Order 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:	Alain Plante
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 **X** Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	000511-21
Original Inspection #:	2021_828744_0004
Licensee:	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services
LTC Home:	Roberta Place 503 Essa Road, Barrie, ON, L4N 9E4
Name of Administrator:	Tricia Swartz

Background:

Ministry of Long-Term Care (MLTC) Inspector #744 conducted a critical incident system inspection at Roberta Place (the Home). The Inspector attended the Home on January 12 and 13, 2021.

The Inspector determined that the Licensee, Barrie Long Term Care Centre Inc. (the Licensee), did not comply with section 5 of the *Long-Term Care Homes Act, 2007* (*LTCHA*). Based on the non-compliance, pursuant to s. 153(1)(a) of the *LTCHA*, the Inspector issued the following compliance order (CO #001):

"The licensee shall ensure:

All requirements specified by the Chief Medical Officer of Health (CMOH) in the latest

version of Directive #3 for Long-Term Care Homes for COVID-19 are implemented in the home. Specifically, the licensee must ensure:

a) Cohorting of affected and unaffected residents and staff in the home to the extent possible; and

b) Isolation of residents required by the direction of the Chief Medical Officer of Health in Directive #3 for Long-Term Care Homes to the extent possible.

This order must be complied with by: January 25, 2021."

Following a review of CO #001 by the Director, CO #001 has been altered and substituted with the Director's Order below.

Order:	CO #001

To **Barrie Long Term Care Centre Inc.**, you are hereby required to comply with the following order by the date set out below:

Pursuant to:

The Director is issuing the following compliance order (s. 153(1)(a)) after finding that the Licensee failed to comply with section 5 of the *Long-Term Care Homes Act, 2007* (*LTCHA*):

Home to be safe, secure environment
5 Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

Order:

The licensee must be compliant with s. 5 of the *LTCHA*.

Specifically, the Licensee shall ensure:

1. All precautions and procedures set out by the Chief Medical Officer of Health (CMOH) in Directive #3 for Long-Term Care Homes for COVID-19 are implemented in the Home. Specifically, in accordance with CMOH Directive #3 and public health guidance, the Licensee must ensure implementation of:

   a) Cohorting of residents and staff in the Home to the extent possible; and

b) Where a resident(s) has presented with symptoms compatible with COVID-19, ensure the isolation of residents required by the direction of the Chief Medical Officer of Health in Directive #3 for Long-Term Care Homes occurs.

Grounds:

1) The Licensee has failed to ensure that the Home was a safe and secure environment for its residents, as it did not cohort residents and staff as required by and in accordance with the Chief Medical Officer of Health's COVID-19 Directive #3 for Long-Term Care Homes issued under s. 77.7 of the *Health Protection and Promotion Act*, date of issuance December 7, 2020 (CMOH Directive #3).

CMOH Directive #3 requires long-term care homes (LTCHs) to immediately implement precautions and procedures. This included LTCHs to have a plan for and use, to the extent possible, staff and resident cohorting to prevent the spread of COVID-19 once identified in the LTCH.

On January 08, 2021, the Simcoe Muskoka District Health Unit declared an outbreak at the Home when one resident tested positive for COVID-19. On January 12, 2021, 5 staff, and 40 residents were positive for COVID-19, and there had been 1 resident death. On January 13, 2021, the active staff cases had risen to 13, and the active resident cases had risen to 43, with and additional resident death.

a) The Inspector identified seven residents' rooms which were shared by both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19. A Personal Support Worker (PSW) indicated that residents within these shared rooms would often come into close contact with each other. The Inspector also observed COVID-19 positive residents in close contact with residents who did not have COVID-19, both of whom were not cohorted.

b) On January 14, 2021, the home was in receipt of the IPAC Hub Preliminary IPAC Assessment. The assessment conducted by Health Experts in IPAC from the Royal Victoria Regional Health Centre recommended cohorting of positive resident to one floor, "hot vs cold zones", and recommended cohorting staff to the specific zones for all shifts.

c) The Inspector identified that certain staff members were providing care to both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19. The Administrator indicated that cohorting of staff on all resident Home areas was not always possible due to the high number of COVID-19 positive residents.

On January 15, 2021, the Medical Officer of Health (MOH-SMDHU) for the Simcoe Muskoka District Health Unit issued an order to the Home under section 22 of the *Health Protection and Promotion Act*. Dr. Gardner ordered the Home to:

- Institute staff (including housekeeping, janitorial, maintenance, etc.) and resident cohorting to prevent spread including but not limited to alternative resident accommodation to maintain spatial separation of 2 metres; cohorting of the infected and uninfected residents; utilizing respite and palliative beds/rooms to provide additionally distanced or isolated resident accommodation; utilizing other rooms within the institution as appropriate to help maintain isolation of affected residents and cohorted staff; Ensure adequate staffing levels (immediately

and in preparation for the remainder of the outbreak) so as to sufficiently designate each staff person to provide care for either a cohort of infected residents or a cohort of uninfected residents during the outbreak, but not both.

The MOH-SMDHU noted that the reasons for the order include the Home having multiple residents and staff diagnosed with COVID-19 and had an active outbreak of COVID-19 with continued transmission. In addition, the order notes that on January 11, 2021, an infection prevention and control assessment of the Home was conducted by staff of Simcoe Muskoka District Health Unit. The assessment, reviewed in-person with leadership onsite at the Home on January 11, 2021, outlined multiple critical concerns for infection prevention and control and outbreak management.

The MOH-SMDHU order clearly sets out that there were multiple critical concerns with infection prevention and control (IPAC) practices in the Home and that the Home was required to institute staff and resident cohorting immediately to prevent the spread of infection in the Home.

In addition, on January 16, 2021, the MOH-SMDHU issued an order under s. 29.2(1) of the *Health Protection and Promotion Act* to the Home. The order required the Home to comply with all direction related to the COVID-19 outbreak at the Home, including but not limited to direction on IPAC measures provided by the Simcoe Muskoka District Health Unit and the agencies/organizations identified in the order. The reasons cited for the order include the Home having inadequate and/or insufficient IPAC knowledge and processes to protect resident needs and the Home's need for assistance, particularly IPAC expertise, to help contain and stop the COVID-19 outbreak at the Home.

Not cohorting staff and residents as required placed other residents in the Home and Home itself at risk of disease transmission.

Sources: Inspector observations on January 12 and 13, 2021; Chief Medical Officer of Health Directive #3 for Long-Term Care Homes, issued date December 7, 2020; Royal Victoria Regional Health Centre IPAC Hub Preliminary IPAC Assessment; Order of the Medical Officer of Health, made pursuant to Section 22 and Section 29.2(1) of the Health Protection and Promotion Act, issued by Dr. Charles Gardner, Medical Officer of Health, Simcoe Muskoka District Health Unit, January 15 & 16, 2021, respectively, and interviews with PSW #104, the Administrator and other staff.

2) The Licensee has failed to ensure that the Home was a safe and secure environment for its residents, as it did not isolate residents as required by and in accordance with CMOH Directive #3 Directive #3).

CMOH Directive #3 requires that once at least one resident had presented with new symptoms compatible with COVID-19, the LTCH should place the symptomatic resident in isolation under droplet and contact precautions.

The Inspector #744 identified that all residents in the Home were required to be in their room isolating under droplet and contact precautions at all times. The Inspector observed multiple residents out of isolation, touching high-touch surfaces and coming in close contact with other residents. Some of these residents were identified as COVID-19 positive. A Registered Practical Nurse (RPN) indicated that they tried to keep residents isolated but some residents refused to stay in their rooms.

On January 12, 2021, the Inspector observed a resident in a lounge area and witnessed an RPN try to re-direct the resident back to their room. The resident was COVID-19 positive. According to CMOH Directive #3, where a resident has presented with symptoms compatible with COVID-19, the Home was required to place the symptomatic resident on isolation under droplet and contact precautions.

Residents not isolating as required placed other residents of the Home and the Home itself at risk for disease transmission.

Sources: Inspector observations on January 12 and 13, 2021; Chief Medical Officer of Health Directive #3 for Long-Term Care Homes, issued December 7, 2020; and interviews with RPN #102 and other staff.

An order was made by taking the following factors into account:

Severity of non-compliance: Actual risk of harm to residents was present by not ensuring a safe and secure environment for residents, including risk of disease transmission given cohorting and isolation was not implemented.

Scope: The scope of this non-compliance was widespread because not ensuring a safe and secure environment affected all residents of the Home; the concerns affected all residents and Home areas,

Compliance History: 12 previous Compliance Orders (COs), 30 Voluntary Plans of Correction (VPCs) and 15 Written Notifications (WNs) were issued to the home related to different sub-sections of the *LTCHA* and O. Reg. 79/10 under the *LTCHA* in the past 36 months.

This order must be complied with by:	**March 16, 2021**

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
347 Preston Street, 4th Floor, Suite 420
Ottawa ON K1S 3J4
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 15 day of March, 2021.	
Signature of Director:	
Name of Director:	Alain Plante