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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 20, 2018	2018_619550_0004	001904-18	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): March 2, 5, 6, 7, 9, 12, 13, 15 and 19, 2018.

This inspection is related to a complaint regarding alleged abuse of residents.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), the RAI-MDS Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), and a resident.

In addition, the inspector reviewed resident health care records, internal investigation files and policies related to abuse of residents.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
8 WN(s)
1 VPC(s)
2 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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home’s Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the DONPC work regularly in that position on site for at least the following amount of time per week:

4. In a home with 40 to 64 licensed beds, at least 24 hours.

In this report, the Director of Nursing and Personal Care (DONPC) is also referred to as the Director of Care (DOC).

Tsiionkwanonhsote is a 50 bed long term care home.

During an interview regarding an incident of staff to resident alleged abuse, the Director of Care (DOC) indicated to inspector #550 they were away on holidays from December 25, 2017 to January 2, 2018 and there was no one replacing them. During this absence, there was no one working in the home in the capacity of Director of Care.

The licensee failed to ensure there was a DOC working on site for at least 24 hours per week for the period of December 25 to 31, 2017.

The severity of this issue was determined to be a level 2 as the absence of a DONPC potentially poses a risk to resident safety and affects every resident living in the home. The scope of the issue was a level 1 as there was no DONPC in the home for 24 hours out of a 7 day observation period. The home had a level 4 compliance history as they had one previous non-compliance with this section of the Regulations that included:
-Compliance order (CO) #001 issued August 19, 2016, with a compliance due date of September 26, 2016 (2016_284545_0022), found to be in compliance on December 1, 2016. [s. 213. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect resident #002 from abuse by Personal Support Worker (PSW) #104.

As per the LTCH Act, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date, the Administrator of the home reported an incident of alleged staff to resident physical abuse through the Action Line. The Administrator reported that PSW #104 had been rough while providing care to resident #002, causing injuries to the resident.

Interviews with Personal Support Workers (PSW) and Registered Nursing staff indicated that this resident does not have a specified behaviour. A progress note was documented by RPN #107 as a late entry for the date the incident occurred. It was documented that as RPN #107 entered resident #002’s room, they witnessed PSW #104 being rough with the resident and had observed injuries to a specific body part on the resident. Resident #002 told RPN #107 they did not want PSW #104 in their room. It was documented by the RPN that PSW #104 told them while trying to provide care to the resident, the resident was exhibiting a specific behaviour. Another progress note documented by RN #106 on the day of the incident indicated that resident #002 had sustained injuries to specified body parts while the resident was receiving care from PSW #104. The RN interviewed PSW #104 at the time of the incident and documented that PSW #104 told them that during a specific care technique, the resident started exhibiting a specified behaviour and that the injuries to the resident had occurred when the PSW was performing a specific care action to the resident. The RN instructed the PSW to leave the resident’s room and not to return. The resident was assigned to another PSW. It was further documented by the RN that during the resident’s assessment, the resident was noted to be fearful of PSW #104 commenting that they did not want that PSW around them. Resident #002 required medication to calm them after the incident occurred.

Resident #002 was interviewed by inspector #550. The resident named PSW #104 as the PSW who had hurt them further indicating this PSW was rough and abusive when providing care. The resident showed inspector a healing injury to a specific body part stating that this was caused by PSW #104. Resident #002 told the inspector they no longer wanted this PSW to care for them anymore.

During an interview, PSW #104 indicated to inspector #550 that the incident occurred as described in the written statement submitted to the DOC. The written statement from PSW #104 was dated sixty-nine days after the date the incident occurred and described the incident as follows:
PSW #104 was providing care to resident #002 and while performing a specific type of care, the resident exhibited a specific behaviour which caused injury to the PSW. PSW #104 then asked the nurse to assign another PSW to this resident.

During an interview, the DOC and the Administrator indicated to inspector #550 that their internal investigation determined that PSW #104 was physically aggressive to resident #002 during care which caused injuries to this resident.

In conclusion, the licensee failed to protect resident #002 from physical abuse by staff #104, when:
1. the incident was not immediately reported to the Director,
2. the police was not notified of this incident,
3. the licensee's policy on abuse was not meeting the set requirements.

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 out of three residents reviewed. The home had a level 2 history with 1 or more unrelated non-compliance in the last 36 months. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident.

A complaint was received through the Action Line on a specified date, reporting incidents of alleged abuse to residents. One of the incidents reported by the Administrator of the home was that on a specified date, a Registered Practical Nurse (RPN) forced a resident to take medication although the resident refused.

During an interview, the Administrator indicated to inspector #550 that on a specified date, he was informed by a staff member that RPN #102 had forced resident #004 to take medication although the resident refused.

During an interview, RPN #102 indicated to the inspector that on the date the incident occurred, they were assigned to resident #004. When the RPN attempted to administer medication to resident #004, the resident refused and was exhibiting a specified behaviour. This resident would exhibit this behaviour on occasion and would sometimes refuse to take any medication. The RPN tried to encourage the resident to take the medication and the resident ended up by taking half of the medication with a specified nourishement. The RPN further indicated that the resident was not forced to take the medication but encouraged.

A review of the resident #004’s health care records and interviews with Registered Nursing staffs, revealed that this resident often refused to take medication. When the resident would refuse, staff would use a gentle approach and provide the resident with encouragement. Sometimes the resident would take the medication and sometimes not. It was documented in the Medication Administration Record (MAR) that the resident refused to take scheduled medication twenty-six days out of a period of eighty-four days.

Resident #004's written plan of care was reviewed by the inspector. The inspector noted that the plan of care did not indicate the resident's refusal of medication therefore it did not set out the planned care for the resident.

The Director of Care confirmed to the inspector that resident #004's behaviour of refusing medication should be included in the plan of care.

Resident #004's written plan of care did not set out the planned care for this resident's refusal of medication and/or treatment. [s. 6. (1) (a)]

2. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident.

Another reported incident was that RPN #105 had been verbally abusive towards resident #003 after the resident had refused to take the prescribed medication on a specified date.

During an interview, RPN #105 indicated to inspector #550 that on a specified date, the RPN went to administer medication to resident #003 but the resident refused to take it displaying a specific behaviour. The RPN indicated that they informed the resident of the outcome if the resident did not take the prescribed medication and reported the resident's refusal to RN #103. RN #103 indicated to the inspector being present when the incident occurred but not having witnessed it. The RN #103 was informed that resident #003 refused to take the prescribed medication, attempted the administration themselves and the resident still refused. RN#103 indicated to the inspector resident #003 often refused to take prescribed medication.

The inspector reviewed resident #003's health care records and noted documented in the Medication Administration Record (MAR) that the resident refused to take scheduled medication and/or refused a treatment sixteen out of twenty-six days in a specified period of time. Interviews with registered nursing staffs, indicated that this resident often refused to take medication and also refused treatments. When the resident refuse to take the medication, the registered nursing staff will leave the resident and return two or three times and even ask another registered nursing staff to attempt the administration. Sometimes the interventions are effective and sometimes they are not. The inspector reviewed the resident's written plan of care and noted that it did not set out the planned care when resident #003 refused to take medication and/or treatment.

The Director of Care confirmed to the inspector that resident #003's refusal of medication and/or treatment should be included in the written plan of care.

Resident #003's written plan of care did not set out the planned care for this resident's refusal of medication and/or treatment. [s. 6. (1) (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 to ensure that the written plan of care for resident #004 and #003 set out the planned care for those residents regarding the refusal of medication and/or treatment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall at a minimum:

(b) clearly set out what constitutes abuse and neglect
(d) contain an explanation of the duty under section 24 of the Act to make mandatory reports
(h) deal with any additional matters as may be provided in the regulations

A complaint was received through the Action Line reporting three incidents of suspected abuse to residents by staff members. All the incidents were reported by the home's Administrator and reported as follows:

1. A PSW forced a resident to get up which caused injury to the resident.
2. A Registered Practical Nurse (RPN) was verbally abusive to a resident after the resident refused to take the prescribed medication.
3. A RPN forced a resident to take medication although the resident refused.

Inspector #550 requested and was provided with the licensee's policy “4.2 Abuse”, revised in November 2017. The inspector noted that the definition of all forms of abuse and neglect identified on pages 2, 3 and 4 were not as per O. Reg. 79/10, s. 2. and s. 5.

According to LTCH Act 2007, c.8, 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:
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.

The Licensee's policy “4.2 Abuse” did not indicate this requirement. On page 7, under “Reporting abuse” it was indicated:
“Anyone with reasonable grounds to suspect a resident has suffered abuse or neglect is required to report the information to the Ministry of Health and Long Term Care. Not doing so is against the law and it may appear as though they are conspiring with the abuser or condoning abuse”. On page 8, under “Reporting to the Ministry of Health and Long Term Care”, it was indicated:
“When an investigation indicates that a resident has, or is likely to have suffered abuse the Program manager or designate shall report to the Ministry of Long Term Care

Compliance advisor or Regional Office within 24 hours via telephone. The Program Manager or designate will complete a Critical Incident Reporting Form and submit to the Ministry Regional Office within five days of discovering that abuse has taken place".

According to O. Reg. 79/10 s.96, every Licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; (e) identifies the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those is a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.
Under "resident abuse by formal caregiver or volunteer" there were no procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The policy did not contain training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those is a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

According to O. Reg. 79/10 s. 97., every licensee of a long-term care home shall ensure that the resident's substitute decision maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect to the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected, or witnessed incident of abuse or neglect of the resident.

Under "Resident abuse by formal caregiver or volunteer", procedure 12 on page 15 indicated "The resident and his/her substitute decision maker will be made aware of information related to the report under investigation". Under "Suspected resident abuse of another resident", on page 17 procedure 6 indicated "the resident's families are both to be notified regarding the incident".

According to O. Reg. 79/10 s.98, every Licensee of a long-term care home shall ensure that the appropriate police force 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. The Licensee's abuse policy did not indicate this requirement. On page 8, “Reporting to the police” indicated:
“All incidents of abuse shall be reported to the Police within 24 hours of receiving the complaint. The Management staff at the facility will assist the Police with any investigation that they initiate”.

According to O. Reg. 79/10 s.99, every Licensee of a long-term care home shall ensure, (a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the Licensee becomes aware of it; (c) that the results of the analysis undertaken under clause (a) are considered in the evaluation; (d) that the changes and improvements under clause (b) are promptly implemented; and (e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The home's policy “4.2 Abuse” did not indicate the above noted requirements.

The Director of Care indicated to the inspector that although their policy was reviewed in November 2017, they were aware it required updating and they were in the process of reviewing it further. [s. 20. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that,
(a) Every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) Abuse of a resident by anyone.

A complaint was received through the Action Line reporting three incidents of suspected abuse to residents. One of the incidents reported by the Administrator of the home was that a Registered Practical Nurse (RPN) was verbally abusive to a resident after the resident refused to take the prescribed medication. This incident was reported to the Administrator by a staff member three days after it occurred. RN #103 who was in charge at the time the incident occurred, did not report the incident as this RN did not believe this incident was an incident of abuse.

During an interview, the Administrator indicated to inspector #550 that although they believed this incident was an incident of resident abuse, the Administrator did not immediately start an investigation. The DOC was absent from the home at that time and was informed of the incident by the Administrator upon their return to work five days after the the date the incident occurred. The DOC indicated the investigation started six days after the incident occurred.

The licensee did not immediately investigate this incident of suspected abuse to resident #003 by RPN #105. The DOC started the investigation three days after the incident was reported to the licensee. [s. 23. (1) (a)]

WN #6: 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:

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

Findings/Faits saillants :

A complaint was received through the Action Line reporting incidents of suspected abuse to residents by staff members. One of the incidents reported by the home's Administrator was that a PSW was rough with a resident which caused injuries to this resident.

Inspector #550 reviewed the documentation in the home's internal investigation file and in resident #002's health care records. It was documented that on a specified date at a specified time, RPN #107 entered resident #002's room and witnessed PSW #104 being rough with resident #002 while performing care to the resident. Resident #002 had injuries to specific body parts.

RN #106 who was the RN in charge at the time the incident occurred, indicated to the inspector they did not report this incident of witnessed abuse to resident #002 to the Director as the reporting is done by the Director of Care only. The home's process is that the RN fills out an incident report and submit it to the DOC who in turn will inform the Director.

During an interview, the Director of Care indicated to the inspector that the incident was not immediately reported to the Director because as they were not working for a specified period of time and there was no one replacing the DOC. When the DOC returned to work, the incident report was in a pile of documents they had to go through but they never got to it.

The incident of witnessed abuse to resident #002 by PSW #106 was not immediately reported to the Director. It was reported by the Administrator through the Action Line three days after the incident occurred, when the Administrator was informed of the incident. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force 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. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was 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.

A complaint was received through the Action Line reporting incidents of suspected abuse to residents by staff members. One of the incidents reported by the home's Administrator was that PSW #104 was rough with resident #002 which caused injuries to the resident.

Inspector #550 reviewed the documentation in the home's internal investigation file and in the resident's health care records. On a specified date and time as RPN #107 entered resident #002's room, the RPN witnessed PSW #104 being rough with resident #002 while performing care. The resident had injuries to specific body parts.

RN #106 who was the RN in charge at the time the incident occurred was interviewed by inspector #550. The RN did not notify the police of this incident of staff to resident abuse. The DOC was not working when the incident occurred and there was no one replacing the DOC during that period of time. The incident report submitted by RN #106 was in a pile of documents they had to go through upon their return to work but they never got to it. The Administrator did not report the incident to the police when they were made aware of this resident.

At the time of this inspection, the police had not been notified of this incident of staff to resident abuse. [s. 98.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the license or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

The Administrator called the Action line on a specified date to report three incidents of staff to resident abuse. The Administrator was informed by the Triage Inspector of the legislative requirements on reporting incidents to the Director through the Critical Incident Reporting (CIR) system. No Critical Incident (CI) report was received by the Director regarding those three incidents.

During an interview, the Administrator indicated that they were made aware of these incidents on a specified date by staff members. Two of the incidents were investigated but a report of the investigation was not submitted to the Director. The Administrator indicated that the DOC is the person who usually submit the CI report to the Director and that the DOC was away at the time the incidents were reported. They further explained that the Administrator did not have access to the CIR system.

The DOC indicated to the inspector that a CI report was not submitted for three incidents as they did not have time to do it. The DOC further indicated being the only person who had access to the CIR system and had now taken steps so access could be given to the Administrator and other staff members.

The licensee did not submit a CI report for the three incidents of staff to resident alleged abuse that were reported to the Director. [s. 104. (1)]

Issued on this 20th day of April, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE HENRIE (550)

Inspection No. / No de l'inspection : 2018_619550_0004

Log No. / No de registre : 001904-18

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Apr 20, 2018

Licensee / Titulaire de permis : Mohawk Council of Akwesasne
P.O. Box 579, CORNWALL, ON, K6H-5T3

LTC Home / Foyer de SLD : Tsiionkwanonhsote
70 Kawehnoke Apartments Road, Akwesasne, ON, K6H-5R7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Vincent Barry Lazore

To Mohawk Council of Akwesasne, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee must be compliant with s. 213. (1) of the Regulation. Specifically, the licensee must ensure that if the the Director of Nursing and Personal Care (DONPC), is absent from the home due to vacation, illness, or is attending a meeting or training related to his or her position as DONPC where he or she is not available by telephone, there must be a Registered Nurse one site to act fully as the DONPC in her absence to meet the required minimum of 24 hours per week.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the DONPC work regularly in that position on site for at least the following amount of time per week:

4. In a home with 40 to 64 licensed beds, at least 24 hours.

In this report, the Director of Nursing and Personal Care (DONPC) is also referred to as the Director of Care (DOC).

Tsiionkwanonhsote is a 50 bed long term care home.

During an interview regarding an incident of staff to resident alleged abuse, the Director of Care (DOC) indicated to inspector #550 they were not working for a specified period of time and there was no one replacing them. During this absence, there was no one working in the home in the capacity of Director of Care.

The licensee failed to ensure there was a DOC working on site for at least 24 hours per week for the specified period of time.

The severity of this issue was determined to be a level 2 as the absence of a DONPC potentially poses a risk to resident safety and affects every resident living in the home. The scope of the issue was a level 1 as there was no DONPC in the home for 24 hours out of a 7 day observation period. The home had a level 4 compliance history as they had one previous non-compliance with this section of the Regulations that included:
-Compliance order (CO) #001 issued August 19, 2016, with a compliance due date of September 26, 2016 (2016_284545_0022), found to be in compliance on December 1, 2016.
(550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 13, 2018

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.
Specifically, the licensee shall prepare, submit and implement a plan to ensure that resident #002 and any other resident, are protected from physical abuse by anyone. The plan must include, but is not limited, to the following:

• Specific actions be taken by the licensee to ensure that every alleged, suspected or witnessed incidents of abuse of a resident by anyone is immediately reported to the Director.
• Revisions of the licensee's Zero tolerance of abuse and neglect of residents' policy to include the definitions of abuse, all the requirements required under s. 20 (2) of the LTCH Act, 2007 and s. 96 to s. 99 of the Ontario Regulation 79/10.

• The revised policy be communicated to staff and their level of knowledge be assessed to ensure compliance with s. 24 of the LTCHA.
• Develop a monitoring process to ensure staff training is completed as required and that staff report every alleged, suspected or witnessed incidents of abuse of a resident as required.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

Please submit the written plan for achieving compliance for inspection # 2018_619550_0004 to Joanne Henrie, LTC Homes Inspector, MOHLTC, by email to SAO.generalemail@ontario.ca by May 4, 2018. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to protect resident #002 from abuse by Personal Support Worker (PSW) #104.

As per the LTCH Act, physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specified date, the Administrator of the home reported an incident of alleged staff to resident physical abuse through the Action Line. The Administrator reported that PSW #104 had been rough while providing care to resident #002, causing injuries to the resident.

Interviews with Personal Support Workers (PSW) and Registered Nursing staff indicated that this resident does not have a specified behaviour. A progress note was documented by RPN #107 as a late entry for the date the incident occurred. It was documented that as RPN #107 entered resident #002's room, they witnessed PSW #104 being rough with the resident and had observed injuries to a specific body part on the resident. Resident #002 told RPN #107 they did not want PSW #104 in their room. It was documented by the RPN that PSW #104 told them while trying to provide care to the resident, the resident was exhibiting a specific behaviour. Another progress note documented by RN #106 on the day of the incident indicated that resident #002 had sustained injuries to specified body parts while the resident was receiving care from PSW #104. The RN interviewed PSW #104 at the time of the incident and documented that PSW #104 told them that during a specific care technique, the resident started exhibiting a specified behaviour and that the injuries to the resident had occurred when the PSW was performing a specific care action to the resident. The RN instructed the PSW to leave the resident's room and not to return. The resident was assigned to another PSW. It was further documented by the RN that during the resident's assessment, the resident was noted to be fearful of PSW #104 commenting that they did not want that PSW around them. Resident #002 required medication to calm them after the incident occurred.

Resident #002 was interviewed by inspector #550. The resident named PSW #104 as the PSW who had hurt them further indicating this PSW was rough and abusive when providing care. The resident showed inspector a healing injury to a specific body part stating that this was caused by PSW #104. Resident #002 told the inspector they no longer wanted this PSW to care for them anymore.

During an interview, PSW #104 indicated to inspector #550 that the incident

occurred as described in the written statement submitted to the DOC. The written statement from PSW #104 was dated sixty-nine days after the date the incident occurred and described the incident as follows:
PSW #104 was providing care to resident #002 and while performing a specific type of care, the resident exhibited a specific behaviour which caused injury to the PSW. PSW #104 then asked the nurse to assign another PSW to this resident.

During an interview, the DOC and the Administrator indicated to inspector #550 that their internal investigation determined that PSW #104 was physically aggressive to resident #002 during care which caused injuries to this resident.

In conclusion, the licensee failed to protect resident #002 from physical abuse by staff #104, when:
1. the incident was not immediately reported to the Director,
2. the police was not notified of this incident,
3. the licensee's policy on abuse was not meeting the set requirements.

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 out of three residents reviewed. The home had a level 2 history with 1 or more unrelated non-compliance in the last 36 months. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

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Name of Inspector / Nom de l'inspecteur : Joanne Henrie

Service Area Office / Bureau régional de services : Ottawa Service Area Office