Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 28, 2013	2013_029134_0006	O-000071-13	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 21 and 22, 2013

The inspector was in the home between March 19 to March 22, 2013 conducting 2 other inspections - a follow-up inspection log # O-000035-13 and a complaint inspection log # O-000054-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Program Manager of Resident Care (PMORC), one Registered Practical Nurse, One Registered Nurse, several Personal Support Workers (PSW) and with Resident #3.

During the course of the inspection, the inspector(s) reviewed Resident #2 and Resident #3's Health Records and the Critical Incident Reports.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The Licensee failed to comply with the LTCHA S.O.2007, c.8 s. 6(7) in that the Licensee failed to provide the care set out in the plan of care for Resident #2 as it relates to responsive behaviors.

Resident #2's progress notes from January to March, 2013, were reviewed. On a specified date in January, 2013 there is a chart entry indicating Resident #2 went to Resident #3's bedroom and Resident #3's family member became upset and told Resident #2 to get out and not to go near Resident #3. On another specified date in January, 2013, there is a chart entry indicating that Resident #2 had allegedly been inappropriate toward Resident #3.

Resident #2's plan of care was reviewed. It had been revised and updated on a specific date in January, 2013 to include the following in bold letters; "Keep Resident #2 away from Resident #3 and family".

On a specified date in February, 2013, there is a chart entry indicating that Resident #2 entered Resident #3's bedroom while a family member was there. There was a physical altercation between Resident #3's family member and Resident #2. Resident #2 sustained minor injuries as a result of the altercation.

On a specific date in February, 2013 Resident #2's plan of care was revised and updated to include the following: "Resident #2 is to be monitored on a "one on one basis" during specified hours to provide safety to Resident #2. As well there is another statement specifying that the assigned staff member is encouraged to not leave Resident #2 unattended at all, during this period of time".

There is a chart entry made on a specified date in March, 2013 indicating that the staff member who was monitoring Resident #2 on a "one on one basis" had left Resident #2 unattended for several minutes. While left unattended for a few minutes Resident #2 went into Resident #3's bedroom where Resident #3's family member proceeded to assault Resident #2 and as a result Resident #2 sustained injuries as a consequence of the physical altercation.

As such the care set out in the revised plan of care of January, 2013 was not provided to Resident #2 and as a consequence Resident #2 was injured during the two physical altercations of February and March, 2013. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident, to be implemented voluntarily.

Issued on this 3rd day of April, 2013

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

Colette Asselin, LTCH Inspector #134