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(s) of the Director

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

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Stacey Colameco
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 X Mandatory Management Order, section 156 □ 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:	Forest Heights
Name of Administrator:	Scott Mumberson

Background:
Forest Heights ("Forest Heights" or "the home") is a long-term care ("LTC") home in Kitchener, Ontario within the Waterloo Wellington Local Health Integration Network ("LHIN"). Revera Long Term Care Inc. is the licensee of the LTC home, which is licensed for 240 beds ("the licensee"). 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 in Ontario. Emergency orders under the EMCPA have been issued to respond to the pandemic, including specific orders to alleviate the impact of COVID-19 in LTC homes. On May 12, 2020, Ontario Regulation 210/20 under the EMCPA came into force. Pursuant to Ontario Regulation 210/20, and despite any requirement or grounds set out in the *Long-Term Care Homes Act, 2007* ("the Act") or Ontario Regulation 79/10 ("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 the 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 the LTC home.

On April 1, 2020, an outbreak of COVID-19 was declared at Forest Heights by the Waterloo Public Health Unit as a resident had tested positive for COVID-19 in a laboratory test. On April 6, 2020, the first two staff members had been confirmed positive. Within two weeks, there were 51 confirmed positive residents, 3 resident deaths and 27 confirmed positive staff, and by May 31, 2020 – 8 weeks after the outbreak was declared – a total of 176 residents and 69 staff members had contracted COVID-19 and 51 residents had died. As of May 31, 2020, the home was still identifying new cases of COVID-19, 55 residents had the disease although 49 of the positive residents had been transferred to local hospitals leaving only 6 positive residents left in the home. The home has not reported to the MLTC how many of the 69 staff members who contracted COVID-19 have recovered, and therefore it is uncertain how many staff members currently have COVID-19.

The home has received significant support throughout the outbreak but has not shown an ability to contain the spread of the disease. The home has received infection prevention and control (IPAC) support from the Waterloo Public Health Unit, St. Mary's Hospital ("St. Mary's Hospital") and Grand River Hospital. It has received staffing support from the LHIN and the licensee's corporate team.

The Waterloo Public Health Unit completed a total of seven IPAC assessments between April 23, 2020 and May 28, 2020. While some improvements were noted in each assessment, the home was not ensuring droplet and contact precautions were in place for all residents, not all staff were using PPE properly, cleaning and disinfecting was not occurring consistently and residents were not being properly cohorted.

Along with the continued spread of infection at the LTC home, Forest Heights is still experiencing staffing challenges and IPAC process breaches, including not properly cohorting residents who are currently in the home, and the staff who are providing care to these residents, leading to new cases of COVID-19.

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 Forest Heights as well as a lack of clinical and administrative leadership. This enhanced management is necessary to return Forest Heights to normal operations and save lives.

Order:	

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to: Subsection 156(1) of the *Long-Term Care Homes Act, 2007*, SO c. 8 as modified by Ontario Regulation 210/20 made under the *Emergency Management and Civil Protection Act*, RSO 1990, c E.9. The Director may order a licensee to retain, at the licensee's expense, a person named by the Director to manage the long-term care home. An order made pursuant to Ontario Regulation 210/20 shall set out the period of time during which the order is in effect but the period shall not extend past the date

that Ontario Regulation 210/20 is revoked.

Order: The Licensee, Revera Long Term Care Inc., is ordered:

(a) To **immediately** retain St. Mary's General Hospital, a division of St. Joseph's Health System at 911 Queen's Blvd, Kitchener, ON N2M 1B2 ("St. Mary's") to manage Forest Heights located at 60 Westheights Drive, Kitchener, Ontario N2N 2A8;

(b) To submit to the Director, LTC Licensing, Policy and Development Branch ("LPDB") 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, LPDB pursuant to section 110 of the Act and to deliver a copy of that contract once executed to the Director, LPDB;

(d) To submit to the Director, LTC Inspections Branch, a COVID-19 recovery management plan, prepared in collaboration with St. Mary's to manage Forest Heights, and that specifically addresses how the licensee will return the home to normal operations with a specific staffing plan to ensure the successful return-to-work of the Forest Height's regular staff and a specific plan to safely return the residents who have been transferred to local hospitals, **within 48 hours** of being served this Order;

(e) To enable St. Mary's to begin managing Forest Heights 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, St. Mary's will manage Forest Heights for 90 days ("Management Period") following the date this Order is served. The Management Period may be extended by the Director.

(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, St. Joseph's Health System and St. Mary's and the Ministry of Long-Term Care associated with retaining St. Mary's as described in paragraph (a) of this Order.

(h) Upon being served with this Order, comply with (a)-(g) and not take any actions that undermine or jeopardize the ability for St. Mary's to manage Forest Heights to its full extent.

Grounds:

Forest Heights ("Forest Heights" or "the home") is a long-term care ("LTC") home in Kitchener, Ontario within the Waterloo Wellington Local Health Integration Network ("LHIN"). Revera Long Term Care Inc. is the licensee of the LTC home, which is licensed for 240 beds ("the licensee").

According to Ministry of Health (MOH) and Ministry of Long-Term Care (MLTC) Emergency Planning and Preparedness website, the COVID-19 pandemic began as an outbreak of a novel Coronavirus (2019-

nCoV) in China in December 2019. The first known case of COVID-19 in Ontario was identified on January 25, 2020. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic.

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 COVID-19 pandemic in Ontario. Emergency orders under the EMCPA have been issued to respond to the pandemic, including specific orders to alleviate the impact of COVID-19 in long-term care (LTC) homes.

On May 12, 2020, Ontario Regulation 210/20 under the EMCPA came into force. Pursuant to Ontario Regulation 210/20, the Director is authorized to make an order under subsection 156(1) of the Act if at least one resident or staff member in the long-term care home has tested positive for the coronavirus (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 the long-term care home.

COVID-19 Outbreak at Forest Heights

On April 1, 2020, an outbreak of COVID-19 was declared at Forest Heights by the Waterloo Public Health Unit as a resident had tested positive for COVID-19 in a laboratory test. On April 6, 2020, the first two staff members had been confirmed positive.

The following chart shows the progression of the outbreak at Forest Heights as reported to MLTC by the LTC home. This information includes the total number of residents who have been confirmed to have tested positive for COVID-19, the number of resident deaths from COVID-19 and the number of staff members who have been confirmed to have tested positive for COVID-19. The numbers in the chart are cumulative and are expressed as a total on the date reported.

Date	Total Confirmed Resident Cases of COVID-19	Total Resident Deaths from COVID-19	Total Confirmed Staff Cases of COVID-19
03/30/2020	0	0	0
04/01/2020	0	0	0
04/02/2020	1	0	0
04/03/2020	1	0	0
04/04/2020	1	0	0
04/06/2020	12	0	2
04/07/2020	13	1	2
04/09/2020	16	0	5
04/13/2020	27	1	14
04/15/2020	54	3	27
04/16/2020	55	4	34
04/17/2020	79	6	38
04/18/2020	87	8	39

04/19/2020	109	11	39
04/23/2020	139	20	47
04/25/2020	139	24	47
04/26/2020	148	31	50
04/27/2020	154	35	50
04/29/2020	160	35	51
05/02/2020	163	37	54
05/04/2020	163	42	57
05/05/2020	167	42	58
05/07/2020	167	45	59
05/11/2020	167	46	59
05/14/2020	165	47	60
05/19/2020	166	49	68
05/22/2020	171	50	68
05/25/2020	171	50	68
05/27/2020	175	50	68
05/28/2020	175	50	68
05/31/2020	176	51	69

Forest Heights is in an Acute Outbreak that is not being Contained

A COVID-19 outbreak was declared at Forest Heights on April 1, 2020; and an acute outbreak was declared on April 23, 2020. A LTC home in acute outbreak has increasing infection rates (active spread), ineffective or poor infection prevention and control and environmental interventions to contain the spread, inability to maintain supply of personal protective equipment and severe staff shortages that the LTC home has not been able to resolve.

The confirmed cases among residents and staff have increased substantially after the outbreak was declared. Within two weeks of the outbreak being declared, there were 51 confirmed positive residents, 3 resident deaths and 27 confirmed positive staff. By May 31, 2020 – 8 weeks after the outbreak was declared – a total of 176 residents (73% of the home's resident population) and 69 staff members had contracted COVID-19 and 51 residents (9% of the resident population) had died. As of May 31, 2020, the home was still identifying new cases of COVID-19, 55 residents had the disease although 49 of the positive residents had been transferred to local hospitals leaving only 6 positive residents left in the home. The home has not reported to the MLTC how many of the 69 staff members who contracted COVID-19 have recovered, and therefore it is uncertain how many staff members currently have COVID-19.

Licensee's Inability to Contain the Spread of COVID-19

There have been three primary factors contributing to the licensee's inability to contain the spread of COVID-19 in the LTC home: (1) infection prevention and control (IPAC) measures, especially cohorting not being implemented and followed to contain the spread; (2) not ensuring proper and consistent use of

personal protective equipment (PPE) amongst staff; and (3) staffing shortages.

On April 18, 2020, a member of the home's clinical team contacted the Acting Medical Officer of Health for Region of Waterloo expressing concerns about the home's ability to manage the outbreak. On April 20, 2020, St. Mary's Hospital ("the hospital") went to the home to provide infection prevention and control (IPAC) support to the home. On April 24, 2020, the Waterloo Public Health Unit completed the first IPAC assessment of the home. At this point it was the third week of the outbreak, and the home was not conducting environmental cleaning, personal protective equipment (PPE) was not been consistently worn by staff and not being changed between resident care, there was not enough PPE for staff, and residents were not being cohorted or kept at least two metres from each other.

As the home was not controlling the spread of the disease, the home started transferring 49 residents who had tested positive for COVID-19 to local hospitals in order to reduce the number of residents per room, and open up beds to allow for cohorting of COVID-19 positive residents. A total of 50 residents have been transferred to and remain in local hospitals. It is uncertain if the residents in hospital are COVID-19 positive, or when these residents will be able to return to the home.

As of April 25, 2020, St. Mary's General Hospital agreed to provide IPAC implementation support to Forest Heights. The Licensee committed to having hospital leadership assistance in the home. More support was needed and Grand River Hospital also agreed to support the home by providing IPAC team members to assist with operationalization of the IPAC plan for the home. The LHIN also obtained additional staff for the home to provide resident care, and cleaning / disinfecting the home.

MLTC Inspectors visited the home in May to conduct an inspection. MLTC had received a complaint that a resident had contracted COVID-19 due to unsafe IPAC practices. Notably, on May 22, 2020 a MLTC inspector observed sixteen COVID-19 negative residents residing on the designated COVID-19 positive floor for more than one month with staff providing care to both positive and negative residents. Inspectors also observed staff not following proper PPE guidance. These observations contradicted the assurances the licensee had provided to MLTC that positive COVID-19 residents were being cohorted and staff were not caring for both positive and negative residents.

On May 22, 2020, the licensee provided assurances to MLTC that it was obtaining increased management oversight at the home from one of its other homes, although this additional management did not arrive at the home until May 24, 2020. At this time, the home had no active plan to review the status of all residents in the home to ensure that cohorting is being maintained in all areas at all times.

Also, on May 24, 2020, MLTC inspectors identified that cleaning and disinfecting was still needed on high touch surfaces, in particular keyboards, hand held devices, monitors, and railings. The MLTC inspectors had significant concerns regarding the home's ability to implement all required IPAC processes and to maintain these processes given previous failures and the gaps that were still present. Given this, it is even more significant that on May 31, 2020, the home reported to the MLTC that one of the home's management staff, who had provided care to residents in both the COVID-19 positive and COVID-19 negative designated units, had contracted COVID-19.

<u>Leadership Concerns, and Infection Prevention and Control</u>

There has been instability with the home's management team throughout the outbreak causing uncertainty in terms of who is providing leadership to the home in managing the outbreak. In the first few weeks of the outbreak, most of the home's leadership was providing resident care because of staffing shortages. The management team also changed frequently throughout the outbreak as different individuals from the corporate licensee were sent to the home.

The home's management team has not been able to implement IPAC measures. The home's consistent pattern of inaction in relation to necessary IPAC practices has caused further spread of the disease and containment cannot occur.

MLTC management have been involved in meetings with the LTC home and have also expressed concerns related to the home's leadership being unable to provide effective direction and planning with respect to managing the outbreak and contain the disease.

This home has an outbreak of COVID-19 that is not being contained. The licensee has not taken urgent action and not provided the clinical and administrative leadership that is needed to ensure necessary IPAC measures are implemented and followed at all times. As such, a COVID-19 mandatory management order is needed to address disease spread in the home and to return the home to normal operations.

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 2nd day of June, 2020.	
Signature of Director:	
Name of Director:	Stacey Colameco