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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2018	2017_572627_0020	024211-17	Resident Quality Inspection

Licensee/Titulaire de permis

JARLETTE LTD.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

SYLVIE BYRNES (627), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 6-10, 2017.

The following additional intakes that were submitted to the Director were inspected during this Resident Quality Inspection:

- Two Critical Incident (CI) reports related to alleged staff to resident abuse,
- One CI report related to alleged resident neglect,
- One complaint (CO) related to alleged abuse from a family member to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (ADOC), Co Director of Care (CoDOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted daily tours of the resident care areas, observed the provision of care and services to the residents, observed staff to resident interactions, reviewed relevant health care records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **2 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. 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 policy titled "Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, was complied with.

A complaint was submitted to the Director alleging physical abuse to resident #007 from an individual know to the resident. Please see WN #2 for further details.

Inspector #687 reviewed the home's policy titled "Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, which indicated that Jarlette Health Services had implemented a zero-tolerance policy that took all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents which included but was not limited to:

- The most Senior Administrative Personnel (or Charge Nurse if no manager in the home) who received a report of resident abuse were to:
- Assess the resident to determine any injury and provide any necessary care,
- Ensured immediate support or assistance was provided to the resident who had been abused, or allegedly abused,
- Staff members, volunteers, substitute decision-makers, family members or any other person who had reasonable grounds to suspect abuse or neglect of a resident were to immediately report their suspicion to the most Senior Administrative Personnel or charge nurse if no manager was on site at the home,
- Advised the abuser, if a family member that an investigation was undertaken and implemented supervised visit between the family member and the resident,
- Notified immediately the appropriate police force of any alleged, suspected or witnessed incident of abuse of a resident that may constitute a criminal office,
- Obtained written and signed statements from all witnesses,
- Immediately notified the Ministry of Health and Long Term Care (MOHLTC) via after hour pager if it was outside of normal business hours and completed a Critical Incident System Report during normal business hours as applicable,
- Documented all pertinent information in the resident's record and completed resident incident reports,
- Completed thorough documentation of all discussions surrounding the incident and further investigation,
- Followed the investigation procedures, signed the "Resident Rights, Care and Services – Administration Investigation Checklist",

- Engaged the assistance of the home's Resident Family Service worker, or delegate to provide ongoing support and assistance to the resident who had been abused or allegedly abused.

Inspector #687 interviewed the Administrator who indicated that they had spoken to resident #007 regarding the alleged abuse. The Administrator stated that no further investigation had been completed as they had obtained inconsistent information from the resident. The Administrator acknowledged that they had not immediately notified the MOHLTC, they had not completed the "Resident Rights, Care and Services – Administration Investigation Checklist" or obtained a written and signed statements from all witnesses, they had not notified the police, they had not engaged the assistance of the home's Resident Family Service worker, they had not advised the individual known to the resident that an investigation would be undertaken or implemented supervised visit between the individual known to the resident and the resident, as per the home's policy titled " Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017 . [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

A complaint was submitted to the Director alleging physical abuse to resident #007. Resident #007 sustained injuries after an incident had taken place between resident #007 and an individual known to the resident. The complainant stated that they were

concerned that the issue was not properly addressed by the home.

Inspector #687 reviewed resident #007's electronic progress notes which indicated that resident #007 had returned from a casual absence on a specific date. The progress note further indicated that there had been a verbal and physical altercation between the resident and an individual known to the resident after returning to the home. The resident had sustained injuries.

Inspector #687 interviewed resident #007 who stated that a disagreement had led to an argument on the date identified from the progress note, between themselves and an individual known to them. Resident #007 informed the Inspector that they had been physically abused. At this time, resident #007 called a nursing staff member for assistance. They stated that they remained fearful of the individual.

Inspector #687 interviewed PSW #116 who stated upon entering resident #007's room, they had observed an argument. Resident #007 told the PSW upon their entry in the resident's room to call the police. The PSW tried to de-escalate the situation and had observed that resident #007 had sustained injuries. The PSW further informed the Inspector that they reported this incident to RN #103 and that an incident report was completed. PSW #116 stated that the Administrator had not interviewed them regarding the incident.

Inspector #687 interviewed RN #103 who stated PSW #116 had reported a physical altercation related to resident #007. The RN further stated that they went to see resident #007 and observed multiple injuries. RN #103 stated that they had reported the incident to the Administrator by telephone immediately. RN #103 informed the Inspector that they had not been interviewed by the Administrator with regards to the incident.

Inspector #687 interviewed the Administrator who indicated that they had spoken to resident #007. The Administrator stated that they observed the resident with injuries at that time. The Administrator stated that no further investigation had been completed as they had obtained inconsistent information from the resident. The Inspector inquired what the Administrator would do to address this incident to which the Administrator replied that they would follow up with the resident and that they would refer the resident to Resident Family Service worker.

Additionally, the home failed to protect resident #010 from abuse as evidenced by noncompliance identified during this inspection related to:

-WN #1, LTCHA, 2007, s. 20 (2), where the license failed to ensure that the home's policy titled ""Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, was complied with".

- WN #4, finding '2', LTCHA, 2007, s. 24 (2), where the license failed to failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director : Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

- WN #6, LTCHA, 2007, r. 98, where the licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Resident #004 was identified as a low risk for incontinence, from their last to most recent Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment.

Inspector #627 reviewed resident #004's most recent RAI-MDS which identified that the resident tended to be incontinent daily, but remained with some control. This was unchanged since the admission RAI-MDS assessment.

Inspector #627 reviewed an "Assessment of Continence" which was completed upon their admission. The assessment indicated that resident #004 was continent.

Inspector #627 reviewed resident #004's progress notes and identified an entry from the Continence Committee meeting identifying that resident #004 was independent with toileting.

Inspector #627 reviewed the documentation in point of care (POC) which identified that resident #004 had two episodes of incontinence during a specified period of time.

A review of the care plan created upon admission for the foci of continence revealed that resident preferred to wear a specific continence product at all times.

During an interview with the Inspector, RPN #111 stated that upon admission, a three day voiding assessment was completed and documented in POC. Afterwards, an Assessment of Continence would be completed by interviewing the resident, and reviewing the POC voiding assessment. The care plan was created from this information. RPN #111 stated that the resident was incontinent upon admission. They could not explain why the Assessment of Continence indicated that the resident was continent, and that perhaps it had been completed with only a resident interview since the RAI-MDS and the Assessment of Continence differed so much.

During an interview with the Inspector, the ADOC and CoDOC #113 stated that resident #004 was incontinent upon their admission. This was part of the reason for their admission. The CoDOC stated that the resident was using a specific continence product upon admission and had progressed to a more absorbent product. The ADOC and CoDOC #113 were unable to explain why the RAI-MDS assessment and the Assessment of Continence were not consistent with each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #001 was identified as low risk of incontinence, from their last to most recent RAI-MDS assessment.

Inspector #627 reviewed resident #001's care plan in effect at the time of the inspection and noted for the foci of toileting that resident #001 asked for and received the necessary assistance.

Inspector #627 reviewed resident #001's electronic progress notes and revealed an entry from a High Risk Rounds interdisciplinary team meeting which indicated "Primary PSW had implemented specific continence interventions which had decreased their incontinence.

During an interview with Inspector #627, PSW #109 stated that resident #001 was toileted at specific intervals (less frequently than indicated in the progress note) and they were not incontinent often. PSW #109 informed the Inspector that they were not the resident's primary PSW, and that their primary PSW was PSW #112.

During an interview with Inspector #627, RPN #111 stated that resident #001's continence level had improved with specific interventions implemented by PSW #112. They further stated that the interventions noted in the care plan had not been effective. They substantiated that the care plan should have been updated to reflect the resident's increased toileting schedule.

During an interview with the ADOC and CoDoc #113, they stated that resident #007's current care plan had not been revised to reflect the resident's care needs with regards to continence care. [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 to ensure that staff and others involved in the different aspects of care for resident #004, and all other residents, collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent and complement each other and to ensure that resident #001 is reassessed and the plan of care is reviewed and revised to reflect the resident's continence care needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director :
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A Critical Incident (CI) report was submitted to the Director regarding a complaint letter that was submitted to the home, alleging improper care of resident #009.

Inspector #627 reviewed the home's internal investigation notes which revealed a document from the previous Director of Care (DOC) acknowledging that they had spoken with the complainant via telephone informing the complainant they were taking the complaint very seriously.

Inspector #627 reviewed the home's policy titled "Resident Rights, Care and Services-Abuse-Zero-Tolerance Policy for Resident Abuse and Neglect", last revised June 2, 2017, which instructed that upon being notified of abuse or neglect of a resident, the Administrator or Director of Care immediately notified the Ministry of Health and Long Term Care via after hours pager if it is outside of normal business and completed a

critical incident system report during normal business hours as applicable.

During an interview with the Administrator, they substantiated that the home had received the complaint letter on a specific date and that a CI report should have been submitted on the same day by the previous DOC. [s. 24. (1)]

2. A complaint was submitted to the Director alleging physical abuse to resident #007 from a family member. The complainant stated that they were concerned the issue was not properly addressed by the home. Please see WN #2 for further details.

Inspector #687 interviewed PSW #116 who stated that they had made RN #103 aware of the physical altercation when they became aware of it.

Inspector #627 interviewed RN #103 who stated that they had made the Administrator aware of the incident by telephone.

During an interview with the Inspector #687, the Administrator stated that they had spoken to resident #007 and obtained inconsistent information. For this reason, they had not reported the alleged incident of abuse to the Director. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which is was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that for a resident who was incontinent, they received a continence assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Resident #001 was identified as a low risk of incontinence, from their last to most recent RAI-MDS assessment.

Inspector #627 reviewed resident #001's last to most recent RAI-MDS assessment which identified that the resident tended to be incontinent daily, with some control present.

Inspector #627 reviewed the home's policy titled "Resident Rights, Care and Services - Required Programs-Continence care and Bowel Management - Program", last revised May, 2017, which identified that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. Each resident received, on admission, an "Assessment of Continence" (urinary and bowel) under Point Click Care (PCC) assessments. The assessment included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Referrals and additional Assessment for Continence were completed with a decline in bowel and/or urinary continence indicated in completing RAI-MDS.

Inspector #627 reviewed the completed assessments in PCC since the resident's admission and could not identify a completed Assessment of Continence.

During an interview with Inspector #627, PSW #109 stated that resident #001 had specific continence care needs. They were mostly continent, but had some incontinent episodes.

During an interview with Inspector #627, RPN #111 stated that when a resident was admitted, a three day continence assessment was completed in POC by the PSWs. An Assessment of Continence which identified causal factors, patterns, type of incontinence and potential to restore function with specific interventions, was completed with the Point of Care documentation and by interviewing the resident. The care plan was updated with the information gathered. RPN #111 substantiated that the resident had not had an Assessment for Continence completed since their admission.

During an interview with Inspector #627, the DOC stated that when a resident was admitted, an Assessment of Continence was completed, the information provided upon admission was reviewed and a three day voiding assessment in POC was completed. The care plan was updated using the aforementioned information. The DOC confirmed that no Assessment of Continence which identified causal factors, patterns, type of incontinence and potential to restore function with specific interventions, had not been completed for resident #001 [s. 51. (2) (a)]

2. Resident #002 was identified as a low risk of incontinence, from their last to most recent RAI-MDS assessment.

Inspector #627 reviewed resident #002's most recent RAI-MDS assessment which identified that the resident had inadequate control with multiple daily episodes of incontinence. Upon further review the Inspector noted that an separate assessment identified that resident #002 tended to be incontinent daily, but had some control present.

Inspector #627 reviewed resident #002's completed assessments in PCC and noted an Assessment of Continence completed on a specific date. No further Assessments of Continence were identified.

Inspector #627 reviewed the home's policy titled "Resident Rights, Care and Services – Required Programs-Continence care and Bowel Management - Program", last revised May, 2017, which identified that referrals and additional Assessments for Continence were completed with a decline in bowel and/or continence indicated in completing RAI-

MDS".

During an interview with Inspector #627, PSW #108 stated that resident #002's urinary continence care needs had changed.

During an interview with Inspector #627, RPN #111 stated the RAI-MDS assessment and the resident assessment protocols (RAPS) were completed quarterly and annually. The care plan was updated at this time, if needed. RPN #111 further stated that if the resident had a decrease in their continence status, the POC documentation was used to note the resident's continence decline and that no other tools were utilized.

During an interview with the Inspector, the ADOC and CoDOC #113 stated that when it was reported by a PSW that a resident had a change in their continence status, a review of the POC documentation was completed. This was discussed during the interdisciplinary high risk meetings and the care plan was updated as needed. The ADOC and CoDOC #113 substantiated that a reassessment using a clinically appropriate tool had not been completed when the resident's continence status changed. [s. 51. (2) (a)]

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 resident #001, #002 and any other resident who is incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

A complaint was submitted to the Director alleging physical abuse to resident #007. Please see WN #2 for details.

Inspector #687 reviewed the home's policy titled " Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, which instructed staff to report to police any abuse or neglect which may constitute a criminal offense

During an interview with Inspector #687, the Administrator confirmed that the police were not called to investigate the alleged physical abuse of resident #007. [s. 98.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #687 observed the narcotic stock with RN #114 and #115 on November 8, 2017, at 1410 hours. The Inspector observed that the narcotic stock was kept in a stationary cupboard, single locked in the medication room.

Inspector #687 reviewed the home's policy titled "Medication Management System-Narcotics and Controlled Substances", last revised July 20, 2017, which identified that all narcotics shall be stored in a permanent affixed cabinet, under double lock at all times, accessible only by a registered staff member.

During an interview with Inspector #687, RN #114 verified that the cupboard where the narcotic stock supply was stored, was only single locked.

During an interview with the ADOC, they informed the Inspector that the cupboard for the narcotic supply stock was in the locked medication room in a locked cupboard. The ADOC further stated that the cupboard was only single locked. [s. 129. (1) (b)]

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

Issued on this 18th day of January, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627), LOVIRIZA CALUZA (687)
Inspection No. / No de l'inspection :	2017_572627_0020
Log No. / No de registre :	024211-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 16, 2018
Licensee / Titulaire de permis :	JARLETTE LTD. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	TEMISKAMING LODGE 100 BRUCE STREET, P.O. BOX1180, HAILEYBURY, ON, P0J-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	FRANCINE GOSSELIN

To JARLETTE LTD., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the home's policy titled "Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, is complied with.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home's policy titled "Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, was complied with.

A complaint was submitted to the Director alleging physical abuse to resident #007 from an individual known to the resident. Please see WN #2 for further details.

Inspector #687 reviewed the home's policy titled "Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, which indicated that Jarlette Health Services had implemented a zero-tolerance policy that took all appropriate actions to address the prevention, reporting and elimination of abuse and neglect of residents which included but was not limited to:

- The most Senior Administrative Personnel (or Charge Nurse if no manager in the home) who received a report of resident abuse were to:
- Assess the resident to determine any injury and provide any necessary care,
- Ensured immediate support or assistance was provided to the resident who had been abused, or allegedly abused,

- Staff members, volunteers, substitute decision-makers, family members or any other person who had reasonable grounds to suspect abuse or neglect of a resident were to immediately report their suspicion to the most Senior Administrative Personnel or charge nurse if no manager was on site at the home,
- Advised the abuser, if a family member that an investigation was undertaken and implemented supervised visit between the family member and the resident,

- Notified immediately the appropriate police force of any alleged, suspected or witnessed incident of abuse of a resident that may constitute a criminal office,
- Obtained written and signed statements from all witnesses,
- Immediately notified the Ministry of Health and Long Term Care (MOHLTC) via after hour pager if it was outside of normal business hours and completed a Critical Incident System Report during normal business hours as applicable,
- Documented all pertinent information in the resident's record and completed resident incident reports,
- Completed thorough documentation of all discussions surrounding the incident and further investigation,
- Followed the investigation procedures, signed the "Resident Rights, Care and Services – Administration Investigation Checklist",
- Engaged the assistance of the home's Resident Family Service worker, or delegate to provide ongoing support and assistance to the resident who had been abused or allegedly abused.

Inspector #687 interviewed the Administrator who indicated that they had spoken to resident #007 regarding the alleged abuse. The Administrator stated that no further investigation had been completed as they had obtained inconsistent information from the resident. The Administrator acknowledged that they had not immediately notified the MOHLTC, they had not completed the "Resident Rights, Care and Services – Administration Investigation Checklist" or obtained a written and signed statements from all witnesses, they had not notified the police, they had not engaged the assistance of the home's Resident Family Service worker, they had not advised the individual known to the resident that an investigation would be undertaken or implemented supervised visit between the individual known to the resident and the resident, as per the home's policy titled " Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017 . [s. 20. (1)]

The decision to issue this compliance order was based on the scope which was

identified as isolated, the severity which was indicated as actual harm and the compliance history indicated one or more related noncompliance in the last three years: written notification (WN) issued on January 9, 2017 (#2016_391603_002). (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall develop,submit and implement a plan to ensure that all residents are protected from abuse.

The plan shall include but not be limited to:

- Retraining the Administrator and the Management team on the home's policy, procedures and responsibilities as outlined in the home's policy titled "Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017. The licensee shall maintain a record of the required retraining.

- Implementing a monitoring system to ensure that the Administrator and the Management team comply with the home's policy titled "Resident Rights, Care and Services- Abuse -Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Nursing Inspector, Long-Term Care Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or faxed to the Inspector's attention, at (705) 564-3133, or email SudburySAO.moh@ontario.ca. This plan must be submitted by January 25, 2018.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that all residents were protected from abuse by anyone.

A complaint was submitted to the Director alleging physical abuse to resident

#007. Resident #007 sustained injuries after an incident had taken place between resident #007 and an individual know to the resident.. The complainant stated that they were concerned that the issue was not properly addressed by the home.

Inspector #687 reviewed resident #007's electronic progress notes which indicated that resident #007 had returned from a casual absence on a specific date. The progress note further indicated that there had been a verbal and physical altercation. The resident had sustained injuries.

Inspector #687 interviewed resident #007 who stated that a disagreement had led to an argument on the date identified from the progress note, between themselves and an individual known to them. Resident #007 informed the Inspector that they had been physically abused. At this time, resident #007 called a nursing staff member for assistance. They stated that they remained fearful of the individual known to them.

Inspector #687 interviewed PSW #116 who stated upon entering resident #007's room, they had observed an argument. Resident #007 told the PSW upon their entry in the resident's room to call the police. The PSW tried to de-escalate the situation and had observed that resident #007 had sustained injuries. The PSW further informed the Inspector that they reported this incident to RN #103 and that an incident report was completed. PSW #116 stated that the Administrator had not interviewed them regarding the incident.

Inspector #687 interviewed RN #103 who stated PSW #116 had reported a physical altercation related to resident #007. The RN further stated that they went to see resident #007 and observed multiple injuries. RN #103 stated that they had reported the incident to the Administrator by telephone immediately. RN #103 informed the Inspector that they had not been interviewed by the Administrator with regards to the incident.

Inspector #687 interviewed the Administrator who indicated that they had spoken to resident #007. The Administrator stated that they observed the resident with injuries at that time. The Administrator stated that no further investigation had been completed as they had obtained inconsistent information from the resident. The Inspector inquired what the Administrator would do to address this incident to which the Administrator replied that they would follow up with the resident and that they would refer the resident to Resident Family

Service worker.

Additionally, the home failed to protect resident #010 from abuse as evidenced by noncompliance identified during this inspection related to:

-WN #1, LTCHA, 2007, s. 20 (2), where the license failed to ensure that the home's policy titled ""Resident Rights, Care and Services - Abuse – Zero-Tolerance for Resident Abuse and Neglect", last revised June 2, 2017, was complied with".

- WN #4, finding '2', LTCHA, 2007, s. 24 (2), where the license failed to failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director : Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

- WN #6, LTCHA, 2007, r. 98, where the licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense. [s. 19. (1)]

The decision to issue this compliance order was based on the scope which was identified as isolated, the severity which was actual harm and the compliance history indicated one or more unrelated noncompliance in the last three years. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 16th day of January, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

Service Area Office / Bureau régional de services : Sudbury Service Area Office