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
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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
Aug 18, 2015	2015_246196_0008	S-000830-15	Resident Quality Inspection

Licensee/Titulaire de permis

ATIKOKAN GENERAL HOSPITAL
120 DOROTHY STREET ATIKOKAN ON P0T 1C0

Long-Term Care Home/Foyer de soins de longue durée

ATIKOKAN GENERAL HOSPITAL
120 DOROTHY STREET ATIKOKAN ON P0T 1C0

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

LAUREN TENHUNEN (196), SHEILA CLARK (617)

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): May 25, 26, 27, 28, 29, June 1, 2, 3, 2015

During the course of inspection, the inspectors conducted a walk through of all resident care areas, observed the provision of care and services to residents, reviewed the health care records of several residents, and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Chief Nursing Officer (CNO), Clinical Manager, Patient Care Facilitator (PCF), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Coordinator, Physiotherapist (PT), Rehabilitation Therapist, Laundry Lead, Maintenance Lead, Dietary Aide, Housekeeping Aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council

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

9 WN(s)
4 VPC(s)
1 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

During the inspection, an interview was conducted with a family member/Substitute Desicion-maker (SDM) of a resident of the home and they reported that they are not always notified of medication changes for their family member at the time changes are made.

An interview was conducted with registered staff member S#101 and they reported that staff don't normally notify the SDM when changes to medications have been made by the physician, but if a resident was to have a change in condition or developed a UTI (Urinary Tract Infection) or pneumonia, or had a fall, staff would notify the SDM.

An interview was conducted with registered staff member S#102 and it was reported that staff would not necessarily notify the SDM of medication changes.

The SDM of residents, are not provided with the opportunity to participate fully in the development of the plan of care, specifically, they are not being informed of medication changes at the time that they are implemented. [s. 6. (5)]

2. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

A Compliance Order was issued to the licensee on November 12, 2014, as a result of a Resident Quality Inspection (RQI) #2014_333577_0007 that was conducted May 20-30, 2014. Full compliance with this order was to be achieved by the licensee by December 5, 2014. The order indicated that staff and others who provide direct care to a resident, specifically resident #004, are to be kept aware of the contents of the residents' plan of care and have convenient and immediate access to it. The findings indicated that the staff providing direct care to the residents did not have access to the computer with the most updated care plan. Staff that had been interviewed during the RQI were unaware of certain care plan provisions included in the care plan.

On June 1, 2015, Inspector #617 reviewed the care plan for resident #004 as had been provided by registered staff member S#101 from the electronic documentation system. The care plan indicated that to promote safety, several interventions were identified for use on resident #004.

Inspector #617 interviewed both S#110 and S#104 regarding the mobility care needs for resident #004 and both of these staff members reported several interventions that were used.

S#110 was asked by Inspector #617 to locate and review the care plan for resident #004 using the electronic documentation system. This staff was able to log onto the computer but was unable to navigate the site and required assistance of another staff member in locating the information regarding mobility needs from the care plan. Staff member S#110 confirmed that they had received training but still had difficulty navigating the site and using the computer system and would elicit assistance from the registered staff to access care plan information. In addition, S#110 told the inspector that they would check the resident care plans at least once a week and would report to the registered staff any changes in resident care needs.

Inspector #617 asked S#104 to locate and review the care plan for resident #004 from the electronic documentation system. They were unable to login to the computer in order to access the care plan for resident #004 and reported that they had not accessed the computer for a long time and that their password had expired. Then registered staff member S#101 accessed resident #004's care plan on the electronic documentation

system using their assigned login and password. S#104 then sat at the computer and was unable to navigate the site and required assistance from S#101 in finding the information from the care plan specific to mobility. S#104 reported that they would access the care plan only when a resident is a new admission or when there is a change in their condition.

Inspector #617 interviewed S#111 and they reported that they provided computer access with passwords and training to all but 3 nursing staff who occasionally work the night shifts and then provided a list of staff training which confirmed both S#109 and S#104 had attended. The training document was not dated nor did it identify the specifics of the training. S#111 went on to report that they would reset the expired passwords for staff and when they are not available, there is an alternative staff member that is also able to do this, S#101. S#111 confirmed that the only resources to reset the expired passwords were S#111 and S#101.

An interview was then conducted with the Chief Nursing Officer (CNO) who reported that the paper copies of the resident care plans were no longer made available to the nursing staff approximately a year ago, and that the staff were expected to access and review the resident care plans on the electronic documentation system at every shift. Both the CNO and S#111 reported that the staff should not have issues with logging in to the system and confirmed to Inspector #617 that the most recent version of the care plan on MED e-care has been difficult for some staff to access and utilize.

Staff and others who provide direct care to residents in the home, do not have immediate access to the care plans nor do they have the ability to navigate the electronic documentation system and the site to gather the contents of the plan of care to determine care needs. [s. 6. (8)]

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. 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. The licensee has failed to ensure that the Minimizing of Restraining policy and procedure were in compliance with and were implemented in accordance with applicable requirements under the Act.

The licensee's "Least Restraint" policy #03-40 and the "Least Restraint" Procedure #03-40-01 (Link to policy 03-40) with last update of February 2015, was reviewed by the inspector. The procedure identified the "Segufix Restraint" and "Posey #4427 Posey Breezeline Pelvic Holder" as the approved physical restraint devices for the Atikokan General Hospital. The policy and the procedure documents, both included "***NOTE: Restraint devices that utilize a separate locking device such as a key or magnet may not be utilized on the ECW." (Extended Care Wing). The policy lists "restraint jackets" as a form of restraint yet this is a prohibited device according to the Long-Term Care Homes Act 2007 as is the "Segufix Restraint" as it requires a separate locking device.

During the course of the inspection, some residents were observed with restraint devices in use.

The licensee's written policy and the procedure titled "Least restraint" did not clearly identify the types of physical devices permitted for use on residents within the long-term care unit. [s. 8. (1) (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 the Minimizing of Restraining policy and procedure is in compliance with the applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Recreation and Social Activities Program includes, the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends.

During the initial walk through of the resident care areas, at the start of the inspection, no activity programming was observed and an activity calendar was not posted. On another day, resident #007 and resident #004 were observed sitting at the nursing station, and there were no activity programs ongoing.

During the inspection, an interview was conducted with the Patient Care Facilitator (PCF) accompanied by staff member S#103 regarding the recreation program. They reported to the inspector that no staff had been in the position of providing recreation programming to the residents since April 7, 2015.

S#104 was interviewed during the inspection and they reported that the residents are bored. An interview was then held with S#101 on another day of the inspection, and they reported that some residents have become more irritated at times and several residents will come to the nursing desk to ask what is going on today, and look at the bulletin board to see what is going on that day, as it had become a routine for them.

When interviewed, S#105 told the inspector that resident #004 liked to participate in the activities when the program was offered, in particular, the balloon toss and chair dancing. Since there have been no programs, the behaviours exhibited by resident #004 have increased and the staff need to spend more 1:1 time with them to keep this resident busy. In addition, S#105 reported that all the residents are asking what is happening next, after breakfast they will ask, "now what are we are doing?", and that it had been a month and a half process getting someone hired and other residents are asking if they are going to hire someone for the recreation program.

The licensee has not had an organized program of recreation and social activities implemented in the home, since April 7, 2015. [s. 65. (2) (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 the recreation and social activities program includes, the development, implementation and communication to all residents and families a schedule of recreation and social activities that are offered during days, evenings and weekends, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy under section 29 of the Act deals with, duties and responsibilities of staff.

The licensee's "Least Restraint" policy #03-40 and the "Least Restraint" Procedure #03-40-01 (Link to policy 03-40) with last update of February 2015, was reviewed by the inspector. Neither of these documents clearly identified the duties and responsibilities of staff that provide care to residents that are restrained.

An interview was conducted with S#105 and they reported that they document on a tick sheet and code for every hour - document hourly and note a resident's position change every two hours. Registered staff member S#102 reported to the inspector that the PSWs do the checks on residents that are restrained.

The policy and the procedure did not clearly identify the duties and responsibilities of the registered and unregistered staff members regarding the restraining of residents. [s. 109. (b)]

2. The licensee has failed to ensure that the home's written Minimizing of Restraining policy under section 29 of the Act deals with, duties and responsibilities of staff, including, who has the authority to apply a physical device to restrain a resident or release a resident from a physical device.

The licensee's "Least Restraint" policy #03-40 and the "Least Restraint" Procedure #03-40-01 (Link to policy 03-40) with last update of February 2015, was reviewed by the inspector. Neither of these documents clearly identified who has the authority to apply a physical device to restrain a resident or to release a resident from a physical device. [s. 109. (b) (i)]

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 the home's written policy under section 29 of the Act deals with, duties and responsibilities of staff, including, who has the authority to apply a physical device to restrain a resident or release a resident from a physical device, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time

when necessary based on the resident's condition or circumstances.

Resident #006 was observed on two different days, during the inspection, with a restraint in place.

The health care record for this resident was reviewed for documentation of the use of the restraint. The "Restraint and Repositioning" form in use on these dates did not include documentation of the reassessment and the effectiveness of the restraining every eight hours at minimum, by a member of the registered nursing staff.

An interview was conducted with registered staff member S#102 and they reported that the PSWs do the restraint checks and that the registered staff do not sign the check sheets to acknowledge the reassessment of the need for the restraint at any time. The registered staff that are working on the night shift would sign as they do the repositioning and hourly checks, but not on the day shifts when the PSWs do it.

The effectiveness and reassessment of the restraint in use on resident #006 was not being evaluated every eight hours by the registered staff. [s. 110. (2) 6.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 4. Consent.

Resident #006 was observed on two different days, during the inspection, with a restraint in place.

The health care record for this resident was reviewed for information regarding the use of a restraint and documentation of consent was not located.

During the inspection, an interview was conducted with registered staff member S#102 and they reported that it is usually the MD that would speak to the SDM/POA regarding the use of restraints and obtains consent and that there is no hard copy of consent from the SDM or POA, and it is not something that the nursing staff does. Inspector #617 conducted an interview with registered staff member S#102 regarding consents for restraints and they reported that consents are not written and recorded rather they are obtained verbally at the care conference and a doctor's order is updated on the health care record.

A restraint was observed on two occasions to be in use for resident #006 but consent from the SDM or POA was not documented. [s. 110. (7) 4.]

3. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 5. The person who applied the device and the time of application.

Resident #006 was observed on two different days, during the inspection, with a restraint in place.

The health care record for this resident was reviewed for documentation of the use of the restraint. The "Restraint and Repositioning" form in use on these dates did not include identification of the person who applied the device on resident #006. [s. 110. (7) 5.]

4. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 6. All assessment, reassessment and monitoring, including the resident's response.

Resident #006 was observed on two different days, during the inspection, with a restraint in place.

The health care record for this resident was reviewed for documentation of the use of the restraint. The "Restraint and Repositioning" form in use on these dates did not include documentation regarding resident #006's response to the restraint. [s. 110. (7) 6.]

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 that ensures that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances; that consent, the person who applied the device and the time of application and all assessment, reassessment and monitoring, including the resident's response are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

On a particular day, during the inspection, the fingernails on both hands of resident #007 were observed to be soiled with debris.

The current care plan was reviewed for information regarding personal hygiene needs. Under the focus of Personal Hygiene it indicated that the resident required assistance from staff.
The most recent RAI MDS assessment, identified resident #007 as requiring extensive assistance of staff with personal hygiene.

Resident #007 was not provided with adequate grooming, specifically fingernail care, as was observed on a particular day during the inspection. [s. 35. (2)]

WN #7: 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. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

On a specific evening, the dinner service, in the main dining room was observed. Resident #007 was observed to be assisted by staff member S#106 with their special diet texture meal. An interview was conducted with dietary staff S#107 and it was confirmed that residents on a special diet texture are not offered a meal choice. According to S#107, there was not enough staff to prepare it nor the equipment to do it. There was only the one option of entree available for those residents that require this special diet texture.

The lunch menu for another day, as posted, read grilled cheese sandwich with pickle slices or Cod with mashed potatoes and vegetables. An interview was conducted with dietary aide S#108 and they reported that choices for special diet texture did not include the grilled cheese sandwich and instead they had only one choice for those residents on this particular diet texture.

During a dinner service and lunch service on two different days of the inspection, the planned menu items were not offered and available for the meal, specifically both entree choices were not available in a special diet texture. [s. 71. (4)]

WN #8: 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: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

On a specific evening, the dinner service, in the main dining room was observed. At 1723hrs, staff member S#109 was observed to offer dessert, a brownie or some fruit, to residents #013, #014, #006, #003 and #015 even though they were still in various stages of eating their main entree.

During the observed dinner service, the meal for each of the identified residents was not served course by course, specifically the dessert was being offered and provided while the main entree was still being consumed. [s. 73. (1) 8.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of contamination of the drinking water supply in the home, followed by the report required under subsection (4).

A Critical Incident System (CIS) report was submitted by the Patient Care Facilitator (PCF) in the summer of 2014, for an incident of contamination of the drinking water supply which had occurred in the town.

During the inspection, inspector #617 interviewed the PCF who reported that they were aware of legislation 107 (1) to report certain circumstances to the Director, however at the time of the incident they were unaware that a contaminated water supply needed to be reported.

Inspector #617 reviewed a copy of the CIS report with the PCF who confirmed that they had reported the incident 7 days after the occurrence.

The CIS report was not submitted until one week after the occurrence of contamination of the drinking water supply nor was the Director notified immediately. [s. 107. (1)]

Issued on this 20th day of August, 2015

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2015_246196_0008
Log No. / Registre no:	S-000830-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 18, 2015
Licensee / Titulaire de permis :	ATIKOKAN GENERAL HOSPITAL 120 DOROTHY STREET, ATIKOKAN, ON, P0T-1C0
LTC Home / Foyer de SLD :	ATIKOKAN GENERAL HOSPITAL 120 DOROTHY STREET, ATIKOKAN, ON, P0T-1C0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Doug Moynihan

To ATIKOKAN GENERAL HOSPITAL, 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) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_333577_0007, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee shall ensure compliance with LTCHA, 2007 S.O. 2007,c.8,s.6(8), whereby staff and others who provide direct care to resident #004 and all other residents, are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The licensee shall prepare, submit and implement a plan for achieving compliance with s.6.(8) of the LTCHA. The plan is to include:
1) Strategies that will ensure that the care plans for all residents, including resident #004, are accessible to the staff who provide direct care.
2) Training for all staff on the use of the electronic documentation system to access residents' plan of care.
3) A contingency plan for accessing plans of care in the event of being unable to access the Internet or MED e-care.

This compliance plan is due to be submitted by Friday August 28, 2015, to Lauren Tenhunen LTCH Nursing Inspector #196. Implementation and full compliance with the plan is to be achieved by Friday September 11, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

A Compliance Order was issued to the licensee on November 12, 2014, as a result of a Resident Quality Inspection (RQI) #2014_333577_0007 that was conducted May 20-30, 2014. Full compliance with this order was to be achieved by the licensee by December 5, 2014. The order indicated that staff and others who provide direct care to a resident, specifically resident #004, are to be kept aware of the contents of the residents' plan of care and have convenient and immediate access to it. The findings indicated that the staff providing direct care to the residents did not have access to the computer with the most updated care plan. Staff that had been interviewed during the RQI were unaware of certain care plan provisions included in the care plan.

On June 1, 2015, Inspector #617 reviewed the care plan for resident #004 as had been provided by registered staff member S#101 from the electronic documentation system. The care plan indicated that to promote safety, several interventions were identified for use on resident #004.

Inspector #617 interviewed both S#110 and S#104 regarding the mobility care needs for resident #004 and both of these staff members reported several interventions that were used..

S#110 was asked by Inspector #617 to locate and review the care plan for resident #004 from the electronic documentation system. This staff was able to log onto the computer but was unable to navigate the site and required assistance of another staff member in locating the information regarding mobility needs from the care plan. Staff member S#110 confirmed that they had received training but still had difficulty navigating the site and using the computer system and would elicit assistance from the registered staff to access care plan information. In addition, S#110 told the inspector that they would check the resident care plans at least once a week and would report to the registered staff any changes in resident care needs.

Inspector #617 asked S#104 to locate and review the care plan for resident #004 using the electronic documentation system. They were unable to login to the computer in order to access the care plan for resident #004 and reported that they had not accessed the computer for a long time and that their password had expired. Then registered staff member S#101 accessed resident #004's care plan on the electronic documentation system using their assigned login and password. S#104 then sat at the computer and was unable to navigate the site and required assistance from S#101 in finding the information from the care plan

specific to mobility. S#104 reported that they would access the care plan only when a resident is a new admission or when there is a change in their condition.

Inspector #617 interviewed S#111 and they reported that they provided computer access with passwords and training to all but 3 nursing staff who occasionally work the night shifts and then provided a list of staff training which confirmed both S#109 and S#104 had attended. The training document was not dated nor did it identify the specifics of the training. S#111 went on to report that they would reset the expired passwords for staff and when they are not available, there is an alternative staff member that is also able to do this, S#101. S#111 confirmed that the only resources to reset expired passwords were S#101 and S#111.

An interview was then conducted with the Chief Nursing Officer (CNO) who reported that the paper copies of the resident care plans were no longer made available to the nursing staff approximately a year ago, and that the staff were expected to access and review the resident care plans on the electronic documentation system at every shift. Both the CNO and S#111 reported that the staff should not have issues with logging in to the system and confirmed to Inspector #617 that the most recent version of the care plan on MED e-care has been difficult for some staff to access and utilize.

Staff and others who provide direct care to residents in the home, do not have immediate access to the care plans nor do they have the ability to navigate the electronic documentation system and the site to gather the contents of the plan of care to determine resident care needs.
(617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 11, 2015

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.

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 18th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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