



**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
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|--------------------------------|--|
| Jan 7, 2016 | 2015_391603_0036 | 032182-15 | Resident Quality Inspection |

Licensee/Titulaire de permis

JARLETTE LTD.
689 YONGE STREET MIDLAND ON L4R 2E1

Long-Term Care Home/Foyer de soins de longue durée

TEMISKAMING LODGE
100 BRUCE STREET P.O. BOX 1180 HAILEYBURY ON P0J 1K0

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

SYLVIE LAVICTOIRE (603), DEBBIE WARPULA (577), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 7-11, December 14-16, 2015

During the course of the inspection, the inspector (s) reviewed residents' health care records, reviewed various policies, procedures and programs, conducted a daily walk-through of the home, observed the delivery of resident care, staff to resident interactions, and observed medication administration. The following logs related to the Ministry of Health and Long-Term Care were also completed during the inspection: A critical incident the home submitted in regards to allegations of abuse to a resident, a critical incident the home submitted in regards to resident to resident abuse, a critical incident the home submitted in regards to a resident fall and injury, a complaint regarding abuse and neglect, and a critical incident the home submitted related to resident fall, injury, and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Co-Director of Care, Maintenance Manager, RN/RAI-Coordinator, Registered Staff (RNs and RPNs), Social Worker, Restorative Care Coordinator, Physio Therapy Aid, Personal Support Workers, Laundry Staff, Residents, and Family Members.

The following Inspection Protocols were used during this inspection:



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**Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing**

During the course of this inspection, Non-Compliances were issued.

6 WN(s)

5 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights
Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

During the course of the inspection, Inspector #617 witnessed PSW #101 enter resident #011's room and abruptly directed resident to leave their room, telling them to "hurry up" as there was a fire drill. PSW #101 put their hand on resident #011's shoulder, rushing resident to get up and the resident stumbled. Inspector noted that resident #011 was upset and heard resident tell PSW #101 to stop pushing them around.

An interview with resident #011 revealed that PSW #101 told them to "hurry up, hurry up", and was rushing and pushing them. Resident #011 reported that it made them very nervous and they felt like they were close to "having a seizure".

A review of the home's internal investigation revealed that the Administrator could not confirm any findings of abuse or rough handling towards resident #011. The Administrator concluded that education needed to be provided to staff concerning approach towards residents.

A review of PSW #101's performance appraisal revealed a specific developmental objective.

An interview with the Administrator confirmed that it was the home's expectation that staff approach the residents in a gentle and respectful manner. [s. 3. (1) 1.]

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 ensuring that resident #011 is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and dignity, to be implemented voluntarily.

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**



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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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

On December 14, 2015, Inspector #603 reviewed 2 complaints reported to the Director. The reports indicated concerns regarding improper and lack of care for resident #017. Inspector also reviewed a Critical Incident (CI) which was reported to the Director. The CI report alleged abuse/neglect of resident #017.

A review of resident #017's care plan indicated that the care requirements must be provided by two staff members at all times. Under different focuses, the resident required assistance of only one staff, which was contradictory.

An interview with RN #114 revealed that the resident was very unpredictable and for this reason, resident #017 required care to be completed by 2 staff members. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #603 reviewed a Critical Incident (CI) Report which was reported to the Director. The CI indicated that on a certain date, resident #020 sexually abused resident #019.

A review of resident #020's health care records revealed another Critical Incident Report (CI) reported to the Director, which happened one week before the last CI. The CI indicated that resident #020 had sexually abused another resident. The care plan was updated, including close surveillance, monitoring resident's whereabouts, and if in close proximity or inside specific resident rooms, the staff were to redirect resident #020. The home implemented hourly checks and documentation was continued until a certain date.

A review of resident #020's care plan indicated that the resident was to be monitored closely for potential inappropriate behaviours and to be redirected if in close proximity or entered specific resident rooms. There was no mention of required hourly checks or how long the monitoring should continue for. [s. 6. (1) (c)]



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 ensuring that the plans of care set out clear directions to staff and others who provide direct care to resident #020 and all residents, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:**

- s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
- (a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
 - (b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
 - (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

On December 8, 2015, Inspector #603 interviewed resident #007 and during the interview, the resident's dentures were not fitting correctly. Resident #007 explained that their dentures were too big and that they were not able and often forgot to apply "glue" to the dentures. Resident #007 also explained that the staff did not assist them to apply the "glue" to the dentures.

A review of resident #007's care plan indicated that the resident's dentures will be properly fitted and that staff are to provide oral hygiene and denture care morning and



night.

A review of resident #007's health care records revealed that for a certain period of time, there was one day where oral care was provided only once and there was no mention of staff applying glue to the resident's dentures.

Inspector interviewed the Director of Care who explained that it is the home's expectation that all residents will receive oral care at least twice a day and that the staff will document on POC.

A review of the home's policy 'Resident Rights, Care and Services - Nursing and Personal Support Services - Oral Care' revealed that Oral care shall be provided each morning and evening, at minimum to maintain the integrity of the oral tissue. [s. 34. (1) (a)]

2. The licensee has failed to ensure the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

On December 8, 2015, Inspector #577 interviewed resident #013 and noted that the resident had dental problems.

Inspector #603 reviewed resident #013's care plan which indicated that the resident did not brush their teeth and the staff were to provide oral hygiene every morning, every night, and as needed.

Inspector #603 reviewed resident #013's health care records and for a certain period of time, there were 13 days where oral care was provided only once a day.

Inspector interviewed the Director of Care who explained that it is the home's expectation that all residents will receive oral care at least twice a day and that the staff will document on POC.

A review of the home's policy 'Resident Rights, Care and Services - Nursing and Personal Support Services - Oral Care' revealed that Oral care shall be provided each morning and evening, at minimum to maintain the integrity of the oral tissue. [s. 34. (1) (a)]



3. The licensee has failed to ensure the resident was offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required.

On December 8, 2015, Inspector #603 interviewed resident #007 and during the interview, the resident's dentures were not fitting correctly. Resident #007 explained that their dentures were too big and that they were not able and often forgot to apply "glue" to the dentures. Resident #007 also explained that they did not remember the last time they were offered an assessment by a dentist or a denturist.

A review of resident #007's care plan indicated that the resident's dentures will be properly maintained and fitted. The health care records revealed no indication of an annual dental assessment being offered or completed.

A review of the home's policy 'Resident Rights, Care and Services - Nursing and Personal Support Services - Oral Care' revealed that the Administrator, in collaboration with the Resident Family Service Coordinator (RFSC) will offer an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident and or their POA (personal care).

An interview with the Administrator and the Director of Care revealed that the home does not offer an annual dental assessment for residents. [s. 34. (1) (c)]

4. The licensee has failed to ensure that resident #013 was offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required.

On December 8, 2015, Inspector #577 interviewed resident #013 and noted that they had dental problems. Resident #013 did not remember the last time they were offered to see a dentist.

Inspector #603 reviewed resident #013's health care records and there was no indication that an annual dental assessment was offered or completed.

A review of the home's policy 'Resident Rights, Care and Services - Nursing and Personal Support Services - Oral Care' revealed that the Administrator, in collaboration with the Resident Family Service Coordinator (RFSC) will offer an annual dental assessment and other preventative dental services, subject to payment being authorized



by the resident and or their POA (personal care).

An interview with the Administrator and the Director of Care revealed that the home does not offer an annual dental assessment for residents. [s. 34. (1) (c)]

5. The licensee has failed to ensure that the resident was offered an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident/SDM if payment is required.

On December 8, 2015, Inspector #603 reviewed resident #014's health care records and there was no indication of an annual dental assessment offered or completed for 2015.

A review of the home's policy 'Resident Rights, Care and Services - Nursing and Personal Support Services - Oral Care' revealed that the Administrator, in collaboration with the Resident Family Service Coordinator (RFSC) will offer an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident and or their POA (personal care).

An interview with the Administrator and the Director of Care revealed that the home does not offer an annual dental assessment for residents. [s. 34. (1) (c)]

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 ensuring that resident #007 and #013 receive oral care to maintain the integrity of the oral issue, including mouth care in the morning and evening and that all residents are offered an annual dental assessment and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training



Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

A review of the direct care staff training list for registered and non-registered staff related to the homes policy to promote zero tolerance of abuse and neglect, revealed that 66 out of 80, or 82.5% completed the required annual retraining. A review of the direct care staff training list related to whistle-blowing protections and duty to make mandatory reports, revealed that 23 out of 35, or 61.5% of PSWs and 8 out of 13, or 61.5% of registered staff members completed the required annual retraining.

An interview with the Educator #103 confirmed that 82.5% completed the required retraining on the homes policy to promote zero tolerance of abuse and neglect and 64.6% of non-registered and registered staff completed the required retraining on whistle-blowing protections and duty to make mandatory reports. Educator #103 confirmed that the home will not reach 100% completion of required retraining by the end of the year 2015.

An interview with the Administrator confirmed that it was the home's expectation that all staff receive annual retraining on the home's policy to promote zero tolerance of abuse and neglect, whistle-blowing protections, and duty to make mandatory reports. [s. 76. (4)]



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 ensuring that all staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,

(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).

(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).

(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).

(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :



1. The licensee has failed to ensure that the Family Council receives the results of the satisfaction survey in order to seek the advice of the Council about the survey.

On December 11, 2015, Inspector #603 interviewed an active member of the Family Council since there was no President of the Council. The member explained that the results of the home's satisfaction survey have not been made available to the Family Council to seek their advice.

An interview with the Administrator confirmed that the home had not made available the results of the satisfaction survey to the Family Council. [s. 85. (4) (a)]

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 ensuring that the Family Council receive the results of the satisfaction survey in order to seek the advice of the Council about the survey, to be implemented voluntarily.

WN #6: 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 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.

On December 14, 2015, Inspector #603 reviewed 2 complaints filed with the Director. The reports indicated concerns regarding improper and lack of care for resident #017. Inspector also reviewed a Critical Incident (CI) which was reported to the Director. The CI indicated alleged abuse/neglect of resident #017.

Inspector reviewed resident #017's health care records, specifically the bathing documentation on POC for a certain period of time. Inspector noted that the resident did not receive baths during 2 specific weeks and during 4 different weeks, the resident received one bath and refused other baths.

Inspector reviewed resident #017's current care plan which indicated 'attempts will be made twice a week to give resident a tub bath'.

Inspector interviewed the Director of Care who explained that the home's expectation is that each resident will receive a bath twice a week and if they refuse or staff are unable to provide the bath, the staff will document if the baths were not completed for any reason. [s. 33. (1)]

Issued on this 7th day of January, 2016

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

Original report signed by the inspector.