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
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
Apr 16, 2021	2021_593573_0007	001763-21	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): March 23 - 26, 29 - 31, 2020

Complaint Log #001763-21 related to resident care and services was inspected.

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

During the course of the inspection, the inspector(s) reviewed the resident’s health care 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:
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
2 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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for the resident set out clear directions to the staff regarding the resident’s routine, specifically related to self administration of their medications.

A resident’s plan of care indicated that the resident required one staff extensive assistance from lying to sitting in the bed. The resident plan of care identified that the resident self administered their medication as per the physician’s order. The resident had a physician’s order to have one of their medication at a specified time for their diagnosis.

The inspector reviewed video footage, whereby a staff member left the resident room after assisting the resident’s care in their bed. The resident was observed in lying and to be waiting in their bed for the staff to assist them to have their medication. Past the resident’s medication scheduled time, the inspector observed that the resident was calling out for help and a staff member assisted the resident to have their medication. A review of the resident’s plan of care indicated that it does not provide clear directions to the staff regarding the resident’s morning routine to address their self administer medications schedule. The resident was left in their bed, past the scheduled time for their medication. As a result, the medication had to be taken late and that delayed their subsequent scheduled medications.

Sources: The resident's plan of care, video footage and interview with the RN . [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The inspector reviewed two residents plan of care for bathing, which identified that the residents were to receive their bath twice a week. The Inspector reviewed both the residents PSW bath record documentation. A review of both the residents bath record during an identified period indicated that the resident did not received their bath twice weekly as required. During an interview, the RN indicated that the PSWs were expected to complete the documentation in the resident’s bath record in relation to the provision of the care. The RN reviewed the two residents bath record and the progress notes. After the review, the RN acknowledged that there was no documentation completed that the two residents received their bath on the identified dates.

Sources: The residents plan of care, progress notes, bath records and interview with the RN. [s. 6. (9) 1.]

WN #2: 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 the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The plan of care for the resident directed the staff to provide the resident’s bath twice a week. A review of the resident’s bath record during an identified period indicated that the resident did not receive their bath twice weekly as required. During an interview, the RN stated that the resident did not have any behavioural concerns where staff would not be able to provide the bath. Furthermore, the RN stated that if the resident refused bath it would be documented in the PSW flow sheet or in the progress notes. After reviewing the resident’s bath record and progress notes, the RN was not able to give any reasons for the resident’s missed bath.

Sources: The resident's plan of care, progress notes, bath record, video footage, and interview with the RN. [s. 33. (1)]

Issued on this 28th day of April, 2021

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

Original report signed by the inspector.