Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Hamilton Service Area Office
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date July 19, 2022
Inspection Number 2022_1443_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Benevolent Society "Heidehof" for the Care of the Aged

Long-Term Care Home and City
Heidehof Long Term Care Home, St Catherines

Lead Inspector
Samantha Perry #740

Inspector Digital Signature
Samantha Perry
Digitally signed by Samantha Perry
Date: 2022.07.20 11:59:38 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 11, 12, 13, 14, 2022.

The following intake(s) were inspected:

- Intake #011664-21 Complaint related to an admission refusal
- Intake #006473-22 Complaint related to alleged abuse

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

- Admission, Absences & Discharge
- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION DOORS IN A HOME

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that a tub room door, that residents should not have access to, was kept closed and locked.

Rationale and Summary
During Infection Prevention and Control (IPAC) observations it was observed that a tub room door was propped open and the water to the tub was running unattended. Inspector observed for staff in the immediate vicinity; however, no staff were located.

Personal Support Worker (PSW) #104, Registered Practical Nurse (RPN) #103 and Administrator #100 all said, they expected the water to the tub would not be running unattended and the tub room door should have been closed and locked.

The risk of injury and or drowning for all residents was increased when the tub was left unattended while the water was running and when the tub room door was not closed and locked.

Sources: Observations and interviews with staff and management. [740]

WRITTEN NOTIFICATION DIRECTIVES BY MINISTER

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA 2021, s. 184(1).

The licensee has failed to ensure that when the policy directive titled, “Minister’s Directive: COVID-19 response measures for Long Term Care Homes” was issued by the Minister, the response measure for Infection Prevention and Control (IPAC) audits, were followed.

Rationale and Summary
During the course of this complaint and IPAC inspection, the home did not have documented records of the required weekly or bi-weekly IPAC audits.

The “Minister’s Directive: COVID-19 response measures for long term care homes” effective date April 27, 2022, stated “Every licensee shall carry out every operational or policy directive that applies to the long-term care home.”

Section 1 of the Minister’s Directive stated, “Licensees must ensure that the requirements in this directive are implemented and met at all times.
Sub-section 1.1 titled “COVID-19 outbreak preparedness plan” stated in part, that the licensee must develop and implement an Outbreak Preparedness Plan and the plan must include regularly conducted IPAC audits in accordance with the “COVID-19 Guidance Document for Long-Term Care Homes in Ontario.

The "COVID-19 Guidance Document for Long-Term Care Homes in Ontario" section 5 titled "Infection prevention and control (IPAC) practices" stated, "Homes must complete IPAC audits every two weeks unless in outbreak. When a home is in outbreak IPAC audits must be completed weekly. Homes are reminded that IPAC audits should be rotated across shifts, including evenings and weekends. At minimum, homes must include in their audit the PHO's COVID-19covid 19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes (PDF). Results of the IPAC audit should be kept for at least 30 days and shared with inspectors from the public health unit, Ministry of Labour, Training and Skills Development, and Ministry of Long-Term Care upon request."

In an interview with Registered Nurse and IPAC lead #102, and Administrator #100 both said they were unaware of the IPAC audits and had not been completing them as required by the Minister's Directive.

The risk of COVID-19 exposure to all residents and staff was increased when the licensee failed to complete the required IPAC audits as required by the Minister's Directive.

Sources: Interviews with the home's management, the Minister's Directive, the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, and the Public Health Ontario (PHO) COVID-19: Self-Assessment Audit Tool for Long-Term Care Home and Retirement Homes. [740]

WRITTEN NOTIFICATION AUTHORIZATION FOR ADMISSION TO A HOME

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA 2007, s. 44(7)(a)(b)(c).

The licensee has failed to ensure the following criteria were met when they refused an applicant's admission to Heidehof Long Term Care Home (LTCH). Clause (a) the home lacks the physical facilities necessary to meet the applicant's care requirements, clause (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements or clause (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint related to an applicant's refusal of admission.

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A letter written by Heidehof LTCH stated the home was refusing an applicant's admission related to their vaccination status.

Directive #3, effective date June 04, 2021, did not provide for an applicant's vaccination status as grounds for an admission refusal. Furthermore, Directive #3 stated, "Admissions/transfers, absences, and visitations described below may be discontinued or modified as directed by the local public health unit as part of their outbreak investigation and management in order to limit the ongoing transmission of COVID-19 throughout the home. All LTCHs and RHs are required to follow the direction of the local public health unit in the event of an outbreak (see Required Procedures for Case/Outbreak Management below)." However, the home was not in an outbreak at the time of the admission refusal and the home did not speak with Public Health (PH) to seek guidance when they decided to refuse the applicant's admission based on their vaccination status.

In an interview with Medical Director (MD) #101, they said when they refused the applicant's admission, they were attempting to mitigate risk for the current residents and staff of the LTCH. Furthermore, MD #101 said they did not speak with the local PH unit to seek guidance in their decision to refuse the applicant's admission to the LTCH.

Sources: Review of Directive #3, the applicant's refusal letter and interviews with the complainant and the LTCH staff. [740]