Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Public Report

Report Issue Date: January 22, 2025

Inspection Number: 2025-1197-0001

Inspection Type:
Critical Incident

Licensee: Jarlette Ltd.

Long Term Care Home and City: Temiskaming Lodge, Temiskaming Shores

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 13-17, 2025

The following intake(s) were completed:

- One Intake related to alleged physical abuse of resident by staff.
- Three Intakes related to alleged neglect of resident by staff.
- One Intake related to an outbreak.
- Two Intakes related to alleged resident to resident abuse.
- Two Intakes related to a fall of resident.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

The licensee has failed to ensure that the provision of care as set out in resident plan of care was documented as provided.

Concerns were brought forward related to resident's care preferences not provided as per their plan of care; and no supporting documentation was completed.

Sources: Resident's electronic medical record; the home's internal investigation notes; and an interview with the DOC.

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that a resident was protected from neglect when the staff did not provide the specified care to the resident.

O. Reg. 246/22, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Sources: Critical Incident; Review of a resident clinical records; Review of the home's policy titled, "LTC Abuse – Zero Tolerance Policy for Abuse and Neglect"; Review of the home's internal investigation notes, and interview with a resident and the DOC.

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1)
Reporting certain matters to Director
s. 28 (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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The licensee has failed to ensure that reasonable grounds to suspect neglect was

immediately reported to the Director.

An incident of potential neglect was reported to the home; however the Director was not notified of the incident until a day later.

Sources: Critical Incident; Investigation notes; and an interview with the DOC.

WRITTEN NOTIFICATION: Medication Administration

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident was provided with their medication as prescribed.

Sources: Critical Incident; Review of resident's clinical records; Review of the home's policy titled, "LTC Administration of Medications including PRN Medications"; Review of the home's internal investigation notes; and interview with a resident and the DOC.