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

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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 20, 2020	2020_593573_0009	003984-20	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

ANANDRAJ NATARAJAN (573)

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 22, 30, 2020, July 02, 03, and 08, 2020, on site and June 23, 24, 25, 26, 29, 2020, July 06, 07 and 09, 2020 off site.

Complaint Log #003984-20 related to allegation of improper care and allegation of staff to resident neglect was inspected during this inspection.

Inspector conducted a concurrent Critical Incident System (CIS) inspection 2020_593573_0011 / 003896-20 related to the identified incident during this inspection.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSW), Housekeeping staffs, Registered Practical Nurses (RPN), Registered Nurses (RN), the Registered Dietician, the Program Manager of Personal Care (PMOPC), the Program Manager of Resident Care (PMORC) and the Administrator.

During the course of the inspection, Inspector(s) reviewed critical incident reports, documents related to the licensee's investigation into the alleged incidents of improper care, resident health care records and staff education/training records. The Inspector(s) observed residents, resident home areas, infection control practices. In addition, inspector(s) observed the provision of care to the resident and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A complaint was submitted to the Ministry of Long Term -Care (MLTC) that indicated that the staff did not treat resident #001 with respect and dignity.

The complainant stated that resident #001 was positioned in the bed, naked from the waist down, while a PSW was feeding the resident. The complainant alleged that no attempts were made by the PSW to assist the resident to cover up prior to feeding.

Inspector #573 reviewed video photo images showing that resident #001 was positioned in the bed, naked from the waist down, while PSW #101 was feeding the resident. Furthermore, it was noted that the resident's blanket was placed at the foot end of the bed.

The Program Manager for Personal Care (PMPC) was provided with and reviewed the video photo images. The PMPC stated that an investigation was immediately initiated for the above complaint. The PMPC stated that during their investigation, PSW #101 reported that resident #001 refused to be covered while being fed. The PMPC indicated that when resident #001 refused to be covered up, the PSW should not have proceeded with the feeding and should have immediately reported to the registered nursing staff on the unit. [s. 3. (1) 1.]

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 to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #001, proper techniques were used to assist with eating, including safe positioning of the resident who require assistance.

A complaint was submitted to the Ministry of Long Term -Care (MLTC) regarding the care and services received by resident #001 at the Long Term -Care home.

Resident #001's plan of care for nutritional status identified that the resident has swallowing difficulties and at risk for choking. Furthermore, the plan of care indicated that the resident required staff assistance for feeding and the staff are to position resident #001 at 90 degree angle, in the sitting position for meals.

Inspector #573 reviewed video photo images, whereby PSW #101 was observed feeding resident #001 in bed. The PSW was observed standing while feeding the resident, and the resident was not positioned at 90 degree angle. Furthermore, it was noted that the resident's body or head was not in the center of the bed and the head was not in an upright position.

An interview with Registered Dietitian #102 confirmed that the above feeding techniques by PSW #101 were not considered safe for resident #001. [s. 73. (1) 10.]

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 to ensure that the home has proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 18th day of August, 2020

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

Original report signed by the inspector.