Ontario

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2013	2013_138151_0001	S-002104-11	Critical Incident System

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

MONIQUE BERGER (151)

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): December 4,5, 2012

This inspection addressed the following:
- S-002104-11 and corresponding CI: 2698-000016-11
- S-001965-11 and corresponding CI: 2698-000014-11
- S-001673-11 and corresponding CI: 2698-000008-11
- S-001884-11 and corresponding CI: 2698-000013-11

During the course of the inspection, the inspector(s) spoke with - Administrator, Director of Care, RNs, RPNs, Personal Support Workers (PSWs), residents and family

During the course of the inspection, the inspector(s)
- walked through of the home several times daily to observe direct care and service delivery to the residents,
- observed the home for falls prevention strategies in use,
- reviewed the home's abuse policies and procedures,
- reviewed the home's falls prevention program,
- reviewed related policies and procedures
- reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the Director is informed of an injury in respect of which a person is taken to hospital no later that one business day after the occurrence of the incident,[O.Reg.79/10,s. 107.(4)]

In regards to a resident, Inspector 151 reviewed the incident of a fall requiring transfer to hospital. Inspector notes that the licensee did not file a report to the Director until 5 days after the occurrence. [s. 107. (3) 4.]

Issued on this 7th day of January, 2013

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

Monique G. Berger