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
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Nov 10, 2021	2021_899609_0010	011811-21, 013875-21	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

CHAD CAMPS (609)

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): October 25-29, 2021.

The following intakes were inspected upon during this Critical Incident Inspection (CIS):

-One intake related to a fall of a resident; and
-One intake related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOCs), Administrative Assistant, infection prevention and control (IPAC) Lead, restorative care staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff and Screeners.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff and resident interactions, reviewed relevant
health care records, internal investigation notes as well as the home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home was a safe and secure environment for its residents related to COVID-19 active screening for of all persons entering the home.

Directive #3 issued to the home on July 16, 2021, required all adults screened on entrance into the home, be asked if they were currently experiencing new or worsening of a total of 11 possible symptoms.

The Inspector was screened a total of five times for entrance into the home and was asked by the Screeners if they were experiencing any symptoms. On each day's screening, none of the 11 potential adult symptoms were listed to the Inspector before they were cleared for entry into the home. A further review of the home's Mandatory Screening process for employees, volunteers, agency staff and students found that three of the 11 symptoms (barking cough/croup, lethargy and myalgias) were not listed on the form.

Screening staff outlined how they would typically list the first few symptoms when screening persons into the home but acknowledged they did not list any when they screened the Inspector. The home's infection prevention and control (IPAC) Lead as well as the home's Administrator verified that all symptoms were to be listed and all questions were to be asked when persons were being screened into the home.

The home's failure of their Screeners to list all symptoms and ask all questions when persons were being screened into the home presented minimal risk to residents.

Sources: Screening observations by the Inspector, Chief Medical Officer of Health (CMOH) Directive #3 issued to the home on July 16, 2021, the home's COVID-19 Screening Process Staff (employees, volunteers, agency staff, students) – Mandatory Screening – Year: September 28, 2021 (version 22), interviews with Screening staff, the home's IPAC Lead and Administrator. [s. 5.]

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 home's Screeners list all symptoms and ask all questions when persons are being screened into the home, to be implemented voluntarily.

WN #2: 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.

On two separate days evidence of potential abuse of a resident was identified by Registered Practical Nurse (RPN) staff. The home's policy required the evidence be immediately reported to the home's leadership, the resident's Substitute Decision Maker (SDM) and an immediate investigation conducted.

The home's leadership was not notified of the potential abuse of the resident and an investigation was not conducted until many days later when a complaint was submitted to the home.

The home's failure to ensure that RPN staff complied with the home's written policy to promote zero tolerance of abuse and neglect of residents presented minimal risk to the resident.

Sources: a CIS report, a resident's electronic/paper clinical records, Point Click Care (PCC) Risk Management, the home's policy titled "Resident Rights, Care and Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect" last reviewed February 1, 2020, interviews with RPN staff and the home's Skin and Wound Lead. [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 the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, received a skin and wound assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

a) Registered staff documented altered skin integrity to a resident. A review of the resident's clinical records found no skin and wound assessment was completed by a member of the registered staff, using the home's skin and wound assessment in PCC.

RPN staff verified they were aware of the resident's altered skin integrity, but indicated that they were unsure when a resident required a skin and wound assessment. They further outlined how they did not have the time to complete skin and wound assessments. This was despite verification that the RPNs had recently completed retraining related to the home's skin and wound program.

b) A skin and wound assessment was completed on a resident which identified altered skin integrity. A review of the resident's clinical records found no mention or skin and wound assessment of the resident's altered skin integrity which was present prior to the initial skin and wound assessment.

The home's Skin and Wound Lead verified that the resident's altered skin integrity should have had a skin and wound assessment completed under the wound note in PCC prior to initial skin and wound assessment.

The home's failure to provide the resident with a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment presented actual risk as the resident was exhibiting altered skin integrity.

Sources: a CIS report/Intake report, a resident's electronic/paper clinical records, the home's policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – PCC Wound Assessment and Treatment" last reviewed January 1, 2020, interviews with RPN staff, RN staff and the home's Skin and Wound Lead. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident's exhibited altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

The Inspector identified a resident exhibiting altered skin integrity. Personal Support Worker (PSW) staff indicated that the altered skin integrity was long-standing. A review of the resident's skin and wound assessments conducted by registered staff found that weekly skin and wound assessments had not been consistently completed.

A review of the resident's weekly skin and wound assessments was conducted with the home's Skin and Wound Lead who verified that the altered skin integrity should have had a weekly skin and wound assessment and that long gaps between assessments was "unacceptable".

The home's failure to provide the resident with weekly skin and wound assessments presented actual risk to the resident exhibiting altered skin integrity.

Sources: Observations of a resident, a resident's electronic/paper clinical records, the home's policy titled "Resident Rights, Care and Services – Required Programs – Skin and Wound Care – Program" last reviewed January 1, 2020, interviews with a resident, PSW staff, the home's Skin and Wound Lead and the Administrator. [s. 50. (2) (b) (iv)]

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 all residents who are exhibiting altered skin integrity, receives a skin and wound assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment initially and at a minimum weekly until resolved, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that a hand hygiene (HH) program was in place in accordance with the Ontario evidence based HH program, “Just Clean Your Hands” (JCYH) related to staff assisting residents with HH after meals.

The Inspector observed the lunch meal service in three of the home's dining rooms, where some staff would provide HH to residents after their meals while others did not. Specifically, three residents left the meal service without HH being provided or encouraged. Another resident was assisted back to their bedroom by PSW staff who verified to the Inspector that they did not provide nor encourage HH to the resident and admitted they were unaware of the need to provide or encourage HH for residents after meals.

The home’s HH policy indicated that it was based on the JCYH Program yet failed to mention that residents required after meal HH be provided and/or encouraged as the JCYH’s program indicated. The home’s IPAC Lead and a Co-DOC both verified that residents should have had their hands cleaned after meals.

The home’s failure to ensure a HH program in place in accordance with the JCYH evidence based HH program presented a minimal risk to residents related to the possible transmission of disease-causing organisms that may have been on their hands.

Sources: Observations of the lunch meal service in three dining rooms, the home’s policy titled “Operation of Homes – Infection Control – Hand Hygiene Program” last reviewed August 10, 2021, the “Just Clean Your Hands Implementation Guide Ontario’s step-by-step guide to implementing a hand hygiene program in your long-term care home” Catalogue #011816 3M September 2009, interviews with PSW staff, the home’s IPAC Lead and a Co-DOC. [s. 229. (9)]

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 home's HH program is in place in accordance with the Ontario evidence based HH program, JCYH related to staff assisting residents with HH after meals, to be implemented voluntarily.

Issued on this 3rd day of December, 2021

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

Original report signed by the inspector.