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

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

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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_0016	S-00350-14	Resident Quality Inspection

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), GILLIAN CHAMBERLIN (593), MONIQUE BERGER (151), VALA MONESTIMEBELTER (580)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

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

During this inspection a follow-up log, 2 critical incident logs, and 1 complaint log were also inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director or Care (DOC), Co-DOC, Food Services Manager (FSM), Activity Director, Restorative Care Staff, Resident and Family Services Coordinator, Laundry and Housekeeping Staff, Registered Nursing Staff, Personal Support Workers (PSW), Family Members, and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2013_140158_0017	575

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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. On Sept 18, 2014 inspector #575 reviewed resident #734's health care record regarding the use of bed rails. The care plan indicated that resident #734 required 2 bed rails up at all times for assistance with bed mobility. On 2 occasions, the inspector observed the resident in bed with only one rail raised, and one rail hinged (not raised). The inspector interviewed staff member #200 who indicated that both bed rails should be up, and if the other rail was to be hinged, it would be written as such.
The licensee has failed to ensure that the care set out in the plan of care is provided to resident #734 as specified in the plan. [s. 6. (7)]

2. Resident #729 was assessed as dehydrated with fluid output exceeding input as indicated in the resident's nutrition and hydration assessment. As a result, an increased fluid intervention was put into place by the home. The resident's care plan was updated to reflect this intervention. The most recent dietary assessment undertaken for this resident continued this intervention as the resident's fluid intake was still below their estimated requirement. A review of the resident diet roster located on the nourishment trolleys, indicated resident #729's fluid requirements at snack passes.
During an interview with inspector #593 staff member #300 advised that residents are not usually woken during the nourishment pass and that staff will leave a cup of water on some residents' bedside tables who do not require assistance with fluids. The staff

member confirmed that resident #729 would be one of the residents that they would leave a cup of water for on the bedside table if they were sleeping during the nourishment pass.
During an afternoon nourishment pass inspector #593 observed staff member #300 provide an orange juice to resident #729 and it was observed that the required amount of fluid was not provided or offered to the resident.
The next day inspector #593 observed during the afternoon nourishment pass that resident #729 was asleep. Staff member #301 was offering fluid to residents during the pass and it was observed that no fluid was left on the bedside table for resident #729.
During an interview with inspector #593, staff member #301 advised that if a resident is asleep during the nourishment pass, they will not wake them but leave iced water on the bedside table. This practice was not observed for resident #729 during this nourishment pass.
During an interview with inspector #593 staff member #500 advised that if a resident is asleep during a nourishment pass, staff are required to leave a cup of water or a Crystal drink with a lid on the resident's bedside table. The staff member also confirmed that resident #729 is required to receive a specific amount of fluid at snacks and that staff should be providing this to the resident.
As such, the home has failed to provide resident #729 with the required fluid intervention at snack time as provided for in the resident's plan of care. [s. 6. (7)]

3. On September 17, 2014 inspector #580 observed a refrigerated injectable medication for a resident which was to be administered by a specialist approximately 9 months ago. On September 17 and 18, 2014 staff members #400 and #401 told the inspector that they did not know why resident #002's medication was still in the fridge. On September 18, 2014 staff member #402 called the resident's family who stated that approximately 9 months ago the resident displayed responsive behaviours and as a result the medication was not administered by the specialist. Staff member #402 confirmed to inspector #580 that there were no physician or progress notes addressing a follow up appointment, no reassessment of the resident's condition, no direction from the resident or their POA regarding the resident's wishes for a specialist follow up visit, and no documentation for the provision of medical care for this specific medical problem for resident #002. Staff member #502 confirmed that there was no follow up documentation regarding resident #002's specialist visit and order for the injectable medication.
On September 18, 2014 the inspector #580 reviewed the following:
-Physician notes indicating that without the medication there may be resulting negative factors;
-a Physician's note in which staff member #501 stated that the resident is concerned

about the medication procedure and that the resident does not think it is worth having the medication procedure, and that staff member #501 will discuss this with the Physician;
-an order for the injectable medication to be given on a set date;
-resident #002's progress notes which stated that the resident's family member cancelled the appointment and will rebook the appointment;
-resident #002's annual health exam which identified certain impairments but no other related documentation;
-resident #002's care plan which addressed certain care needs.
On September 22, 2014 inspector #580 reviewed resident #002's updated progress notes in which the staff noted that they spoke with the resident's family member regarding the resident's visits to the specialist, that during the visit, the family member stated that resident #002 became agitated and ultimately the resident did not receive the medication.
It was not until the inspector inquired about the medication in the fridge did the home follow up with the family and the plan of care for the resident. Therefore, the licensee failed to ensure that the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care are documented. [s. 6. (9)]

4. On August 23, 2014 resident #751 sustained a fall. Inspector #575 reviewed the resident's health care record regarding the incident. The inspector noted that on the incident report, staff identified a new intervention to prevent further falls. The inspector reviewed the resident's most recent care plan and under the focus 'risk for falls' the intervention identified by staff in the incident report was not noted. The resident's care plan did not identify certain risk factors or indicate the new intervention. On September 24, 2014 during an interview staff member #200 told the inspector that the resident does exhibit certain risk factors. Further, this information is not identified on the Kardex available to the home's PSWs.
The licensee has failed to ensure that resident #751's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [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 ensuring that the care set out in the plan of care regarding the use of bed rails, nutrition and hydration is provided to residents as specified in the plan; that the provision of the care set out in the plan of care, outcomes, and effectiveness of the plan of care are documented; and that resident plans of care are reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. Observations by inspector #593 during the morning nourishment pass found staff member #300 offering fluids to residents at this time. It was observed that the fluids being offered to residents were cranberry juice, water and milk. This was confirmed by the staff member who also advised the inspector that coffee and tea were not available during the morning nourishment pass. Staff member #300 was observed to offer 2 residents a cranberry juice and no other fluid options were offered. Resident #729 was also observed to be offered a juice during this nourishment pass by staff member #300 and no other fluid options were offered to the resident at this time.
Observations by inspector #593 during the afternoon nourishment pass found staff member #302 offering fluids to residents. During an interview with inspector #593, staff member #302 advised that the fluids available were milk, water, and orange juice. Staff member #302 further advised that tea and coffee is available but only in the dining room and residents are required to go to the dining room if they want tea or coffee. The staff member proceeded to enter a resident's room and ask the resident if they would like a juice and no alternative fluids were offered at this time. Another resident in a different room was observed to ask the staff member for tea and the staff member advised that they would have to go to the dining room if they wanted tea. Inspector #593 further observed staff member #302 provide another resident a cup of water and no other fluid options were given; a resident in a different room was offered juice, the resident declined and no other fluid options were given; and another resident was provided an orange juice, this resident was also not offered a choice of fluid during this nourishment pass.
The next day, inspector #593 observed staff member #303 providing fluids to residents in the home during the morning nourishment pass. A resident was observed to ask the staff member for an apple juice, the staff member responded that they did not have apple juice and offered orange juice instead. The resident accepted, no other fluid choices were offered to the resident. Shortly after, another resident declined an orange juice and was heard saying "I am so sick of orange juice", this resident declined a beverage at this time.
During an interview with inspector #593, staff member #500 advised that tea and coffee has not been offered as part of the AM and PM nourishment pass for several years. They further advised that it is expected that staff are to offer all fluids available to each resident during each nourishment pass.
A review of the home's hydration policy dated July 10, 2013 by inspector #593 identified that the standard fluids to be available at meal times and snacks are water, juice, milk, tea and coffee.
As such, the home has failed to provide and offer the planned fluids as provided for in the home's hydration policy. [s. 71. (4)]

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 planned menu items including water, juice, milk, tea and coffee as indicated in the home's hydration policy are offered and available at each meal and snack, to be implemented voluntarily.

WN #3: 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. On September 15, 2014 during a tour of the home, inspector #151 observed the door to the tub room in the South corridor open to the hallway with the tub filling. No staff was in attendance in the room. The inspector also noted the following hazardous liquids accessible in the open tub room:
- 2 bottles of Dynakil-Plus liquid germicidal cleaner with a hazardous warning not to use unless staff had goggles and gloves on; and
- 2 bottles of Scrub E-Z with a hazardous warning not to use unless staff had goggles and gloves on.
Further, the inspector observed the tub room door open in the adjacent corridor and no staff in attendance of the room with the same hazardous liquids accessible.
As such, the licensee has failed to ensure that the home is a safe and secure environment for its residents. [s. 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Resident #751 sustained a fall. Inspector #575 reviewed the resident's health care record and noted that the resident was at high risk for falls. The inspector reviewed the policy titled 'Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program' (FPMP) effective September 16, 2013 and noted that the policy identified a system which identifies resident's who are at high risk for falls. The inspector did not see this system used for resident #751. Two staff members (#304 and #305) confirmed to the inspector that residents who are at high risk for falls are to be identified using this system. The inspector interviewed staff member #200 who indicated that there is a 'home specific' policy regarding the falling star program. The policy titled 'Falling Star' revised November 2013 was provided to the inspector. The inspector confirmed with the Administrator that the policy titled 'Falling Star' contraindicated the FPMP policy (there was no mention of the 'Falling Star' program within the FPMP). Additionally, the FPMP indicated that staff are to complete follow up progress notes for at least 3 shifts following fall incident. The inspector noted and staff member #200 confirmed that only 2 follow up notes were completed after resident #751's fall. Therefore the licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. During an interview with inspector #151, staff member #500 confirmed they are responsible for communicating with Residents' Council and Food Committee about food and menu issues. The staff member further stated that they have never reviewed the meal and snack times with the Residents' Council or the Food Committee.
Therefore, the licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council. [s. 73. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).**

Findings/Faits saillants :

1. On September 16, 2014 inspector #151 observed staining of towels/face cloths. Inspector #575 and #580 observed the clean utility room. The inspectors observed the hand towel bin and observed some towels with stains and one with holes. Inspector #575 interviewed staff member #201 regarding the stained hand towels. The staff member stated that the home is aware of the yellow stains on some towels and are currently in process of resolving the issue. As such, the licensee did not ensure that as part of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours. [s. 89. (1) (c)]

WN #7: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector #575 reviewed the immunization records for 6 residents. Upon review, the inspector noted that 3/6 records were not complete. Resident #766 was admitted to the home and the tuberculosis (TB) screening was completed 1 month after admission, more than 14 days after admission. Resident #775 was admitted to the home and the TB screening was completed more than 90 days prior to admission, and more than 14 days after admission. Resident #777 was admitted to the home and there is no record of TB screening.
Staff member #502 confirmed the above findings to the inspector.
The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

Issued on this 20th day of January, 2015

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

Original report signed by the inspector.