Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
April 13-14/11	2011_154_2698_12Apr151045	Complaint

Licensee/Titulaire
Jarlette Ltd., 689 Yonge Street, Midland, ON L4R 2E1
Fax: 705-528-0023

Long-Term Care Home/Foyer de soins de longue durée
Temiskaming Lodge, 100 Bruce Street, Haileybury ON P0J 1K0
Fax: 705-672-5734

Name of Inspector(s)/Nom de l'inspecteur(s)
Gail Peplinskie #154

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Administrator, Director of Care, Registered Staff, Personal Support Workers (PSW).

During the course of the inspection, the inspector:
-Reviewed the health care record of the resident named in the complaint
-Reviewed the Health Care Records of 3 residents related to continence care
-Observed breakfast and lunch service on April 14/11
-Reviewed the home's Continence/Incontinence Care Management Policy
-Reviewed the home's Continence Care Products Policy

The following Inspection Protocols were used during this inspection:
-Personal Support Services
-Nutrition and Hydration
-Continence Care and Bowel Management

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, S.O. 2007, c.8, s.3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. On April 14/11 @ 08:15 a.m. Inspector #154 observed one of the Registered staff, administer Insulin to a

resident, in the abdomen, while the resident was lying on the bed in their room. The Registered staff did not provide privacy in treatment and in caring for the resident's personal needs. The Registered staff did not pull the privacy curtain and the door from the resident's room to the hallway was left open with other residents walking past the room.

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WN #2: The Licensee has failed to comply with O. Reg. 79/10, s. 229 (4): The licensee shall ensure that all staff participates in the implementation of the program.

Findings:

1. The Licensee did not ensure that all staff participates in the implementation of the Infection Prevention and Control Program. On April 14/11 @ 08:00 a.m. Inspector #154 observed a Registered staff member, place a cup containing medications on top of a dirty linen cart, while discussing the medication pass and trying to show the Inspector the Medication Administration Record.
2. The Licensee did not ensure that all staff participates in the implementation of the Infection Prevention and Control Program. On April 14, 2011 @ 1:07 p.m. Inspector #154 observed a 4 bag linen cart with one bag of dark personal clothing, which was wet and had leaked on the floor in the hall. The brown liquid, which had leaked from the linen bag, was observed to be dried on the hall floor.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** June 7/11