Ontario

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Original Public Report

Report Issue Date: November 29, 2023
Inspection Number: 2023-1290-0005
Inspection Type: Complaint Critical Incident
Licensee: Mohawk Council of Akwesasne
Long Term Care Home and City: Tsiionkwanonhsote, Akwesasne

Lead Inspector	**Inspector Digital Signature**
Karen Buness (720483)	Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.12.01 14:42:06 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 8, 9, 10, 2023

The following intake(s) were inspected:

- Intake: #00099740 - Complaint related to resident to resident contact.
- Intake: #00099749 - Unlawful conduct that resulted in harm/risk of harm to a resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

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.

Summary and Rationale:
On a specific date the licensee notified the Director of unlawful conduct that resulted in harm/risk of harm to resident. A review of the critical incident report submitted by the licensee revealed no additional authorities including the police were notified.
In an interview with the Director of Care they confirmed the police were not notified stating they did not think the police needed to be notified of the incident.

Failure to notify the police potentially delayed the investigation of the incident which could have put the resident at an increased risk of abuse.

Sources:
CIS report, Interview with the Director of Care

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WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

Summary and Rationale:
In an interview with the Director of Care they stated that due to registered nurse staffing shortages in the home the designated IPAC Lead hours have been decreased to 8 hours a week. The Director of Care reported that additional tasks that are the responsibility of the IPAC lead are being completed by another registered nurse staffed in the home.

Sources:
Interview with Director of Care

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