Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 2, 2020	2020_657681_0002	007568-20	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

STEPHANIE DONI (681)

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): May 11-13, 15, and 19-20, 2020, as an off-site inspection.

The following intake was inspected during this Critical Incident inspection:

- One intake related to an unexpected incident that occurred.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Personal Support Workers (PSWs), and Occupational Therapists (OTs) with the Home and Community Care Division of the North East Local Health Integration Network.

The Inspector also reviewed relevant resident care records and home policies.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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 the home’s written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted to the Director related to an unexpected incident that occurred. While inspecting this critical incident, Inspector #681 identified progress notes in resident #001's electronic medical record related to allegations of resident to resident abuse. A progress note indicated that a PSW reported to RPN #109 that they saw resident #001 act inappropriately towards resident #003. The note indicated that RPN #109 did not have the chance to speak with resident #001, but that they would speak to the resident on the following shift. A second note, entered by the Administrator, indicated that they spoke to resident #001 about ensuring that they did not act inappropriately toward other residents and that the prior incident was not acceptable.

During an interview with PSW #103, they stated that they were aware of incidents where resident #001 acted inappropriately towards resident #003.

The Inspector reviewed the home's policy titled Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect, last revised April 25, 2019. The policy indicated that any person 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 was on site at the home. The most Senior Administrative Personnel on site or Manager On-Call had the delegated responsibility to report to the Ministry of Long-Term Care immediately and would do so as required. The most Senior Administrative Personnel (or Charge Nurse if no manager was in the home) who received the report of resident abuse or neglect would:
- Assess the resident to determine any injury and provide any necessary care.
- Assess the resident’s condition, evaluating the safety and emotional and physical well-being of the resident.
- Advise the abuser, if a resident, that an investigation would be undertaken and implement supplement staffing for 1:1 supervision of the resident if warranted.
- Notify the resident’s attending physician, or on-call physician of the situation, and outcomes of the resident’s assessed safety, emotional and physical needs.
- Notify the resident’s substitute decision maker (SDM) within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.
- Commence a preliminary investigation by obtaining written and signed statements from all witnesses and documenting all pertinent information in the resident’s record and

complete resident incident reports.

During an interview with the Administrator, they stated that, in this incident, the two residents were separated and the home spoke to resident #001. The Administrator stated that they were uncertain of resident #003's condition following the incident, but believed that any significant change would have been documented in the progress note. The Administrator stated that resident #003’s SDM was not notified of the incident.

2. The Inspector identified a progress note which indicated that resident #001 was witnessed to be acting inappropriately towards resident #002. The note further indicated that it was explained to resident #001 that their behaviour was inappropriate.

During an interview with PSW #103, they stated that they were aware of incidents where resident #001 acted inappropriately towards resident #002.

During an interview with RN #107, they stated that, after they were made aware of the incident, they spoke with resident #001 and advised them that their behaviour was inappropriate. RN #107 stated that they were not sure how resident #002 reacted to the incident. When asked if the incident was reported to anyone, RN #107 stated that they only included the incident in the shift report so that the oncoming shift would be aware of what occurred.

During an interview with the Administrator, they stated that they did not recall being made aware of this incident. The Administrator stated that there was nothing in the documentation to indicate resident #002's condition following the incident. The Administrator also stated they did not know if resident #002’s SDM was made aware of th

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was reassessed and their plan of care reviewed and revised when the resident's care needs changed.

A CIS report was submitted to the Director related to an unexpected incident that occurred involving resident #001.

The Inspector reviewed resident #001's electronic medical record and identified that, in the three months prior to the critical incident, there were concerns involving resident #001's mobility device that resulted in risk to the residents in the home.

During an interview with RN #102, they stated that, at times, resident #001 would use their mobility device inappropriately. RN #102 recalled incidents where resident #001's actions put other residents at risk of injury.

The Inspector reviewed one of the home's policies related to the use of mobility devices, which indicated that, in the event of an incident where a resident either puts themselves or others at risk due to the unsafe use of the mobility device, the resident would not be able to use their mobility device until after they were assessed by an Occupational Therapist (OT).

The Inspector reviewed documentation from Occupational Therapy Services that resident #001 received, which indicated that resident #001's ability to use their mobility device had not been assessed in the three months prior to the critical incident.

During an interview with the Administrator, they stated that they were not aware of any concerns related to this resident's use of their mobility device. The Administrator stated that they completed a chart review following the critical incident, but they did not recall anything about inappropriate use of the mobility device. The Administrator stated that they did not believe that resident #001's use of their mobility device had been formally reassessed or documented. [s. 6. (10) (b)]

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 residents are reassessed and their plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

Issued on this 3rd day of June, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681)
Inspection No. / No de l'inspection :	2020_657681_0002
Log No. / No de registre :	007568-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 2, 2020
Licensee / Titulaire de permis :	Jarlette Ltd. c/o Jarlette Health Services, 711 Yonge Street, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	Temiskaming Lodge 100 Bruce Street, P.O. Box 1180, HAILEYBURY, ON, P0J-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Francine Gosselin

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Jarlette Ltd., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the Long-Term Care Homes Act.

Specifically, the licensee must:

a) Ensure that every allegation or suspicion of abuse or neglect is immediately reported to the most Senior Administrative Personnel on site at the home or the Manager On-Call. The allegation or suspicion must then be reported to the Ministry of Long-Term Care and investigated.

b) Ensure that when there is an allegation of abuse or neglect the resident's condition, including emotional and physical well-being, is assessed and documented and, in cases of alleged sexual abuse, it is determined if the encounter was consensual.

c) Ensure that the resident's substitute decision maker is notified of all alleged, suspected, or witnessed incidents of abuse or neglect.

Grounds / Motifs :

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

A Critical Incident System (CIS) report was submitted to the Director related to an unexpected incident that occurred. While inspecting this critical incident, Inspector #681 identified progress notes in resident #001's electronic medical

record related to allegations of resident to resident abuse. A progress note indicated that a PSW reported to RPN #109 that they saw resident #001 act inappropriately towards resident #003. The note indicated that RPN #109 did not have the chance to speak with resident #001, but that they would speak to the resident on the following shift. A second note, entered by the Administrator, indicated that they spoke to resident #001 about ensuring that they did not act inappropriately toward other residents and that the prior incident was not acceptable.

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- Assess the resident to determine any injury and provide any necessary care.
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- Advise the abuser, if a resident, that an investigation would be undertaken and implement supplement staffing for 1:1 supervision of the resident if warranted.
- Notify the resident's attending physician, or on-call physician of the situation, and outcomes of the resident's assessed safety, emotional and physical needs.
- Notify the resident's substitute decision maker (SDM) within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.
- Commence a preliminary investigation by obtaining written and signed statements from all witnesses and documenting all pertinent information in the resident's record and complete resident incident reports.

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two residents were separated and the home spoke to resident #001. The Administrator stated that they were uncertain of resident #003's condition following the incident, but believed that any significant change would have been documented in the progress note. The Administrator stated that resident #003's SDM was not notified of the incident.

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During an interview with the Administrator, they stated that they did not recall being made aware of this incident. The Administrator stated that there was nothing in the documentation to indicate resident #002's condition following the incident. The Administrator also stated they did not know if resident #002's SDM was made aware of the incident.

The severity of this issue was determined to be a level two, as there was minimal harm or minimal risk to the residents of the home. The scope of the issue was a level two, as it related to two of three residents reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the Long-Term Care Homes Act that included:

- a compliance order (CO) issued January 16, 2018, which was complied September 24, 2018 (#2017_572627_0020);
- a voluntary plan of correction (VPC) issued November 7, 2019 (#2019_805638_0024); and

- a VPC issued March 10, 2020 (#2020_805638_0007). (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jul 06, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of June, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stephanie Doni

Service Area Office /
Bureau régional de services : Sudbury Service Area Office