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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 3, 2013	2013_211106_0007	1233-12, 1232-12	Complaint

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

MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 22, 23, 2013

Logs inspected during this inspection:
Log # S-001232-12, S-001233-12

During the course of the inspection, the inspector(s) spoke with Administrator, Patient Care Facilitator, Education Coordinator, Recreation Coordinator, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and Families.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed cared provided to residents in the home and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Sufficient Staffing

Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The plan of care was reviewed for resident #003, it indicates that the resident's skin is intact in one section and in another section it indicates that the resident has a dressing change every 2 days. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The progress notes for resident # 003 were reviewed, a post-it note with "please leave space for me to chart" written on it, was found in the middle of the page dated March 11, 2013 to March 13, 2013 and a space of 6 lines was left in the progress notes. Staff member #S-100 identified, that the writing looked like staff member #S-101's writing. Staff member #S-100 told inspector that this has happened previously with this particular staff member. The licensee failed to ensure that the following was documented the provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care. [s. 6. (9)]

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 provision of the care set out in the plan of care, the outcomes of the care set out in the plan of care and the effectiveness of the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. On March 5, 2013 resident #003 had altered skin integrity. No skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was found. [s. 50. (2) (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 when a resident, specifically resident #003, exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, they receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector observed staff member #S-102 shaving resident #004 in the dining room, while other residents were present, with an electric razor. When asked if this was a common practice the staff member stated that the resident often becomes upset and cries out if they are moved. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was respected. [s. 3. (1) 8.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. On April 22, 2013, inspector 106 asked staff member #S-103 for a copy of the homes written staffing plan. Staff member #S-103 reported that other than the schedule the home did not have a written staffing plan. The licensee failed to ensure that there is a written staffing plan for the organized program of nursing services and the organized program of personal support services. [s. 31. (2)]

Issued on this 13th day of May, 2013

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