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
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Public Report

Report Issue Date: December 30, 2024
Inspection Number: 2024-1290-0003
Inspection Type: Critical Incident
Licensee: Mohawk Council of Akwesasne
Long Term Care Home and City: Tsiionkwanonhsote, Akwesasne

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11-13, 17, 2024

The following intake(s) were inspected:

- Intake: #00124642/ CI #2800-000006-24 - related to alleged staff to resident abuse
- Intake: #00124853/ CI #2800-000007-24 - related to resident care

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan. A resident's written plan of care had specific directions related to the resident's door to the room, however, these directions were not followed on two occasions as per their plan of care.

Sources: CI# 2800-000007-24, home's internal Incident Report, and interview with Director of Care #102.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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 has failed to ensure that the Director was immediately informed of the allegation of abuse of a resident by a direct care staff.

Resident reported an alleged incident of abuse to Registered Practical Nurse (RPN) #107. The Director of Care (DOC) was made aware of the incident the next day, however, the Director was not made aware of the alleged incident until two days after the alleged incident.

Sources: Interviews with RPN #107 and DOC #102, licensee's zero tolerance of abuse and neglect policy, Critical Incident Report and the home's internal investigation notes.

WRITTEN NOTIFICATION: Air temperature

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that air temperatures measured under subsection (2) are documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night for two specific months.

Administrator #107 confirmed that registered staff are responsible for measuring and documenting air temperatures when maintenance staff are not available in the home, however, temperatures were not measured or documented as required on several dates during the two specific months.

Sources: Interview with Administrator #107 and air temperature logs.

WRITTEN NOTIFICATION: Notification re incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 104 (2)
Notification re incidents

s. 104 (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

The licensee failed to ensure that a resident's substitute decision-maker (SDM) was notified of the results of the investigation of an alleged incident of abuse immediately upon the completion of the investigation. Director of Care (DOC) #102 confirmed that the SDM was not notified of the results of the investigation upon conclusion of the investigation.

Sources: Interview with Director of Care #102, home's internal investigation notes, resident's electronic health records on Point Click Care (PCC)