Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 6, 9, 27, Aug 21, 22, Sep 4, 5, 2012	2012_104196_0017	Mandatory Reporting

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI coordinator, Administrative staff and residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas, observed the provision of care and services to residents and reviewed the health care records for several residents.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The inspector reviewed the progress notes for resident #002 for the time period of August 8, 2011 through to August 27, 2011. During this time period, there were eight separate notations made regarding resident #002 being upset, suspicious or acting out towards resident #001. In addition, resident #001 was noted to have an injury on August 12, 2011 and to have a personal belonging broken. Despite resident #002 displaying responsive behaviours towards resident #001, these residents remained in close proximity. The home did not implement interventions to minimize the the risk of altercations between these two residents.

The licensee failed to ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; [O. Reg. 79/10, s. 55.(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 that will ensure that, procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. On July 9, 2012 at 1315hrs, the Inspector observed resident #003 sitting beside the nursing desk in a chair with the front portion of their pants obviously wet and incontinent of urine. Interview was conducted with staff member #S-100 and it was identified that this resident was last toileted and changed at 1100hrs. The care plan for resident #003 was reviewed and noted they were "frequently incontinent - bladder, tended to be incontinent daily, but some control present (eg. day shift), use pads or briefs, check and change pads every two hours and prn". Based upon the information provided by the staff member and by the inspector's observations, continence care was not provided to the resident as specified in the plan of care, as the resident was observed to be incontinent and it had been more than two hours since they were last checked for incontinence.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007,S.O.2007, c. 8, s. 6 (7).]

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 will ensure that the care set out in the plan of care is provided to resident #003 and all residents as specified in their plans, to be implemented voluntarily.

WN #3: 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 subsections:

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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person brought their concerns regarding a physical injury and a broken personal belonging of resident #001, forward to the home on August 25, 2012 and had questioned if another resident could have been responsible. The home did not notify the Director until August 30, 2012 at which time a mandatory report was submitted. This is five days after the suspected abuse was reported by a person to the home.

The licensee failed to ensure that 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:
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. [LTCHA 2007,S.O.2007,c.8,s.24.(1)2.]

Issued on this 5th day of September, 2012

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

J. Lehner #96