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**

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 apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 27, 2017 | 2017_624196_0012 | 017008-17 | 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), JULIE KUORIKOSKI (621), NATASHA MILLETTE (686)

### 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): August 28 - September 1, 2017**

**The following Critical Incident System (CIS) intakes were inspected during this inspection:**

**- one intake related to an incident of resident to resident physical abuse; and**
**- one intake related to a residents' fall.**

**During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Acute Care/Emergency Department Nurse Manager, Nurse Manager of Extended Care Wing (ECW), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Dietary Aides (DA), Acting Resident Assessment Instrument (RAI) Coordinator, Risk Management/Infection Control staff member, Recreation Therapist, Food Services Manager, Housekeeping Aides, residents and their family members.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed several licensee policies, procedures, programs, relevant training and resident health care records.**

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

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

**7 WN(s)**
**5 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During a record review by Inspector #621, resident #007 was identified as having had a weight change and a corresponding Body Mass Index (BMI).

During an interview, resident #007 reported to Inspector #621 that they had a weight change, had difficulty with an aspect of nutrition, and since the spring of 2017, had requested staff provide them with a specific type of textured diet.

During the inspection, Inspector #621 reviewed resident #007's plan of care.
- the current diet order, as noted in the "Quarterly Physician's Order Review" last reviewed on a particular date in 2017, indicated a specific diet type with a specific texture;
- the most recent Registered Dietitian (RD) quarterly assessment dated on a particular date in 2017, indicated that resident #007 was on the same specific diet type with no specifications to their diet texture;
- the resident's care plan, under the focus of "Nutrition Status" identified that resident #007 was on a specific diet type and also another specific diet type and food texture on request of the resident on a particular date in 2017. It was also noted that the expected outcome was to maintain this resident's ideal body weight (IBW), and that since a particular date in 2014, there was an intervention identified that staff may offer a specified amount of nutrition supplement at designated times.

During an interview, RD #102 reported to Inspector #621 that resident #007 was on a specific diet and texture type as requested by the resident. RD #102 also confirmed resident #007 had a specific body weight with a weight change over the previous six months. Additionally, RD #102 reported that they completed nutrition assessments with documentation found in the interdisciplinary progress notes, that they updated diet orders in the physician's order section of this resident's chart, and met with the Resident Assessment Instrument (RAI) Coordinator at least quarterly to review the nutrition care plan, with the RAI Coordinator making the required changes on their behalf.

During an interview, with PSW #106, they reported to Inspector #621 that resident #007 was on a specific diet and texture type and was not on any nutrition supplements.

On a day during the inspection, RPN #106 reviewed and confirmed that resident #007's most current diet order was not consistent with what was identified in the current nutrition care plan. RPN #106 also confirmed that resident #007 was not ordered a nutrition supplement and that the current nutrition care plan was not reflective of this resident's prescribed nutrition requirements.

During an interview, Nurse Manager of Extended Care Wing (ECW) #112 identified to Inspector #621 that it was their expectation that the resident's plan of care provided clear directions to staff who provided direct care to the resident. On review of the plan of care for resident #007, they confirmed that there was unclear direction with respect to this resident's diet order, nutrition supplement requirements, and weight management goals. [s. 6. (1) (c)]

***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 the written plan of care for each resident set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council**

**Specifically failed to comply with the following:**

**s. 59. (7) If there is no Family Council, the licensee shall,**
**(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).**
**(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that if there was no Family Council, the licensee, convened semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council.

During the Entrance Conference interview with the Chief Nursing Officer (CNO), they reported to Inspector #196 that there was no Family Council currently and provided contact information for the former President #113.

On a day during the inspection, Inspector #621 reviewed copies of meeting minutes of Family Council, which indicated that the last active meeting of Family Council had been on June 16, 2016.

During an interview with the former President of Family Council #113, they reported to Inspector #621 that the Family Council had not had a meeting since June 16, 2016, and that the home had attempted to convene a meeting in November 2016, however that meeting had been cancelled.

During an interview with Nurse Manager of ECW #112, they confirmed to Inspector #621 that there was no active Family Council and that the last meeting of Family Council had been documented on June 16, 2016. Additionally, Nurse Manager of ECW #112 confirmed that the licensee had not convened semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council, since November 2016. [s. 59. (7) (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 that ensures that if there is no Family Council, the licensee, convened semi-annual meetings to advise residents' families and persons of importance to residents of the right to establish a Family Council, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that they consulted regularly with Residents' Council, if any, and in any case at least every three months.

During an interview with resident #010, who was an active member of Residents' Council, they reported to Inspector #621 that the home's management staff had not consulted with Residents' Council, at least every three months over the previous year.

During the inspection, Inspector #621 reviewed copies of Residents' Council meeting minutes over the previous 12 months, and with the exception of the Assistant to the Residents' Council, there was no documented representation of the licensee at the three meetings convened between September 8, 2016, and March 14, 2017. Additionally, it was identified that there had been no meeting of Residents' Council for more than three months between March 14, 2017, and August 30, 2017.

During an interview, Recreation Therapist #104, who served as the Assistant to Residents' Council since February 2017, reported to Inspector #621 that representation from the licensee, including the Nurse Manager of ECW #112, had not consulted with Residents' Council at least every three months.

During an interview, the Nurse Manager of ECW #112 confirmed to Inspector #621 that they or a representative of the licensee had not consulted with Residents' Council at least every three months, as per legislative requirements. [s. 67.]

***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 the licensee consults regularly with Residents' Council, if any, and in any case at least every three months, to be implemented voluntarily.***

---

**WN #4: 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. (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 every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following was documented: All assessment, reassessment and monitoring, including the resident's response.

On a particular date during the inspection, resident #003 was observed by Inspector #196 with a specific number of bed rails elevated when lying in bed.

During an interview , RPN #114, reported that resident #003 used a specific number of bed rails when in bed, and RPN #105 reported the resident required a specific number of half rails elevated on their bed, and they had a specialized mattress and the resident requested the rails be elevated when they are in bed. Both staff members confirmed to the Inspector that the specified number of bed rails were a restraint device.

The "Restraint Monitoring Record" dated over a 12 day period was reviewed by the Inspector for documentation. There was missing documentation of the registered staff every eight hours. Specifically, at 1500hrs between the noted dates there were no registered staff initials, and at 2300hrs, there was one shift that had been initialed by a RPN.

Inspector #196 reviewed the home's policy titled "Minimizing Restraining of Residents: Use of Restraints - N-LTC-03-40", last revised Sept. 2015. On page 2 of 9 it read "Authorized staff: "Reassess (physician, RNEC or registered staff only) the resident's condition, effectiveness of the restraint, need for ongoing restraint, potential to employ a less restrictive restraint at a minimum of every 8 hours and more frequently as determined by the circumstances or resident's condition."

An interview was conducted by the Inspector with Nurse Manager of ECW #112, who reported that the registered staff were to initial at 0700, 1500 and 2300hrs on the restraint monitoring record and confirmed that this had not been done consistently. They also confirmed there were no registered staff initials to indicate a reassessment for the continued need for use of the specific number of bed rails and staff had not followed the licensee policy "Minimizing Restraining of Residents: Use of Restraints", N-LTC-03-40, Sept. 2015, specifically the reassessment every 8 hours by registered staff members. In addition, the response to the restraint device was not documented. [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 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 is documented: All assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**s. 135. (3) Every licensee shall ensure that,**
**(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).**
**(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).**
**(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #196 reviewed the licensee's medication incident reports which included the following:

- A report that identified that resident #011 had not received their dose of prescription medication; and

- A report that identified that resident #002 had not received their dose of prescription medication; and

- A report that identified that resident #004 had not received two doses of prescription medication; and

- A report that identified that resident #012 had not received a dose of prescription medication.

On a date during the inspection, Inspector #196 conducted an interview with Nurse Manager of ECW #112. They confirmed to the Inspector:
- the incorrect medication incident forms were completed for the occurrences involving resident #002 and #004; and
- there were no progress notes documented in the health care records of #002, #004 and #012 outlining the medication incidents and actions taken to assess and maintain the resident's health; and
- the pharmacy service provider had not been notified of any of these four medication incidents that had occurred in the home; and
- the physician had not been informed of the medication incidents involving resident #011, #002 and #004; and
- there was no record that either the residents' or the Substitute Decision Makers (SDMs) were informed of the medication incidents that involved these four residents.

Nurse Manager of ECW #112 also reported to Inspector #196 that it was expected that

staff made a progress note when a medication incident occurs and the registered staff members had not followed the licensee's policy titled "Medication Error Reporting - #07-10". Inspector #196 reviewed the policy which specified:
- "it is to be reported immediately to the physician in charge of the patient/resident or if he/she is unavailable, to the physician on call. In cases where the error does not cause harm to the patient the nurse will inform the patient of the error immediately."; and
- "the nurse committing the error is to complete an incident report (GA-10-02-01-02) immediately and submit it to the physician and CNO or designate".

In addition, Nurse Manager of ECW #112 reported that staff had also not followed the pharmacy service provider's policy, regarding medication errors. Inspector #196 reviewed the policy which specified:
- that medication administration errors are to be reported to the RN, Resident's Physician, family/responsible party, Pharmacy Provider, and the Facility administrator or designee;
- "notify the Director of Nursing immediately"; and
- notify "resident's family/responsible part and report on the status of the resident". [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and a written record is kept of everything provided for in clauses (a) and (b).

During an interview with the Nurse Manager of ECW #112, they reported to Inspector #196 that there had not been a quarterly review undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review. In addition, they reported that the pharmacy service provider had not been notified of medication incidents that had occurred in the home that involve residents. [s. 135. (3)]

***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 every medication incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.***

---

**WN #6: 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 failed to ensure that, a person who had 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: 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 System (CIS) report was submitted to the Director on a specific date in 2017, which outlined an incident of resident to resident abuse which had occurred the evening before. The report indicated the specifics of the incident.

During an interview with the Nurse Manager ECW #112, they reported to Inspector #196 that the incident should have been reported immediately to the Director at the Ministry of Health and Long-Term Care (MOHLTC), by the charge RN #116, via the after hours telephone pager number.

Inspector #196 reviewed the licensee's procedure titled "Zero Tolerance of Abuse and Neglect Procedure - 01-15-01 - link to policy 01-15" last reviewed Nov. 2014. The procedure refers to appendix D for reporting to the MOHLTC and specified "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" noted the section of the LTCHA s.24(1)2. Identified the action to be taken by LTC home to notify MOHLTC to "phone the After hours Pager #" and the reporting time frame "immediately upon becoming aware of the incident". [s. 24. (1)]

---

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that that any actions with respect to a resident under a program, including assessments, were documented.

During the inspection, Inspector #621 reviewed resident #001's weight record over the previous quarter, and was unable to identify an admission weight.

During an interview with RPN #105, they reported to Inspector #621 that resident #001 was admitted on a specific date in 2017, and as part of the responsibilities of the Registered Practical Nurse (RPN) was to ensure residents' weights were taken on admission and documented on the "Vitals Sheet" as part of their plan of care.

On review of resident #001's "Vitals Sheet", RPN #105 identified that there was no weight documented for resident #001 on their admission, and their should have been.

During an interview with Nurse Manager of ECW #112, they confirmed to Inspector #621 that there was no weight documented for resident #001 on this resident's admission and it was their expectation that the Registered Practical Nursing staff (RPNs) ensured weights were measured and documented for all residents on their admission, as per legislative requirements. [s. 30. (2)]

---

**Issued on this 28th day of September, 2017**

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

**Original report signed by the inspector.**