Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
Facsimile: 613-569-9670

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
Ottawa ON K1S 3J4
Téléphone: 613-569-5602
Télécopieur: 613-569-9670

October 28, 2013

Ms. Helen McKenzie
Administrator
Tsiionkwanonhsote
70 Kawehnoke Apartments Road
Akwesasne, ON K6H 5R7

Dear Ms. McKenzie:

Please find enclosed the ***Inspection Report-Public Copy*** for an inspection conducted on September 25, 2013 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

This inspection report must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. The report will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

Lynne Duchesne for

Amanda Nixon
LTC Home Inspector – Dietary

c. President, Resident's Council
President, Family Council

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 27, 2013	2013_200148_0035	O-000548-13, O-000162-13	Critical Incident System

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 25, 2013

This inspection included information related to two Critical Incident Reports.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Registered Nursing Staff, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed resident health care records, home investigation notes related to identified fall incidents and reviewed information related to the fall prevention program/committee.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.107 (3), whereby the licensee did not ensure that an injury of person that resulted in transfer to hospital was reported within one business day to the Director.

As indicated by the resident health care record and a Critical Incident Report, Resident #2 had an un-witnessed fall on a specified date in which minor injuries were sustained. The resident was sent to hospital for assessment and returned the same day.

The Director was informed of the incident described above, through the Critical Incident System on several days after the incident. The Director was not informed within one business day of an injury that resulted in transfer to hospital.

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was applied. [s. 107. (3.1)]

Issued on this 27th day of September, 2013

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

Amanda Nix RD LTCH Inspector