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
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Sudbury, ON, P3E 6A5
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Original Public Report

Report Issue Date: July 31, 2024

Inspection Number: 2024-1249-0001

Inspection Type:
Proactive Compliance Inspection

Licensee: Atikokan Health and Community Services

Long Term Care Home and City: Atikokan General Hospital, Atikokan

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8 - 12, and 15 - 17, 2024

The following intake(s) were inspected:

- Proactive Compliance Inspection

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

Medication Management
Food, Nutrition and Hydration
Safe and Secure Home
Quality Improvement
Pain Management
Restraints/Personal Assistance Services Devices (PASD) Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Reporting and Complaints

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
1) During the initial tour of the home, a treatment room door was found to be unlocked. A Personal Support Worker (PSW) and the Director of Care (DOC) were

notified and the door was locked.

2) On another date, a resident was observed to open a janitor room door that was unlocked and housekeeping staff intervened immediately and secured the door.

There was low impact and risk to residents.

Sources: Observations conducted on July 8, 2024, and on July 16, 2024.

Date Remedy Implemented: July 16, 2024

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident; and

a) The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
Inspector reviewed a resident's care plan in which it stated they required a certain type of assistance with an activity of daily living (ADL). The resident's care plan also stated a different way to assist with the ADL. A Registered Practical Nurse (RPN) confirmed only one of the ways is correct and the plan of care should have been

updated to reflect the resident's current status.

A low risk was identified for not having set out clear directions for transfers for the resident.

Sources: Resident's health records and interview with a RPN.

b) The licensee failed to ensure a resident's plan of care provided clear instructions to staff and others who provide direct care to the resident.

Rationale and Summary
A resident was observed with a physical device in place.

Their care plan indicated the use of two physical devices. The MD quarterly assessment identified only one physical device to be used and the physician orders with the same date indicated the use of the physical device as a needed basis.

The DOC confirmed the health care records were unclear what type of physical device to be used and when they were to be used for the resident.

There was low risk and impact to the resident as a result of the unclear direction in the resident's health care records.

Sources: Observations of a resident; Resident's health care records; and an interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 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.

The licensee failed to ensure improper or incompetent treatment or care of a resident, that resulted in a risk of harm to the resident, was reported to the Director.

Rationale and Summary
An incident occurred where the resident did not have a specific device in place as was outlined in the resident's plan of care.

Upon review of the Critical Incident System (CIS), a report had not been submitted to the Director for improper or incompetent care treatment or care of the resident.

Sources: Review of resident's health care records, care plan, and progress notes; CIS; and an interview with the LTC Coordinator.

WRITTEN NOTIFICATION: Provision in plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 5.
Restraining by physical devices
s. 35 (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the

resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

The licensee has failed to ensure the restraining of a resident had been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Rationale and Summary
A resident had a restraint ordered for support. During the on-site inspection, inspector observed the restraint applied on the resident daily. Consent for the use of this restraint was not documented in the resident's plan of care.

A RPN confirmed consents for restraints should be obtained prior to its use.

There was minimal risk for the resident not having documented consent for the use of a restraint.

Sources: Observation of a resident; Review of resident's medical records and interview with a RPN.

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to seek advice of the Residents' Council (RC) in carrying out the survey and in acting on its results.

Rationale and Summary
A survey was completed in 2023 to assess residents' and families' experiences with the home and the care, services, programs, and goods provided. The home was unable to provide documentation to demonstrate that the survey had been shared with the RC.

A Recreational Coordinator stated that they were unaware of the requirement to share the survey with and to seek input from the RC and did not do so during their time as an appointed RC assistant.

There was minimal risk to residents when the RC was not asked for input prior to conducting the survey and acting on the results.

Sources: Review of RC meeting minutes and interview with Recreational Coordinator.

WRITTEN NOTIFICATION: Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
9. Infection prevention and control.

The licensee failed to ensure that a staff member received infection prevention and control (IPAC) training before performing their responsibilities.

Rationale and Summary
A staff member started at the home in their role on a specific date.

On a later date, it was determine that the staff member had not received IPAC training at the time of hire.

Sources: Interview with a staff member; and email from the DOC outlining the missed IPAC training.

WRITTEN NOTIFICATION: Communication and response system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (c)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(c) allows calls to be cancelled only at the point of activation;

The licensee failed to ensure the resident-staff communication and response system allowed calls to be cancelled only at the point of activation.

Rationale and Summary
During inspection, the call bell at the bedside of resident room was activated and it was determined the bell could be cancelled at the nursing desk, with staff not needing to go to the resident room to cancel the bell.

The LTC Coordinator confirmed that the staff can answer the bell at the nursing desk, speak to the resident and cancel the bell at the nursing desk.

Sources: Observations conducted of the resident-staff communication and response system; and interviews with a a PSW and the LTC Coordinator.

WRITTEN NOTIFICATION: Air temperature

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
Temperature readings from throughout the home often read less than 22 degrees Celsius as identified on a printout provided by the Maintenance Lead.

Observed temperature readings in the dining room, by nursing desk and a two resident rooms on a specific date, showed all readings were less than 22 degrees Celsius.

In interviews, two residents reported they felt cold.

This had low impact and was low risk to the residents of the home.

Sources: Review of recorded home temperatures from a month time period; Observed temperature readings on a specific date in four separate home areas; and interviews with residents.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
A staffing plan was provided to the inspector by the DOC. The DOC was unable to provide a written record of an evaluation of the current staffing plan which should be evaluated and updated at least annually in accordance with evidence-based practices.

In an interview the DOC confirmed, although the staffing plan was evaluated, a written record of the evaluation was not kept.

Sources: Record review of staffing plan and interview with the DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee failed to ensure that a resident who exhibited a skin condition that was likely to require or respond to nutrition intervention, was assessed by a registered dietitian (RD) who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration were implemented.

Rationale and Summary
A resident was identified as having areas of impaired skin integrity.

The LTC Coordinator confirmed a referral for a RD assessment was not completed in relation to these areas of impaired skin integrity and should have been done.

There was low risk and low impact as the resident's impaired skin integrity was documented as healing.

Sources: Review of resident's health care records, including care plan, wound assessment and treatment flowsheet documents; Review of the home's LTC skin and wound care program; and interview with the LTC Coordinator.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (1) 1.
Requirements relating to restraining by a physical device
s. 119 (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 35 of the Act or pursuant to the common law duty described in section 39 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions.

The licensee failed to ensure the staff applied the physical device on a resident in accordance with any manufacturer's instructions.

Rationale and Summary
A resident was observed with a physical device in place not properly applied.

The LTC Coordinator observed the placement of the physical device and confirmed it was not applied properly.

There was a moderate risk of potential harm to the resident as a result of the restraint device having been improperly applied.

Sources: Observations of a resident; Interview with the LTC Coordinator; and review of the manufacturer's instructions for the use of the physical device.

WRITTEN NOTIFICATION: Requirements relating to restraining by a physical device

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.
Requirements relating to restraining by a physical device
s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent.

The licensee failed to ensure consent was obtained for the use of a specific restraint device.

Rationale and Summary
A resident was observed with a physical device applied while seated.

The LTC Coordinator confirmed the use of a physical device for the resident.

The health care records included a consent for the use of a different form of physical device, not the one used at the time.

Sources: Observations of resident; Interview with the LTC Coordinator; and review of the consent for use of a restraint device.

COMPLIANCE ORDER CO #001 Communication and response system

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A) Conduct a documented assessment of the resident-staff communication and response system to determine which location in the home it is not audible to staff.
B) Develop and implement a documented plan to address the deficiencies identified in part A).
C) Develop and implement a documented plan to ensure the resident-staff communication and response system can only be de-activated at the point of activation.

Grounds
The licensee failed to ensure that the home was equipped with a resident-staff communication and response system was properly calibrated so that the level of sound was audible to staff.

Rationale and Summary
The resident-staff communication and response system was not consistently

audible at various areas in the resident care areas.

In interviews, staff reported the call bell alarms and bed alarms could not always be heard throughout all areas of the home; and that this had been an ongoing issue for approximately two years.

The Maintenance lead confirmed, after a walkthrough with the inspector, that the call bell alarms were not always audible throughout all areas of the long-term care home.

There is a moderate risk and moderate impact to residents when the resident-staff communication and response system was not audible to the staff of the home.

Sources: Observations of the resident-staff communication and response system on July 8 and 16, 2024; and interviews with a RPN, LTC Coordinator, Maintenance staff and Maintenance Lead.

This order must be complied with by September 16, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.