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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY-JEAN SCHIENBEIN (158)
Inspection No. / No de l'inspection :	2013_140158_0017
Log No. / Registre no:	S-000071-13, S-000035-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 6, 2013
Licensee / Titulaire de permis :	JARLETTE LTD. 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	TEMISKAMING LODGE 100 BRUCE STREET, P.O. BOX 1180, 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)

Linked to Existing Order /
Lien vers ordre existant: 2013_099188_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that the plan of care and kardex for residents exhibiting responsive behaviours sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. Resident # 04 who has cognitive impairment, wanders and attempts to elope from the home.
Although the resident's computerized plan of care identifies the above behaviours, the kardex which is used by the front line staff does not identify the behaviour and therefore does not provide clear directions to manage or prevent the behaviours to staff and others who provide direct care to resident # 04. (158)

2. CO # 02 was issued during the January 2013 RQI Inspection # 2013_099188_004. (158)

3. Two episodes of physical aggression by resident # 01 towards two different residents occurred in June 2013. No one sustained injury as a result of the altercations. The Inspector reviewed resident # 01 plan of care and although it identifies that resident # 01 becomes verbally and physically aggressive in unpredictable situations and when provoked, the interventions documented fail to provide clear direction regarding management and prevention of the behaviour to staff and others who provide direct care to resident # 01 when

resident # 01 becomes physically aggressive towards other residents. (158)

4. A resident's family member reported to staff # S-104, their concern regarding an area on resident # 01 body. Staff # S-105 attempted to assess the area however the resident refused to have the area measured by pulling away. When Staff # S-104 went to see the resident, resident # 01 refused to allow a dressing be applied. The Inspector reviewed resident # 01 plan of care and it fails to identify the resident's refusal of care assessment, treatment and the resident's impaired skin integrity. (158)

5. It was documented in resident # 01 progress notes that the resident was agitated and aggressive with staff for AM care and refused to get out of bed or go eat in the dining room. It was further documented that the staff notified the family that on some mornings, resident # 01 does not want to get to eat and becomes verbally and physically aggressive when encouraged. The Inspector observed that the resident refused to come to eat in the dining room on August 1, 2013 and that resident # 01 still refused and became upset and was physically aggressive after encouragement attempts were made by staff. The Inspector reviewed Resident # 01 plan of care and it fails to identify the resident's refusal of care, the resident's refusal to eat in the dining room and resident # 01 aggressive behaviour when encouraged. (158)

6. It was documented in resident # 02 progress notes that resident # 02 was self transferring even though resident # 02 was assessed as requiring assistance of staff to transfer. It was also documented that resident # 02 often refuses treatments and medications. Resident # 02 plan of care was reviewed and it fails to identify the resident's risk of injury related to self transferring, refusing treatments and fails to identify interventions to manage the behaviours. (158)

7. It was identified in the MDS assessment that resident # 02 can be impatient and would like to be in control of their care. It was also identified that resident # 02 has had paranoid thoughts. Although the evaluation identified that the care will be care planned, the resident's anxiety and paranoia and interventions to prevent or manage the behaviour are not documented. Clear direction was not provided to staff and others who provide direct care to resident # 02. (158)

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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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of August, 2013

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : KELLY-JEAN SCHIENBEIN

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 6, 2013	2013_140158_0017	S-000071-13, S-000035-13	Follow up

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 30, 31, August 1, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Directors of Care, Registered staff, Personal Support Workers, the maintenance staff, Activity staff, residents, and visitors.

During the course of the inspection, the inspector(s) conducted daily tours of the home, reviewed various residents' health care records, reviewed various home policies, observed delivery of care to residents by staff, and reviewed vendors reports of completed maintenance work in the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. It was identified in the MDS assessment that resident # 02 can be impatient and would like to be in control of their care. It was also identified that resident # 02 has had paranoid thoughts. Although the evaluation identified that the care will be care planned, the resident's anxiety and paranoia and interventions to prevent or manage the behaviour is not documented. Clear direction was not provided to staff and others who provide direct care to resident # 02. [s. 6. (1) (c)]

2. It was documented in resident # 02 progress notes that resident # 02 was self transferring even though resident # 02 was assessed as requiring assistance of staff to transfer. It was also documented that the resident often refused their medications and treatments. Resident # 02 plan of care was reviewed and it fails to identify the resident's risk of injury related to self transferring, refusing treatments and medication and interventions to manage the behaviours. [s. 6. (1) (c)]

3. It was documented in resident # 01 progress notes that the resident was agitated and aggressive with staff for AM care and refused to get out of bed or go eat in the dining room. It was further documented that the staff notified the family that on some mornings resident # 01 does not want to get to eat in the dining room and becomes verbally and physically aggressive when encouragement is given. The Inspector observed that the resident refused to come to eat in the dining room on August 1, 2013 and that resident # 01 still refused and became upset and was physically aggressive after encouragement attempts were made by staff.
The Inspector reviewed Resident # 01 plan of care and it fails to identify the resident's refusal of care, the resident's refusal to eat in the dining room and resident # 01 aggressive behaviour when encouraged. [s. 6. (1) (c)]

4. A resident's family member reported to staff # S-104 their concern regarding an area on resident # 01 body. Staff # S-105 attempted to assess the area however the resident refused to have the area measured by pulling away. When Staff # S-104 went to the resident, resident # 01 refused to allow a dressing be applied. The Inspector reviewed resident # 01 plan of care and it fails to identify the resident's refusal of care assessment and the resident's impaired skin integrity. [s. 6. (1) (c)]

5. Two episodes of physical aggression by resident # 01 towards two different residents occurred in June 2013. No one sustained injury as a result of the altercations. The Inspector reviewed resident # 01 plan of care and although it identifies that resident becomes verbally and physically aggressive in unpredictable

situations and when provoked, the interventions fail to provide clear direction to staff and others who provide direct care to resident # 01 when resident # 01 becomes physically aggressive towards other residents. [s. 6. (1) (c)]

6. CO # 02 was issued during the January 2013 RQI Inspection # 2013_099188_004. [s. 6. (1) (c)]

7. Resident # 04 who has cognitive impairment, wanders and attempts to elope from the home.
Although the resident's computerized plan of care identifies the above behaviours, the kardex which is used by the front line staff does not identify the behaviour and therefore does not provide clear direction to staff and others who provide direct care to resident # 04. [s. 6. (1) (c)]

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. Resident # 03 returned from a medical appointment with specific recommendations from the health practitioner, to use a medicated rinse. Staff # 102 and staff # 103 identified that the medicated rinse was used during resident # 03 care on July 30 and 31, 2013. Inspector spoke with staff # S-100 and staff # 101 who identified that an order for a medicated rinse should be obtained from the doctor and written as an order. The administrator confirmed the above process. Although, the health practitioner's recommendation for the medicated rinse was documented in resident # 03 progress notes, there was no written order for the medicated rinse. The licensee did not ensure that the medicated rinse was prescribed for resident # 03. [s. 131. (1)]

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

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. 15. (2)	CO #001	2012_138151_0019	158
O.Reg 79/10 s. 21.	CO #901	2013_099188_0004	158
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2013_099188_0004	158

Issued on this 6th day of August, 2013

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