Ontario

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

Ministère des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	Licensee Copy/Copie du Titulaire X **Public Copy/Copie Public**
Name of Director:	Brad Robinson (Acting)
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 □ Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 **X** Mandatory Management Order, section 156 / O. Reg. 210/20, *Reopening Ontario (A Flexible Response to COVID-19 Act), 2020* □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	Not Applicable
Original Inspection #:	Not Applicable
Licensee:	Revera Long-Term Care Inc.
LTC Home:	Westside 1145 Albion Road, Etobicoke ON M9V 4J7
Name of LTC Home Administrator:	Stephanie Karapita
Manager (pursuant to this Order)	UniversalCare Canada Inc. c/o Joseph Gulizia 12959 Hwy 27, Nobleton, ON L0G 1N0

Background:
On March 17, 2020, the Premier and Cabinet declared an emergency in Ontario under the *Emergency Management and Civil Protection Act* ("**EMCPA**") due to the novel coronavirus ("**COVID-19**") pandemic. Emergency orders under the EMCPA were issued to respond to the pandemic in Ontario, including specific orders to alleviate the impact of COVID-19 in long-term care ("**LTC**") homes. On May 12, 2020, Ontario Regulation 210/20 (Management of Long-Term Care Homes in Outbreak) under the EMCPA came into force.

Following the termination of the Declaration of Emergency on July 24, 2020, O. Reg. 210/20 made under the EMCPA was continued under the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020* ("**ROA**") to ensure measures remained in place to address the sustained threat of COVID-19 in LTC homes once the provincial Declaration of Emergency came to an end. The ROA came into effect on July 24, 2020.

Pursuant to Ontario Regulation 210/20 under the ROA and despite any requirement or grounds set out in the *Long-Term Care Homes Act, 2007* (the "**Act**") or Ontario Regulation 79/10 (the "**Regulation**") made under that Act, the Director appointed under the Act may make an order under subsection 156(1) of the Act if at least one resident or staff member in an LTC home has tested positive for COVID-19 in a laboratory test ("**a COVID-19 mandatory management order**"). In a COVID-19 mandatory management order, pursuant to Ontario Regulation 210/20, the Director may set out the name of the person who is to manage an LTC home and shall specify the duration.

The Director is issuing a COVID-19 mandatory management order because, as outlined in the grounds, the licensee requires enhanced management capacity to address disease spread in the LTC Home and to provide effective clinical and administrative leadership to address the outbreak. This enhanced management is necessary to return the LTC Home to normal operations and save lives.

Order:	

To the Licensee, you are hereby required to comply with the following order by the date(s) set out below:

Pursuant to: Subsection 156(1) of the Act as modified by Ontario Regulation 210/20 under the ROA.

Order: The Licensee is ordered:

(a) To **immediately** retain the Manager to manage the LTC Home;

(b) To submit to the Director, Capital Planning Branch, a written contract pursuant to section 110 of the Act **within 24 hours** of being served this Order;

(c) To execute the written contract **within 24 hours** of receiving approval of the written contract from the Director, Capital Planning Branch pursuant to section 110 of the Act and to deliver a copy of that contract once executed to the Director, Capital Planning Branch;

(d) To submit to the Director, LTC Inspections Branch, a COVID-19 recovery management plan, prepared in collaboration with the Manager, to manage the LTC Home and that specifically addresses how the Licensee will return the LTC Home to normal operations with a specific staffing plan to ensure the successful return-to-work of the LTC Home's regular staff **within 5**

days of being served this Order;

(e) To enable the Manager to begin managing the LTC Home in accordance with the written contract described in paragraph (c) of this Order **immediately upon** execution of that written contract;

(f) Subject to Ontario Regulation 210/20, the Manager will manage the LTC Home for 90 days following the date this Order is served;

(g) Any and all costs associated with complying with this Order are to be paid by the Licensee, including for certainty, but not limited to, all costs borne by the Licensee, Manager and the Ministry of Long-Term Care associated with retaining the Manager as described in paragraph (a) of this Order; and

(h) Upon being served with this Order, comply with (a)-(g) and not take any actions that undermine or jeopardize the ability for the Manager to manage the LTC Home to its full extent.

Grounds:

COVID-19 Outbreak at the LTC Home

On November 12, 2020, an outbreak of COVID-19 was declared at the LTC Home by the Toronto Public Health Unit as one resident of the LTC Home had tested positive for COVID-19 in a laboratory test. As of December 11, 2020, cumulatively, there have been 133 confirmed resident cases, 95 confirmed staff cases, and 18 resident deaths as a result of COVID-19.

Since the outbreak was declared, the LTC Home experienced a significant increase of total confirmed cases (in residents and staff) in a short period of time, indicating an active spread of the infection in the LTC Home. Confirmed cases of COVID-19 are still being identified in the LTC Home and the outbreak cannot be meaningfully contained without enhanced management assistance.

Licensee's Inability to Manage the COVID-19 Outbreak

The LTC Home has an outbreak of COVID-19 that is not being effectively contained. The Licensee has not taken the necessary actions and has not displayed the clinical and administrative leadership needed to ensure appropriate measures are implemented and followed at all times to contain the spread. As such, a COVID-19 mandatory management order is needed to address disease spread in the LTC Home and to return the LTC Home to normal operations.

The following factors are noted to support the need for enhanced management at the LTC Home:

Assistance to Date

The LTC Home has received support throughout the outbreak from various parties, including William Osler Health System (William Osler), Toronto Public Health Unit (TPHU), Public Health Ontario (PHO), Ontario Health (OH), and the Licensee's (Revera) corporate office.

Specifically, the LTC Home has received infection prevention and control ("IPAC") support from the Central West Local Health Integration Network's (CWLHIN) IPAC Extenders, PHO IPAC specialists,

corporate IPAC support, and an IPAC Leader from Humber Valley Terrace long-term care home.

This IPAC support has included on-site education to staff at the LTC Home on appropriate IPAC practices, which has been delivered by William Osler, CWLHIN IPAC Extenders and PHO since November 20, 2020. During the outbreak, TPHU has also provided guidance to the LTC Home related to cohorting of residents. In addition, PHO conducted an IPAC assessment at the LTC Home on November 24, 2020. It identified deficiencies with respect to IPAC and made recommendations to the Licensee to improve its IPAC practices.

On November 21, 2020, during the LTC Home's daily outbreak management meeting, OH communicated to the LTC Home the importance of early implementation of outbreak measures, including taking proactive IPAC practices, as there was limited capacity for William Osler to continue to assist the LTC Home. Given the complex care of the outbreak and starting November 27, 2020, the LTC Home also received additional assistance from Nurse Practitioners and Physicians from William Osler and agencies, who have conducted clinical assessments of residents.

Despite the external assistance received by the LTC Home throughout the outbreak, ranging from IPAC measures to care-related assistance of residents, the outbreak at the LTC Home continues and is not being effectively contained by the Licensee.

Infection Prevention and Control

On November 24, 2020, PHO attended the LTC Home to review and assess the IPAC practices implemented at the LTC Home. Following their assessment, PHO issued a report on November 24, 2020 which made findings and recommendations with respect to improvement of IPAC practices, including:

- Physical distancing: Recommendation with respect to the staff break room, including keeping staff to one end of the room, well away from where resident food trays were prepared.
- Testing: A single nurse was observed performing staff laboratory testing in the lobby. It was recommended that if resources were available, two staff members conduct the testing rather than one for greater efficiency and reduced risk.
- Personal Protective Equipment (PPE): Five staff members were observed wearing two medical masks which provided additional risk of exposure on removal. Recommendations were made to continue to support staff with correct use of PPE through peer support and reinforcement. In addition, findings and recommendations were made for:
    - Reinforcement of safe areas for staff to change masks and for appropriate use of PPE.
    - Reinforcing cleaning and disinfecting eye protection and changing of masks after completion of care or whenever visibly soiled, before returning to nursing station or going for breaks.
    - Improper use of and donning and doffing of gloves of staff members was observed.
- Environmental Cleaning: Repair and replace surfaces and items that are not able to be easily cleaned or disinfected.
- Cohorting: Fast-tracking cohorting decisions regarding residents to rapidly reduce the risk of

exposure to other residents.

- IPAC Education and Champions: The LTC Home was to consider extending hand hygiene champions/leaders on floors to have an increasing role in IPAC, including PPE practice and auditing.

PHO conducted a follow-up IPAC assessment at the LTC Home on December 11, 2020 and the report is pending.

On December 3, 2020, the Licensee increased its IPAC leadership in the LTC Home through corporate support and personnel. Despite this and PHO's IPAC recommendations from November 24, 2020, deficiencies in IPAC practices were still noted at the LTC Home on December 11, 2020 during a site-visit by two executives from William Osler. In particular, staff were observed to be inappropriately using PPE (e.g. donning and doffing practices), COVID-19 residents were present in hallways and using elevators, and a COVID-19 resident removed their mask at the main entrance while under the supervision of an agency staff member. In addition, there was a lack of cohorting of residents, staff were observed not practicing social distancing, housekeeping staff were placing clean PPE in an actively used garbage cart, staff were observed walking from an infected room to a clean room, and concerns related to the uncleanliness of the LTC Home.

Enhanced management is necessary to ensure that appropriate and effective IPAC measures are sustainably implemented at the LTC Home to contain the outbreak.

Staffing

During the outbreak, Physician and medical coverage at the LTC Home was noted as a concern. The Licensee was asked by TPHU during the November 21, 2020 outbreak management joint call to explore options to increase medical coverage at the LTC Home. The Licensee assigned corporate resources.

In addition, William Osler has assisted by providing Physicians and Nurse Practitioners to the LTC Home to assist with medical coverage at the LTC Home during the outbreak, such as conducting clinical assessments of residents. It was not until December 10, 2020 that the LTC Home hired Physician Assistants to help provide clinical support and care to the residents.

Lack of urgency and improvement

Since the commencement of the outbreak, the LTC Home has been exploring options to receive assistance from its corporate Licensee office and sister LTC homes. On November 27, 2020 and December 4, 2020, the Ministry of Long-Term Care, OH, TPHU and William Osler held meetings with representatives of the LTC Home and the Licensee to discuss the key areas of deficiency with respect to IPAC, leadership issues and lack of urgent implementation of outbreak measures as recommended by TPHU and PHO. Despite these meetings, recommendations and external assistance received by the LTC Home throughout the outbreak, the Licensee has not urgently taken all necessary actions and outbreak measures to contain the outbreak in the LTC Home. Accordingly, for the reasons above, the LTC Home has not demonstrated effective clinical and administrative leadership to contain the outbreak on its own without enhanced management.

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This order must be complied with by:	The dates as outlined and specified in this Order

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

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

Issued on this 14th day of December, 2020	
Signature of Director:	Brad Robinson
Name of Director:	Brad Robinson (Acting)