

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
Telephone: (877) 779-5559

Public Report

Report Issue Date: April 2, 2026

Inspection Number: 2026-1290-0001

Inspection Type:

Complaint
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): March 25, 26, 27, 30, 31, 2026 and April 1, 2, 2026

The following intake(s) were inspected:

- Intake :00169556 – CI:2800-000001-26 – related to an allegation of improper or incompetent care to a resident by a staff member.
- Intake :00172658 – CI: 2800-000003-26 – related to a resident fall resulting in injury.
- Intake: 00172013 – complaint related to care and services.

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

Skin and Wound Prevention and Management
Medication Management
Safe and Secure Home
Prevention of Abuse and Neglect
Residents' Rights and Choices
Falls Prevention and Management

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
Telephone: (877) 779-5559

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc

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

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Licensee did not ensure that the resident's Substitute Decision Maker (SDM) was provided the opportunity to fully participate in the development and implementation of the plan of care. On the specified date, the resident experienced a fall. The following day, the resident's condition changed, and they were transferred to hospital for further assessment; however, the SDM was not notified of either the fall or the subsequent hospital transfer.

Sources: resident 's clinical care records; investigation notes and interview with staff.

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) 1.

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

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
Telephone: (877) 779-5559

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.

On the specified date, an allegation of improper or incompetent care was made, indicating that a resident was left unattended during personal care. The incident was reported to the Acting Director of Care (A-DOC) but was not reported to the Director within the required timeframe.

Source: resident's clinical health records and interview with staff.

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The Licensee did not ensure that all doors leading to non-residential areas were kept locked when not under staff supervision. Specifically, on the specified date, a resident was found lying on the floor in the tub room on the southwest ground floor; the door to this room had been left unlocked and without staff supervision.

Sources: resident's clinical health care records and interview with staff.

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
Telephone: (877) 779-5559

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by an authorized person described in subsection (2.1)

(ii) upon any return of the resident from hospital, and

The Licensee did not ensure that the resident received a skin assessment upon returning from the hospital on the specified date. The resident had sustained an injury and underwent surgery. A review of the resident's assessment record shows that no skin assessment was completed at the time of return.

Sources: resident's clinical care records and interview with staff.