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: May 23, 2025
Inspection Number: 2025-1290-0002
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): May 14, 15, 16, 20, 21, 22, 23, 2025

The following intake(s) were inspected:

- Intake: #00140147 - Injury to resident of unknown etiology.
- Intake: #00141975 - Alleged improper care of a resident by a staff member.
- Intake: #00144280 - Alleged staff to resident verbal/emotional abuse.
- Intake: #00145106 - Injury of a resident of unknown etiology.

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

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

The licensee has failed to ensure that a staff completed orientation training prior to performing their responsibilities.

WRITTEN NOTIFICATION: Safe Transfer Techniques

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

Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff use safe transferring techniques when assisting residents. Specifically, on a day in March, 2025, two staff members did not follow the home's "Safe Lift and Transfers Policy", revised November 15, 2024, and transferred a resident from the bathtub to their wheelchair using a Sara lift transfer device, instead of using a full mechanical lift transferring device, as identified in the resident's plan of care.

Sources: Review of resident health records, home's policy "Safe Lift and Transfers Policy, revised November 15, 2024, and interviews with staff and the Administrator.