Inspector observed a saturated blanket in the area in front of the balcony door, within the lounge. The inspector observed that the floor area in front of the balcony door was wet.

Related to the 7th floor, Inspector spoke with housekeeping staff #115, they indicated that at the beginning of their shift, they will check for any water infiltration at the balcony door. If they noticed the water coming in from the balcony door, they would clean the area and place the blanket in front of the balcony door. Housekeeping staff #115 stated that the water infiltration usually coincided with the rain, nor when the snow melts. Furthermore, they indicated that they had noticed this problem even after the installation of the new balcony door.

Further, related to the 6th floor, on January 21, 2020, Inspector spoke with housekeeping staff #114, they indicated that when they start their shift in the morning, sometimes they will notice accumulated water on the floor in the area of the balcony door. The housekeeper indicated that they would clean the area and place the blanket underneath the carpet in front of the balcony door. Furthermore, the housekeeping staff #114 stated that they will frequently monitor for any water infiltration and document the actions taken in the water infiltration tracking record. The housekeeping staff stated to the inspector that sometimes the blanket will be saturated and sometimes it will be damp.

On January 21, 2020, Inspector #573 observed the area of the balcony doors on the 6th and 7th floors in the presence of Facility Supervisor, Manager of Hospitality Services and the Administrator. They all agreed with Inspector #573 that there is evidence of water infiltration into the home in the area of the balcony doors on the 6th and 7th floors. Furthermore, the Administrator stated that they will consult with the contractor who installed the new balcony doors to permanently rectify the issue of water infiltration.

In summary, the licensee has failed to comply with all the aspects of Compliance Order #001, issued as a result of Follow up inspection #2019_625133_0017. As a result of the continuing non-compliance, there is minimal risk of harm to the residents on the 6th and 7th floors. The Compliance Order (CO) was reissued to the same section and subsection. (573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of April, 2020 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by LYNE DUCHESNE (117) - (A1)

Service Area Office / Bureau régional de services : Ottawa Service Area Office