SENIORS FOR SOCIAL ACTION (SSAO) RESEARCH REPORT

FAILURE TO ACT:
GOVERNMENT'S LACK OF INSPECTION AND OVERSIGHT AFTER DOCUMENTED SUBSTANDARD CARE IN ONTARIO'S LONG TERM CARE FACILITIES

August, 2020

LONG TERM CARE HOMES UNDER DIRECTOR'S REFERRALS AND DIRECTOR'S ORDERS

Preamble

On June 29, 2018 Doug Ford became Premier of Ontario.

Information supplied by the Official Opposition obtained from Legislative Research shows that there is currently:

- No ability for the government to levy fines against homes that repeatedly violate the Long Term Care Homes Act;
- That since July 2018, there have not been any non-renewals of licenses, even of homes found to be in repeated violation of the Long Term Care Homes Act;
- That since July 2018, there have not been any license revocations even for licensees that have been found to be in repeated violation of the Long Term Care Homes Act and were under Director's Referrals[1] or Director's Orders;
- That since July, 2018 inspectors at the Ministry's Inspection Branch made 99 Director's Referrals about 47 facilities;
- That since July, 2018, of these 99 Director's Referrals made by inspectors, only 7 resulted in Director's Orders being issued.

Scaling Back Of Comprehensive Annual Inspections

Since coming to office the Ford government has scaled back comprehensive inspections, essentially creating a complaint and critical incident driven inspection process rather than a proactive annual, comprehensive process.

By 2019 only 9 of 626 long term care facilities received a comprehensive yearly inspection in spite of claims to the contrary on the Ministry's website (Pedersen et al, April 15, 2020).

Even facilities that had repeated violations, critical incidents, and complaints or had been subject to Director's referrals by inspectors, did not receive comprehensive annual inspections, nor had facilities that were the subject of press or military reports.

What this means is that in Ontario, with this lack of oversight and a greatly weakened inspection service, residents have essentially no protection against substandard care unless family members, staff, or other visitors make a report to the Inspection Branch or a critical incident occurs that is actually reported by a facility. It should be noted that quite a number of facilities have been cited by inspectors in the past for failing to report critical incidents to the Director. This is basically an honor system for a long term care sector that has, to date,

[1] Director's Referrals occur where an inspector has identified a high risk situation and taking further action is beyond the power of the inspector, the inspector may make a referral to the Director under the Long Term Care Homes Act (LTCHA) to take further action. (Legislative Research, 2020).

according to inspection reports, shown that it is not always worthy of trust. Even when complaints are made, they are likely to be followed up in a very specific manner, narrowly focused on the complaint with no examination of other conditions in the facility.

Repeated critical incident reports and complaints do not appear to result in increased oversight of a facility, nor do they seem to trigger a more comprehensive inspection.

The Case Of Park Lane Terrace, Paris, Ontario

One example is Park Lane Terrace in Paris, Ontario, owned by APANS Health Services, also listed by Legislative Research as having been the subject of a Director's referral.

Families, former staff members, and a resident have all spoken out about conditions at this facility and have repeatedly pointed to problems "with management and understaffing, heightened after a series of layoffs that began in 2018" commenting that "nothing changes for the better. It just gets worse, day in and day out," according to resident Peter Albers (Bimman, April 23, 2019).

After Global TV requested an interview with APANS, the Ministry of Health and Long Term care pulled the inspection report from its public website. When it reappeared it had been amended to give the facility more time, changed from mid-March to May, to address Ministry requirements in half of 8 compliance orders. One of the infractions the facility was given more time to correct was "failing to protect residents from abuse that led to actual harm". The Ministry offered no explanations for its actions. (Bimman, April 25, 2019).

Park Lane is one of the few facilities that has received a comprehensive Resident Quality Inspection since the Ford government came to office. That occurred on March 27, 2019. It resulted in 40 Written Notices, 28 Voluntary Plans Of Correction, 8 Compliance Orders, and a Director's Referral. According to this report:

- Staff had not received training in the home's mission statement, the Residents' Bill of Rights, the abuse and neglect policy, the duty to make mandatory reports, fire prevention and safety, the policy to minimize use of restraints, emergency and evacuation procedures, infection prevention and control, Ministry Acts, regulations, and policies etc. (Pg. 8 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21873&FacilityID=20377
- "The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs". (Pg. 9) Consequently residents were not receiving appropriate nourishment, nor were they given 3 meals a day, continence care needs were not being met, residents were not dressed, some were not bathed or toileted, residents had skin ulcers and pressure sores that were not appropriately addressed, residents were not receiving scheduled medication nor were some administered correctly, the facility failed to ensure that residents were protected from abuse where police had to be called.(Pgs. 9 through 41).
- The inspector also noted that the home did not provide a safe and secure environment for residents (Pg. 42). This included a resident being placed in a bed that was an

entrapment risk, concrete missing in sidewalks, resident being injured due to responsive behaviors, residents left in bed (increasing the risk of pressure ulcers), resident sustaining an injury while receiving care, residents not checked for incontinence for hours, fall prevention program and head injury routine not being followed, unwitnessed falls, medication errors, exits to the facility not secured, no hot weather related illness prevention plan, (residents reported as uncomfortable and not able to get relief (Pg. 64), failure to ensure that abuse is reported or appropriately followed up, "on an identified date in April, 2018, resident #004 was allegedly sexually assaulted" and the home did not immediately report it (Pg. 72), "PSW #111who reported that due to staff shortages they were not able to get all residents to the dining room. The residents were in bed because they did not have time to provide care to them. Also, between meal beverages and after meal snacks were not being provided to the residents as the staff had been exempted from distributing the snack cart for 12 weeks" (Pg. 73), lifts and transfers not safely conducted, untrained staff used without PSW qualifications (Pg 82) and , licensee did not ensure that all the staff of the home had the proper skills and qualifications to perform their duties" (Pg. 92), lack of response to issues raised by Family Council, cleaning and disinfecting of facility not done – infection control person did not conduct audits of facility (Pg 96), adverse drug reactions not monitored (Pg. 116).

- Laundry and linen unavailable (Pg 100),
- Plumbing not free of corrosion or cracks- "rusted toilet paper holders, rust stains in toilet bowls and/or rusted sink drains were observed in but not limited to identified resident rooms ("Pg. 101, 102),
- "The licensee failed to ensure that the appropriate police force was immediatelynotified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence"re: sexual assault (Pg. 109),
- Home's water temperature not adequately monitored.

It becomes clear why a Director's referral was initiated with respect to this facility. Nevertheless, from July 11, 2019 to July 29, 2020, 4 additional Complaints investigations were done, and 7 Critical Incidents were reported and followed up, with 4 of these resulting in Inspector's orders, including:

- July 15, 2019 – 12 Written Notices, 5 Voluntary Plans of Correction, 6 Compliance Orders, and another Director's Referral , many as a result of lack of reasonable care plans or failure to follow through resulting in neglect and falls, registered nurses not being on duty as required, lack of staff training, non-compliance with medication administration protocols, failure to report abuse or neglect, baths not given as required. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22744&FacilityID=20377
- On November 6, 2019 a Critical Incident inspection resulted in a further 2 Written Notices and 2 Voluntary Plans of Correction this time concerning water leaks, and failure to address flooding and sewage issues. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=23893&FacilityID=20377
- November 21, 2019 another Critical Incident inspection occurred resulting in Inspector's orders. 25 Written Notices were issued, 14 Voluntary Plans of Correction, and 7 Compliance Orders. Again there was a failure to provide a safe and secure environment for residents, problems with

meals, and residents not fed, drug administration problems, failure to protect residents from abuse and neglect, facility exits not secured, care plans not followed, PSW's reporting they were too busy to provide adequate care, unsanitary conditions, skin impairments not properly managed, abuse not reported to the Director, fire risk, resident on resident abuse not prevented, medication not secured, fall prevention not done, staff not complying with policies and procedures etc. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24081&FacilityID=20377

- A November 21, 2019 also resulted in a Written Notice issued by the inspector for an inadequate care plan. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24082&FacilityID=20377
- February 3, 2020 Another Critical Incident Inspection occurred resulting in 6 Written Notices, 1 Voluntary Plan of Correction, 2 Compliance Orders, and 2 Director's Referrals. Same problems – safe transfers not happening, falls and lack of follow-up, staff not complying with medication administration requirements, inadequate dietary services, medications not secured, failure to deal appropriately with responsive behaviors, facility exits not secured. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24671&FacilityID=20377
- A February 27, 2020 Complaints investigation also resulted in 7 Written Notices and 6 Voluntary Plans of Correction for dietary and nutrition problems. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24814&FacilityID=20377
- By April 16,2020 with the pandemic having begun, a Critical Incident inspection resulted in 6 Written Notices, 1 Voluntary Plan of Correction, 2 Compliance Orders, and 2 Director's Referrals for unsafe transfers, falls and head injury routine not implemented, unwitnessed falls, problems with medication management, medication not secured, incidents between residents not managed, exits to facility not secured, medications not appropriately given http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25159&FacilityID=20377
- July 29, 2020 The home remains not in compliance. A Critical Incident Inspection results in 3 Written Notices, and 2 Voluntary Plans of Correction for unsanitary conditions, errors in medication administration and compliance orders not addressed, fall risks not managed. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25662&FacilityID=20377

Why was this facility's license not revoked? Why were admissions not ceased? Why has there not been a police investigation related to alleged abuse? The problems went back years.

People often believe that they will never end up in a place like this but they do.[2]

[2] In January of 2013, a long-time volunteer with Community Living Brant, Sally Munroe, died at Park Lane Terrace. Sally's daughter had Down Syndrome, and she also became active with the Hamilton Association for the Mentally Retarded. In 1973 she was named Hamilton Citizen of the Year. She had been a strong advocate of the rights of people with developmental disabilities chairing the Brantford Coordinating Committee for the Developmentally Handicapped and the Brant Residential Placement Advisory Committee. Married to a urologist, she was also honored by the Ministry of Community and Social Services for her tireless work for over 5 decades. https://www.brantfordexpositor.ca/2013/01/03/tireless-volunteer-and-advocate-got-job-done/wcm/813aced5-9a2e-d7e0-7a6b-5c5fc782e876 In 2013, the year Sally Munroe died in Park Lane, it was cited for equipment not being clean and sanitary, staff not collaborating in providing care including incontinence care and toileting. 2 Written Notices were issued. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=6559&FacilityID=20377 The following year a comprehensive inspection report noted the same and even more problems. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=9035&FacilityID=20377

This is an example of a disempowered Inspection Branch, one where inspectors generally do their jobs, but where a facility can, again and again, disregard compliance orders and even Director's referrals with impunity and retain its license. And it is the residents and their families who suffer.

Facilities Described in Military Reports Not Subject To Director's Referrals

Sadly this is not the only facility where this has occurred. It should be noted that not one of the facilities described in the report by Canada's military that caused the Premier of Ontario to describe the report as heartbreaking, horrific, and shocking (DeClerq, May 26, 2020) were the subject of even a Director's referral from inspectors. This seems to indicate that inspectors did not find these to be the most high risk facilities in spite of the serious concerns outlined in the military report.

It raises the question of how many other substandard facilities there may be where Director's Referrals are not made. Two of the facilities described by the military were part of a class action lawsuit filed against the owners in April, 2020 (Wilson, April 27, 2020). The government issued a press release saying that "six teams of two long-term care inspectors will go into each of the homes to do an expanded, stringent inspection process over a two-week period" after the military report was released (Ontario, May 27, 2020). It should be noted that this does not constitute a Resident Quality Inspection which often involves teams of at least 4 inspectors – nursing, dietary, rehabilitative, and environmental - attending at a facility over an extended period of time. The news release was clear in saying that inspectors would only look at what the military reported.

It should also be noted that even when inspectors were ordered into these facilities after the military reported, it sometimes took two months for reports to be publicly filed by the Inspection Branch.

No public information has since been provided on whether or not police, public health, Ministry of Labour, or professional college investigations were triggered as a result of the military report. Some members of SSAO are now being forced to request this through Freedom of Information.

FACILITIES DESCRIBED IN THE MILITARY REPORT

Eatonville Care Centre, Etobicoke

- **42 RESIDENTS DEAD AT ETONVILLE/105 STAFF INFECTED** (Aguilar, May 21, 2020)
- **CLASS ACTION FILED AGAINST CORPORATE OWNER IN APRIL, 2020** (Wilson, April 27, 2020).
- **UNION WROTE TO PREMIER AND HEALTH MINISTER IN APRIL INDICATING CONCERNS ABOUT HOW HOME WAS BEING MANAGED.** (Aguilar, April 16, 2020).

- **ONTARIO NURSES ASSOCIATION (ONA) REQUESTS SUPERIOR COURT TO ORDER THE FACILITY TO STOP BREACHING DIRECTIVES OF THE CHIEF MEDICAL OFFICER OF HEALTH**
- **TEMPORARY MANAGEMENT APPOINTED** (McLean & Welsh, April 17, 2020).

The Public Inspections Website shows that:

- **3 Resident Quality Inspection reports** (RQI's) were publicly posted in 2016 and 2017 **during the Liberal government term** (February 4, 2016; February 3, 2017; and October 10, 2017).
- **No Resident Quality Inspections were completed during the Conservative government term.** This means that from October 10, 2017 to August, 2020, no comprehensive inspections were done in this facility.
- **During the period of the Conservative government term** 7 Critical Incidents were reported resulting in inspections (1 resulting in Inspector's Orders); 6 inspections occurred as a result of complaints, and 1 Follow-Up Inspection also occurred.

In spite of serious concerns raised by the military report about infection control, standards of practice and quality of care, a culture of fear of using needed supplies, communication and staffing issues, inappropriate behavior including aggressiveness and ignoring residents indicating they were in pain and inaccurate charting, no comprehensive Resident Quality Inspection of this home was ordered by either the Minister or the Premier.

Written notices were, however, issued by inspectors for the licensee failing to protect residents from abuse (Pg 3 – http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25593&FacilityID=20238) resident care plans not being followed by staff, multiple falls recorded, lack of mouth and eye care, weight monitoring not taking place, residents being administered expired medications, drugs not being stored in a secure location, staff not taking part in infection prevention and control program etc. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25594&FacilityID=20238

Any of these should have triggered a comprehensive Resident Quality Inspection and compliance orders as well as actions by the Inspection Branch to protect the health and safety of residents. Any facility with infractions this serious should have a Cease Admissions notice issued. None was.

Instead none of these resulted in the Minister of Long Term Care, the Premier, or the Inspection Branch requiring a comprehensive Resident Quality inspection.

Hawthorne Place Care Centre, North York

- **46 RESIDENTS DEAD/33 STAFF INFECTED** (Palamarchuk, May 27, 2020)
- **CLASS ACTION LAWSUIT FILED AGAINST CORPORATE OWNER IN APRIL, 2020** (Wilson, April 27, 2020).

- **ONTARIO NURSES ASSOCIATION (ONA) REQUESTS SUPERIOR COURT TO ORDER THE FACILITY TO STOP BREACHING DIRECTIVES OF THE CHIEF MEDICAL OFFICER OF HEALTH** (McLean & Welsh, April 17, 2020).

The Public Inspections Website shows that:

- **3 Resident Quality Inspections were conducted during the Liberal government term** (September 15, 2015; June 8, 2016; February 26, 2018). In addition inspectors conducted 6 Critical Incident Inspections, 7 Complaints Inspections, and 1 Follow-up Inspection during this period.
- **1 Resident Quality Inspection was conducted during the Conservative government term** (December 13, 2018). In addition inspectors conducted 4 Critical Incident Inspections, 8 Complaints inspections, and 1 Follow-up inspection during this period.

The military report raised serious issues related to infection control, standards of practice and quality of care, communication, staffing, access to supplies including wound care supplies and linen shortages. Nevertheless no comprehensive Resident Quality Inspection (RQI) was ordered for 2019 or 2020 even following the military report.

In May, 2019 inspectors found care plans not followed, failure to protect residents from abuse, failure to manage responsive behaviors in residents to prevent resident to resident abuse, failure to send a written report to the Director concerning a critical incident involving a serious injury and transfer to hospital, failure to report abuse/neglect (Pgs 4, 8, 13, 19, 22 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22645&FacilityID=20595)

Failure to follow care plans, failure to report serious incidents to the Director, residents being abused, and not having adequate supplies available to provide wound care should have triggered rigorous follow up in the form of an RQI and if these were repeat problems, a Director's Referral. All of the above should have triggered compliance orders instead of written notices, since all placed residents in jeopardy. They did not.

Even after the military report and continuing serious issues in this home neither the Minister of Long Term Care, the Premier, nor the Inspection Branch appear to have insisted on a comprehensive Resident Quality Inspection.

Orchard Villa, Pickering

78 RESIDENTS DEAD/NUMEROUS LAW SUITS FILED BY FAMILIES (Katawazi, May 11, 2020; Mandel, May 27, 2020).

FAMILIES WRITE TO POLICE ASKING FOR INVESTIGATION OF ALLEGATIONS OF CRIMINAL NEGLECT https://globalnews.ca/news/6960274/coronavirus-orchard-villa-families-letter/

FAMILIES ALLEGE FACILITY DISCOURAGED THEM FROM HAVING DYING RESIDENTS TRANSFERRED TO HOSPITAL https://www.cbc.ca/news/canada/toronto/orchard-villa-families-hospital-pandemic-1.5614511

FAMILIES FILE A $40 MILLION CLASS ACTION LAWSUIT AGAINST COMPANIES THAT OWN AND MANAGE ORCHARD VILLA - https://torontosun.com/news/local-news/mandel-proposed-40-million-class-action-lawsuit-filed-against-orchard-villa-owners

On May 11, 2017 and March 26, 2018 during the Liberal government term inspectors conducted 2 Resident Quality Inspections with a follow-up inspection on June 8, 2018.

No Resident Quality Inspections were done during the Conservative government term from June, 2018 to August, 2020. Amazingly, in spite of numerous previous infractions, the first Complaint inspection that took place during the Conservative government term on August 28, 29, 31, and September 20, 2018 resulted in no infractions being found.
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=20270&FacilityID=20100

However there were 8 Complaints Investigations, 5 Critical Incident Inspections (2 with Inspector's Orders), and 2 Follow-up Inspection (1 with Inspector's Orders)

Orchard Villa has a long history of health and safety related issues for residents which may explain the reasons why the Inspection Branch, under the previous Liberal government completed two Resident Quality Inspections in one year.

What is both questionable and problematic is that in the two year period that followed, in spite of serious issues having been documented in the previous two Resident Quality Inspections, no comprehensive inspections were completed under the Conservative government. However 15 other inspections were completed related to critical incidents, complaints and follow-up. None triggered a Resident Quality Inspection.

The military report outlined very serious issues related to resident care at Orchard Villa including: problems under all of the headings listed in previous reports, however their degree of seriousness appears to have been compounded – cockroaches and flies prevalent, rotten food smells, residents left in soiled diapers, feeding residents lying down – subjecting them to choking hazards, unsafe medication administration, serious injuries not addressed, staff being unable to report anything other than medication errors as critical incidents (therefore presumably serious injuries resulting from falls or abuse would not be reported as a critical incident), oxygen generators not filled, problems calling doctors, problems with residents choking, residents moved into dirty rooms, lack of teamwork and collaboration, RN's not having access to electronic records.

More serious issues were documented in Inspector's reports:

July 2019 through December 6, 2019:

- Failure to follow up adequately on serious injury (also failure to use safe transfer protocols or fall prevention strategies) (Pgs 4, 6, 9, http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22869&FacilityID=20100)
- Failure to ensure RN on duty (Pg 4 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=20670&FacilityID=20100
- Inadequate follow up report to Director, failure to ensure fall prevention care plan followed (Pgs 4, 6 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21782&FacilityID=20100)
- Physician not contact as needed, failure to use safe transferring protocol, lack of sufficient clean laundry (Pg 4, 7, 9 including face and bath towels http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21960&FacilityID=20100)
- Lack of appropriate follow-up re: resident injury, inadequate care provided, lack of compliance with fall prevention and safe transferring procedures, (Pg 4 , 6, 8, 9 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22869&FacilityID=20100
- Failure to protect residents from abuse, failure to prevent falls or take appropriate action after a fall (Pg 4, 6, http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24062&FacilityID=20100)
- Resident failed to receive adequate continence care, failure to report incompetent care or treatment (Pg 7, 9 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24063&FacilityID=20100

Problems Continued – May 26, 2020 – July 27, 2020 (while Lakeridge Health was still in the facility)

- Inadequate wound care, Verbal and physical abuse captured by a video camera not reported, lack of follow up after medication administration, failure to protect residents from verbal and physical abuse (Pg 5, 10, 12,13 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25326&FacilityID=20100)
- Residents not bathed twice weekly, (Pg 4 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25327&FacilityID=20100)
- Care plan not followed re: fall (Pg 5 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25687&FacilityID=20100)
- Baths not happening twice per week, failure to prevent resident on resident abuse, fall prevention not happening, residents not helped to get dressed. (Pg 4, 7 , 9, 12 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25327&FacilityID=20100
- Another fall incident. (Pg 5 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25687&FacilityID=20100)

A July 27, 2020 (inspection conducted May 20 – June 29, 2020) – report shows 13 Written Notice, 9 Voluntary Plans of Correction, and 2 Compliance Orders – this is the Inspection report with the most serious issues identified since the annual comprehensive inspections of

two and three years ago – failure to notify physician of nutrition related problems, failure to prevent fall that resulted in serious injury and transport to hospital, equipment including mechanical lifts not kept in good repair, staff failure to comply with falls prevention protocol, no post fall assessment done, inadequate wound care, inadequate pain management, inadequate nutrition and hydration, medication errors, failure to ensure staff take part in infection control program, substitute decision maker not notified if resident required new belonging, linens not change once a week, failure to report critical incidents, staff not trained within one week of being hired according to a memo issued March 20, 2020, by the Assistant Deputy Minister, Long-Term Care Operations Division of the Ministry of Long-Term Care, specific to Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to the COVID-19 Pandemic. (Pg 5,6, 8,10, 13, 14, 17, 18, 22, 27, 29 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25688&FacilityID=20100)

It should be noted that the Assistant Deputy Minister's memo required that staff be trained within one week of being hired in:

- **Zero tolerance of abuse and neglect of residents**
- **Infection prevention and control**
- **The Resident's Bill of Right**
- **Mandatory reporting duty of abuse and neglect under Section 24 of the Long Term Care Homes Act**
- **Fire prevention and safety**
- **Emergency evacuation procedures**

The latter is especially important since this facility is located less than 4 km from the Pickering Nuclear Power Plant.

It should also be noted that PSW's were failing to follow appropriate infection control procedures in a facility with the highest death rate in the province, months after the onset of the pandemic. See page 25 - http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25688&FacilityID=20100

On June 12, 2020 Lakeridge Health was asked to assume the day to day operations of Orchard Villa.
https://www.lakeridgehealth.on.ca/en/news/index.aspx?_mid_=2095&newsId=845ed91c-09c2-4353-a550-5376568982ad

While this was occurring, inspectors were in the facility on June 1 - 5, 7 - 12, 14 - 19, 21 - 26, 29, 2020 still citing this facility for staff failing to collaborate in providing care with the physician and dietician not being notified of a resident's dietary issues (resident not tolerating a nutritional supplement); falls prevention was still not occurring; mechanical lifts were still not in good repair; post fall assessment of a resident with a skin injury and complaining of pain was

not done; skin assessments not done with altered skin conditions; pain assessments not completed; resident weight not being recorded; new staff were not receiving training as required by an Assistant Deputy Minister's memo dated March 20, 2020 specific to among other things infection prevention and control, and the protocol concerning resident abuse and neglect. Pg 21
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25688&FacilityID=20100

Ongoing activities like this that endanger the health, safety, and life of residents, even while a Lakeridge Health Team is in place should have triggered at the least a Cease Admission order and a license revocation in this facility. At the very least they should have triggered a Director's referral and order.

None happened in this case and it appears that Orchard Villa residents remain in jeopardy.

Altamont Care Community, Scarborough

53 RESIDENTS DIED AT ALTAMONTE/FAMILIES HAVE FILED A 20 MILLION CLASS ACTION LAW SUIT (Goodfield, K, June 1, 2020)/**ONE STAFF MEMBER DEAD OF COVID-19** (Aguilar, April 16, 2020).

On January 25, 2017 and February 15, 2018 during the Liberal government's term 2 Resident Quality Inspections took place.

On February 26, 2019 during the Conservative government's term 1 Resident Quality Inspection occurred.

After the Resident Quality Inspection, an additional 4 Critical Incident Inspections - 2 with Inspector Orders, 4 Complaints Investigations – 2 with Orders, and 1 Follow-up Inspection occurred.

The military report also raised serious concerns for Altamont under each of the same headings as in previous reports. These included: inadequate nutrition; a significant number of pressure sores (which generally happen when residents are left in bed and not re-positioned, and the report confirms this saying residents had been bed bound for weeks); inappropriate wound care; alleged abuse and neglect; inappropriate medication administration; lack of clinical skills in staff; severe understaffing; staff using derogatory language.

From February 26, 2019 to January 21, 2020 the following was documented in inspection reports:

- Home furnishings and facility unsanitary, wound care not appropriately handled, falls prevention not appropriately handled and multiple falls the result, residents not assessed after falls, drugs not safely stored, medication administered not in accordance with directions, failure to ensure that staff engage in effective infection control

procedures, symptoms including the presence of infection not recorded – resident died, inappropriate reporting of incident to Director, (Pg 4, 7, 12, 26, 27, 36, 39, 42 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21466&FacilityID=20009)

- Failure to investigate abuse and neglect, failure to ensure baths x 2 weekly for residents (Pg 6, 8 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22256&FacilityID=20009
- Failure to implement interdisciplinary training programs on wound care, falls prevention, continence care, and pain management, falls resulting in injuries, medications administered not in accordance with directions, residents hospitalized after medication errors, failure to ensure a safe and secure environment for resident, failure to provide adequate continence care, neglect of residents, failure to ensure that staff use safe transferring methods, wound care not provided, physical altercations between residents not prevented or managed, failure to secure medications, staff failed to take part in infection control program, failure to get staff to comply with written policy of zero tolerance of abuse and neglect, staff failure to report resident to resident abuse resulting in harm, failure to notify substitute decision make of results of abuse investigation, resident's dementia related records not kept at the facility, (Pg 5, 13, 14, 16, 19, 21, 23, 26, 30, 38, 39, 41, 44, 46, 48, http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=23815&FacilityID=20009) 14 Written notices, 8 Voluntary plans of correction, 2 Compliance orders.
- Resident's care plan not followed re: diet, continence care, or regular bathing (Pg. 4, http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24523&FacilityID=20009)

In spite of all of this no Director's Referrals were made, no Cease Admission Notices were issued, and no license revocation occurred.

Holland Christian Homes (Grace Manor), Brampton

17 STAFF AND 44 RESIDENTS TEST POSITIVE, 27 DEAD/1 PSW DIED (Frisque, April 20, 2020; Frisque, April 24, 2020; DiManno, May 5, 2020)

The military report into conditions at this facility, the only non-profit to which the military was deployed, is much shorter than reports of the other facilities, but nevertheless details inappropriate infection control procedures, improper sterile techniques used to change dressings, food left in a resident's mouth while sleeping, aggressive repositioning of residents, improper use of lifts, and residents not receiving assistance with eating.

On September 23, 2016 and May 12, 2017, during the Liberal government term, 2 Resident Quality Inspections took place with a June 25, 2018 Follow-up Inspection.

No resident quality inspections took place during the Conservative government term from June 29, 2018 to July 26, 2020.

EXAMPLES OF HEALTH AND SAFETY RELATED ISSUES IN FACILITIES SUBJECT TO DIRECTOR'S REFERRALS

A chart attached to this report details the types and frequency of inspections that occurred that resulted in Director's Referrals and Director's Orders.

Again it appears clear that Complaints and Critical Incident Inspections were not what triggered comprehensive inspectors, Director's Referrals or Director's Orders.

It remains unclear why the facilities with the highest death rates in Ontario that required external management and intervention by the military do not appear as facilities where Director's Referrals and Orders were issued since most appear to have health, safety and care related issues every bit, if not more serious, than those facilities where these Orders and Cease Admissions were instituted.

REQUIRED ACTION

Something is not right with the Inspection Branch. There appears to be no uniform approach to issuing Cease Admissions, making Director's Referrals, or issuing Director's Orders – something that appears to occur very infrequently.

Licenses are not revoked, even for serious repeat offenders.

Charges are not brought when it seems that issues outlined in Inspection Reports may rise to the level of criminal negligence, when residents' funds are stolen, and when they are subjected to assaults resulting in injuries.

Consequently SSAO is calling for:

- Immediate reinstatement of yearly, comprehensive Resident Quality Inspections (RQI's as recommended by the Auditor General;
- Director's Referrals to be shown on the Ministry website and their contents posted;
- Re-introduction of a prosecution policy in the Inspection Branch in conjunction with a Crown Attorney cross appointed to the Inspection Branch by the Ministry of the Attorney General;
- The revocation of licenses of facilities that have a history of placing residents in jeopardy;
- Uniform orders of Cease Admissions for facilities that are repeatedly short staffed and that demonstrate an inability to care for residents;
- The addition of a Regulation in the Long Term Care Homes Act allowing the Ministry to levy fines against facilities that repeatedly contravene the Act and Regulations;

- The need for forensic accountants to be available to the Inspection Branch and enabling legislation allowing them to examine the books of facilities that repeatedly short staff and/or do not have sufficient supplies needed for the care of residents.

All of these actions are required to re-build an Inspection Branch left weakened by the elimination of yearly comprehensive inspections of facilities and the ability to institute meaningful consequences for facilities that repeatedly contravene the law.

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