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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 30, 2014	2014_332575_0017	S-000187-14	Complaint

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

LINDSAY DYRDA (575)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 15-19 and 22-26, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-DOC, and Family Members.

The following Inspection Protocols were used during this inspection:

Admission and Discharge

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	Legendé 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. Inspector #575 was informed that resident #001's diet texture was changed without the knowledge of the resident's substitute decision-maker (SDM). The inspector reviewed the resident's health care record and determined that the resident's diet type was changed. The progress notes indicated that the SDM was not informed until a few months later. The Administrator confirmed that the SDM was not notified of the initial change. The licensee did not ensure that the resident, the resident's SDM, if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident #001's plan of care. [s. 6. (5)]

2. A decision was made by the home and resident #001 was discharged due to responsive behaviours. The resident's SDM told the inspector that they frequently visited the resident and they were not advised of any increased behaviours or any incidents involving the resident.
The inspector reviewed resident #001's health care record.
A progress note identified that staff member #200 told the SDM that they did not notice any changes in the resident's behaviour. Three months later, staff member #100 informed resident #001's SDM that there are times when the home may have to remove a resident from the home when behaviours escalate. Approximately 1 week later, the SDM spoke with staff member #101 who informed the SDM that on two separate occasions resident #001 was involved in incidents with other residents and that if there were any further incidents between now and next week that resident #001 would have to go to the hospital.
During a care conference 2 weeks later, the resident's SDM indicated that they were aware of some behaviours however they were not aware of past incidents involving other residents and staff. Staff member #101 reviewed several incidents that occurred over a period of approximately 1 year with the SDM during the care conference. Documentation from the care conference outlined that the resident had increased behaviours and incidents involving other residents and staff.
Physician notes stated that the resident's SDM was not informed of each incident as they occurred and that the decision to move the resident was a shock to the SDM as they thought things were going well. During an interview, the Administrator told the inspector that the resident's behaviours and incidents were not communicated to the resident's SDM.
The licensee did not ensure that the resident, the resident's SDM, if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (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 ensuring that the resident, the resident's SDM, if any, and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care including any changes of a resident's diet type and any altercations or incidents involving any resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. Resident #001 was discharged from the home, a decision made by the home. During an interview, the Administrator told the inspector that a written letter detailing the explanation of the supporting facts, as they relate to both the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident was not provided to the SDM before the resident was discharged from the home. Therefore, the licensee failed to ensure that before discharging resident #001 under subsection 145 (1) (the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident of the safety of persons who come into contact with the resident), a written notice was provided to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. [s. 148. (2) (d)]

Issued on this 30th day of December, 2014

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

Original report signed by the inspector.