

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

**Amended Public Report
Cover Sheet (A1)**

Amended Report Issue Date: December 2, 2024

Original Report Issue Date: December 2, 2024

Inspection Number: 2024-1220-0002 (A1)

Inspection Type:

Critical Incident

Licensee: Six Nations of the Grand River

Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken

AMENDED INSPECTION SUMMARY

This report has been amended to:

Removed section about windows schedules and preventative maintenance audits from CO#003.

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

Amended Public Report (A1)

Amended Report Issue Date: December 2, 2024

Original Report Issue Date: December 2, 2024

Inspection Number: 2024-1220-0002 (A1)

Inspection Type:
Critical Incident

Licensee: Six Nations of the Grand River

Long Term Care Home and City: Iroquois Lodge Nursing Home, Ohsweken

AMENDED INSPECTION SUMMARY

This report has been amended to:
Removed section about windows schedules and preventative maintenance audits from CO#003.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22, 24, 31, 2024 and November 1, 4, 2024.

The inspection occurred offsite on the following date(s): November 5, 12, 13, and 14, 2024.

The following intake(s) were inspected:

- Environmental - Other - Mould in resident room closet.

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

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

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

Non-compliance with: O. Reg. 246/22, s. 102 (8)

Infection prevention and control program

s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff, specifically personal support workers (PSWs) participated in the implementation of the infection prevention and control (IPAC) program.

Summary and Rationale

The licensee written IPAC program policies and procedures could not be verified as the adopted Extendicare IPAC Manual policies and procedures were not

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

customized to the specific needs of the home.

The written procedure for cleaning and disinfecting bedpans, urinals and slipper pans located in the Davis wing soiled utility room directed staff to insert the used item into a paper cover and physically transport soiled bedpans, urinals and slipper pans after discarding the contents into the toilet to the Isaac wing soiled utility room to complete the chemical 2-step disinfection process. The written procedure does not explicitly state how bedpans, urinals and slipper pans should be stored to prevent post-contamination following cleaning and disinfection.

During the onsite inspection on October 24, 2024, washbasins and urinals were improperly stored. Several were stored upside down in resident ensuite washroom hand sinks, some contained used towels and other items, singly and double-stacked on the floor.

The home did not have home-specific written and developed policies to verify for infection prevention and control. Infection prevention and control best practices recommend developing and implementing cleaning and disinfecting procedures as part of the IPAC program which would reduce the transmission of communicable diseases.

Sources: Observations, interviews with IPAC lead and nursing staff, review of the Extendicare IPAC Manual.

**COMPLIANCE ORDER CO #001 Home to be safe, secure
environment**

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 5

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

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

**The inspector is ordering the licensee to comply with a Compliance Order
[FLTCA, 2021, s. 155 (1) (a)]:**

The licensee shall be compliant with FLTCA, 2021, s.5 The licensee shall complete the following:

1) Immediately conduct a level 2 mould remediating procedure for an identified resident room and the dirty utility room which includes all of the materials determined to be contaminated by mould as indicated in the environmental assessment report dated October 7, 2024. The precautions and recommendations identified in the report shall be followed and all work to be conducted in accordance with applicable mould abatement guidelines.

2) Conduct air clearance sampling as per the recommendations in the environmental assessment report after resident room and the dirty utility room are remediated. The report indicating the results shall be forwarded to the inspector.

3) All downspouts shall be directed away from the building foundation and eavestroughs cleared and free draining.

4) As per the environmental assessment report, conduct a level 1 mould remediation procedure for identified residents' rooms, tub washroom, nursing station, staff breakroom and the activity room. This includes cleaning surfaces with a HEPA vacuum, followed by damp wiping with a solid surface disinfectant. Ensure that as the cleaning process occurs, that an air scrubber equipped with a HEPA filter is in

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

operation.

5) Thoroughly have dust and debris removed from the exhaust, air supply ducts and vents throughout the home.

6) Equip residents' rooms and any other unoccupied room(s) sealed due to visible mould or elevated levels of mould spores with a lock that requires keyed access.

7) Immediately inform the licensing department of the MLTC as to the number of beds that have not been occupied as a result of the mould contamination.

Grounds

The licensee has failed to ensure that the home was a safe environment for its residents.

Rationale and Summary

A critical incident report was received in early September 2024 related to a water leak from a pipe in the dirty utility room which travelled to an identified resident room and displacing a resident from their room. Mould was identified in the dirty utility room at the time.

The report was updated several times to identify what repairs were completed and that an environmental company was hired to complete an assessment of the air quality and to take samples from various surfaces in mid- September 2024.

Based on the assessment report dated October 7, 2024, heavy concentrations of a black mould (*Stachybotrys chartum*) which release mycotoxins, and other mould

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

strains were identified in a resident room and the dirty utility room. Air samples taken in an identified resident room, washroom, tub room, nursing station, staff break room, and the activity room also revealed higher than normal concentrations of mould spores from the air samples taken.

In an identified resident room included visible mould growing on the walls in the closet as a result of water leaks from the roof. The concentration of mould spores inside was many times higher than outdoor samples and exposure may contribute to a variety of adverse health effects, especially for immune-compromised individuals.

During the inspection on October 22, 2024, an identified resident room and the dirty utility room had red tuck tape around the perimeter of the door. The washroom in the spa room and resident room had plastic sheeting around the entire door, using tuck tape to hold it in place. Soiled linen carts were parked in front of the resident room doors as a deterrent to keep residents out. The identified resident rooms were however not equipped with hardware/locks to prevent staff or residents from entering the rooms. Several residents were displaced and accommodated in other rooms.

Staff reported entering and exiting the above noted rooms, leaving the plastic sheeting improperly re-applied to ensure a proper seal.

Black stained ceiling tiles were observed in the hair salon and in many resident rooms. A large section of plaster on the ceiling near the front entrance was missing. The exterior of the building, specifically the brick and wood siding were in poor condition as a result of water damage. The brick was flaking and crumbling (spalling) and had heavy amounts of water scale on the surface in areas where water dripped or cascaded down. Some downspouts were placed near the building

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

where water was allowed to accumulate near the foundation.

The licensee submitted a critical incident report identifying that water had seeped into the home after heavy rains in April 2023, which affected resident rooms and the hair salon. In August 2023, a second report was submitted regarding a leaking pipe in the dirty utility room that travelled to a closet in a resident's room. The conditions required identified residents to be displaced.

Factors contributing to the mould growth in the home were identified by the environmental consultants and included water leaks from the roofing system (roof leaks, clogged eavestroughs and poorly placed downspouts), water leaking from a pipe in the dirty utility room, ventilation ducting that had not been cleaned for many years, and a leaking wall mounted air conditioner in resident room. The flood from April 2023 and subsequent floods may also have contributed to excessive moisture in the home.

At of the time of inspection, the licensee had not provided any final plans to secure a contractor/or company to complete the removal of the mouldy materials and complete structural repairs where necessary.

Failure to mitigate the conditions that favor the growth of mould increases the likelihood that residents will be exposed to mould mycotoxins and create an unsafe environment.

Sources: Observations of the home (interior and exterior), including photographs of RHAs and roof. Interviews with the Administrator (interim and former), Environmental Services Supervisor, and IPAC Lead. Reviewed past CI reports, Environmental Health Officer inspection report, Six Nations Council Facilities Supervisor mould abatement actions and event timeline, Extendicare Manuals, and the Grande Environmental

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

Project Ltd. (GEP) report dated October 7th, 2024. Consulted with environmental specialists: GEP report author dated Oct 7th, 2024, and Pinchin Environmental Specialist.

This order must be complied with by December 31, 2024.

COMPLIANCE ORDER CO #002 Food production

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)

Food production

s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,

(c) a cleaning schedule for the food production, server and dishwashing areas. O. Reg. 246/22, s. 78 (7).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall be compliant with O. Reg. 246/22, s. 78 (7)(c) The licensee shall complete the following:

1) Thoroughly deep clean and/or replace the rusted shelving in the walk-in cooler, where necessary.

2) Develop and implement a cleaning schedule for the food production, server and dishwashing area for staff to follow, that identifies which surfaces and equipment require daily, weekly and monthly cleaning.

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

3) The Food Services Manager shall conduct regular audits of the food production areas; servery and dishwashing areas, and the kitchen staff performance, to ensure adherence with the developed cleaning schedules and verify the effectiveness. The Food Services Manager should store the audits for a period of one year.

Grounds

The licensee failed to ensure that the staff of the home complied with a cleaning schedule for the food production, servery and dishwashing areas.

Rationale and Summary

An inspection of the kitchen and dish wash area occurred on October 24, 2024, and the following observations were made:

- a) Food storage surfaces poorly maintained; walk-in cooler shelving was severely rusted and rendered porous and uncleanable.
- b) Heavy food accumulation and particulate matter observed on kitchen walls and floors, shelving and gaskets of walk-in cooler and small upright fridge, food contact counter surfaces and underneath, and on dishwashing appliances and walls near dishwasher.
- c) The dishwashing area and back splash covered with heavy mineral scale; surface rendered uncleanable.
- d) Accumulated unknown brown murky liquid substance collected under dishwasher observed on October 24th, 2024.
- e) Handwash basin discoloured with extreme superficial scratches. Repair and/or replace basin to render surface easily and readily cleanable.

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

Cleaning schedules were not provided for review. The Food Services Manager advised during a meeting on October 31, 2024, deep cleaning has been scheduled for the entire kitchen and dish wash area.

Failure to implement a detailed cleaning schedule that outlines the daily, weekly and monthly tasks along with adequate allocation of staff for cleaning tasks increases the likelihood of cross-contamination between dirty surfaces and food items.

Sources: Observations, interview with the Environmental Services Supervisor, Food Services Manager, review of Extendicare Operations manual.

This order must be complied with by December 31, 2024

COMPLIANCE ORDER CO #003 Maintenance services

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

Maintenance services

s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

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

The licensee shall be compliant with O. Reg. 246/22, s. 96 (1) (b) The licensee shall complete the following:

1) Amend any existing written maintenance procedures or develop written preventive maintenance procedures, ensuring they are home-specific to Iroquois Lodge for furnishings, fixtures, equipment, operational systems (i.e., hot water and potable water supply, cooling, heating, ventilation, resident staff communication and response system, fire safety systems, lighting, drainage, door access control systems), and surfaces (roof, doors, walls, floors, windows, ceilings, etc.).

Include in each procedure a minimum of the following information:

- a) Who is responsible for monitoring the equipment, surface, fixture, furniture, surfaces or system (whether home staff or an external service provider) and how often;
- b) What forms or checklists are to be completed to assist with any monitoring task
- c) What the staff member is required to do, observe or test based on their skill level and manufacturer's requirements.
- d) The required or acceptable condition of the equipment, surface, fixture, furniture or system (derived from the manufacturer, prevailing or best practices, building, electrical and fire code, requirements, CSA standards, etc.);
- e) Follow up requirements if an unacceptable condition is identified and any documentation requirements.
- f) Acceptable time frames, based on risk, for repair or replacement; and
- g) Any additional tasks as required to maintain the fixture, surface, equipment, system and furniture in a good state of repair.

2) Develop an audit or checklist that includes all of the spaces in the home. Each space shall be inspected routinely for condition and include the surfaces, fixtures, equipment, and furnishings in each space.

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

3) Conduct an audit of the resident rooms, all washrooms, common areas and utility rooms using the developed audit form or checklist to determine what additional deficiencies require attention that have not been identified in the grounds below. The audit results shall be maintained for one year and include who conducted the audit(s), what was identified, the date of the audit(s), course of action that was taken to address the deficiency and the date the deficiency was resolved.

4) Provide the inspector with an action plan that lists the deficiencies identified in the grounds below and include who will be responsible for addressing the maintenance deficiencies and the proposed allocated time to complete the work. Please send the requested plan to the attention: Miechelle Gill at hamiltondistrict.mltc@ontario.ca

Grounds

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

In accordance with O. Regulation 246/22, s. 11(1) (a), the licensee is required to ensure that the procedures and schedules are in compliance and implemented in accordance with applicable requirements under the Act, specifically s. 19(1)(c).

Rationale and Summary

The licensee had adopted written policies and procedures from Extendicare Canada, which included numerous checklists and tasks for maintenance staff to complete, specifically with respect to keeping documentation of actions taken and results from audits of the building interior and exterior for condition. The procedures

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

did not include how the roof would be maintained, by whom and how often it would be inspected for condition. The licensee did not customize the adopted policies and procedures to their unique home design, layout, and operation.

Documentation was not provided, and no audits were completed over the last 12 months. The Environmental Services Supervisor reported that they had been without a qualified maintenance person for over four months in order to address the known deficiencies. As a result, various deficiencies were not identified for action.

Other deficiencies that were known to the licensee but had not been scheduled for repair due to a lack of funding, as reported by the licensee during a meeting on November 5th, 2024, with the Six Nations of Grand River Council Members.

A tour of the home revealed various deficiencies which included but were not limited to:

- Water and weathered damaged brick, siding, and wood.
- Insufficient length and poorly placed downspouts
- Discoloured roof shingles from moisture build-up along lower half, above overhang
- Cracked and damaged wall and ceiling
- Missing crank handles for windows
- Poorly affixed and dust clogged exhaust grilles in various areas in the home
- Bathroom towel bars were insufficient for shared rooms, partially installed, or missing.
- Incomplete wall treatment; patched walls unpainted
- Flooring wax improperly stripped, sealed, and maintained.

Failure to develop, implement and comply with the maintenance program schedules and procedures has created adverse conditions in the home which does

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

not align with the fundamental principle under the Fixing Long Term Care Act to live in a place with dignity and in a safe and comfortable environment.

Sources: Observations of the entire home, including the roof. Interviews with the Environmental Services Supervisor, IPAC Lead, Administrator (former and interim), Six Nations Council Members - Licensee/owner, housekeeping staff. Reviewed Extendicare Manuals Operations.

This order must be complied with by January 31, 2025

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.