Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: July 25, 2024
Inspection Number: 2024-1617-0005
Inspection Type: Complaint Critical Incident Follow Up
Licensee: City of Ottawa
Long Term Care Home and City: Garry J. Armstrong Home, Ottawa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 15-19, 2024, July 22-25, 2024

The following intakes were completed in this Critical Incident (CI) inspection:
Intake: #00114333/CI#M622-000028-24 regarding an allegation of neglect
Intake: #00114616 /CI#M622-000030-24 regarding an allegation of abuse
Intake: #00116026 /CI#M622-000036-24 regarding an allegation of improper/Incompetent treatment

Intake: #00117775/CI#M622-000044-24 regarding a written complaint associated with infection prevention and control
Intake: #00119498/CI#M622-000048-24 regarding a severe hypoglycemic incident
Intake: #0011993/CI# M622-000051-24 regarding a missing resident >3 hours
Intake: #00116831/CI#M622-000039-24, and Intake: #00117444/CI#M622-000043-24 regarding falls prevention and management

The following intake was completed in this Follow up inspection
Intake #00117032 regarding a follow up to a compliance order that was issued to O. Reg. 246/22 - s. 140 (2)

The following intake was completed in this Complaint inspection
Intake: #00117608 regarding compliance with plan of care

The following intakes were completed in this inspection:
Intake:#00113551/CI#M622-000027-24, Intake#00117412/CI#M622-000042-24, and Intake: #00115804/CI#M622-000035-24

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1617-0003 related to O. Reg. 246/22, s. 140 (2) inspected by Gabriella Kuilder (000726)

The following Inspection Protocols were used during this inspection:

Continence Care
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care fails to provide clear directions to staff and others who provide direct care to the resident.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that a written plan of care was set out providing clear directions to staff and others who provide direct care a resident.

Sources: CI #M622-000045-24, observations, a resident's clinical records, and interviews with a Personal Support Worker, a Registered Nurse, and an Administration staff.
[000807].

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
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.

The licensee has failed to ensure the care set out in the plan of care for a resident was provided on a specific time and date resulting in the resident falling.

Sources: Video clips of the incident on a specific date, a resident's health records, licensee's internal investigation notes, and interviews with a Personal Support Worker (PSW), a Registered Nurse (RN), and a Program Manager. [000723]

WRITTEN NOTIFICATION: Records on restraining of residents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 37 1.
Records on restraining of residents
s. 37. Every licensee of a long-term care home shall keep records in the home, as provided for in the regulations, in relation to the following:
1. The restraining of a resident.

The licensee has failed to keep records in the home as provided for in the regulations, regarding the restraining of a resident.

Sources: Interview with a Registered Nurse (RN), a Personal Support Worker (PSW), a resident's health care records, a Program Manager, Policy: 335.10-Minimizing Restraints and Personal Division Resident Care Assistance Service Devices (PASDs) (revised January, 2024)
[000726]

WRITTEN NOTIFICATION: Transferring and positioning

techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring devices and techniques when assisting a resident into bed post-fall on a specific date.

Sources: Video clips of the incident on a specific date, a resident's health records, Lifting and Transferring Residents policy and procedure (350.05), last reviewed June 2024, and interviews with a Personal Support Worker (PSW), a Registered Nurse (RN) , and a Physiotherapist. [000723]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 56 (2) (b)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

The licensee has failed to ensure that a resident, who has episodes of incontinence, has an individualized plan, as part of their plan of care, to promote and manage continence based on the home's assessment and that the plan is implemented.

Sources: a resident's health care records, interview with a Program Manager, and a Personal support worker.
[000726]

WRITTEN NOTIFICATION: Notification re incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (2)
Notification re incidents
s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee has failed to ensure that a resident's substitute decision maker was notified of the results of an investigation of alleged neglect by staff towards the resident immediately upon completion of the investigation.

Sources: Critical incident report M622-000041-24, licensee's internal investigation notes, and interview with a Program Manager. [000723]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to include the contact information for the patient ombudsman as required under the Excellent Care for All Act, 2010 in a response to a complainant.

Sources: Interview with a Program Manager, and response letter to a complainant. [000726]