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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 23, 2018	2018_619550_0003	004061-18	Critical Incident System

Licensee/Titulaire de permis

Mohawk Council of Akwesasne
P.O. Box 579 CORNWALL ON K6H 5T3

Long-Term Care Home/Foyer de soins de longue durée

Tsiionkwanonhsote
70 Kawehnoke Apartments Road Akwesasne ON K6H 5R7

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

JOANNE HENRIE (550)

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): March 2, 5, 6, 7, 9, 12 and 13, 2018.

This inspection is related to a critical incident the home submitted related to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN) and several Personal Support Workers (PSW).

In addition, the inspector reviewed a resident's health care records, an internal investigation file and a policy and procedure on reporting of critical incidents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **1 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	Legendé 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. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours,
(c) Actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that responses to interventions are documented.

A Critical Incident Report (CIR) was submitted to the Director reporting an incident of an unexpected death. It was reported that resident #001 was found in bed in a specified position with no vital signs. The Medical Death Certificate signed by the Physician, indicated the cause of death.

Resident #001 was admitted to the home with several diagnoses including a specified psychological disorder. A review of the resident's healthcare records and interviews with multiple staffs, indicated that resident #001 required assistance to communicate. The resident was also known to have responsive behaviours where they would display specific actions and put themself at risk.

Inspector #550 reviewed the documentation from the home's internal investigation report which included notes from the DOC when reviewing the video footage from the incident date and interviews with staff members. The inspector also reviewed the resident's health care records. It was determined the sequence of events to have occurred as follows on that specified shift:

Resident #001 was brought to the nursing station to make a phone call to a family member. When the resident was brought back to their room, staff could not determine if

the resident could speak with the family member or not and the resident started to display responsive behaviours. PSWs were not able to understand what the resident wanted even with the use of an assistive device which caused the resident's behaviours to escalate. Resident #001 displayed a specific behaviour which put the resident at risk of injury to themself. Both PSWs transferred resident #001 to bed and placed the resident in a specified position. Before leaving the resident's room to attend to other duties, they turned the lights off except for an electronic device in the room and closed the bedroom door halfway. RPN #102 was the RPN responsible for resident #001 and had heard the behaviours as the RPN had been tending to another resident in an another room nearby. Fourteen minutes after both PSWs left resident #001's room, RPN #102 stopped in to see resident #001. The RPN observed that the resident was in bed in a specified position and was still displaying responsive behaviours. Twenty one minutes after putting resident #001 to bed, PSW #101 went to check on the resident and informed PSW #100 that they had checked on the resident, and that the resident was still having responsive behaviours. Approximately one hour later, although PSW #100 was able to hear that resident #001 was still having responsive behaviours, the PSW did not go check up on this resident. One hour and ten minutes later, when doing a round, PSW #100 could no longer hear resident #001 having responsive behaviours. The PSW entered the resident's room, turned on the light and noted resident #001 to be in a specified position in bed. The PSW was unable to wake up the resident and noted the resident had passed away.

During an interview, PSW #100 indicated to inspector #550 they did not return or check up on resident #001 after the initial check twenty minutes after the resident was put to bed or when they could still hear that the resident was still having responsive behaviours. The PSW indicated they returned to verify the resident approximately two hours and twenty-three minutes after putting the resident to bed and this is when the resident was found deceased. PSW #101 indicated not having returned to the resident's room to check up on resident #001 after the initial check twenty-one minutes after the resident was put to bed. RPN #102 indicated although resident #001 had medication prescribed as needed for the management of the responsive behaviours, the RPN did not offer or attempt to administer any of the prescribed medication. RPN #102 indicated the resident was to be verified every 15-20 minutes when agitated but stated they did not check up on the resident after a specified time. Resident #001 was not verified for a period of 123 minutes.

The resident's plan of care in place at the time of the incident was reviewed by the inspector and it indicated specific interventions for the management of responsive

behaviours.

The inspector reviewed the progress notes for the specific shift for the date of the incident. There was no documentation from RPN #102 on resident #001's responsive behaviours and any events leading up to the resident's death. A late entry note was created by RPN #102 describing the events for the date of the incident nine days after the incident had occurred and the same day following the inspector's initial visit to the home.

The Director of Care and the Administrator indicated to the inspector during an interview that they viewed the video footage for the specified shift on the date the incident occurred. They observed that no staff was observed entering resident #001's room from the time PSW #101 left the resident's room twenty-one minutes after the resident was put to bed and the time the resident was found in bed deceased by PSW #100. The resident was not assessed or reassessed by staff for a period of over two hours when the resident was having responsive behaviours.

Despite the fact that resident #001 was exhibiting responsive behaviours and staffs' knowledge of the resident's history of injuries to self when the resident was exhibiting responsive behaviours, no staff had returned to check up on the resident for over two hours after the resident was put to bed. Resident #001 was left alone in their room with no light on except for the light coming from an electronic device and the bedroom door closed halfway.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one resident. The home had a level 2 compliance history with 1 or more unrelated non-compliance in the last 36 months. [s. 53. (4) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply?

A Critical Incident Report (CIR) was submitted to the Director on a specified date, reporting an incident of an unexpected death which had occurred two days earlier. It was reported that on a specified date and time, resident #001 was found in bed with no vital signs. The Medical Death Certificate signed by the Physician indicated the cause of death.

During an interview, the Director of Care (DOC) indicated to inspector #550 they were called at their home late in the evening on the date of the incident by RN #103 who informed them that resident #001 had passed away and that the physician had been called. At the time of this call, the DOC was not informed by RN #103 that it was an unexpected death. The DOC was not working the following day and the Administrator indicated to the inspector that they received a report from staff on the event two days after the date of the incident. The Administrator and the DOC indicated to the inspector that after regular business hours, the Registered Nurse (RN) working in the home is the person in charge and that the RN should have immediately reported the incident to the Director as per their policy as this person was aware that this was an unexpected death. The incident was reported two days later when the DOC returned to work and submitted a CIR to the Director.

During an interview, RN #103 indicated to inspector #550 being the nurse in charge at the time the incident occurred, specifying that they were in in charge of the residents and the staffs only. RN #013 indicated although being aware that resident #001's death was unexpected, they did not report the incident to the Director because this is done by the DOC and not the RNs. The RN informs the DOC of the incident and the DOC is responsible of informing the Director.

This incident of unexpected death of resident #001 was not immediately reported to the Director; it was reported two days later. [s. 107. (1)]

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 critical incidents are reported to the Director within the time frame specified by the Ontario Regulations 79/10, to be implemented voluntarily.

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

Issued on this 19th day of April, 2018

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

Original report signed by the inspector.