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

Amended 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:	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:	Tyndall Senior Villages Inc
LTC Home:	Tyndall Nursing Home 1060 Eglinton Ave East, Mississauga, Ontario L4W 1K3
Name of LTC Home Administrator:	Belisha Ke
Manager (pursuant to this Order)	Joseph Brant Hospital 1245 Lakeshore Rd, Burlington, ON L7S 0A2

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 5, 2020, an outbreak of COVID-19 was declared at the LTC Home by the Peel Public Health unit as one staff member of the LTC Home had tested positive for COVID-19 in a laboratory test. As of November 20, 2020, cumulatively, there were 97 confirmed resident cases, 83 confirmed staff cases, and 17 resident deaths as a result of COVID-19. Since the outbreak was declared, the LTC Home experienced a significant increase of confirmed cases (in residents and staff), 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 Trillium Health Partners (THP), Peel Public Health, and Ontario Health (OH).

Specifically, the LTC Home has received infection prevention and control ("IPAC") support from Public Health Ontario. On November 13, 2020, Public Health Ontario conducted an IPAC assessment at the LTC Home and provided on-site education to staff on infection prevention and control practices. Further, Joseph Brant Hospital has been providing IPAC-related support to the LTC Home since November 19, 2020.

With the support of OH, staffing agencies have provided staff to the LTC Home in order to fill gaps for various positions at the LTC home, including registered staff positions, due to staffing shortages. The LTC Home has also been supported by a Nurse Practitioner stat team who conducted clinical assessments for residents and assisted with feeding residents. THP has also provided physician coverage to augment medical expertise and palliation in the LTC Home. Despite the Licensee receiving external assistance throughout the outbreak, ranging from infection prevention and control assistance to staffing support, the outbreak at the LTC Home continues.

Infection Prevention and Control

On November 13, 2020, Public Health Ontario visited the LTC Home to review and assess the IPAC practices implemented at the LTC Home. Following their assessment, Public Health Ontario issued a report on November 19, 2020, which highlighted several areas of deficiency including:

- Active screening of staff for COVID-19 not being consistently done – passive self-screening was observed, which is not sufficient;
- Staff double masking and there being incorrect doffing of personal protective equipment (PPE); staff not changing gowns when interacting with different residents;
- Staff drinking at nursing station;
- PPE caddies not well stocked with PPE;
- No garbage containers available at resident room doors for ease of doffing PPE;
- Lack of signage on resident rooms doors that differentiates COVID-19 positive and negative residents and lack of instructions to guide staff with donning and doffing steps;
- More hand sanitizer stations needed in the hallways and in resident rooms at point of care; and
- Staff moving from working with presumed negative/non-exposed residents to exposed, symptomatic, then known positive residents;

Deficiencies in IPAC practices were also observed by a Ministry of Long-Term Care Inspector during an on-site inspection at the LTC Home between November 18-20, 2020. In particular, staff were observed to inappropriately use PPE (e.g. don and doff PPE) and there were concerns with proper hand hygiene.

Staffing

During the outbreak, due to staff shortages, the Licensee has been mostly relying on agency staff to staff positions at the LTC Home. The Executive Director of the LTC Home is symptomatic and currently self-isolating and assisting off-site. The Corporate Director of Operations is on-site daily.

The Licensee has reported significant staffing shortages at the LTC Home for positions such as Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) since November 16, 2020. The staffing shortages have occurred mainly because of the high number of staff who remain off work due to a positive status of COVID-19 and the reluctancy of staff to return to work despite following their clearance from the infection. This is also contributed by the lack of registered staff available from agencies to support the LTC Home.

On November 18, 2020, during an inspection, an MLTC Inspector observed no registered staff on an identified floor of the LTC Home on the day shift for a period of approximately 4.5 hours. This resulted in

some residents missing their morning medications. Registered staff did not arrive at the LTC Home until the end of the morning, at approximately 11:30 am.

The Licensee has not consistently ensured an adequate level of staff at the LTC Home. During the outbreak, it has relied significantly on agency staff to fill key positions. The LTC Home recently has had difficulty in ensuring the presence of registered staff at the LTC Home. Without being able to ensure registered staff (and other staff) are consistently present at the LTC Home at adequate levels, this poses a risk to meeting residents' care needs and a risk of the infection continuing to spread.

In addition, this LTC Home is physically an older, long-term care home building. There are 5 private rooms. The remaining rooms are basic accommodation, standard rooms that contain 4 beds separated by curtains and which the 4 residents in the room share a bathroom. Structurally, this poses challenges with cohorting and isolating residents effectively with appropriate distance between them in order to minimize the risk of spread of infection.

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 November, 2020	
Signature of Director:	
Name of Director:	Brad Robinson (Acting)