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 [X] **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:	ATK Care Inc.
LTC Home:	River Glen Haven Nursing Home
Name of Administrator:	Karen Ryan

Background:

River Glen Haven Nursing Home ("River Glen Haven") is a long-term care ("LTC") home in Sutton, Ontario within the Central Local Health Integration Network ("LHIN"). ATK Care Inc. is the licensee of the LTC home, which is licensed for 119 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 27, 2020, an outbreak of COVID-19 was declared at River Glen Haven by York Region Public Health as 8 residents had tested positive for COVID-19 in a laboratory test. Since the outbreak, the number of confirmed cases among residents and staff has increased substantially. As of May 22, 2020, 63 residents and 28 staff members at River Glen Haven had tested positive for COVID-19 and a total of 19 residents had died from COVID-19.

Along with the increased spread of infection at the LTC home, River Glen Haven is experiencing critical staffing challenges. The licensee is unable to ensure minimal staff are present at the LTC home to provide care to residents, notwithstanding receiving assistance from the Southlake Regional Health Centre, Central LHIN and paramedical services.

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

Order:	

To ATK 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, ATK Care Inc., is ordered:

(a) To **immediately** retain Southlake Regional Health Centre ("Southlake"), located at 596 Davis Drive, Newmarket, ON L3Y 2P9 to manage River Glen Haven Nursing Home located at 160 High St. Sutton, ON L0E 1R0 ("River Glen Haven");

(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 Southlake to manage the LTC home 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 LTC home's regular staff **within 48 hours** of being served this Order;

(e) To enable Southlake 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, Southlake will manage River Glen Haven 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, Southlake and the Ministry of Long-Term Care associated with retaining Southlake 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 Southlake to manage the LTC home to its full extent.

Grounds:

ATK Care Inc. ("the licensee") is licenced to operate a long-term care home known as River Glen Haven Nursing Home at 160 High St. Sutton, ON L0E 1R0, Ontario with 119 beds.

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.

<u>COVID-19 Outbreak at River Glen Haven</u>

On April 27, 2020 an outbreak of COVID-19 was declared at River Glen Haven as 8 residents were confirmed positive for COVID-19. On May 1, 2020, 2 staff members had tested positive for COVID-19 in a laboratory test.

The following chart shows the progression of the outbreak at River Glen Haven 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 Confirmed Staff Cases of COVID-19	Total Resident Deaths from COVID-19
April 27, 2020	8	0	0
April 30, 2020	21	0	0
May 01, 2020	21	2	0
May 4, 2020	26	14	1
May 5, 2020	25	21	1
May 7, 2020	30	18	2
May 8, 2020	35	18	2
May 11, 2020	35	18	5
May 13, 2020	38	19	5
May 14, 2020	48	20	11
May 15, 2020	48	20	12
May 19, 2020	62	27	18
May 20, 2020	62	27	18
May 22, 2020	63	28	19

As of May 22, 2020, 63 residents and 28 staff members at River Glen Haven had tested positive for COVID-19, and a total of 19 residents had died from COVID-19.

River Glen Haven is in an Acute Outbreak that is not being Contained

River Glen Haven has been in an acute outbreak of COVID-19 since April 27, 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. From the onset of the outbreak on April 27, 2020 to May 22, 2020, the total confirmed cases of COVID-19 has increased from 8 to 63 for residents and 2 to 28 for staff members. There has been a total of 19 resident deaths, which accounts to 16% of the total resident population in the LTC home. This has all occurred within a 3-week time period despite the ongoing supports provided to this LTC home (as noted below). Since the outbreak until May 22, 2020, there has been no decline in the number of confirmed COVID-19 cases for residents or staff members.

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) insufficient staffing and critical staffing shortages; (2) infection prevention and control measures not implemented to contain the spread; and (3) not providing staff with personal protective equipment (PPE).

On May 1, 2020, Southlake completed an IPAC assessment of the LTC home. Subsequently, they agreed to provide ongoing leadership and IPAC support to the LTC home. Southlake has been providing daily on-site assistance to the LTC home since May 6, 2020.

Southlake has facilitated assessments with respect to infection prevention and control (IPAC) practices at the LTC home. The IPAC assessments, which were also completed by York Region Public Health, indicated that the LTC home overall had poor IPAC interventions in place, thereby failing to limit the spread of the disease. Staff were not using PPE appropriately (i.e. observed to be using multiple masks at a given time). In addition, the LTC home was unable to cohort residents with COVID-19 from those residents who did not have COVID-19. There were also no clean areas within the LTC home that could be identified for donning and doffing of PPE safely.

In addition to Southlake, the LTC home has been receiving assistance from the Ministry of Long-Term Care (MLTC), York Region Public Health, the Central LHIN and paramedical services with respect to stopping the spread of COVID-19 in the LTC home. Daily status meetings have been held via tele-conference between the licensee and these groups. Despite the LTC home receiving assistance from these various external parties, the LTC home continues to be unable to contain the spread of COVID-19 in the LTC home or act urgently to do so. It is notable that between May 15, 2020 and May 19, 2020, the number of resident cases of COVID-19 increased by close to 30% and the number of staff cases of COVID-19 cases increased by 35%.

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

The LTC home lacks the leadership and the ability to contain the spread of COVID-19 in the LTC home, eradicate COVID-19 and bring it back into normal operations. The LTC home's management team has not been able to accurately track numbers related to residents and staff who have been confirmed to have COVID-19. Without accurate and timely information of the number of cases and who is infected with the virus, containment cannot occur.

The management of the LTC home has also not been able to ensure sufficient staffing for the LTC home to ensure sustainable care for residents. For example, on May 5, 2020, less than 50% of staff were reported to attend the LTC home. The management team of the LTC has been unable to ensure a consistent and sustained staffing schedule which ensures that staff are consistently available to attend the LTC home.

Southlake also determined that the LTC home required significant support related to implementing IPAC controls in the LTC home. Southlake provided IPAC training to staff on May 6, 2020 and began to provide daily on-site support and leadership as the outbreak situation was not improving.

The Central LHIN has reported they filed a report to the Ministry of Labour related to their concerns of staff at the LTC home not wearing PPE appropriately, not following PPE instructions and lacking in clinical skills. The Central LHIN indicated that operational leadership at the LTC home did not attend mandatory meetings and are unable to provide status updates regarding resident illness, death and staffing schedules. The Central LHIN has also reported major concerns with the sustainability of this LTC home to

prevent the spread of COVID-19 with its current management team. MLTC management have been actively involved in daily meetings with the LTC home and have also expressed concerns related to the home's leadership being unable to provide accurate numbers related to positive cases, staffing volumes and deaths. This LTC home has an outbreak of COVID-19 that is not being contained. The licensee has not taken urgent action and lacks the clinical and administrative leadership that is needed to ensure appropriate staffing and IPAC measures are adopted. 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.

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 25th day of May, 2020.	
Signature of Director:	
Name of Director:	