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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Public Report

Report Issue Date: March 26, 2025
Inspection Number: 2025-1220-0005
Inspection Type: Critical Incident
Licensee: Six Nations of the Grand River
Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: March 24, 25, and 26, 2025.

The following intake was inspected:
Intake: #00140778 - related to a Critical Incident System report for a disease outbreak.

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

Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident related to care needs. Signage posted and directions in their care plan were not consistent related to their care needs.

On March 26, 2025, directions for staff were clarified when the posted signage was changed to be consistent with the care plan.

Sources: Observation of signage and a resident's clinical health record and interview with staff.

Date Remedy Implemented: March 26, 2025

WRITTEN NOTIFICATION: Menu Planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)
Menu planning
s. 77 (5) The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

The licensee has failed to ensure that the planned menu items were offered or available. Residents were not offered a choice of entrée, side or dessert as posted on the menu.

Sources: Observations of a meal, review of the posted menu and interview with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required.

The licensee has failed to ensure that on every shift immediate actions were taken to reduce the transmission of infections. Progress notes identified that a resident presented with symptoms of an infection and remained in their room. They continued to display symptoms and were added to the home's line listing two days later. Immediate actions were not taken to reduce transmission when the resident was not immediately included on the list listing and Public Health was not notified.

Sources: Reveiw of line listing, Respiratory Outbreak Management procedure, and clinical health record for a resident and interview with staff.

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