Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

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Original Public Report

Report Issue Date: November 18, 2022	
Inspection Number: 2022-1197-0001	
Inspection Type: Critical Incident System	
Licensee: Jarlette Ltd.	
Long Term Care Home and City: Temiskaming Lodge, Haileybury	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2022.11.18 16:24:40 -05'00'
Additional Inspector(s) Inspector #000699 (Vikki Larocque) attended this inspection as an observer.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 18-20, 2022

The following intake(s) were inspected:

- One intake related to resident-to-resident physical abuse.

The following **Inspection Protocols** were used during this inspection:

Responsive Behaviours
Infection Prevention and Control

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was **remedied** by the licensee prior to

the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applies to the long-term care home related to COVID-19 screening for all persons entering the home, was complied with.

Rationale and Summary
The Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, identified that homes must ensure COVID-19 screening requirements as set out in the "COVID-19 Guidance Document for Long-Term Care Homes (LTCHs) in Ontario", or as amended, were followed.

The COVID-19 Guidance Document for LTCHs Ontario, updated October 6, 2022, identified that LTCHs must establish and communicate an operational plan including guidance for staff, students, volunteers, support workers, caregivers, and general visitors to self-monitor for symptoms of COVID-19 (passive screening). Additionally, it recommended that LTCHs establish and communicate the process for conducting active screening for COVID-19 symptoms and exposures for visitors and caregivers entering the home.

On day two of the inspection, the screener stated they were not aware of the process for screening for COVID-19 for visitors and caregivers entering the home. The home was in a COVID-19 outbreak at the time.

The Director of Care (DOC) identified that all visitors entering the home should be actively screened using the home's screening tool. After speaking with the Inspector, the DOC informed the screener about the home's expectations related to "active screening" for COVID-19, for all visitors and essential caregivers.

There was no impact and low risk to the residents, at the time of the non-compliance, when the screener was not aware of the process implemented by the home for COVID-19 screening, as

no other visitors or essential caregivers had entered the home that day.

Sources: Observations; review of the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022; COVID-19 Guidance Document for Long-Term Care Homes in Ontario, updated October 6, 2022; Ministry of Health COVID-19 Screening Tool for Long-term Care Homes and Retirement Homes - version 13., dated August 31, 2022; the home's COVID-19 screening tool; home's visitor/staff sign in and sign out sheets; and interviews with a screener and the DOC.

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Date Remedy Implemented: October 19, 2022.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Specifically, the licensee did not ensure that the signage posted at the entrance to a resident's room or bed space, indicated the enhanced IPAC measures necessary, as was required by 9.1 (e) of the IPAC Standard.

Rationale and Summary

On the first day of the inspection, a sign was observed at the entrance to a resident bedroom, indicating additional precautions were required.

The resident's care plan and progress notes indicated that the resident was to be on a different type of additional precautions than were posted.

The IPAC Lead verified that the signage posted was not correct and after speaking with the Inspector, posted the correct signage.

There was minimal impact and risk to the resident, at the time of the non-compliance, when the home did not ensure that the correct IPAC related signage was posted for a resident, as the appropriate PPE was located outside the room and staff demonstrated an awareness of the additional precautions required.

Sources: Observations of a resident room; review of a resident's progress notes and care plan; and interviews with staff and the IPAC Lead.

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Date Remedy Implemented: October 18, 2022.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that staff participated in the implementation of the IPAC Program, specifically related to routine precautions.

Rationale and Summary
An additional precautions sign was observed at the entrance to a resident bedroom.

Prior to leaving the resident bedroom, a staff member removed their mask, put on a new mask, and did not perform hand hygiene.

The home's policy titled, "Routine Practices", stated that after the removal of a mask, hand hygiene was to be performed.

The staff member, IPAC Lead, and the DOC all acknowledged that the staff member should have performed hand hygiene after taking off and before putting on, a new mask.

Staff failing to participate in the implementation of the IPAC program, by not performing hand hygiene as required, put the residents at moderate risk of contracting a health care associated infection in the home.

Sources: Observations; review of Public Health Ontario: Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, November 2012; home's policy titled, "Routine Precautions", last revised September 14, 2022; and interviews with a registered staff member, IPAC Lead, and the DOC.

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WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the operational or policy directive that applies to the long-term care home, related to PPE requirements for suspected or confirmed cases of COVID-19, was complied with.

Rationale and Summary
The Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, identified that homes must ensure the PPE requirements as set out in the COVID-19 Guidance Document for LTCHs, or as amended; and the Management of Cases and Contacts of COVID-19 in Ontario, were followed.

The Ministry of Health COVID-19 Guidance Document for LTCHs, effective October 6, 2022, identified that LTCHs must adhere to any guidance provided by the local Public Health (PH) with respect to implementation of any additional measures to reduce the risk of COVID-19 transmission in the setting.

On a specified date, the local PH declared a COVID-19 outbreak in the home. All residents with a positive or suspected COVID-19 infection were to be isolated using contact and droplet Precautions. In addition to this, the local PH directed the home to ensure that staff always wore

face shields throughout the resident home areas (RHAs).

On the first day of the inspection, the following was observed:

- A registered staff member prepared medication, entered and exited a resident room with contact and droplet precautions in place, and then performed their duties in the RHA, without wearing a face shield.
- A housekeeper performed duties in the RHA and did not wear a face shield.
- A personal support worker (PSW) assisted a resident in their room with contact and droplet precautions in place, prior to putting on a face shield.

The staff, the IPAC Lead, and the DOC all verified that a face shield was always required in the resident home areas, and that full PPE, including a face shield, was to be worn upon entering resident rooms on contact and droplet precautions.

There was moderate risk to residents for disease transmission, when staff did not use PPE correctly, including not wearing face shields as directed.

Sources: Critical Incident Systems (CIS) report; observations of staff; review of the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022; COVID-19 Guidance Document for Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units in Ontario, version 8, updated October 6, 2022; Ministry of Health Management of Cases and Contacts of COVID-19 in Ontario, version 15, revised August 31, 2022; the home's policy titled, "LTC Outbreak Management-Additional Precautions, last revised June 6, 2022; and interviews with staff, the IPAC Lead, and the DOC.

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WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that behavioural triggers for a resident were identified, and that strategies for addressing the responsive behaviours were developed and implemented.

Rationale and Summary

A resident had been involved in physical and verbal altercations with other residents.

A review of the care plan for the resident revealed that there were no behavioural triggers, nor any strategies related to the resident's behaviours identified in the care plan for the resident.

The Behaviour Support of Ontario (BSO) Lead in the home confirmed they were aware that the identified resident had exhibited behaviours previously, and that information related to triggers and interventions had not been included in the resident's care plan and should have been.

The home's failure to ensure that the behavioural triggers were identified and that strategies were developed and implemented when the identified resident exhibited the behaviours, presented a moderate risk to the safety of other residents in the home.

Sources: CIS; Observations of an identified resident; review of a resident's care plan and progress notes; the home's Risk Management reports; BSO minutes of meetings; and interviews with staff, the BSO Lead, and the DOC.

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WRITTEN NOTIFICATION: PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that the written plan of care for a resident gave clear directions to those who provided direct care to the resident.

Rationale and Summary:

1. On the first day of the inspection, the Inspector observed an intervention in place.

The resident's care plan did not include that the intervention was in place.

The BSO Lead in the home, acknowledged that they trialed the intervention and should have put this information in the resident's care plan and had not done so.

There was moderate risk to the resident's safety, when the home did not ensure that the written plan of care provided clear direction to staff and others about the use of the intervention for the resident.

Sources: Observations of a resident and their bedroom; review of a resident's care plan and progress notes; BSO minutes of meeting; and interviews with staff, the BSO Lead and the DOC.

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2. On a specified date, the home's line listing indicated that two residents who shared a bedroom, required additional precautions for COVID-19.

A sign indicating additional precautions was observed at the entrance to the resident bedroom for one of the bedspaces.

The progress notes for the other bedspace revealed the other resident was also on additional precautions however, their care plan did not include a focus for the additional precautions.

The IPAC Lead verified that both residents in the bedroom required additional precautions.

Staff members, the IPAC Lead, and the DOC all confirmed that when additional precautions were indicated for a resident, their care plan should include the additional precautions required.

There was minimal impact and low risk to the resident, at the time of the non-compliance, when the home did not ensure that the written plan of care provided clear direction to staff regarding the additional precautions required.

Sources: Observations; a resident's care plan and progress notes; the home's line listing for COVID-19 outbreak; home's Outbreak Tracking Form for Daily Report; and interviews with staff, the IPAC Lead, and the DOC.

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