Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2019	2019_805638_0024	020288-19, 020393-19	Critical Incident System

Licensee/Titulaire de permis

Jarlette Ltd.
c/o Jarlette Health Services 711 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

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 4 - 6, 2019.

The following intakes were completed in this critical incident system inspection:
-One log was related to an alleged incident of staff to resident verbal abuse; and
-One log was related to an alleged incident of staff to resident improper care and neglect.

A complaint inspection #2019_805638_0023, was conducted concurrently with this critical incident system inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, investigation notes, training and resident health care records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff complied with the home's policy to promote zero tolerance of abuse and neglect.

A critical incident system (CIS) report was submitted to the Director which indicated that RN #105 had verbally abused resident #003.

a) Inspector #638 reviewed resident #003's health care records and identified a progress note created by RN #105 on the date of the incident, which indicated that the resident continued to demonstrate specific responsive behaviours.

The Inspector reviewed resident #003's care plan and identified two different interventions to support the resident when demonstrating responsive behaviours.

b) Inspector #638 reviewed the home's internal investigation notes and identified an interview between PSW #111 and the DOC which described both RN #105 and the resident's demeanor that shift.

The investigation notes indicated that PSW #110 and RPN #107 said that RN #105 was verbally abusive towards resident #003.

The investigation notes identified that RN #105 received disciplinary action. The notes identified the home found the RNs actions, when they were verbally abusive towards resident #003 was unacceptable.

In an interview with Inspector #638, PSW #110 indicated they had witnessed resident #003 demonstrating specific responsive behaviours. The PSW indicated that RN #105 reported providing a specific intervention to the resident multiple times and when the resident began demonstrating a specific responsive behaviour again, they overheard the RN make a verbally abusive statement towards the resident.

During an interview with Inspector #638, RPN #107 indicated that they overheard RN #105's statement towards resident #003.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 2019, described verbal abuse as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that was made by anyone other than a resident.

In an interview with Inspector #638, the Administrator, DOC and Co-DOC #103 indicated that speaking to or about a resident in the manner that was alleged was never appropriate. The Administrator indicated that the RN was trained on the home's zero tolerance of abuse policy. [s. 20. (1)]

2. A CIS report was submitted to the Director related to an incident of staff to resident verbal abuse. Please see WN #1, finding #1 for details.

Inspector #638 reviewed the dates of the incident and when the home first notified the Director and identified that the incident had occurred on a specific date, however, the after-hours line was only contacted six days later and the CIS report was submitted another three days later. Six days had passed between the incident and when the Director was first notified.

The Inspector reviewed the home's internal investigation notes and identified that PSW #110 had reported the incident to RPN #107 at the time of the incident. In a separate note the RPN indicated that they were notified by the PSW.

In an interview with Inspector #638, PSW #110 indicated that upon witnessing the incident they notified RPN #107 who also was uncertain of the steps to take. The PSW indicated that they sat on the information for a day or two and then reported to RN #112. The PSW indicated the RN stated they had to report this incident and completed the report to management at that time.

During an interview with Inspector #638, RPN #107 indicated they were not sure what they learned in orientation, but now knew they were to immediately report the incident and if it was the charge nurse involved, they were able to report directly to management.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last revised April 2019, indicated that suspected and or confirmed allegations of abuse shall be reported immediately. The process included any staff member who had reasonable grounds to suspect abuse or neglect of a resident must immediately report their suspicion to the most Senior Administrative Personnel or Charge Nurse if no manager is on site at the Home. The policy further identified the Manager On-Call is to be notified if the allegation of abuse or neglect occurred after hours.

In an interview with Inspector #638, the Administrator, DOC and Co-DOC #103 indicated that RPN #107 was up to date with their training and that they did not follow the home's policy when they did not report what PSW #110 had reviewed with them regarding RN #105's approach towards resident #003. [s. 20. (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 to ensure that staff implement and comply with the home's policy to promote zero tolerance of abuse and neglect, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (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 his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent had an individualized plan as part of their plan of care to promote and manage bowel and bladder continence that was implemented.

A CIS report was submitted to the Director related to an incident where resident #002 was found by the oncoming shift PSW, sitting on the toilet, upset and crying. The resident identified that the PSW on the previous shift told the resident they only had a short period of time to provide care and the resident indicated they "might as well leave" then. The report identified that the PSW did not report to the oncoming staff that the resident required care.

Inspector #638 reviewed the home's investigation notes and identified that PSW #109 was directed to respond to resident #002's call bell at a specific time, by RN #106. The notes further identified that PSW #109 told the resident they only had a few minutes to complete care and the resident stated they might as well leave as they were rushed. The PSW left the resident and did not report to the oncoming shift staff what care the resident still needed. The resident was found on the toilet crying 40 minutes later by PSW #108.

In an interview with Inspector #638, PSW #109 they indicated they had been directed by a registered staff member to respond to the resident's call bell. The PSW indicated that when they arrived the resident was sitting on their bedside and asked the resident if they were ready for their care and the resident indicated they can be toileted. The PSW indicated they asked the resident again if they could get going as it was getting close to the end of their shift and they would like to get started with care. The PSW indicated the resident told them to leave as a result of that statement and the PSW left the resident sitting on their bed. The PSW indicated they did not place the resident on the toilet and the resident toileted themselves. The PSW indicated they received disciplinary action for approaches when they informed the resident their shift was almost done and wanted to get going.

The Inspector reviewed resident #002's care plan and identified under the toileting foci that the resident was able to complete some care independently but required staff assistance for other care during the toileting process.

During an interview with Inspector #638, RN #106 indicated that they had directed PSW #109 to respond to resident #002's call bell at a specific time. The RN indicated they were called to resident #002's room about 40 minutes later and found the resident sitting on the toilet and had been crying. The resident indicated that the PSW had told them they only had a short period of time to complete care and the resident responded by stating you might as well go home and the PSW left.

In an interview with Inspector #638, the Administrator, DOC and Co-DOC #103 indicated that it was not made clear if the PSW had assisted the resident to the toilet prior to leaving but indicated their approach towards the resident and failure to report care that still had to be done was not acceptable. [s. 51. (2) (b)]

Issued on this 8th day of November, 2019

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

Original report signed by the inspector.