Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 3, 2021	2021_796754_0002	001404-21	Critical Incident System

Licensee/Titulaire de permis

Derbecker's Heritage House Limited
54 Eby Street St Jacobs ON N0B 2N0

Long-Term Care Home/Foyer de soins de longue durée

Derbecker's Heritage House
54 Eby Street St. Jacobs ON N0B 2N0

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

TAWNIE URBANSKI (754)

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): January 27, 2021.

The following intake was completed during this critical incident inspection:
Log #001404-21, related to outbreak management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Dietary Manager/Infection Lead, housekeeper, Registered Practical Nurse (RPN), and Personal Support Workers (PSW's).

During this inspection, the inspector toured the home and observed resident care and common areas areasof the home, reviewed relevant records of the home, and observed the general maintenance, cleanliness and safety condition of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité 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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that a safe and secure environment was provided for its residents, specifically related to the home not fully cohorting housekeeping, PSW, and registered staff.

On March 17, 2020, the Premier of Ontario Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On March 22, and 30, 2020, Directive #3 was issued and revised on December 7, 2020, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care after the Region of Waterloo Public Health Unit declared an acute respiratory illness outbreak at the home when the first staff member tested positive for COVID-19.

At the time of inspection the home confirmed that 2 residents and 2 staff members had tested positive for COVID-19.

A) Observations were completed on a non-outbreak home area and outbreak home area. The same housekeeping staff was observed to be cleaning on both units throughout the day.

There were two housekeepers working the day shift for three resident home areas. One was assigned a non-outbreak home area and the other was assigned a non-outbreak home area and an outbreak home area. They tried to clean the non-outbreak home area first and then the outbreak home area for all high touch surface areas, however, there were instances where this was not always possible.

B) Registered staff were cohorted to one half of the home. One registered staff would be responsible for caring for residents on both the non-outbreak home area and outbreak home area. The result being that registered staff would potentially care for both COVID-19 positive and COVID-19 negative residents during their shift. Registered staff attempted to care for COVID-19 negative residents first, although this was not always possible when providing care.

C) PSW staff were cohorted to individual home areas, but not designated to only provide care to a specific resident cohort. PSW's provided care to both COVID-19 positive and COVID-19 negative residents. While they tried to provide care to COVID-19 negative

residents first, this could not always be done when trying to meet the individual needs of residents.

PSW staff were provided with a break area within the outbreak home area. All staff working on the outbreak home area were to break in this area. This break area was shared with PSW staff who provided care to both COVID-19 negative and positive residents.

Failure to fully cohort staff during the COVID-19 outbreak may have increased the risk of exposure and transmission of the virus to residents and staff throughout the home.

Sources: Interview with the Administrator, Dietary Manager/Infection Lead, Housekeeping, PSW staff, and Observations of the outbreak home area and non-outbreak home area. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

Issued on this 5th day of February, 2021

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

Original report signed by the inspector.