

Ministry of Long-Term Care

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

Ottawa District

347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Public Report

Report Issue Date: July 31, 2025

Inspection Number: 2025-1617-0006

Inspection Type:

Complaint
Critical Incident

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 22, 23, 24, 28, 29, 2025

The following intake(s) were inspected:

Critical Incident System Report (CIS)

- Intakes #00149777 (CIS #M622-000033-25) and #00151714 (CIS #M622-000040-25), related to alleged abuse of a resident by visitor.
- Intake: #00152903 (CIS #M622-000050-25) related to a fall of resident resulting in injury.

Complaints

- Intake #00150543 related to a bed refusal.
- Intake: #00151758 related to an injury to a resident.

The following **Inspection Protocols** were used during this inspection:

Prevention of Abuse and Neglect
Falls Prevention and Management

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Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls prevention and management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

Plan of care

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.

The licensee has failed to ensure that a resident's intentional rounding was documented as per plan of care.

The resident was identified as being at high risk for falls and experienced a fall with injury. As a result, hourly intentional rounding was required. The documentation from a period in July 2025, indicated that the intentional hourly rounding was not consistently recorded.

Sources: Intentional hourly rounding record. Interview with a staff member.

WRITTEN NOTIFICATION: Bed refusal

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 51 (7) (b)

Authorization for admission to a home

s. 51 (7) The appropriate placement co-ordinator shall give the licensee of each

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selected home copies of the assessments and information that were required to have been taken into account, under subsection 50 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

The licensee has failed to comply with FLTCA, s. 51 (7) (b) when they withheld applicant's approval for admission to the home.

The written notice to the applicant stated that the home lacked the nursing expertise required to meet the applicant's care needs, related to specified behaviours. The Behavioral Assessment Tool indicated that the applicant exhibited identified responsive behaviors.

Staff members confirmed that the home has a program for managing responsive behaviors and staff are trained to support residents exhibiting such behaviors.

Furthermore, the home has access to additional resources, including geriatric psychiatry outreach team, and the capacity to implement interventions such as one-to-one monitoring when necessary. A review of the admission package revealed that the applicant does not require any specialized resources to meet the applicant's care needs.

Sources: Review of Written notice, InterRAI Home Care Assessment, Behavioral Assessment Tool, Health Assessment - Ontario Health at Home and interviews with staff members.