

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

159 Cedar St, Suite 403 Sudbury, ON, P3E 6A5 Telephone: (800) 663-6965

Public Report

Report Issue Date: January 14, 2025 Inspection Number: 2025-1249-0001

Inspection Type:Critical Incident

Licensee: Atikokan Health and Community Services

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

INSPECTION SUMMARY

The inspection occurred offsite on the following dates: January 6 - 9, 2025.

The following intake was inspected:

One Intake regarding alleged misappropriation of resident funds.

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

Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Report

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse



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by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure a resident was protected from financial abuse.

Sources: Review of a Critical Incident report, a resident's health care record, home's investigation notes, home's policy titled, "Zero Tolerance of Abuse and Neglect"; and interviews with staff.

WRITTEN NOTIFICATION: Police Notification

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the police were immediately notified of suspected financial abuse of a resident that may have constituted a criminal offence.

Sources: Review of a Critical Incident report, a resident's health care record, home's investigation notes, home's policy titled, "Zero Tolerance of Abuse and Neglect"; and an interview with a staff member.