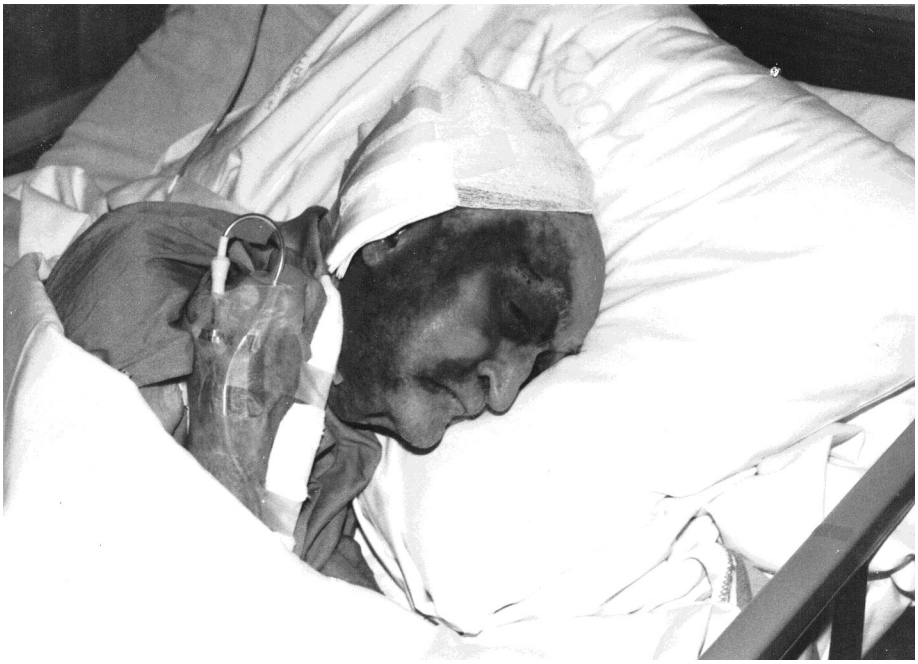
THE NEED FOR CRIMINAL INVESTIGATIONS INTO CONDITIONS IN ONTARIO'S LONG-TERM CARE INSTITUTIONS



"No due process. No rights and no humanity. This legacy and the intended wiping out of the memories of loved ones who have died because of the negligence of long-term care providers is surely unacceptable to say the least. One would expect that our laws are there to promote and protect the well-being of our citizenry."

(Marvin Zuker, 2020.
Retired Judge Ontario Court of Justice,
Associate Professor, University of Toronto,
Co-Founder Seniors for Social Action Ontario)

Dr. Patricia Spindel, Chair, Seniors for Social Action (Ontario)

November, 2024

In memory of Dr. Birthe Jorgenson, a good friend, and lifelong advocate for elders, the environment, and for a better world.

THE NEED FOR CRIMINAL INVESTIGATIONS INTO CONDITIONS IN ONTARIO'S LONG-TERM CARE INSTITUTIONS

THE HISTORY

> "In 1986, Criminologist Birthe Jorgensen published a research paper, Crimes Against the Elderly in Institutional Care. The paper is based on Dr. Jorgensen's analysis of complaints about treatment of residents in nursing care facilities brought to the attention of Concerned Friends of Ontario Citizens in Care Facilities. Her findings revealed that approximately 46 percent of 56 detailed complaints received held sufficient grounds for the laying of criminal charges of theft, assault or breach of the legal duty to provide the necessaries of life or proper medical care established by certain sections of the Canadian Criminal Code. Although Dr. Jorgensen acknowledged there are obstacles to criminal prosecutions, including the vulnerability of elderly victims to retaliation and the unfamiliarity of much of the general public, including the police and crown prosecutors, she nevertheless concludes that such prosecutions can and should be initiated."
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> (Statement by Continuing Care Watch, 2022, quoted by RISEN Warrior Senior Advocacy Crusade ASLM All Senior Lives Matter, January 20, 2022).

In the aftermath of Dr. Jorgenson's report, on November 3, 1986 Robert Nixon rose in the Ontario Legislature to make this statement:

> "On Friday, the Minister of Health asked his cabinet colleagues to review the report with a view to determining whether an Ontario Provincial Police investigation was warranted. That review was begun immediately, and I am now able to tell the House an OPP investigation will be launched. A detective inspector of the OPP met with crown law officers and an official of the Ministry of Health earlier today to lay some of the groundwork for the investigation." (Hansard, November 3, 1986).

In 1986, a Liberal government in Ontario took action to ask the OPP to investigate crimes against residents in long-term care institutions based on Dr. Jorgenson's report.

In 2022, in spite of a public press release by Seniors for Social Action Ontario calling for criminal investigations in nursing homes where 4500 or more residents died during the pandemic and the Canadian military documented horrendous conditions, many of which would likely rise to the standard of failure to provide the necessaries of life, the Ontario government failed to request a similar investigation by the OPP. In fact the government went further, protecting operators of these facilities legally by requiring that lawsuits brought by families of the dead meet higher legal standards in order to succeed (Wilson, 2020).

A NEW CALL FOR A CRIMINAL INVESTIGATION INTO ALLEGED CRIMINAL ACTS IN LONG-TERM CARE FACILITIES

Since the Canadian military documented what appear to amount to criminal acts in long-term care facilities, including failure to provide the necessaries of life and reasonable medical and nursing care to residents during the pandemic, these failures continue, as documented in Ministry of Long-Term Care inspection reports.

Seniors for Social Action Ontario wishes to extend its thanks to those inspectors who have shown the courage of their convictions in documenting these conditions. Yet in spite of the efforts of its own inspectors to document these conditions in long-term care facilities with very problematic histories, the Ontario government continues to fail to act. It has not called for an OPP investigation into documented cases that appear to meet the level required for charges under Canada's Criminal Code.

Criminal Code, R,S,C,, 1985, c. C-46 Section 215 is clear in its definition of failure to provide the necessaries of life placing every person under this duty to a person "under his charge if that person is unable by reason of detention, age, illness, mental disorder or other cause to withdraw himself from that charge, and is unable to provide himself with the necessaries of life".

Criminal Code, R.S.C., 1985, c. C-46 Section 219 is also clear in its definition of criminal negligence as doing anything or omitting to do anything that it is his duty to do that shows wanton or reckless disregard for the lives or safety of other persons (Criminal Code of Canada, 1985).

Seniors for Social Action Ontario has reviewed conditions in the five facilities contained in the Canadian military report. This report will show that life-threatening conditions and failure to provide the necessaries of life continue in most of these facilities without any resulting action on the part of the Ontario government to ask the OPP to investigate.

Eatonville Care Centre

By April, 2020, the press was reporting 34 dead at Eatonville Care Centre (Shephard, 2020). 77 staff were also recovering (Aguilar, 2020). Eatonville was, at the time, owned by Rykka Care Centres, as was the next facility listed in this report, Hawthorne Place. In total Rykka had three facilities accounting for 71 resident deaths in April 2020 (Draaisma, 2020). Rykka continues to operate these facilities.

In May, 2020, the Canadian military documented numerous instances of grossly substandard care in this facility that included: inadequate infection prevention and control including infected residents housed with non-infected residents; non-hygienic supply issues; medications not given for pain and expired medications being used; failure to post needed information concerning care in a patient's room presenting a safety risk to residents; COVID status of residents not updated or

available; inaccurate charting; untrained staff and severe understaffing; vital signs not taken; patients not repositioned in bed; aggressive and abusive behavior by staff including not stopping or slowing when residents report pain, pulling residents, aggressive transfers, degrading and inappropriate comments directed at residents; catheter care that resulted in physical harm to residents including abnormal discharges, bleeding, and bleeding fungal infections, some of which resulted in no required follow-up treatment.

A general culture of fear to use supplies important for care of residents existed in this facility, including fluid bags, dressings, gowns, extra soaker pads, and gloves was reported by the military, with key supplies kept under lock and key. Failure to use these supplies could result in bedsores and infections, yet these supplies appear to have been deliberately withheld in this facility.

It is clear from the military report that there were several instances of failure to provide reasonable nursing or medical care, necessaries of life, and of abusive behavior by staff. Nevertheless there was no follow-up requested from the OPP by the Minister responsible or the Ontario government.

Today, numerous care-related issues continue to be documented by inspectors in this facility. Some appear to rise to the level of criminal conduct as outlined in Sections 215 and 219 of the Criminal Code. These include:

- A resident at high nutrition risk not being provided additional labeled food items at meals as per dietitian recommendations. These items were not provided by the dietary department. This presented an increased nutritional risk to the resident.
- Food temperatures were not taken prior to serving thereby increasing the risk of food borne illnesses.
- Failure to post signage outside a resident's room increased the risk of transmission of an infectious disease in the facility thereby endangering other residents. (Ministry of Long-Term Care Inspection Report, August 21, 2023 https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=31657&FacilityID=20238
- By May 17 2024, there were still serious care-related problems in this facility including subjecting at least one resident to a risk of poor hygiene and infection, and at least one other to risk of skin breakdown. Residents' safety and well-being was also in jeopardy because of failure to intervene appropriately when residents abused other residents. The presence of infection in a resident was not documented or monitored (Ministry of Long-Term Care Inspection Report, May 17, 2024 https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=33459&FacilityID=20238)

It should be obvious from these reports that this facility remains at risk of outbreaks of infectious disease that puts residents at risk of illness or death, and that other care-related issues continue to cause harm to residents.

Hawthorne Place

In May, 2020 the Canadian military also documented instances of grossly substandard care in this facility that included: poor training related to infection prevention; gross fecal contamination in patients' rooms; a near 100% contamination rate for equipment, patients and the overall facility; poor cleanliness standards; insect infestation; not changing soiled residents leading to skin breakdown; abusive behavior including forceful and aggressive transfers; little to no repositioning of bedridden patients; forced feeding and hydration resulting in choking and aspiration; residents crying for help receiving no assistance; high risk of dosing errors with narcotics; residents not bathed for weeks; dangerous feeding practices; lack of charting causing gaps in information; tube feeding not changed and contents found foul and coagulated; catheters in situ weeks beyond scheduled change dates; topical prescription medicine shared between patients; lack of appropriate wound care and wounds occurring due to improper packing and non-sterile technique; wound care supplies locked away; no crash cart for cardiac arrest; linen shortages; residents left uncared for; no RN in the building or 1 RN for 200 patients; staff disappearing and leaving the floor unattended; food left on tables, but residents unable to feed themselves.

It should be obvious that many of these findings by the military rise to the level of failure to provide the necessaries of life, assault, and failure to address a duty to provide care, all of which required criminal investigations yet none were requested of the OPP by the Ontario government.

Numerous care-related issues continue to be documented by inspectors today, with some likely also rising to the level of criminal conduct as outlined in Sections 215 and 219 of the Criminal Code. These include:

- Failure to transfer resident to hospital after a fall increasing the risk of delayed treatment causing further complications;
- Lack of collaboration regarding falls prevention possibly resulting in further risk of injury to residents;
- Resident not protected from sexual abuse by other resident(s).
- "The home submitted a CI report on a specified date, related to staff neglect of a resident that resulted in harm. The resident was transferred to the hospital on a specified date, with several health related issues and subsequently passed away. Record review showed a pattern of inaction by staff when the resident's health started to decline"(Pg. 8/9) "Failure to assess and intervene when there was a change in resident's health status, placed them at increased risk of compromised care and negative health consequences."
- Failure to comply with the Act and Regulations resulted in a monetary penalty against this facility for PSW's failing to adhere to care plans especially regarding falls prevention and showering. (Ministry of Long-Term Care Inspection Report, December 18, 2023 https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=32448&FacilityID=20595)

On September 24, 2024 an inspection was conducted in this facility where a Written Notification was issued against the facility for failure to report a criminal incident to police. The report acknowledges that "failing to immediately notify the police of alleged incidents of abuse placed residents at risk of harm" Pg. 6 (Ministry of Long-Term Care Inspection Report, September 24, 2024 https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=35125&FacilityID=20595)

This was forwarded to the Director under the Act and a monetary penalty of $16,500. was applied since it was the third time the facility had not complied. Compliance Order and Administrative Monetary Penalty issued for $5,500 on December 18, 2023. Compliance Order and Administrative Monetary Penalty issued for $11,000 on June 28, 2024. Pg 10 Inspection Report https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=35125&FacilityID=20595

Monetary penalties but no referral for investigation by the police? Clearly residents of this facility were not protected from abuse. Due to documented neglect, and failure to provide care and supervision residents were obviously at increased risk of physical harm and hospitalization. One resident died due to neglect. No referral for criminal investigation of this incident was every made.

The Minister ducked by saying it was up to the Coroner's Office to determine if there was enough evidence to call in the police. Toronto police said they had not received anything from the Coroner's Office related to deaths at Hawthorne Place. That office also apparently also failed in its duty to report clearly documented evidence of breaches of the Criminal Code to police.

The Ontario Provincial Police also reported that they were not aware of any ongoing criminal investigations into deaths in the facilities that were the subject of the military report. Instead the OPP was reviewing the report of the COVID 19 Commission (Beattie & Reddekopp, 2021).

Orchard Villa

By June, 2020 local Durham Region press was reporting 78 dead at Orchard Villa (Follert, 2020) during the first COVID wave – the highest death and infection rate in the province.

The Medical Officer of Health had, in April, 2020, ordered the facility to work with the local hospital, Lakeridge Health, to save lives.

By April 28th things were so bad that the Canadian military had to be called in and what it reported described the depths of hell for the helpless residents of this facility. Residents' experiences have also been documented in A Perfect Storm: The Tragic Story of Orchard Villa (Spindel, 2020).

Not only did the Ontario government not ask for a police investigation of the actions of management and owners of this facility, it later approved a major bed expansion and attempted to force a Minister's Zoning Order (MZO) on Pickering City Council that had voted

unanimously to reject the MZO that would have allowed Southbridge to build a 15 storey institution on the Orchard Villa site (Howlett, 2023).

A court challenge by a daughter of one of the residents who died concerning the granting of this license was recently heard by a panel of judges of the Ontario Divisional Court (Ontario Health Coalition, 2024).

Here are the conditions described in Orchard Villa in May, 2020 by the Canadian military:

Cockroach and fly infestation; rotten food smell in hallway with multiple old food trays stacked on a bedside table; inappropriate personal protective equipment throughout the facility, doctors included, and poor infection prevention and control practices; residents left in soiled diapers; mouth care and hydration lacking; positioning not occurring; residents being fed lying down with a danger of aspiration - observation of an incident like this that appears to have led to a resident's death; unsafe nursing medication administration errors; food and belongings placed outside of residents' reach; resident's fractured hip not addressed; multiple falls without being assessed; lack of pain treatment; liquid oxygen generators not filled and unusable; inaccessible wound supplies; suction units not functional; oxygen concentrators not accessible; residents lying on bare mattresses because of lack of access to fresh linens and soaker pads; ability to report incidents and access assessments not occurring causing confusion in provision of care; communication issues throughout the facility between staff; lack of training for new staff; no accountability for staff regarding basic care; RN's working with no access to the charting system.

What the military reported were obviously instances of failure to provide adequate medical and nursing care and in some cases failure to provide the necessaries of life that demanded criminal investigation, yet no police investigation ever occurred in spite of residents' families asking for one (Wallace & Kennedy, 2020). The Ontario government also made no criminal referrals and instead rewarded Southbridge corporation that owns Orchard Villa with more beds and refurbishment funds across the province.

It should be noted that a brand new facility owned by this corporation in Owen Sound had its admissions stopped by the Ministry of Long-Term Care Inspection Branch because of harm to residents (Carter, 2023).

Today problems continue at Orchard Villa.

- Facility maintenance continues to be a problem and residents' families continue to complain about resident care (Ministry of Long Term Care Inspection Report, November 3, 2023) https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=32228&FacilityID=20100
- Assessments after falls appear to still not be occurring;

- Equipment is still in a state of disrepair, with leakages in the facility constituting a safety hazard;
- Residents are still not being protected from abuse and neglect resulting in injury. There is a failure to report this to the Director;
- A screen missing in a resident's room creates a risk of injury or death;
- Behavioral triggers are not addressed and responsive behaviors are still not properly managed;
- Skin and wound care is still not up to standard;
- Residents still experience unmanaged pain;
- Kitchen staff are not wearing hair restraints putting residents at risk of unsanitary conditions and a chain of transmission of infections;
- Food is not stored properly creating a risk of contamination and food borne illnesses;
- There is a lack of timely assistance with eating so food is served tepid increasing risk of food borne contamination;
- High water temperatures creating risk of skin injuries for residents;
- Treatment resulting in injury not reported to the Director;
- Lack of documentation of effects of medications on residents;
- Residents causing injury to other residents and interventions not initiated to prevent or minimize these;
- Kitchen, dishwashing and servery areas not kept clean increasing the risk to residents. (Ministry of Long-Term Care inspection report, May 8, 2024 https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=33306&FacilityID=20100)

In spite of compliance orders having been issued and Orchard Villa's troubled history, there has not been a full, comprehensive Proactive Compliance Inspection since August 2023 – 14 months.

It is also clear that residents in this facility remain unsafe, and that conditions there fall well below the standards set out in the Act and continue to place residents at risk of harm.

Altamont Care Community name changed to Glen Rouge Community

This nursing home owned by Sienna Senior Living is where 53 residents died during the first COVID wave. Sienna is also a company whose facilities had over 300 deaths during the onset of the pandemic. Workers described severe understaffing and lack of personal protective equipment as contributing to the outbreak (Russell, 2020).

The May 2020 the Canadian military report outlined the horrific conditions found in this facility: inadequate nutrition with residents left "underfed"; a significant number of residents with pressure ulcers from being left in bed and not having been turned; wound dressings not available or not applied by staff; wound care nurse unavailable; residents bed bound for weeks and not

washed properly when the military arrived; a resident alleged abuse and neglect by a PSW; agency staff without adequate clinical training; potentially dangerous administration of insulin to resident with low blood sugar; wrong bandages and sterile dressings being used and insufficient wound care supplies; would care not done appropriately; disagreement between physician and RPN on the administration of nitroglycerin; flooding issue in a ward and no access to accurate nominal roll of residents rooms and bed locations; medications documented as being given, but not given; evening staffing unstable; understaffing on all shifts; arguments between staff and derogatory language used; staff making degrading and inappropriate comments to residents; military staff supplementing with own food to ensure residents don't go hungry.

Many of these conditions demand criminal investigation yet none occurred.

Today in spite of the name change, little has changed at Altamont Care Centre/Glen Rouge.

Unaccompanied resident without assistive device fell and health status changed; failure of staff to respond appropriately to responsive behavior. (Ministry of Long-Term Care Inspection Report, September 15, 2023) https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=31847&FacilityID=20009

Lack of screens in windows contributing to possible harm to residents; failure to provide adequate food intake; food and fluids served were not safe or palatable increasing risk of food borne illnesses. (Ministry of Long-Term Care Proactive Inspection, March 18, 2024). https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=32799&FacilityID=20009

Failure to maintain adequate records and documentation related to an infection outbreak creating a risk of exposure to infectious diseases for residents and staff; the facility failed to report an infectious disease outbreak to the Director; the Medical Officer of Health's directives and guidance were not followed; care related complaints not addressed in timely manner; complaint concerning inadequate care related to several residents was not reported to the Director; staff failed to report abuse of resident by another staff member – no report to Director; hazardous substances were accessible to residents. (Ministry of Long-Term Care Inspection Report, September 5, 2024). https://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=34860&FacilityID=20009

Once again it is clear that this facility continues to have serious care and safety-related issues that place residents at risk yet there has been no referral for criminal investigation of these incidents.

Tendercare Living Centre

81 residents died at this facility during the COVID outbreak, and since then this facility has been cited for failing to comply with health and safety regulations including residents not receiving sufficient water, timely medication, inappropriate use of PPE, and lack of infection prevention measures (Russell, 2021).

These serious care-related problems continue in this facility as reports from 2022 onward show.

There was no back up staffing plan for nursing and personal care staffing – PSW's were handling 18 residents on some days and PSWs were not replaced when off sick (Ministry of Long-Term Care Inspection Report, January 31, 2022) https://publicreporting.ltchomes.net/fr-ca/File.aspx?RecID=29057&FacilityID=20490

Allegations of abuse of a resident by an RPN was not followed up; resident's right to refuse treatment was ignored; infection prevention and control directives were not followed; safe transferring techniques were not used. (Ministry of Long-Term Care Inspection Report, January 10, 2023). https://publicreporting.ltchomes.net/fr-ca/File.aspx?RecID=30489&FacilityID=20490

Resident experiencing unmanaged pain; failure to comply with Minister's Directive on indoor masking thereby exposing residents to infectious diseases; failure to protect a resident from neglect by a personal support worker; resident fell and transferred to hospital – no post-fall assessment completed and resident at risk of unidentified injuries; skin and wound assessment not done; infection prevention and control protocols not followed potentially exposing residents to infection. (Ministry of Long-Term Care Inspection, May, 31, 2023) https://publicreporting.ltchomes.net/fr-ca/File.aspx?RecID=31119&FacilityID=20490

A Proactive Inspection in July 2024 found: residents wearing jackets in the activity room because of low temperatures in the facility; continuous quality improvement protocols were not documented. (Ministry of Long-Term Care Inspection Report, July 12, 2024). https://publicreporting.ltchomes.net/fr-ca/File.aspx?RecID=34048&FacilityID=20490

This facility continues to experience serious care-related issues with no real penalties applied by the Inspection Branch or criminal referrals made for care issues that expose residents to risk of serious harm or death.

ISSUES IN FACILITIES REQUIRING POLICE INVESTIGATION

It should be clear to the Ministry, the Inspection Branch, and the police that a range of issues identified in the military and this report require criminal investigation.

When staff knowingly do not follow infection prevention and control guidelines four years after a pandemic, they are clearly putting residents and other staff at risk of harm. That demonstrates reckless disregard for the safety of others.

When residents are not protected from abuse or neglect by staff or other residents, they are at risk of further harm.

When abuse and neglect are not reported to the Director, there is evidence of a cover up of sometimes serious incidents where residents have been injured.

When conditions in a facility are so unsafe or unsanitary that residents are exposed to risk of falling or food borne infections, it should be clear that failure to address these issues involves doing or omitting to do something that involves a reckless disregard of the safety of others, especially extremely vulnerable people.

When residents are not fed sufficiently or given water it should be obvious that they are not receiving the necessaries of life.

Failure to transfer residents to hospital after they have suffered injuries from “unexplained” falls should also trigger criminal investigation.

Giving medications like insulin without proper training or the ability to assess whether or not the medication should be given or assess its aftermath not only potentially harms residents, but it can cause their death. Why are incidents like these not investigated as possible criminal negligence causing bodily harm or death?

Skin and wound assessments not being done or treated appropriately subjects residents to infection and bed sores. RN’s know, or ought to know this, yet skin care appears to be seriously neglected in these facilities, raising concerns about dangerous and/or neglectful medical and nursing practices.

ACTION IS REQUIRED

It appears that the same companies that own the facilities with some of the worst track records in the province continue to run them to this day. None have had their licenses not renewed or revoked. Almost none have faced financial penalties or even cease admission orders. In spite of serious care-related issues, especially at Orchard Villa, that facility is one that has not had admissions ceased.

It is time that the Ontario government protected the vulnerable residents of these facilities from actions that clearly call for criminal investigations rather than continuously shielding the operators, managers, and staff from potential criminal charges and rewarding these companies with additional beds.

It is also past the time for the responsible Ministers to act and approach the OPP with the request of an investigation of criminal acts in these facilities during and after the pandemic.

Failure to do so will mean that residents of Ontario's long-term care facilities have less protection from criminal acts now, in 2024, than they had in 1986.

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