Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 7, 2021	2021_879621_0002	024429-20, 024953-20	Critical Incident System

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 26 - 28, 2021.

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

- Two intakes related to falls management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Infection, Prevention and Control (IPAC) Lead, the Recreation Therapist (RT), a Housekeeping Aide (HA), and residents

The Inspector also conducted daily tours of the resident care areas; observed the provision of care and services to residents; and reviewed the home's supporting documentation and relevant resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 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	Légende 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

A CIS report submitted to the Director, identified that a resident had returned to the home on a date in December 2020, and sustained two falls the next day. It was identified from the home's internal safety reports for both falls, that staff assisted the resident from one location to another, with no mention of the use of a particular safety device for transfer. During an interview with an RPN, they reported that in both incidents, staff assisted the resident without use of a specified safety device. The DOC reported that they would have expected staff to use the required safety device with this resident in both incidents.

Sources: CIS report; the resident's post falls assessment records and progress notes, internal falls incident reports, Falls Prevention and Management Program for LTC policy; and Interviews with two RPNs, the DOC and other relevant staff. [s. 36.]

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 staff uses safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument, specifically designed for falls.

A CIS report submitted to the Director, identified that a resident had returned to the home on a date in December 2020, and sustained two falls the next day. On review of the resident's healthcare record, the inspector was unable to locate a post falls assessment for either fall. On review of the resident's electronic medical record (EMR), an RPN confirmed that a post falls assessment, had not been completed for either falls incident. The home’s falls program identified that as part of post fall assessment and management of a resident, registered nursing staff were to complete a post falls assessment in the EMR.

Sources: CIS report; the resident's healthcare record, the home's internal falls incident reports, the Falls Prevention and Management Program for LTC policy; and Interviews with RPNs, the DOC and other relevant staff. [s. 49. (2)]

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 has fallen, the resident is assessed and a post-fall assessment is conducted using a clinically appropriate assessment instrument, specifically designed for falls, to be implemented voluntarily.

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Issued on this 14th day of May, 2021

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

Original report signed by the inspector.