



**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**

**Division de la responsabilisation et de la
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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 27, 2013	2013_029134_0005	O-000054- 13	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): March 19 to March 22, 2013

Two other inspections were conducted at the time of this inspection; a follow-up inspection log # O-000035-13 and a critical incident inspection log # O-000071-13.

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

During the course of the inspection, the inspector(s) reviewed Resident #1's health records and narcotic sheets.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Nutrition and Hydration

Pain

Personal Support Services

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. (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).**

Findings/Faits saillants :



1. The licensee failed to comply with the LTCHA, S.O. 2007, c.8 s.6 (1) (c) in that the plan of care does not provide clear directions to staff as it relates to Resident #1's mouth care and early morning care.

Resident #1's plan of care was reviewed. There is an entry specifying that staff is to adhere to Resident #1's biological clock and to let resident sleep as per resident's wishes day and night. There is another entry indicating to apply super absorbent incontinent products to allow undisturbed sleep; to keep the light on in bathroom to allow Resident #1 to find the bathroom during the night. Staff member #S01 was interviewed and indicated that Resident #1 is unable to toilet self at night and that staff will wake Resident #1 between 6:30 and 7:00 for toileting, washing and to get dressed.

Staff members #S101 and #S102 were interviewed and both indicated that Resident #1 is deep asleep at 6:30 in the morning but they will proceed to wake resident for toileting and washing even though the resident is difficult to arouse. [s. 6. (1) (c)]

2. Resident #1's Substitute Decision Maker (SDM) was interviewed and indicated that mouth care was not done consistently and that Resident #1's teeth are not always brushed.

Resident #1 has an upper partial plate as well as own lower teeth. The plan of care and the staff assignment sheet were reviewed on March 19, 2013. There were no clear directions provided to staff related to mouth care and denture care for Resident #1.

As such the plan of care does not provide clear directions to staff who provide direct care as it relates to early morning care, night toileting and oral care. [s. 6. (1) (c)]



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Issued on this 3rd day of April, 2013

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

Collette Asseli, LTCH Inspector # 134