Spindel & Associates
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LONG TERM CARE IN ONTARIO: A HISTORY OF TRAGEDY AND FAILURE

A Report Amid the COVID 19 pandemic, February – May, 2020

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This report is prepared in memory of those who have died, and in support of those residents who live with fear, and who have been harmed in long term care facilities in Ontario.

It is also an acknowledgement of the caring families who so courageously advocated for their loved ones in these facilities.

And it is an acknowledgement of the staff who had the courage to speak up on their own, or through their unions on behalf of the individuals for whom they were caring.

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The families and friends of residents of Orchard Villa who persevered irrespective of obstacles to advocate for their loved ones.
You know who you are.

Long Term Care In Ontario: A History of Tragedy and Failure

Preamble

As the people of Ontario sat in front of their TV's during March, April, and May of 2020[1], watching the death toll in long term care facilities rise[2] [3] a tragic truth began to present itself, as did some frightening questions. How could this happen? How dangerous are these places? What will happen to me when I get old? Is my relative safe in one of these places? What can be done?

The tragic truth is that the way we treat older adults and younger people with disabilities – warehousing, isolating, and putting them away in facilities – is not the way anyone should be treated, especially those with complex care needs who are in the final stages of their lives. Older people, during the most vulnerable period of their lives, should not be ripped from familiar surroundings, people, and places and forced to live with sometimes hundreds of others, with little to no privacy, cared for by strangers, some of whom are abusive and neglectful. Even the caring staff who are kind and attempt to provide good care cannot take the place of familiar faces and home.

It Won't Happen To Me

No one ever thinks they will end up in one of these places, but they do. Real estate agents, stock brokers, doctors, nurses, lawyers, politicians, truck drivers, factory workers, white collar workers, government employees – no one is safe from institutionalization in Ontario. At least one former deputy minister was also institutionalized. Premier Ford's mother in law also sadly tested positive for COVID 19 in a long term care home (Westoll, April 23, 2020), bringing the tragedy so many families were also facing home to the most powerful man in Ontario. Visibly shaken at a news conference, he said that his heart was breaking for residents and their families - as were all of our hearts.

But with almost one third of people who reach the age of 85 living in a long term care facility, chances are almost one in three (31.6%) of ending up in one if one lives long enough (Elections Canada, 2012).

Anyone currently in power, and formulating long term care policy in Ontario, who believes that they will never end up living with the results of their decisions in a long term care facility is

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[1] "More than 70 per cent of COVID 19 fatalities in Essex County" occurred in just three long term care homes. https://windsorstar.com/news/local-news/death-toll-rising-at-local-long-term-care-homes/

[2] As of April 22nd, 2020 almost 400 had died in long term care facilities. https://torontosun.com/news/provincial/rate-of-new-cases-tapers-off-but-ontario-death-toll-grows

[3] By the end of April, that number had climbed to 530 and was continuing to rise (Public health Ontario, Epidemiologic Summary, January 15, 2020 – April 29, 2020). https://files.ontario.ca/moh-covid-19-report-en-2020-04-30.pdf

sadly mistaken. It does not matter how wealthy someone is, or how fit and healthy they are, old age may bring changes that they never anticipated.

Those who believe they will have time to take "a little blue pill" so that would never happen to them may find themselves shocked after a stroke or critical illness to realize that they are not in a position to even take their own lives, and that others will decide their fate.

For all of these reasons, long term care reform is in all of our interests – old, young, powerful or not.

Younger People Are Also Admitted

Older adults are not the only ones living in long term care facilities. All it takes for a young person to become disabled is a car accident or a serious illness. 6.6% of younger people, aged 0-64 who have developmental and/or physical disabilities are also forced to live in these institutions[4] (Long Term Care Association, 2019) because, as is true for older adults, smaller residential alternatives are seldom available for those who are unable to be cared for at home, and very little funding is available for home-based support.

In 2016, the Ombudsman of Ontario in his report Nowhere To Turn, detailed "1,400 complaints from families of adults with developmental disabilities who are in crisis situations, including being abandoned, abused, unnecessarily hospitalized and jailed." (Ombudsman Ontario, 2016). Smaller, community based homes, called group homes, often have decades long waiting lists (Viau, August 12, 2019), and home care provides so few hours of support to individuals and their families that it is not an alternative to having to place someone in a facility. Jo Anne Poirier of the Victorian Order of Nurses had this to say: "home care is in desperate need of a fix. Services are rationed, rigid, and difficult to access. Policies contribute to high staff turnover and to the widespread shortage of community nurses and personal support workers."(Poirier, February 20, 2020).

The question is "what can be done"?

This report provides some answers to this and other questions including "what can be done to stop the abuse, neglect and, it has to be said, possible criminal acts being committed against residents of these facilities that are detailed in inspection reports?" And "what alternatives are there to institutionalizing people who require the care of others?"

[4] In July, 2006 a joint Long Term Care Access Protocol For Adults With A Developmental Disability was developed by the Ministry of Community & Social Services and the Ministry of Health and Long Term Care that paved the way for younger people to enter these facilities in the absence of community residential and other support services that sometimes had decades long wait lists. This reversed years of more progressive policies aimed at ensuring that people with disabilities remained in their communities with the necessary supports. Tragic press exposes followed showing that families were left little choice but to place young people – some as young as 21, with developmental and other disabilities in these institutions. Please see: Nowhere Else To Go, Trish Crawford, Toronto Star, Feb. 16, 2007. https://www.thestar.com/life/2007/02/16/nowhere_else_to_go.html

This report also provides a description of long term care in Ontario, and details, based on inspection reports, what is actually occurring in many long term care facilities across the province.

It also contains comprehensive recommendations on what actions government can take to address the shortcomings in the long term care system and provide other alternatives.

THE LONG TERM CARE PICTURE IN ONTARIO

Who Provides Long Term Care In Ontario?

Long Term Care Facilities

Long term care is provided in government funded long term care facilities, and in unfunded institutions, called retirement homes, as well as community-based congregate or group living homes.

627 long term care facilities are licensed to provide services to primarily older adults in Ontario with 78,500 beds (Central East Local Health Integration Network; Ontario Ministry of Health and Long Term Care, February 2018). They are funded by the provincial government with residents and their families paying co-payments.

Private, For-Profit Facilities Have The Advantage In Getting New Beds

58% of these homes are operated for-profit, often by large, multi-national corporations, some of which trade on the stock exchange.

Having this high a percentage of long term care facilities operated by large companies became problematic during the pandemic as for-profit homes had much higher numbers of deaths than non-profit and municipally operated homes (Oved et al, May 8, 2020).

One of the reasons why municipalities have such difficulty competing for long term care beds so that more could be provided in the non-profit sector is that government proposal calls tend to have only a two week turnaround. For non-profits with Boards, and municipalities that must get things passed by Councils, this is not enough time to allow them to compete, and puts them at a serious disadvantage. Hence most of the beds go to for-profit companies. In this way, the government advantages for-profits over not for profit bidders, almost ensuring that all or most new beds will go to for-profit companies.

"Lisa Levin, CEO of AdvantAGE, an association representing non-profit services for seniors in Ontario, including long-term care, housing and community services, says it's important that beds be allocated to all types of facilities, regardless of funding model: private, as well as community-based not-for-profit, charitable and municipal. The last time the province put out a call for proposals for new LTC beds, in April 2018, people had two weeks to put together their pitches. "Municipal homes weren't able to respond," says Levin. "They have unique circumstances and

everything goes through council." Large chains, she says, have an easier time applying for beds, because they have proposal writers on staff and a quick internal approval process." (Izenberg et al, September 13, 2018).

Only 24% of beds are not for profit, often operated by charitable organizations, and about 16% are municipally operated.

The government bidding process described earlier goes a long way towards explaining why these numbers are as low as they are.

Long term care facilities also tend to be large. Approximately 60% of these homes have more than 100 beds, with only 40% being under 96 beds (Ontario Ministry of Health and Long Term Care, February, 2019; Ontario Long Term Care Association, 2019)

Retirement Homes

Retirement homes are not government funded, but rely entirely on payments made by residents and their families (Government of Ontario, 2020). Residents can expect to pay anything from about $1453.00 per month to upwards of $4500.00 and some homes charge much more depending upon their size, location, and the number of amenities offered (ComfortLife, 2020).

They are regulated under the Retirement Homes Act (2010) by the Retirement Homes Regulatory Authority (RHRA, 2011), "an independent, self-funded not for profit regulator" (RHRA, 2020). RHRA inspects homes, responds to complaints, and is empowered to address compliance and risk issues in these homes.

The Minister responsible is the Minister of Seniors and Accessibility appointed in 2017. This Minister is responsible for the safety and security of older adults, and for implementing the Retirement Homes Act, overseeing the RHRA, and delivering Ontario's Strategy to Combat Elder Abuse (Ontario, 2018).

RHRA also provides information to operators and the public through its database. RHRA did provide information on which retirement homes had outbreaks of COVID 19 during the pandemic – 86 homes had outbreaks, but there was no listing of how many residents were affected and how many died on the RHRA website (RHRA Outbreak Report, April 30, 2020).

Wait Times For Long Term Care Beds

Information provided by Health Quality Ontario (2018/19) shows the median wait time for those seeking a bed in a long term care facility is 161 days, whereas if they enter from hospital it is 90 days. Approximately 36,245 people were waiting for long term care beds as of September, 2019 (Boyle, September 16, 2019).

As with younger people with disabilities these high wait times reflect the Ontario government's complete lack of a plan to provide smaller, community-based alternatives to these facilities that could be operated by municipalities or other non-profit groups. Older adults have literally no

options but long term care institutions once their care needs exceed those that families are able to provide.

The sad state of home care and lack of in-home (Crawley, January 7, 2020) and other respite programs compounds this problem significantly and contributes to the high number of people on these waiting lists. Individuals attempting to return home from hospital listed lack of adequate home care as their major concern. “The three biggest problems for patients surveyed about their discharge from Ontario hospitals all concern publicly funded home care, according to new research published in an international medical journal” (Crawley, January 7, 2020).

Non-Profit Community-Based Programs

Supported Independent Living (SIL)

Supported Independent Living (SIL), Group Homes, Specialized Homes, and Family Homes for people with disabilities became popular in the 1970’s. Prior to that many people with developmental and physical disabilities were forced to live in terrible conditions in large institutions like Huronia Regional Centre or Rideau Regional Centre (Loriggio, December 9, 2013).

SIL programs separate housing from support services, so residents live in their own apartments or condos (leased or owned) and the Ministry of Community and Social Services pays the service costs in order to allow housing flexibility. Individuals who provide care and support can be trained by the residents themselves, family members, or by an agency. These programs were established to provide an alternative to institutions such as nursing homes or other unsuitable environments (Ontario Association of Independent Living Service Providers, 2017).

Group Homes

Group homes are 24 hour staffed residences of 6-8 people usually operated by social services agencies such as Community Living Associations that provide assistance with activities of daily living and aim to include residents in their communities.

Specialized Homes

Specialized Homes are residential homes in the community that often have built in mental health or other specialized behavioral supports for residents.

Family Home Program

Family Homes are provided through the Host Family Program to adults with developmental disabilities who live with host families who provide the support, care and services that they require. The goal is to create positive relationships over the long term and integration into the community.

All of these community-based programs are funded by the Ministry of Community and Social Services (Ontario Ministry of Community & Social Services, 2018).

Almost none are available to older adults.

Who Lives In Long Term Care Institutions?

The Long Term Care Association claims to support and care for over 115,000 people and their families every year with 78,500 beds in long term care facilities. 90% of residents in these facilities experience cognitive challenges. Over 80% have neurological disabilities, and more than 80% need assistance with activities of daily living. Half are over the age of 85 (Long Term Care Association, 2019).

Who Funds Long Term Care Facilities in Ontario?

Government Funding

Local Health Integration Networks (LHINs) fund licensees of long term care homes according to an approved per diem (cost per day), that is set by the Ministry of Health and Long Term Care for every licensed bed under the Long-Term Care Homes Level-of-Care Per Diem, Occupancy and Acuity-Adjustment Funding Policy (Ontario Ministry of Health and Long Term Care, MOHLTC, May, 2019).

Other funding and financial management policies, applicable service accountability agreements, and applicable laws may also have an impact on funding for these homes, however, per-diems are the primary funding mechanism.

The base level of care per diem can be modified by a Case Mix Index (CMI) or acuity adjustment, meaning that a home will be paid a higher amount if it can be shown that a resident requires more care. "The LOC (Level of care) per diem amount for the NPC (nursing and personal care) envelope may vary among beds as the amount may be adjusted based on resident acuity; specifically the base amount is adjusted by the home's Case Mix Index (CMI)" (Ontario Ministry of Health and Long Term Care, May, 2019).

There are four funding "envelopes" that include:

- **nursing and personal care (**which includes an acuity and non-acuity adjusted portion). This includes "expenditures related to nursing and other direct care staff who assess, plan, provide, assist, evaluate, and document the direct care provided to residents; as well as, supplies and equipment used by staff to provide care to residents."

- **program and support services** -"funds expenditures related to staff and equipment related to programs and therapies provided to residents";

- **raw food - "**funds expenditures related to the purchase of raw food including food materials used to sustain life including supplementary substances such as condiments and

prepared therapeutic food supplements ordered by a physician, nurse practitioner, registered dietitian, or registered nurse, as appropriate, for a resident. It excludes costs related to other programs and cost of food preparation."

- **other accommodation** -"funds expenditures related to housekeeping services, buildings and property operations and maintenance, dietary services (nutrition/hydration services), laundry and linen, general and administrative services, and costs that will maintain or improve the care environment of the LTC home."

  Reference: (Ontario Ministry of Health and Long Term Care (MOHLTC), May, 2019).

However, these funding envelopes are not hard and fast because a licensee can apply surplus funds from one envelope to offset expenditures in another envelope under certain conditions (except for the raw food envelope) established in the Long-Term Care Homes Level-of-Care Per Diem, Occupancy and Acuity-Adjustment Funding Policy.

Types of Beds In Long Term Care

There are five types of beds in long term care homes:

- **Long stay beds** (for 24 hour on site nursing care, assistance with activities of daily living, and on-site supervision and monitoring to ensure well-being of residents);

- **Short stay beds** (essentially respite or temporary relief beds – maximum length of stay is 60 days, but up to 90 days in a year if respite and convalescent care are combined – these beds are also adjusted for resident acuity);

- **Unclassified beds** (newly licensed beds funded at a base level of care where new residents' care needs have not yet been calculated – Case Mix Index (CMI) of 1.0);

- **Convalescent care beds** (these are used to support the recovery of residents, usually those returning home from hospital, who will return home within 90 days. The per diem is not adjusted based on a CMI and these beds receive the base per diem funding, but they may receive an additional subsidy allocated between the nursing and personal care, program and support services, and other accommodation funding envelopes. This subsidy is set by the Ministry and updated from time to time);

- **Interim beds** (these receive the base level of care per-diem at a CMI of 1.0 for the applicable period). (Ontario Ministry of Health and Long Term Care (MOHLTC, May, 2019).

There is also a funding formula for these beds that takes into account the case mix index (CMI). The funded CMI of a home times the classified bed count, times the nursing and personal care per diem, times the number of days of a period under consideration will determine the funding level.

The CMI measures "the relative resource use based on residents' acuity [and it] represents the average acuity for all of the residents in a home in a given year" (Ontario Ministry of Health and Long Term Care (MOHLTC), May, 2019). The CMI is determined using resident assessments that are reported through a Resident Assessment Instrument – Minimum Data Set (RAI-MDS).

In addition to all of this, the Ministry also applies Resource Utilization Groups (RUGs) - another classification system that groups residents with similar resource utilization based on levels of care and treatment. "Each resident's assessment is assigned to the highest weighted RUG cell that they are qualified for based on the reported medical conditions, activities of daily living, nursing rehabilitation and therapy. For each assessment, the number of assessed days in the assessment period is calculated and multiplied by the RUG weight to give RUG Weighted Days (RWD). These values are summed for all assessments at the home in the assessment period and the ratio of RWD to assessed days is the CMI of a home." (Ontario Ministry of Health and Long Term Care (MOHLTC), May, 2019).

Two Measures of Case Mix Indexes (CMI's)

Reported and funded CMI's are also used.

•**Reported CMI**: This represents the CMI derived from the data reported by a home. Special Rehabilitation (SR) Limited CMI: This represents the CMI derived from the application of a maximum of 5% limit to the assessed days assigned to the SR RUG category.

•**Funded CMI**: This represents the CMI used for NPC funding and is derived following adjustments to the reported CMI. Key determinant for the change in the NPC funding for a home is the funded CMI."

Reference: Ontario Ministry of Health and Long Term Care (MOHLTC), May, 2019.

If you think this is a very complicated funding formula, you are correct.[5] It is almost impossible for a lay person to be able to determine what funding should be assigned to a home or to each resident.

[5] The Ontario Health Coalition in its January 2020 report, Caring in Crisis reported the following: "Provincial government data shows that the Case Mix Measure (a key measure of acuity) increased by 12.2 per cent overall from 2004 –2009 and the Case Mix Index increased by 7.63 per cent from 2009 – 2016. These are measures on two different scales but they both reveal dramatic increases in levels of care needs. The MAPLe score (Method for Assigning Priority Levels) is used by care coordinators to classify clients according to their level of care needs. The MAPLe score of residents was 76 per cent in 2010. By 2016 it had increased by 8 per cent to 84 per cent, a very significant leap in 6 years alone. Today, the vast majority (84 per cent) of those currently admitted to long-term care homes are assessed as having high and very high needs. Government data reveals that 81 per cent of individuals in long term care have some form of cognitive impairment with nearly 1/3 displaying severe cognitive impairment. As many as 86 per cent of individuals diagnosed with dementia will experience displays of aggression as the disease progresses. Nearly half of residents in long-term care display aggressive behaviours." (Page 7) https://www.ontariohealthcoalition.ca/wp-content/uploads/final-PSW-report-for-tour.pdf

Resident Funding

Residents are responsible for paying for accommodation under the Long Term Care Homes Act (2007), and this is called a co-payment.

If someone is unable to pay the full basic accommodation charge, Regulation 79/10 allows for a rate reduction for anyone who is eligible. Rate subsidies are available up to $1891.31 per month, but only for basic accommodation (Ontario government, 2019).

Four bed wards which are now considered basic accommodation, are slated for elimination. The for-profit sector is making a case that when licenses expire in 2025, in order to acquire new licenses many of the homes that require extensive renovation (about 70%) will need to eliminate four bed wards. "Of the roughly 78,000 LTC beds in the province, 30,000 are in homes that need to be redeveloped, says Candace Chartier, CEO of the Ontario Long Term Care Association, which represents nearly 70 percent of LTC homes in Ontario. These homes, many of which opened in the '70s and '80s, have licenses that will expire in 2025, and in order to acquire new licenses, one thing the homes need to do is eliminate any four-bed wards. This means these LTC homes must renovate existing facilities or build new ones—either way, they will need new beds. The OLTCA wants these homes to be first in line for the first half of the promised beds which the Ministry has said will be added in the next five years."(Izenberg et al, September 13, 2018).

It is time that the Ontario government levelled the playing field and facilitated municipal and non-profit homes' abilities to bid on long term care beds. This is especially true in light of the much higher death rates found in for-profit homes during the pandemic (Oved, May 8, 2020)

Any revenue generated from these accommodation charges is deducted from the total of the four funding envelopes. It should be noted that it is this Other Accommodation funding envelope from which profit can also be taken in the privately operated homes.

As of July 1, 2019, the resident co-payment in long term care facilities is:

Basic long stay	$62.18 per day ($22,695.70 per year)
Semi-Private long stay	$70.70 - $74.96 per day
Private long stay	$81.35 - $88.82
Short stay (Respite)	$40.35

(Long Term Care Association, 2019)

Recent Increase in Global Funding for Long Term Care Homes

As of April 1, 2019 there was a global increase in per diem funding to the level of care per diem provided to long term care homes not adjusted to the Case Mix Index. This was done to "enhance direct care services as well as to support other operating costs within any of the four envelopes" with unspent funds subject to recovery (Ontario Ministry of Health and Long Term Care (MOHLTC), May, 2019).

This was a boon to the homes since they could allocate up to 32% of the global per diem funding amount to the Other Accommodation envelope – the one from which profit can be drawn in for-profit homes.

The rest (68%) had to be applied to the other envelopes. What this means is that only 68% of this global increase was actually earmarked for application to resident care and support. This raises an important question. Should any taxpayer funds be going into the pockets of the for-profit long term care industry? The government of Ontario has allowed up to 32% of the global per diem to go into the funding envelope from which long term care companies draw their profits.

Is Calling For More Funding The Answer?

The Ontario and Canadian Long Term Care Associations that represents long term care facilities and the companies that own them have successfully lobbied for increases in funding on behalf of their members for decades, arguing that their residents are older and sicker than ever before, and that they need more staff. Even though government has poured billions into funding long term care homes, it is never enough according to their associations, who appear to use every story about substandard care and now high infection and death rates in their facilities as reasons to lobby for even more funds for their members.

But are their claims true? How would we know? Is there publicly available verifiable information on how government funds are spent in long term care facilities? Does government regularly monitor them to ensure that the funds that are provided actually go into staffing and supplies, and how would the public gain access to information about this for each home? The answer appears to be that neither the public nor the government has effective monitoring, accountability, and reporting systems that would allow them to determine whether or not the funding being provided from the tax base is being spent on providing the highest quality of care to residents, and to determine how much of it is going into profit margins of the large companies.

Consequently this seems a peculiar strategy by the long term care lobby in the sense that the companies that own these homes appear not to be subject to the kind of financial accountability that would require that they make their actual profit margins public. With neither government nor the public having accurate information about how much these long term care companies make in profit, it is difficult to determine whether their claims that more funding is needed are accurate.[6]

[6] As of 2018 the Ontario government invested 4.28 billion (7% of the overall provincial **health** budget) in long term care facilities - $149.95 per resident, per day ($54,730 per year) - approximately $100.91 per day for nursing and personal **care** (such as assistance with personal hygiene, bathing, eating, and toileting) Ontario Long Term Care Association - https://www.oltca.com/oltca/OLTCA/Public/LongTermCare/FactsFigures.aspx

Profit or People?

Even before COVID 19 struck in 2018, over 200 families joined a lawsuit, known as a "mass tort" against Revera, Extendicare, and Sienna Senior Living alleging that "the nursing homes they paid to look after their loved ones failed them miserably."

The suit says that "Extendicare, a public company with revenues of a billion dollars a year from all sources which includes 96 long term care homes across Canada" paid its President and CEO just under $4 million, and also paid $37 million in dividends to shareholders in 2017. As well, Sienna has "annual operating revenues of more than $500 million which includes 45 long term care homes" paid its CEO just over $1.2 million and paid out $36 million in dividends to its shareholders. Revera does not report financial data, but operates 73 homes."(O'Keefe, November 2, 2018).

The pandemic has shone a light on the degree to which the system of for-profit facilities places residents in more danger than non-profits. A Toronto Star investigation has revealed that "residents of for-profit nursing homes in Ontario are far more likely to be infected with COVID-19 and die than those who live in non-profit and municipally-run homes"(Oved et al, May 8, 2020).

Simply demanding more funding for these homes and private corporations appears not to be the answer without effective financial accountability mechanisms and monitoring systems to ensure that taxpayer dollars actually go into the care of residents and staffing instead of the pockets of large multi-national nursing home companies that families allege are failing their loved ones and not providing the care promised.

Who Are The Care Providers In Long Term Care?
Personal Support Workers

Personal support workers (PSW's) are the primary care providers in long term care facilities, making up about 85% of staff according to their Association (Personal Support Network of Ontario, 2020).

PSW's are unregulated health care workers who receive a Certificate[7] rather than a Diploma upon graduation. They generally earn between $12.50 - $23.00 per hour (Personal Support Network of Ontario, 2020). Average starting salaries are around $28,000 per year (ontariocolleges.ca).

PSW's working conditions are often quite appalling. Even though they are unregulated and often earn $20.00 per hour or less, they perform the most intimate tasks for residents – bathing, dressing, feeding.

Long term care facilities prefer to hire part-time staff rather than full-time because they cost less. This requires that most PSW's have to combine part-time jobs in several facilities and/or community agencies to make ends meet, and this proved very problematic during the 2020

[7] Certificates are generally one year and are offered by community colleges. Diplomas are usually 2-3 years.

pandemic as PSW's traveled from home to home and out into the community to provide care (Mitchell, April 7, 2020). Having to work in these kinds of conditions has created what the Ontario Health Coalition terms a critical shortage of PSW's in long term care. Representing more than a half million Ontarians in 400 member organizations as diverse as seniors groups, unions, nurses and other health care professionals, non-profit community agencies and cultural organizations, they speak with a strong voice when it comes to understanding conditions in these facilities.

The Ontario Health Coalition charges that:

- "In every town, in virtually every long-term care home, on virtually every shift, long-term care homes are working short-staffed (short 1 – 2 PSW's on almost every shift, a shortage of 5-10 PSW's in every 24 hour period. Some homes were reported to be short 20-50 PSWs in 24 hours)." This means that many residents are not getting even basic care in these homes. (Ontario Health Coalition, January 2020:7);

- With wages not much higher than the minimum and heavy workloads, PSW's are leaving to work in retail, restaurants, in housekeeping positions, and in hospitals and school boards where they can find better pay and working conditions. Many of the best are leaving the system;

- Residents have more care complexities (medication, comorbid conditions, dialysis, palliative care, post-operative pain control and management, suctioning etc);

- Long term care facilities are generally not designed to provide this kind of complex care (and previous governments eliminated chronic care hospitals that could provide this kind of care);

- People with aggressive behaviors are being discharged from hospitals to long term care facilities in crisis admissions, while half of the homes have no in-house Behavioral Supports Ontario (BSO) Program (Ontario Health Coalition, January, 2020). .

Other reports also seem to support the assertion that aggressive residents are a serious problem in long term care facilities with almost 90% of long term care workers reporting physical violence in their workplaces (Davis, April 10, 2019).

"One peer-review study entitled, "Breaking Point: Violence Against Long-term Care Staff," was conducted by Canadian researchers, Dr. James Brophy and Dr. Margaret Keith, who are associated with the University of Windsor and the University of Stirling in the United Kingdom. They held group interviews with 1,000 long-term care staff in seven Ontario communities. Their report concluded that long-term care staff are "bloodied and broken," both physically and psychologically. "Long-term care homes in Ontario are largely staffed by women. Their work is based on compassion and care," stated Keith. "And yet, they themselves are expected to tolerate an environment in which physical, verbal, racial and sexual aggression are rampant. Adding to their burden is the implicit threat that they will be disciplined or fired if they speak publicly about these abuses."(Davis, April 10, 2019)

The believed immediate causes of this violence were outlined by these researchers as "resident fear, confusion, and agitation and such underlying causes as task-driven organization of work, understaffing, inappropriate resident placement, and inadequate time for relational care. They saw violence as symptomatic of an institution that undervalues both its staff and residents. They described how violence affects their own health and well-being—causing injuries, unaddressed emotional trauma, job dissatisfaction, and burnout. They outlined barriers to preventing violence, such as insufficient training and resources, systemic underfunding, lack of recognition of the severity and ubiquity of the phenomenon, and limited public awareness." (Brophy et al, (2019:1)

The Canadian Union of Public Employees and the Ontario Council of Hospital Unions also commissioned a study of long term care staff and workplace violence. They found that 88% of personal support workers and registered practical nurses had experienced physical violence, with 62% experiencing at least one incident each week. 69% of racialized staff experienced harassment. Almost 70% want to leave their jobs (Davis, April 10, 2019).

Registered Practical Nurses (RPN's)

According to the National Nursing Assessment Service (2020) registered practical nurses in Ontario complete a two year post-secondary nursing program at the college level based on nursing theory. They provide direct care and coordinate care for individuals in a range of settings, however 40% are employed in long term care homes in Ontario (Long Term Care Association, 2019).

They are represented by the 45,000 strong Registered Practical Nurses Association, which is the voice of the thousands of RPN's who work in long term care facilities. They strongly supported the previous Public Inquiry concerning long term care's recommendation citing the need to examine having adequate levels of registered staff in these facilities. The Association has also strongly supported enhanced staffing in these facilities and encouraged a standard of excellence in care in this system (Registered Practical Nurses Association of Ontario, 2020).

What is required is that homes hire more full time staff and part-time staff designated to each home so that there is less reliance on agency staffing and less likelihood of staff having to travel between homes and community services in order to make financial ends meet. Hiring more full-time staff would begin to meet legislative requirements for better continuity of care to residents while reducing the likelihood of spread of infection between homes. The province placing mandatory limits on the ratio of full-time to part-time staff in these facilities would be an important first step.

Registered Nurses

"Of the total number of health-care providers in LTC, RNs (registered nurses) account for nine per cent, RPNs (registered practical nurses) for 17 per cent, and NPs (nurse practitioners) for less than one per cent."(Registered Nurses Association of Ontario, RNAO, 2020).

Inspection reports in some homes (see Orchard Villa) show that long term care homes often do not have enough registered nurses on staff, and many shifts are missing them even though they are required under provincial legislation.

"Generally speaking, rates of RN pay are based on years of service scales, and start at $21.75 per hour reaching as high as $40 per hour" (RNAO, 2020).

At these differences in pay rates between PSW's, RPN's, and RN's it is easy to see why a long term care industry primarily delivered by for-profit companies, is seeking to keep staffing costs down in order to benefit profit margins.

Private Duty Nurses

Some families, concerned about the low level of care and support provided to their loved ones in long term care facilities hire private duty nurses and may even be urged to do so by the home. "Private duty nursing (PDN) is skilled nursing care that is provided in the patient's residence" (Algonquin College, 2020).

Some of the agencies that provide private duty nurses are also owned by the long term care companies in which families employ them. ParaMed, Extendicare's Home Health Care Division company provides a range of health care services in the community, but families may also access care providers from ParaMed to help staff long term care facilities, some owned by Extendicare.

In 2015 Extendicare acquired Revera Home Health for $83 million in cash (Extendicare, January 15, 2015). Prior to that presumably Revera's Home Health care division also allowed families to purchase the services of its staff to help staff residents housed in its long term care facilities.

The other large provider of long term care beds in Ontario, Sienna Senior Living Inc. announced on April 28, 2016, the sale of its home care business, called Preferred Health Care services, to Spectrum Health Care, for "cash proceeds of $16.5 million before working capital adjustments"(Sienna Senior Living, April 28, 2018).[8]

Both home health care and long term care are big businesses in Ontario and at least some are owned by the same companies.

Lobbying To Further Reduce Qualifications In Long Term Care Facilities

The Long Term Care Association is lobbying for the exact opposite of what the nursing professionals are calling for. It is asking for less qualified staff to work in their homes, referred to as health care aides. They refer to this as more "flexible staffing" that they believe would help reduce staffing shortages in these homes.

[8]Novacap, a leading Canadian private equity firm, has acquired a majority interest in Spectrum Health Care. "Novacap plans to continue to invest in the company's growth and help it expand throughout Ontario. Novacap sees tremendous growth potential in Spectrum and will work with management to strengthen Spectrum's position as a market leader in Home Care in Ontario….. Founded in 1981, Novacap is a leading Canadian private equity firm with $3.2 billion of assets under management" (Novacap, July 15, 2019). https://www.newswire.ca/news-releases/novacap-acquires-interest-in-spectrum-health-care-819980268.html

If they are successful in this Ontario will return to a system where long term care homes can simply hire unqualified staff, called health care aides, off the street to provide intimate care and services to vulnerable residents.

The Association would also like to see less qualified registered practical nurses take on more of the roles of registered nurses when many believe it is the opposite that is required – that registered nurses and nurse practitioners have more responsibilities in long term care because of their expertise in complex care and infection control (Long Term Care Association, 2019:9).

Since many residents and families already consider PSW's not to be qualified for the roles they perform, further degrading the qualifications required to care for residents, some with complex needs, would appear to be the industry lobbying for even fewer care-related safeguards. This speaks to a culture of business and profits taking precedence over the needs of vulnerable people, and strengthens the case that providing long term care services should not be a business. Being able to pay staff less because they have fewer qualifications is good for the bottom line, but not so good for the care of vulnerable people.

WHAT ARE CONDITIONS LIKE IN LONG TERM CARE FACILITIES?

"The crowded conditions in which we warehouse our frail elderly aren't just an issue of personal privacy, they contribute to the spread of disease" Dr. Amrit Arya (April 26, 2020).

Dangerous and Unsafe Conditions For Residents

For decades, there have been press exposes showing that residents are not safe in long term care facilities; that adequate care is not provided; and that residents are subject to abuse, neglect, falls, injuries, medication errors, and other serious breaches in care standards (Sourtzis & Bandera; 2015; Ouellet & Brown, 2018; Dubinski, 2018; O'Keefe, 2018).

Public Inquiry Into Safety And Security Of Residents

Just last year, in July, 2019 the Long Term Care Homes Public Inquiry, was established after it was learned that Elizabeth Wettlaufer, a registered nurse, had between 2007 and 2016, murdered at least 8 people, tried to murder at least 4 more, and assaulted at least two others. She was charged with and convicted of eight counts of first-degree murder, four counts of attempted murder, and two counts of aggravated assault. No one picked up her trail of murder and mayhem in these facilities until she, herself, confessed to the murders (Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, July 31, 2019).

The report of the public inquiry made numerous recommendations on the changes needed in these facilities, however, the over 1000 deaths of residents and staff in 200 outbreaks in long term care facilities by early May during the 2020 pandemic has further underlined the continuing and ongoing serious failures in this system and the tragedies that have resulted (Pelley, May 5, 2020).

Call For Another Public Inquiry And Police Investigations

On May 5, 2020, the Service International Employees Union representing 60,000 Ontario health care and community service workers called on the Ford government and local police forces to "launch a public inquiry and criminal investigations into long-term care deaths tied to COVID 19" (Pelley, May, 2020) .

"The union is calling for:

- A public inquiry by the provincial government into the rising number of deaths of residents and front-line workers at long-term care homes, to be commissioned immediately.
- Criminal negligence investigations by Toronto and Peel Regional Police at a yet-undisclosed number of long-term care homes and home care providers.
- An investigation into the deaths by Ontario's Office of the Chief Coroner." (Pelley, May 2020)

All that Premier Ford had to say in light of the strong call for a public inquiry and police investigations was "we're pulling out all stops on this" without agreeing that he would call such an inquiry. Instead on May 7, 2020 with hundreds dead in long term care facilities Minister Merrilee Fullerton, a doctor, said the provincial government will conduct a "review" of the long term care system, not a full, independent, investigative public inquiry (Katawazi, May, 7, 2020).

High Levels of Abuse

In 2018, CBC Marketplace did an expose of 40 nursing homes with the highest rates of abuse in the province (Ouellet & Brown, January 25, 2018). Its documentary *Crying Out For Care* showed that violence was on the rise in these facilities and that reported resident on resident and staff on resident abuse had more than doubled between 2011 and 2016. Staff to resident abuse was up 148% from 2011 to 2016. "In 2016, there were 2,198 reported incidents of staff-on-resident abuse. This means, on average, that six seniors at long-term care homes in Ontario are abused every day." The Advocacy Centre for the Elderly says that families report abuse all the time. "We hear stories of people being illegally detained, of being left in bed for days, filthy conditions, cockroaches, assault," says Meadus."[9]

It is interesting to note that by April of 2020, of the 40 homes Marketplace identified, Orchard Villa in Pickering appeared on both Marketplace's list and in other press reports listing the highest death rates in the province (Tubb & Wallace, April 26, 2020). By May 5, 2020 there were 321 cases of COVID at Orchard Villa and 62 people had died (Durham Radio News, May 5, 2020). By May 6, 2020, 67 people are reported to have died (Gilligan, May 6, 2020). Orchard Villa also had repeated reports of abuse by staff according to inspection reports going back years (Inspection Reports, Orchard Villa, http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2693&tab=1)

[9] Jane Meadus is an institutional advocate with the Advocacy Centre For The Elderly in Toronto.

An Ottawa lawyer concerned about his father in an Ottawa long term care facility had this to say when he installed a camera in his grandfather's room at the Garry J. Armstrong Home in Ottawa after he noticed that his grandfather had injuries:

"*Every time we'd ask for an explanation from the facility, we would be told that there was no documentation, there's no information to elaborate or to clarify or shed light on what occurred," says Nassrallah.*

"I'd had enough, the family had had enough, and we said, you know what, you need something to use as an investigative tool and potentially a deterrent to determine what's really going on here," he says.

The camera caught a PSW punching Karam 11 times in the face while he lay in his bed." (Pedersen et al, January 18, 2018)."

Lack of Information Even During A Pandemic

Throughout the 2020 pandemic, desperate families attempting to discern the true situation in long term care facilities housing their loved ones could not get accurate information concerning the nature or extent of the outbreak. Information was lacking for the homes themselves and for individual residents.

The Ministry of Health, when asked during the week of March 26, 2020 how many long term care homes in the province had any cases of COVID 19, were unable to say, and the Globe and Mail was forced to try to obtain the information directly from public health units (Grant, March 26, 2020). But was that information even accurate? The answer is no.

The Toronto Star was reporting the same week that "crucial provincial data that could track the spread of the novel coronavirus, as well as who has it, is missing from statistics released Tuesday by the Ontario government. More than 60 per cent of the confirmed cases of COVID-19 in the database, released on the province's Open Data website don't list how the virus was transmitted. Age and gender is missing for around half the cases and about 40 per cent of cases don't include the outcome, which refers to whether a patient was in hospital or self-isolation, among other things." (Winsa, March 25, 2020).

A disparity existed between public health data and the data supplied by labs that were doing the testing. "Non-Public Health Ontario labs do not receive the same level of detail obtained by Public Health Ontario's labs, such as age and gender," said Hayley Chazan, spokesperson for health minister Christine Elliott, in an email. The public health lab is affiliated with the provincial government. Information may also be missing as cases continue to be investigated by local health agencies." (Winsa, March 25, 2020).

A month later, on April 23, 2020, the Toronto Star had all but given up trying to get information from provincial sources and set up its own database. It reported "for families and friends with loved ones in an Ontario long-term-care or retirement home, there is no public database with up-to-date information about COVID 19 outbreaks and deaths in these facilities." (Wallace et al,

April 23, 2020). The province was apparently relying on a totally unreliable and outdated database to track cases of COVID 19 in what was, by then, ground zero for new cases – long term care facilities in Ontario.

Dr. Colin Furness, an infection control epidemiologist at the University of Toronto said "the absence of a co-ordinated post-mortem testing strategy prevents a more complete scientific and demographic understanding of how the virus works, who it kills, why it kills and what underlying medical conditions put people at greater risk…it's a national embarrassment that we're not doing post-mortem testing," Furness said, noting that COVID-19 is an "asymptomatic pandemic. "How are we going to say we understand this disease if we don't do this kind of measurement?" Furness said post-mortem sampling would also detect missed virus-related deaths. "Every government is undercounting the dead," Furness said. "Everyone is doing it."(Ormsby, April 27, 2020).

Poor testing and reporting data in Ontario and a government too slow to act as long term care homes were losing front line workers to the infection, were seriously understaffed, and residents were placed at risk. Is it any wonder?

A Local Medical Officer of Health Moves to Protect Residents

Around the time of the Toronto Star's report of the lack of an up to date information system at the provincial level to inform family and friends of COVID outbreaks in long term care homes, the Durham Region Medical Officer of Health, Dr. Robert Kyle, took matters into his own hands concerning Orchard Villa – the facility with the highest death rate in the province.

On April 21, 2020 he took the step of issuing an Order under the Ontario Health Protection and Promotion Act to the Orchard Villa home in Pickering "to address the immediate risk of COVID-19 to residents and staff of this home. The Order indicates that a communicable disease outbreak exists at this facility, which presents a risk to the health of residents and staff in the home."(Lakeridge Health, Durham Region, Southbridge Care Homes, April 21, 2020).

Dr. Kyle's order was very specific. It ordered Lakeridge Health's Infection Prevention and Control and clinical teams to take the lead in assessing, monitoring, investigating and responding to the outbreak, and required Southbridge Care Homes Inc. which operated Orchard Villa to "enhance measures for the protection of residents and staff including:

- active screening of residents, staff and visitors
- active and ongoing surveillance of all residents
- active and ongoing oversight of the delivery of clinical care
- screening for new admissions
- managing essential visitors
- changes to when an outbreak of COVID-19 is declared at a home, including when it is over
- specimen collection and testing for outbreak management
- implementation of all of the above measures including the adoption and implementation of Infection Prevention and Control"

And to determine "what additional care services are required with the goal of putting in place appropriate solutions to limit the risk of transmission and protect resident and staff safety" (Durham Health News Release, April 21, 2020)

It required a local Medical Officer of Health to order the protection of residents and staff of this home. Where was the province?

Sadly, on the same day that the Durham Health press release was issued, a daughter of a man who died at Orchard Villa told CTV news that families "have been left in the dark about the 31 deaths, staffing shortages and more than 100 cases of the disease." (Katawazi, April 22, 2020). The daughter said that he had no fighting chance against the disease and she could not get accurate information from the administration of the home.

Later the military was called into the home to assist, and a major data breach also occurred at this home on May 10, 2020 raising serious questions about just how bad conditions were in Orchard Villa prior to the pandemic that such extraordinary measures had to be taken, and still there was a data breach.

Families And Staff Disempowered When They Voice Concerns

The questions are often asked "why don't families act?" "Why don't staff blow the whistle?" The answer is that they do but nothing happens.

Families and former staff of Park Lane Terrace (APANS Health Network), a 132 bed long term care home in picturesque Paris, Ontario, that had obtained 3 year accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) according to its website - the highest level of accreditation available, went public with their concerns on April 23, 2019.

Park Lane says it offers "specialized care areas [where] we are able to meet the needs of all seniors" (Park Lane, 2020). But families and former staff tell a different story. They say that there are problems with management and understaffing due to layoffs, and that they filed "countless complaints with the home's management, Ontario's Ministry of Health and Long-Term Care and in a couple of cases, police, but nothing changes" (Bimman, April 23, 2019). In fact, they say, it just gets worse. One family had this to say about Park Lane Terrace's "specialized care":

"Probably the most disturbing was my wife arriving to see her mom and finding her soaking wet in her own urine," says Vice. With a diaper so full, urine was "flooding down her knees," and Vice wonders how long she had been left like that. (Bimman, April 23, 2019).

The Ministry prepared a 172 page report about Park Lane, having cited it for "a long list of mistakes, everything from how it handled alleged sexual, verbal and physical abuse to understaffing, medication errors, missed baths and incontinence issues" (Bimman, April 23, 2019). That report was removed from the Ministry's website after a query by a reporter.

But this raises an important question – how is it that a home like Park Lane Terrace, with 3 year accreditation, would have such serious infractions as reported by inspectors, staff, and family members? Is accreditation really an effective way of determining the quality of services provided by a long term care facility if this is the case?

On April 29, 2020, the families of residents in the Orchard Villa Nursing home issued a letter to Premier Ford saying they had been left in the dark about the condition of their loved ones and calling for a full investigation of the high death rate in that facility (Katawazi, April 29, 2020).

In May, 2018 more families went public. Two more families talked about their loved ones' suffering at homes run by Extendicare and Leisureworld (Sienna Senior Living), both targets of a class action suit by families.

"*Jospeh Novo, his family alleges, wasted away, dehydrated and malnourished after being placed in a Brampton, Ont. nursing home following a major stroke. The home was operated by Leisureworld, which has since been renamed Sienna Senior Living. When Novo died less than two years later at age 65, his body was pitted with gaping bedsores, some so deep that bone could be seen poking through."*

Amani Oakeley, lawyer for families at Extendicare and Leisureworld (now Sienna), had this to say. "We've got to take it beyond simply cataloguing the misery and we need to start talking about fines, we need to start shutting down some of the homes… (and) halting admission until some of these issues are dealt with…". "Each of the class actions is seeking $150 million in damages to address "systemic negligence" at the companies' homes, Amani Oakley, the lawyer who is leading both lawsuits, said Thursday." (CTV News, May 3, 2018).

PPE Not Getting To Staff

The Ontario Nurses Association (ONA), in late April was forced to seek a court order forcing long term care homes to provide their staff with personal protective equipment (PPE) because of concerns that without it, staff would "continue to transmit COVID-19 and "become infected and possibly die."(DeClerq, April 22, 2020). The court filing named four long term care homes, some with among the highest infection and death rates in Ontario, for "allegedly restricting or denying the use of PPE in their facilities." The ONA charged that "in some cases, homes locked the masks up and "actively dissuaded nurses from using the precise PPE that they have deemed necessary."

ONA admitted it had been "flooded with concerns since the pandemic was declared, and that members feared for their safety." (DeClerq,April 22, 2020).

At a news conference on May 1, 2020, Premier Ford was asked by a reporter why front-line staff in long term care homes keep reporting that they are not getting personal protective equipment (PPE) appropriate to the care needs of residents and sufficiently protective for them. With many staff across the province becoming ill with COVID, the staffing shortage has further been exacerbated requiring that both hospital teams and the military be sent into homes to assist. Premier Ford replied that there was sufficient PPE and that managers of the homes needed to call

to ensure that they received it for their staff. What was missing from Mr. Ford's response was any accountability mechanism on the part of the government to ensure that the PPE that was being sent to these homes was actually being given out to staff. This is part of a continuing story of the government apparently not monitoring what is actually occurring in long term care homes, as opposed to what it thinks is occurring there.

INSPECTIONS IN LONG TERM CARE FACILITIES

Severe Cutbacks In Inspections Under The Ford Government

Most people would think that since long term care facilities house such vulnerable residents, that they are vigorously inspected, at least annually. They would be wrong. That is not the case.

For decades one government after another of every political stripe, bowing to the lobbying efforts of the long term care industry, has eased up on inspections in long term care facilities.

In 2019, only 9 of 626 homes in Ontario received the more rigorous annual inspections called resident quality inspections (RQI's). Prior to 2018, most homes received this comprehensive RQI, but that number dropped to only half the homes receiving them in 2018, and only 9 in 2019 (Pedersen et al, April 15, 2020). Inspections dropped dramatically under the Ford government.

Inspections fall under the categories of;

- **Resident quality inspections** (RQI's) - generally comprehensive and done yearly, these are supposed to be unannounced.
- **Critical incident inspections** - often after there has been an issue related to resident injury or unexpected death,
- **Complaint investigations** – instituted after staff, residents, or families have made a formal complaint.

In the latter two, the homes usually know inspectors are coming and may have time to try to address problems before they arrive, or at least have a believable explanation for what occurred.

The RQI's are the most important because inspectors do a comprehensive review of a facility's whole operation, usually in a team that includes dietary, nursing and environmental inspectors. These are the inspections that have uncovered major problems including abuse, neglect, medication issues, poor sanitation, falls and injuries, critical incidents not reported to the Director, and infection control and other issues.

Some of the homes with the highest infection and death rates in Ontario were not among the few that had RQI's in the previous year. In 2018, during the Long Term Care Homes Public Inquiry into how Elizabeth Wettlaufer managed to murder at least 8 residents and go undetected, the importance of comprehensive yearly inspections of this nature was underscored (Pedersen et al, April 15, 2020).

The Ford government appears to have ignored the Inquiry's recommendation in this regard and has moved away from comprehensive yearly inspections towards what appears to be a complaint and critical incident based inspection approach - less comprehensive, less protective of vulnerable residents, and not proactive. Fewer inspection reports also mean less public accountability. The public and press are no longer in a position to access important information that was formerly generated in comprehensive yearly inspections. Again, the government appears to be assisting the long term care industry to hide its inadequacies and avoid public accountability.

With fewer inspection of things like staffing levels, quality of care being provided, and infection control, is it any wonder that Ontario facilities had the high infection and death rates that they did once the 2020 pandemic hit?

How Effective Are Inspections?

The short answer, since the "relaxing" of inspections and practical elimination of resident quality inspections (those yearly comprehensive inspections that involve a team of inspectors entering, unannounced, to conduct reviews lasting days of all of a home's policies, practices, and protocols), is that they are not effective at all.

The inspection system in Ontario is now nothing more than a complaints-based system, and a system of determining whether or not critical incidents were handled appropriately once the damage has been done. There is nothing pro-active about inspections in Ontario anymore, and therefore residents are now at much more serious risk of harm, and, it appears, so are staff.

When there is little to no oversight, especially of facilities operated by large multi-national corporations, caring for extremely vulnerable people, it is a recipe for disaster – exactly the kind of disaster that occurred during the 2020 pandemic.[10]

The Ford government seems to have completely abandoned its oversight responsibilities of the long term care facilities sector which set the stage for lack of infection control, lack of oversight to ensure that residents were safe in these facilities, and lack of responsibility for the kind of care being delivered, if indeed it was being delivered at all in light of the severe staff shortages in this system during the pandemic.

The summary of inspection findings for homes with some of the highest death rates in the province will show that there was little to no action taken to ensure appropriate infection control, that even serious occurrences were treated lightly, that homes repeatedly out of compliance with provincial legislation did not have their licenses revoked, intakes stopped, fines levied, or charges laid, that where there were reasonable grounds to be concerned that criminal acts may have taken place - from theft, to mishandling of medications, to criminal negligence causing

[10] It should be noted that according to inspection reports, instead of issuing compliance orders, inspectors generally issued written notices and left it up to the homes to institute voluntary plans of correction. There is no legislative requirement to share these plans of correction with residents and their families and generally speaking inspectors do not follow up on either these plans or the written notices that were issued (Source: former Board Member, Concerned Friends Of Ontario Citizens in Care Facilities).

bodily harm or even death, to physical and in some cases sexual assault – either staff to resident or resident to resident, police were not called, and ambulances were not called even when residents suffered grievous injuries. Homes that should have been taken over by the Ministry because they were endangering their resident's health, safety, and lives were not taken over.

In summary, once vulnerable, frail residents entered these facilities they did so at their own risk without the normal protections afforded any other citizen of this province. And they did so without oversight by the government bodies established for that specific purpose. This raises the specter of a toxic form of systemic ageism directed against the province's most vulnerable people.

No Takeover Of Dangerous Homes

Even when long term care facilities had high infection and death rates of residents and staff the Ford government refused to allow takeover of these facilities. British Columbia and Quebec had already done so.

On April 17, 2020 the Service International Employees Union took the unprecedented step of asking the Government of Ontario to take over two of the facilities with the highest death rates. Sharleen Stewart, President of the union called on the Ford government to take over Eatonville Care Centre in Toronto and Anson Place Centre in Hagersville, calling both homes out of control. She claimed that staff in those homes still did not have appropriate personal protective equipment and that effective sanitation practices were not being following with management not being forthcoming.

The response to this unprecedented request by a major union representing health care workers in these homes by the Ontario Minister of Long Term Care was that other provinces operated differently, and that her Ministry would assist other companies to come in to provide support. Again, in light of high rates of infection and death in these facilities no direct action was taken by the Ford government (Stone & Howlette, April 17, 2020). Once again, the provincial government was badly failing residents and ignoring the request of one of the province's largest health care workers' unions to protect residents and staff in these facilities.

The Minister Has Authority To Take Over Homes

This inaction by the Ford government stands in sharp contrast to the actions of the Davis government in 1983 when the Hon. Larry Grossman rose in the Ontario Legislature to say that he was taking strong action against the Ark Eden nursing home in Stroud, Ontario after an inquest into the death of a 21 year old man who had died there of complicating factors involving malnutrition, dehydration, and hypothermia.

Mr. Grossman said "I have advised the operators of the home I do not intend to renew their licence to operate a nursing home when that licence expires on March 31. It is our intention to begin immediately to relocate all the residents of the home….. If, by March 31, all the remaining residents cannot be relocated to proper facilities, the Ministry of Health will assume control and

operation of the home to protect the health and safety of the residents until it is vacated."(Hansard, February 18, 1983).

The Ministry of Health did indeed take over Ark Eden as the Minister invoked the Health Facilities Special Orders Act to protect the remainder of the residents.

This raises the question of why Ontario's Long Term Care Minister, Merrilee Fullerton, a doctor, did not do the same as death tolls rose in long term care homes in Ontario and unions were charging that appropriate personal protective equipment was not being given to front line workers. Instead she simply stated that the government would "review" the long term care system once the pandemic was over.

This completely inadequate response in failing utterly to protect residents of these homes will go down in Ontario history as one of its darkest chapters.

Why Not A Police Investigation – the Government Has The Authority

The Attorney General of Ontario also had the option of asking police forces across the province to begin investigating possible criminal acts in nursing homes using, as a starting point, some of the issues outlined in inspection reports.

The government claims it does not have the authority to direct the OPP and other police forces in this way and yet in 1989 the Liberal Attorney General, Ian Scott, sent a "directive to police forces asking that they prosecute perpetrators of criminal acts against nursing home residents" (Spindel, 1995:45).

Led by Inspector Ted Rowe, the OPP began investigating, and "on August 1, 1989, an Ontario Supreme Court judge upheld the committal to trial on criminal negligence charges, the husband and wife operators of a long term care institution for individuals with Alzheimer's" (Spindel, 1995:45) "On the same day, two retirement home operators were charged with criminal negligence causing death, and an additional 23 charges, including unlawful confinement, unlawful forcible restraint, and criminal negligence causing bodily harm"(Globe and Mail, August 2, 1989:A12).

One wonders if significant criminal acts have been occurring in these facilities for decades and not being caught. Certainly in the case of Elizabeth Wettlaufer, she was able to go on a rampage, murdering helpless residents from at least 2007 on until she, herself confessed, she was not caught and the murders of these residents were not picked up by inspectors or by the Coroner's Office.

The Ford government has the power to ask provincial police forces to investigate the facilities with the highest infection and death rates after reviewing provincial inspection reports, some of which appear to indicate possible criminal acts, and yet it has failed to do so.

A Word About Inspector Pay and Qualifications

One might ask what qualifications a long term care inspector is expected to have.

According to a job posting the Ministry is looking for: a certificate of competence as a Registered Nurse from the College of Nurses of Ontario or current registration as a Physiotherapist with a certificate of competence from the College of Physiotherapists or current registration as a Dietitian with the College of Dieticians of Ontario. Inspectors must possess class "G" drivers licenses or the equivalent and be able to travel extensively and work irregular hours. They must also complete Resident Quality Inspections (RQI) certification - the ministry's formal training program. These are mandatory requirements.

Other skills said to be nice to have include investigative, analytical and organizational skills; communication skills; leadership, interpersonal, problem-solving, negotiation skills and judgement; health care knowledge and experience, and computer skills.

And what is the pay for these qualifications? $1,477.19 - $1,776.65 per week as per the OPSEU agreement for a Nurse 2, Public Health position (so in the range of $77,000.00 per year) (Ontario Ministry of Health and Long Term Care Position Description, August 31, 2018).

What are Nursing Directors in long term care homes paid? It appears their average salary is $75,394.00 per year (payscale.com) and registered nurse supervisor's salaries in general are between $53,000 and $99,000. per year. So it is possible that inspectors of these facilities are paid less and required to have fewer qualifications than nurse supervisors in the facilities. This could pose legal problems should inspectors and their Director decide to charge homes and these cases end up in court.

Historical Long Term Care Industry Influence on Public Policy In Ontario

The government of Ontario's apparent inaction in the face of a rising death toll in long term care raises an interesting question. Why is the government not calling a public inquiry or for police investigations? Could the answer lie in the powerful lobbying ability of the long term care industry?

A Far Reaching Influential Sector

The long term care industry in Ontario is ubiquitous - it is everywhere. Its principles give donations to charitable organizations, including those that would normally advocate for individuals in its facilities. They serve on the boards of organizations that would normally advocate for individuals with age or disability related conditions who may end up in long term care facilities. They serve on hospital boards. They are affiliated with universities whose research might influence government policies and practices. And they appear to have significant influence with politicians and senior government officials. Industry lobbyists seem able to launch major publicity campaigns if required because it appears that they have very deep pockets. The influence of the long term care industry is far reaching with its principles also involved in real

estate, financial institutions, pharmaceuticals, medical laboratories and many other businesses. Some examples follow.

Extendicare Assist - the management and consulting services division of Extendicare (Canada) Inc. is "partnered with" the Alzheimer's Association, having made a five year commitment supporting a "culture change" initiative with the stated intent of improving "the quality of care and life for Canadians living with Alzheimer's disease and other dementias in long term care homes"(Extendicare, 2020). Orchard Villa, with one of the highest death rates in the province, where the military had to step in and the Durham Region Medical Officer of Health ordered in Lakeridge Health teams was being managed by Extendicare Assist (Extendicare, 2020b).

Norma Beauchamp, an Independent Director of Extendicare "volunteers her time on the respective boards of ALS Society of Canada and Ontario Caregivers Organization" (Extendicare, undated).

Dr. Michael Guerriere, Non-independent Director, President and Chief Executive Officer of Extendicare is in a good position to play a major policy development role in Ontario in light of his "adjunct appointments in the Institute of Health Policy Management and Evaluation at the University of Toronto and the School of Health Information Science at the University of Victoria." He also chaired Ryerson University's Board, and is affiliated with the Canadian Institute for Health Information, and the Institute of Clinical Evaluative Sciences (Extendicare, undated).

At Revera, Bill Davis, the former Premier of Ontario is the Chair Emeritus. Dr. Calvin Stiller, the Chair of Revera's Investment Committee and a member of the Quality Assurance Committee, is a Professor Emeritus in Medicine at the University of Western Ontario, Chair of the Ontario Institute of Cancer Research, and a Director of MaRS (Revera, 2020).

Lois Cormack, Director of Sienna Senior Living, previously served on the Board of Governors of Seneca College (Sienna Senior Living, 2019). Paula Jourdain Coleman, who has a long history in the long term care industry in Ontario, serves on the Board of Directors of, and is a member of the International Women's Forum, having previously served on the Board of Directors of St. Joseph's Health Care Centre and George Brown College Foundation (Sienna Senior Living, 2019). Jack C. MacDonald, another Sienna Director, has served on a number of boards - including "Honourary Chair of the Board of Directors of Toronto Zoo Campaign — "Wild for Life"; Chair of the Board of Directors of Canadian Aboriginal Business Hall of Fame; member of the Province of Ontario Investment and Trade Advisory Council; Chair of the Board of Directors of Canadian Foundation for Dietetic Research, Chair of the Board of Directors of President's Advisory Council for Humber College; Director of the Colorectal Cancer Screening Initiative Foundation, and Director of the Canadian Physiotherapy Association."(Sienna Senior Living, 2019). Brian Johnston, also a Director with Sienna Senior Living also "serves as a Director of the C.D. Howe Institute, the Bruce Trail Conservancy, and is a member of the Board of Regents at Victoria University in the University of Toronto. He was previously a director of the Canada Mortgage and Housing Corporation (CMHC) from 2008 to 2016, among other prior board appointments" (Sienna Senior Living, 2019).

These are examples of the wide ranging involvement of the principles of only three of the major long term care companies in Ontario. With this broad involvement and the resulting contact networks is it any wonder that Ontario long term policy has favored the continuation and expansion of for-profit residential and home care services in Ontario?

A Hand In Glove Relationship?

There was also a history of senior Ministry officials taking positions with the nursing home industry after leaving their government positions (Spindel, 1995:32).

One of the most blatant examples of the toing and froing between government and the long term care industry was Shelly Jamieson. Her career is indicative of the close relationship between the Ontario government and the long term care industry. Prior to 2012 "Ms Jamieson held Ontario's highest-ranking civil servant role as Secretary of Cabinet, Head of the Ontario Public Service and Clerk of the Executive Council. She also served as Ontario's Deputy Minister of Transportation. Roles previously held by Ms. Jamieson include President of Extendicare Canada; volunteer commissioner on the Health Services Restructuring Commission; and Executive Director of the Ontario Nursing Home Association (now the Ontario Long-Term Care Association)"(Health Quality Ontario, 2020). So prior to becoming the most powerful bureaucrat in the Ontario government, Ms. Jamieson was President of Extendicare, one of the largest long term care providers in Ontario, and Executive Director of the Ontario Nursing Home Association, which was at the time the lobby organization representing the for-profit long term care sector in Ontario.

Dino Chiesa, Chair and Director of Sienna Senior Living has "held several positions within the Government of Ontario, including Assistant Deputy Minister, Municipal Affairs, and Housing and Chief Executive Officer of each of Ontario Housing Corporation and Ontario Mortgage Corporation… Pat Jacobsen, the Chair of Revera's Quality Assurance Committee was the Deputy Minister of Transportation in Ontario (who played a major role in bringing in toll highways like the 407) (Sienna Senior Living, 2019).

Not much appears to have changed with the more recent appointment of a former Governor General to Schlegel Health Care's Board of Directors. "Dr. Ron Schlegel, Chairman of Schlegel Health Care, is pleased to announce the appointment of The Right Honourable David Johnston to its Board of Directors. David Johnston was Canada's 28th Governor General." (Homewood Health Inc. May 29, 2018).

Ontario also has a long history of the long term care industry making campaign donations to politicians and of meeting regularly with senior bureaucrats in the Ministry of Health (Spindel, 1995).

Political Contributions

Going back decades the industry has also made large political contributions to politicians. As early as the 1980's the New Democratic Party's research branch had found that nursing home

companies had contributed tens of thousands of dollars to the Progressive Conservative Party (Spindel, 1995:33).[11]

In 2001 there still seemed to be considerable influence by political donors in the long term care sector. CBC News (March 20, 2001) reported a link between the awarding of long term care beds and who had made donations to the Conservative government:

"Political scientist Robert MacDermid was hired by Marketplace to analyse contributions by private nursing home companies to the Ontario Conservative Party. "The companies that received the most beds, they also seemed to be the companies that gave the most money," he said. CPL Reit won contracts worth $1.3 billion in subsidies. From 1995 to 1999, companies owned by CPL Reit gave the Ontario Conservatives almost $23,000. They won contracts to build almost 1,700 nursing home beds. Those contracts are worth about $1.3 billion in government subsidies over 20 years. Another private nursing home firm Extendicare gave the Ontario Conservatives almost $37,000 between 1995 and 1999. They were awarded more than 900 beds worth about $700 million in subsidies over 20 years."

From 2010 to 2015, the provincial government's contribution database shows that companies like Revera had donated thousands to Conservative and Liberal governments in power (Political donations Long Term Care Final, 2010 – 2015).

When the Ford government constituted a long term care staffing advisory group, an owner of a for-profit company that had donated $20,000.00 to the Health Minister and Deputy Premier, Christine Elliot's leadership campaign in 2015 was tapped to be part of it. "James Schlegel, the CEO of Schlegel Villages, was one of the ten people appointed to the long-term care staffing panel last month. The Schlegel family owns 19 nursing homes across Ontario and has contributed $120,624.00 to political parties since 2007 (Rank and File Labour News Analysis, (March 3, 2020; Ontario Government, February 13, 2020).

Contributions by principles of this industry are now more difficult to trace since corporate donations have been disallowed. What is clear is that some members of the industry, their families, and staff, appear still to be donating.

One example is the Kuhl family, owners of All Seniors Care Living Centres, serving over 20,000 Canadians, and some members of their team having collectively donated about $10,000.00 to Premier Ford's leadership campaign (Elections Ontario, Page 25, https://finances.elections.on.ca/en/contributions?entityNames=Ford,%20Doug&fromYear=2014&toYear=2020)

Should individuals who are well known to government as owners of large long term care companies, their staff and families be allowed to make thousands of dollars in political contributions to the very politicians who will be responsible for the regulation, funding, and inspection of the facilities they run and profit from? Many would consider this to be a conflict of

[11] An interesting side note here is the Helmuth Buxbaum, later found guilty of having murdered his wife, had made an over $10,000.00 donation to the Conservative Party in 1983. (Spindel, 1995:33)

interest. For years, there have been calls to end this process and yet in Ontario, in 2020, the practice continues.

Lobbying Clout

The long term care association also exerts considerable lobbying clout through its provincial association, the Ontario Long Term Care Association. The Association is able to put out glossy publications each year making its case for more public funding. Unfunded non-profit advocacy groups are seldom in this kind of position.

Historically the for-profit sector has organized rallies of staff and residents at Queen's Park to "end the funding discrimination between themselves and the [non-profit] homes for the aged" (Spindel, 1995:44). Organized by Milt Graham, who had been a former nursing home chief inspector with the Ministry of Health but then became a consultant to the industry, rallies like this were intended to drive a wedge between the advocacy group Concerned Friends of Ontario Citizens in Care Facilities and the people they were representing.

At the time, the Ontario Nursing Home Association (predecessor to the Ontario Long Term Care Association), also launched a $300 million lawsuit against the Ontario government saying residents in for profit homes were being discriminated against because of this lack of funding parity.

History shows the government folded, since all homes, for-profit and not for profit, are now funded under the same Act. This set the stage for for-profit homes to obtain more public funds even though they had previously argued that they could do things more efficiently and at less cost than the not for profits.

With key individuals from industries and commercial enterprises across Ontario's broad business spectrum also involved in the long term care business, their lobbying bodies are well positioned to fend off demands for reform of the industry by advocacy groups and the public. What they are not positioned to do is to prevent the defeat of "friendly" governments that fail to act to correct major injustices in the long term care sector, because of an outraged public.

WHAT DO THE INSPECTION REPORTS SAY

What few inspection reports have been completed in 2019 and in the years before tell a tragic story of abuse, neglect, falls and injuries, medication errors, homes in poor repair, not enough linen, RN's not on duty for days at a time, staffing shortages, and a host of other problems.

Many of these homes were a disaster waiting to happen. Add a pandemic and you have a perfect storm, complete with high infection and death rates, families left feeling helpless and devastated, staff unable to work because of illness or refusing to work because of unsafe conditions, and a government that appears equally helpless, and unable to begin to address the horribly broken system of long term care causing these tragedies. This was, in many ways, a government-orchestrated disaster because of the too influential relationship of the long term care industry.

A few inspection reports will be reviewed here, especially those related to homes with high infection and death rates, in order to explain how conditions prior to the pandemic likely contributed to these high death rates.

Orchard Villa, Pickering

This home, at time of writing, has the highest death rate in the province. It also has a history of non-compliance orders, written notices, voluntary plans of correction, directors referrals (which are only made when homes do not come into compliance after an inspector has cited them several times), and director's orders (which only occur after numerous citations and failure to comply).

Some of the findings of inspection reports going back five years since Southbridge Homes Inc. took over this facility are listed here.

To provide some background, a host of press reports concerning this home have detailed conditions there and the difficulty that residents' families were having obtaining basic information.

On April 23, 2020, it is reported that April Beckett, the acting executive director of the facility, wrote to families detailing the sharp rise in COVID 19 cases and deaths at this 233 bed facility acknowledging the grave concerns family members had been raising. Her letter promised twice weekly updates. At the time 131 residents and 66 staff had tested positive, and 40 people had died. The home admitted that it had been struggling with a severe staffing shortage even before the outbreak (Katawazi, April 23, 2020).

By April 29, 2020, families took matters into their own hands and released their own open letter to the Premier of Ontario which appeared to be in complete contradiction to the letter released by the acting executive director.

It called for a full investigation of the facility and alleged that management had kept families in the dark since the announcement of the outbreak on April 9th. The letter stated "we at no time agreed to place our loved ones in another's care with the understanding that we would receive no communication about their health, safety and wellbeing…At the present time, and during the preceding two weeks, information regarding our family members has been withheld from us and this is no longer acceptable to us."(Wilson, April 29, 2020). Family members were demanding immediate and complete information about the safety and wellbeing of their loved ones including assurances that their family members were receiving adequate hydration and 3 meals a day.

It seems a small thing to ask.

By the next day the Toronto Star was reporting just how bad things were at that facility. Having reviewed inspection reports going back five years the Star reported that this home had "a lengthy history of failing to comply with provincial rules designed to protect long-term-care residents" and that it had "faced a litany of citations for non-compliance with regulations and previous

ministry orders, including those around ensuring living areas are kept clean and sanitary; protecting residents from staff abuse; meeting residents' continence and toileting needs; and preventing falls." (Wallace, April 30, 2020).

By this time, 52 residents had died - 12 more than the week before, with the death toll still rising.

The Executive Director was, inexplicably, saying that the home's full attention was on the needs of its residents, which raises the question of where its attention had been prior to the outbreak, and that it "could not commit resources to address specific details of its inspection history", saying that it had made significant progress since its takeover of the home in 2015 and "co-operates transparently with the ministry in all inspections and work(s) to quickly resolve any areas noted for improvement or required action." (Wallace, April 30, 2020).

Readers are left to determine the veracity of that statement in examining the chronology attached to this brief. However it is noteworthy that The Star reported from July 2015 to December, 2019 "Orchard Villa underwent 34 ministry inspections, two dozen of which led to a combined 127 notices of failure to comply with the Long-Term Care Homes Act and its regulations. Among them were two incidents in which doctors were not notified immediately after patients were injured and found bleeding. In one case, the senior died hours later." (Wallace, April 30, 2020).

In order to fully understand just how bad things were are Orchard Villa, an examination of the level of remedial actions that were found to be necessary and implemented is in order:

- 50 Canadian Armed Forces (CAF) personnel in 5 teams of the Joint Task Force Central were deployed to Orchard Villa under Operation LASER composed of 2 nurses, 12 medical technicians from the 4 Health Services Group, and personnel to perform other duties in support of operations;
- This is what was needed to bring staffing up to the level "required to care for the residents of the home" with 20 – 25 CAF task force members on-site each day in two shifts, 7 days a week (Durham Post, May 3, 2020);
- As well the Lakeridge Health clinical team was ordered on-site by the Durham Region Medical Officer of Health to "deliver direct care to residents" as residents are being moved to clear areas of the home and residents will finally be able to connect with loved ones using information technology.
- "more highly trained clinicians and staff are on-site" as well to provide residents with care and personal supports, including Lakeridge Health registered nurses, registered practical nurses, personal support workers and dietary professionals.
- A Lakeridge Health Infectious Disease physicians is also on-site with an infection prevention and control team conducting a "detailed review" in order to enhance safety in this home as new protocols and processes are introduced.
- These new protocols include enhanced mandatory education and re-training of the staff who work there.
- Contractors are on-site to deep clean the entire home and it will take a few weeks to complete this process.
- Designated family members are finally being contacted and provided with information (Durham Post, May 3, 2020).

It is difficult to imagine the situation residents must have found themselves in that it has taken this level of staffing, cleaning and support to finally bring this home up to the necessary standard.

But the sad story of Orchard Villa was not over at time of writing. On May 9, 2020 the CBC reported that a data breach at Orchard Villa had been reported to the Privacy Commissioner. Merrilee Fullerton, the same Minister of Long Term Care who had not publicly expressed concern about the high death rate at Orchard Villa did express concern about the data breach calling it "disturbing news" (CBC News, May 9, 2020). What should have been more disturbing to her is what her own government's inspection reports were saying prior to the pandemic that resulted in this home having the highest death rate in the province.

A Brief Overview Of Orchard Villa Inspection Reports

In taking a closer look at the inspections that occurred over that five year period where the home's acting executive director is claiming "significant progress":

Not long after Southbridge took over from Community Lifecare Inc. 5 written notices, 2 voluntary plans of correction, and 1 non-compliance order were issued after a resident is alleged to have had an unwitnessed fall. "The resident was found on the floor in a pool of blood, with blood noted to extremities, night gown and the bedside drapes. The CIR [critical incident report], resident incident report and progress notes all indicated resident sustained substantial injuries, as a result of the fall". Bandages were applied without a registered nurse checking injuries first. A registered practical nurse disagreed with a registered nurse's orders that he not be taken to hospital even after bandages had been changed twice, saturated with blood both times. (**MOH Inspection report: July 30, 2015,** Page 4 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=14003&FacilityID=20100)

Staff to resident abuse was reported later that year with the home cited with 11 written notices and 2 compliance orders. 13 days before a critical incident, two staff members had reported a third for improper care of a resident. The resident had expressed fear of the staff and did nto want her looking after them and was upset and crying. The reporting staff said the staff being reported had a history of getting back and staff and residents when complaints were made about her. This same staff was allowed to continue to provide care to the resident in question but was alleged to have refused to toilet the resident. A third complaint letter came in about the same person but disciplinary action did not occur until "further allegations were received". The home was cited by the inspector for failing to ensure that the resident was protected from ongoing emotional abuse. **MOH Inspection report: September 28, 2015**, Page 6 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=13712&FacilityID=20100

The following year, allegations by a resident that money was stolen were not documented by the home; a resident was injured during a lift which was referred to as "physical abuse"; a resident who suffered an injury was found on the floor in a lot of pain and was not given required pain medication when needed and continued to complain of pain, but had ice packs administered, was later found unresponsive and finally transferred to hospital; medication was given to the wrong resident; a palliative resident was not given prescribed medication for pain as ordered; the

Director (of Inspections) was not notified as required of an unexpected death of a resident; more resident abuse was reported; written complaints by the Resident's Council did not receive appropriate responses (call bells not answered, lack of privacy, unclean premises, complaints about personal care, lack of restorative care, dietary etc); **MOH RQI Inspection: April 19, 2016** http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=15133&FacilityID=20100

More compliance orders were issued to the home on follow up inspections and complaint investigation, and the home was sufficiently out of compliance that a Director's Order was issued on March 10, 2017. Specifically "The Licensee is ordered to provide the Director with a detailed written report on the status of actions taken to address the requirements of Order # 001 issued to the Licensee on January 24, 2017as part of inspection #2016_199626_0032 (A1). In particular, the report is to identify the specifics of the nursing leadership provided by the management company, including their role, actions taken and attendance at the home. Further, the licensee is to provide the Director with a monthly update until September 30, 2017 demonstrating actions taken to ensure and sustain compliance." (**MOH Director's Order, March 10, 2017. Page 4**
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=17363&FacilityID=20100)

One would think things would improve after a Director's Order, however that was not the case.

Less than two months later an RQI resulted in 23 written notices, 7 voluntary plans of correction and 3 additional compliance orders. Residents not fed, allegations of staff to resident physical and verbal abuse (two staff were allegedly rough when providing care to a resident in a way that resulted in pain and that inappropriate remarks were made); resident to resident abuse of an inappropriate sexual nature; lack of appropriate linens with staff providing incontinence care with bed sheets because towels were unavailable, and then residents not being able to be put to bed in the absence of sheets; (**MOH RQI Inspection, May 11, 2017,**
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=17740&FacilityID=20100)

By November 8, 2017 things were not much better. In a Complaints Inspection with Orders, 13 written notices, 7 voluntary plans of correction, and 5 compliance orders were issued with 3 Director referrals. Problems included: short staffing, call bells not answered, falls, inappropriate wound care resulting in deteriorating bed sores with a resident crying out in pain and foul smelling drainage occurring, resident to resident abuse etc. (**MOH Complaints Inspection With Orders, November 8, 2017,**
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=19481&FacilityID=20100)

December of 2018 there were no RN's on duty in the home on at least 14 identified dates. A written notice and voluntary corrective plan were issued. **(MOH Complaints Inspection: December 3, 2018,**
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=20670&FacilityID=20100)

Almost four months later an injured resident was found on the floor of their room and transported to hospital. (**MOH Critical Incident Inspection, March 21, 2019.**
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21782&FacilityID=20100)

A month later an inspection found that a medication had not been given as ordered by a doctor and the doctor ordered the resident transferred to hospital. There was also a significant shortage of towels and bed linens. (**MOH Complaints Inspection, April 11, 2019,** http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21960&FacilityID=20100)

Three months later another resident fell, was injured and complained of severe pain. The doctor was not notified and the resident was not immediately transferred to hospital, but was finally transferred exhibiting clear signs of injury. 3 Written notices, 3 voluntary corrective plans, and 1 compliance order were issued.
(**MOH Critical Incident Inspection**, **July 25, 2019,** http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22869&FacilityID=20100)

By early December, 2019 Orchard Villa was again cited for 4 written notices, 2 voluntary correction plans, and a compliance order for alleged falls, and alleged abuse of residents by staff as reported by a registered practical nurse. **(MOH Critical Incident Report, December 6, 2019.** http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24062&FacilityID=20100)

Also on December 6, 2019 two MOH inspections occurred – one a follow up inspection, the other a complaints inspection. In these cases a total of 4 written notices, 2 voluntary plans of correction, and a compliance order were issued. Problems that were identified were: personal care, especially continence care was not done; PSW's reported not having time to complete the care. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24063&FacilityID=20100

It is quite clear in examining these reports that care in this home was not what was required.

Then in March 2020 the pandemic hit, and by April 2020 this home had the highest death rate in the province.

Hawthorne Place, Etobicoke

With deaths having risen to 23, with 41 residents and 78 staff having confirmed cases of COVID 19, Hawthorne Place in Etobicoke is another home that recently made the news (Toronto Star, May 2, 2020).

Its last resident quality inspection (RQI) was in May of last year, 2019, and it received 8 written notices, 3 voluntary correction plans, and 2 compliance orders.

While this home's history is not as significant as that of Orchard Villa, the litany of problems reads the same – repeated falls resulting in injury and some requiring transfer to hospital, care plans not followed, resident to resident sexual inappropriateness without appropriate behavioral interventions occurring, resident to resident physical abuse, residents' pain not adequately monitored, serious incidents not reported to the Director as required by the Act etc. (**Hawthorne Place Inspection Report, June 3, 2019** http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22645&FacilityID=20595)

Altamonte Care Community

In April of 2020, a health care worker at this home died of COVID 19. There were 87 confirmed cases and 12 deaths at Altamont by this time (Passifiume, April 17, 2020).

This home's last resident quality inspection was on February 26, 2019, and at that time inspectors issued 11 written notices, 7 voluntary correction plans, and 3 compliance orders.

Problems flagged in that inspection concerned: the home failing to ensure clean and sanitary conditions; inappropriate skin and wound care resulting in bedsores (possible problems with nutrition and hydration among other things); written care plan not followed regarding transfers resulting in repeated falls; appropriate assessment and interventions after falls; failure to provide safe storage of medications; medication incidents; "t**he licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program"(page 36).** (**Altamonte Care Community Inspection Report, February 26, 2019**
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21466&FacilityID=20009

This last citation by inspectors is extremely important because there was no follow up comprehensive resident quality inspection a year later which would have been February, 2020 (a month before COVID hit) as there should have been. The Ford government had "relaxed" inspections for these homes by then.

What this means is that there was no appropriate follow up a year later by the Inspection branch to ensure that staff was getting training in infection control procedures just before the pandemic occurred.

Eatonville Care Centre, Etobicoke

As of April 26, 2020, this facility had 173 resident cases of COVID 19, 37 resident deaths and 66 staff cases – 70% of its residents had tested positive. (Tubb & Wallace, April 26, 2020; Stone & Howlett, April 17, 2020).

This home had not had a resident quality inspection since October 10, 2017 even though during its last inspection it had received 12 written notices and 7 voluntary correction plans including problems with care plans being based on a resident's assessed needs that resulted in a transfer device not being used when it should have been with a resulting injury, no notification of substitute decision maker regarding medication change, the home not being clean or sanitary and being in a state of disrepair (uncleanliness of a serving counter, torn chairs, missing doors, rusted hinges etc), residents not being assisted to eat, failure to ensure that controlled substances were safely stored, failure to ensure proper administration of medication to residents, **failure to ensure that all staff took part in the infection prevention and control program (Page 16.** (**Eatonville Care Centre, Etobicoke Inspection Report, October 10, 2017**)
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=18502&FacilityID=20238

This is particularly important since this is what the inspectors said at the last inspection:

"1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

Inspector #684 **observed infection control bags which held Personal Protective Equipment (PPE) hanging on resident room doors with no signage to indicate what the precautions were for, or which PPE was to be used.** (Page 16: http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=18502&FacilityID=20238)

Inspector #687 also noted multiple resident rooms with PPE hanging on the doors but no signage to indicate which resident was on isolation, the type of precautions required, nor which PPE to use. (Page 16 - http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=18502&FacilityID=20238)

During an interview with ADOC #144, they verified there were multiple residents demonstrating symptoms in the past six months and that these symptoms were not indicated on the Infection Surveillance list until the residents were receiving treatment for their symptoms. [s. 229. (4)] (Page 18 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=18502&FacilityID=20238

The licensee has failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and staff on every shift record symptoms of infection in residents and take immediate action as required. (Page 18 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=18502&FacilityID=20238)

It should be obvious why these citations by inspectors on October 17, 2017 with no comprehensive resident quality inspection having occurred again by March, 2020 at the time of the pandemic would appear to indicate the province's failure to protect both staff and residents in this home.

What Rights Do Residents and Families Have?

In the mid-1980's Concerned Friends of Ontario Citizens in Care Facilities was successful in lobbying for a Resident's Bill of Rights to be included in what was then the Nursing Homes Act. That Bill of Rights continues to be used today by inspectors who have cited homes for its violation.

The reason that the public is now able to even see inspection reports, is because Concerned Friends successfully lobbied for them to be made public in the early 1980's. The organization also was successful in getting mandatory reporting of abuse and neglect into the legislation among other positive changes.

One of its other successes was a strengthened Inspection Branch that instituted a prosecution policy against homes that endangered residents.

However by the late 1980's during a Liberal government, that prosecution policy was eliminated after intense lobbying by the industry.

In fact, many of the procedural gains made by an earlier generation of advocates have now been lost, although the legislative gains remain in the Act.

The Power of POA's

Those holding Powers of Attorney for Personal care have the right to residents' records. Residents have the right to their own personal physicians. Residents have the right to refuse consent to enter a long term care facility in the first place.

Another of Concerned Friends' accomplishments was the formation of the Advocacy Centre for the Elderly (ACE), a legal clinic established to assist older adults. Co-founded by the author of this report and Dr. Birthe Jorgenson, ACE has produced numerous information pieces outlining the rights of residents and their families (Advocacy Centre For The Elderly, 2020). Readers are urged to go to the ACE website for a more comprehensive view of residents and family rights http://www.advocacycentreelderly.org

A RIGHT TO A BETTER LIFE: ALTERNATIVES TO WAREHOUSING AND INSTITUTIONALIZING AGE AND DISABILITY

Is it really necessary to warehouse older adults?

Other groups of people with complex needs have fought for, and gotten, other alternatives to institutions. Throughout the 1970's and 80's groups representing people with physical and developmental disabilities fought for, and won an end to segregated institutions. These are now considered to be absolutely the wrong place for people who require the care of others - except for older adults. Ageism is so strong in Ontario that the question of alternatives to institutions for elders has never really been effectively raised.

Everyone believes that there are only two alternatives for older, disabled adults – home care or a long term care facility. The lack of creativity in considering other options is unfortunate when you consider that these alternatives are in place for others.

Not only are older adults institutionalized in huge numbers, but they are also subjected to care for profit, with little to no oversight by an effective inspection branch. This recipe for disaster became obvious during the 2020 pandemic as after 100 days since Ontario's first COVID 19 case, the virus had killed 1300 people, with 75% of them in long term care facilities (Hasham & McLean, 2020).

This should be the heads up that this province needs to demonstrate that this outdated and dangerous system of caring for older, disabled adults is not what is needed.

What follows are non-profit, community-based alternatives to long term care facilities that are intended to not only provide a better level of care and support to older adults, but also to preserve

their dignity and ensure that they remain part of their communities, close to family, friends and other natural supports.

The time for an ageist, institutionalized and segregated approach to caring for older adults is now long past and needs to be replaced.

Smaller Congregate Living Options

Communities of choice could be considered as options for older adults where they have the opportunity to pool their resources and purchase large homes that can house up to 8 people on a lease hold or rental arrangement. Older adults would pay for their accommodation and the home's upkeep, but the government would fund dietary and personal support services so that individuals living there could receive assistance with activities of daily living.

Volunteers, family, and friends would be welcome to visit and provide emotional support.

At a cost of $920.00 per week ($23.00 hr x 40 hrs) + benefit costs, residents could have the services of a personal support worker or workers for 40 hours per week. Personal support workers employed in this kind of arrangement could be full time, earning over $44,000.00 per year plus have full benefits, and staffing would be on a 1:8 staff to resident ratio rather than the much higher staff to resident ratios seen in nursing homes.

Non-profit social services agencies (family services, senior serving agencies, municipalities, charitable groups) could provide staffing to these kinds of homes and offer nursing and other supervision as well. 10 – 15 homes of this nature in a community could serve up to 120 older adults in a more dignified, community-based, inclusive environment where ALL of the funding provided by government would go into the care and support of the older adults who require it.

Active Older Adult Lifestyle Communities With Support Services Built In

The Village By The Arboretum is an active lifestyle community for people 55+ offering almost 500 single family homes and town homes, 81 mid-rise luxury condos in two buildings, 211 apartments and full service retirement suites (Village of Arbour Trails), 93 luxury mid-rise apartment rental suites (Ailsa Craig Neighborhood), 6 rental townhomes, an on-site medical centre with doctors, a pharmacy and medical testing services, as well as a range of amenities including fitness facilities (Village By The Arboretum, 2020).

Would it not make sense to provide incentives to developers to build fully accessible communities like this in towns across the province, then fund non-profit "hubs" located close to these communities that provide support and care services to older adults in these communities? Services could range from meal deliveries to personal care, to nursing support, to palliative care in people's own homes.

A small, non-profit in-patient hub of 10 -15 beds could also be made available to provide medical support if it was required. This type of hub could be established as an auxiliary unit to the local hospital.

If the community was gated, with security, it would also provide a safe place for people with Alzheimer's to wander, and in fact, trails could be built into the community for that purpose.

Again, individuals would pay for accommodations, and some accommodation could be offered on a sliding scale with rent subsidies for the apartment rental suites for lower income older adults.

Consider that a community of this nature could serve up to 2000 people, and provide them with the security of knowing that they would never have to leave their own homes and that support services would come to them.

Supported Independent Living

Many adults with developmental disabilities now live independently with staffing support provided by community agencies.

Why is this option not as available to older adults?

Individuals with physical disabilities could manage quite well in accessible apartments if personal care and support was offered to them and meals could be delivered.

Community based services like Neighborhood Link's Akwasti Program (designed for frail, vulnerable older adults who would otherwise quality for a long term care facility but who wish to remain independent) are currently offering these kinds of services, and these need to be greatly expanded across the province (Neighborhood Link, 2020).

Etobicoke Support Services is another agency that offers personal support, homemaking, security checks and other services, termed assisted living, to help older adults to maintain their independence. This agency also offers adult day programs for people experiencing cognitive disabilities. By greatly expanding services of this nature many more older adults could avoid institutionalization (ESS Support Services, 2020).

This is another kind of service that needs to be greatly expanded across Ontario.

Staffed Small Group Homes

For individuals with cognitive disabilities, small, staffed group homes are a better answer than a large impersonal institution.

Using trauma informed approaches to calm the deeper brain centers, individuals with even advanced dementias are able to experience a far better quality of life.

Housing individuals requiring this type of support in smaller settings is more home-like, allows family to visit, and allows specialized support to be provided.

Having a safe, fenced outside area attached to a home with paths and gardens, allows safe wandering. It is not necessary to institutionalize cognitive disability. It is possible to house it in a setting where individuals can receive far better humane care and support than they would in a long term care facility.

Family Home Programs

Where a family is no longer able to care for an older adult because it is too physically taxing for an older spouse, or children work and cannot leave an older adult unattended, family home programs may be the answer. In these programs a host family is paid to provide care and support to an older individual, and additional funds can be made available for nursing support if it is required.

Family Home Programs are currently available in Ontario for people with developmental disabilities who require support and supervision. Why not for older adults who require the same?

Enhanced In Or Out of Home Respite For Caregivers

Family caregivers can become exhausted if there is not support available to them. Currently agencies like ESS Support Services provide in-home and overnight respite for caregivers who wish to take breaks from caring for a family member.

These kinds of services could also be expanded using Family Home Programs for out of home support for an older adult, or expanded in-home support to allow caregivers to take vacations.

It should not be necessary for an older adult to be institutionalized in a respite bed in a long term care facility for a caregiver to get a break. These kinds of services and supports could be expanded within the community.

A Word About Home Care

At the present time Home Care offers far too few hours a week to be of any real assistance in preventing the institutionalization of older adults. Between 2005 and 2016 Community Care Access Centre (CCAC)[12] funding for home care increased by 73% to $2.5 billion but has remained a constant of only 4 – 5% of the overall provincial health budget. What that means is that the average costs for CCAC services were about $3400.00 per person (Home Care Ontario, 2017).

Consider the cost per person of long term care in comparison – over $22,000.00 per year for basic ward accommodation.
Rather than creating thousands more institutional beds in the province, the government would be well advised to boost home care to 20 hours per week to allow individuals to remain in their own homes with the necessary supports.

[12] As of June 2017, all Community Care Access Centres (CCAC's) transitioned into Local Health Integration Networks (LHINs).

Groups like the Victorian Order of Nurses should be funded to provide much higher levels of in-home service to individuals. Boosting home care hours to up to twenty per week would also allow the same personal support worker to care for an individual rather than making visits to several homes.

SUMMARY AND RECOMMENDATIONS

This report has provided an overview of all that is wrong with Ontario's institutionally based long term care system. It is a system that has been shown to be a threat to the health, safety, and lives of residents and staff.

Ontario has failed completely in its responsibility to ensure appropriate oversight of long term care facilities, and failed in its duty to provide safe and secure environments for the most vulnerable people in the province.

In so doing, it has also failed families in not providing appropriate information and care to their loved ones.

And it has failed the staff who devote their lives to caring for individuals who are unable to care for themselves. It has placed them in dangerous situations without the appropriate protection to allow them to fulfill their duties.

It is time for a change, and for the government to finally take the appropriate action to ensure effective oversight of this system impose penalties to operators who fail to provide safe and appropriate care to residents and information to families, reasonable pay and working conditions for staff. Furthermore there need to be alternatives to these institutions for older adults who do not wish to be institutionalized, but remain as independent as possible.

Below are a series of recommendations, that if implemented, would go a long way to fixing what is clearly a completely broken system of caring for older adults in Ontario.

These recommendations also begin to address the ageist policies and practices that have been the hallmark of public policy in Ontario for far too long.

Ontario has, for years, engaged in discussions of racism and sexism and has instituted some policies, although not sufficient ones, to address these extensive and systemic social problems. What it has not done is address the widespread and systemic ageism directed against older adults who have, for too long, been forced to live in unsafe, demeaning, impersonal, and dangerous conditions in long term care facilities, with few to no safeguards available to them.

This needs to stop today. The recommendations that follow provide a road map to government on how to provide more humane and effective options that begin to address the ageist policies and practices that have been in effect in Ontario for decades.

It is recommended:

Systemic Actions By The Premier

- That the Premier ask the OPP to review the inspection reports of the homes with the highest infection and death rates in Ontario and to conduct whatever confidential interviews with residents, staff, and families are necessary, with a view to conducting criminal investigations of any findings that may involve criminal acts such as criminal negligence causing death or bodily harm, and that criminal charges be laid against the individual or individuals found responsible;
- That the Premier appoint a Provincial Court Judge to oversee an Investigative Public Inquiry, and include a broad mandate to determine what caused the infection and death rates in long term care facilities, and to recommend necessary changes;
- That the Premier immediately, in concert with the Minister of Health, begin negotiations with the Registered Nurses Association, the Registered Practice Nurses Association, the Personal Support Worker Association, and the major unions representing these staff to come up with a plan to address staffing shortages in Ontario long term care facilities;
- That the Premier initiate a section on staffing requirements in the Long Term Care Homes Act requiring registered nurses and nurse practitioners to have a greater presence and additional responsibilities in long term care facilities;
- That the Premier hold discussions with geriatric physicians and gerontological experts, families, and staff in concert with the Coroner's Office to determine how that office might more effectively respond to, and flag, unexpected deaths in long term care facilities, and how to use the inquest process to bring about change where required;
- That the Premier of Ontario immediately ask the Minister of Health, Minister of Community & Social Services, Minister of Long Term Care, and Minister of Municipal Affairs and Housing to negotiate ways to partner to introduce non-profit, community based residential and in-home support service alternatives to address and prevent Ontario's high rate of institutionalization of older adults in long term care facilities, and that funding be re-directed to alternative initiatives rather than announcing more long term care institutional beds.
- That the Premier ensure that the Director of the Inspections Branch, the Attorney General, the Solicitor General and the Chief Coroner conduct a joint review of protocols for the investigations of deaths and serious assaults in LTC homes, with a view towards ensuring that incidents are investigated with the same level of thoroughness and scrutiny as those that occur outside of LTC homes.

Inspections and Enforcement

- That at least yearly (and twice yearly or more for problem facilities) comprehensive resident quality inspections of long term care homes be immediately reinstated;
- That the Inspection Branch be funded to provide an accounting infrastructure allowing it to monitor and determine that funding provided to long term care facilities be used for the purposes for which it was earmarked;
- That the Inspection Branch significantly increase its complement of inspectors and that they be paid at nurse manager rates to ensure higher level qualifications;

- That the Inspection Branch be re-centralized in the Ministry of Health so that it can work more effectively with hospital-based teams and allow the Director to ask that hospital-based teams go into long term care facilities to correct infection control and care-related issues where required. This should take the place of long term care companies obtaining the services of other long term care companies like Extendicare Assist to address problems in these homes;
- That the Director of the Inspection branch be empowered to revoke the licenses of homes that endanger their residents in the event that a Director's Order is not addressed;
- That the Director of the Inspection branch be empowered to introduce a prosecution policy to charge and fine homes that fail to provide safe and secure environments for residents and that fail to implement appropriate care plans;
- That the Director of the Inspection branch have the authority to immediately stop intakes in homes that do not have sufficient staffing to meet the needs of their residents;
- That the government of Ontario immediately reinstate in the Health Facilities Special Orders Act the ability of the Minister of Health to take over any long term care facility that is endangering the health or safety of its residents;
- In introducing a prosecution policy of homes that fail to provide a safe and secure environment for residents and fail to implement appropriate care plans, that the Minister of Health work with the Attorney and Solicitors General to ensure the support of the police and Crown Attorneys to assist the Director in charging and prosecuting homes, especially where it is found that criminal acts may be occurring;
- That the Director of the Inspection Branch have the authority to order forensic audits of long term care facilities and companies that fail to provide staff with appropriate personal protection equipment, supplies such as linens and towels, and sufficient staffing to ensure that residents' needs are met;
- That legislation be strengthened to require long term care facilities to have pandemic plans that include evacuation of residents to hospital if they are unable to safely segregate positive from negative residents;
- Reinstate Ministry SWAT teams to bring homes with repeated non-compliance with the care requirements of the Act back to compliance rather than relying on other for-profit companies that often lack the expertise to bring homes into compliance and are expensive;
- That the Director be empowered to negotiate with municipalities, charitable and religious organizations and other non-profit providers to take over management of long term care facilities that have had their licenses revoked and been taken over under the Health Facilities Special Orders Act;
- That the Director be empowered to issue staffing directives to homes whose staffing levels are not sufficient to provide adequate care and support to their residents. Placing mandatory limits on the ratio of full-time to part-time staff would also be an important step to ensure more staff designated to specific homes and less reliance on agency staff having to travel between homes.

Funding

- That all provincial funding increases to long term care and all taxpayer funded services in long term care facilities be spent on services and supplies for residents and are not allowed to be used for the profit of long term care companies.
- That the Government of Ontario, in order to increase parity between for-profit and not-for-profit homes, award any new beds to the not-for-profit sector and municipal sectors.

Recommendations To The Federal Government

- Institute a national long term care policy with an emphasis on providing residential, respite, and home care alternatives to long term care institutions and fund it under the Canada Health Act. This could be introducing through the funding of pilot projects;
- Canada needs legislation to protect and encourage whistleblowing in the long term care system. The U.S. False Claims Act provides an example of what is required.

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Dr. Spindel is also a former Coordinator of the Social Services Worker Program and former Associate Dean of Health Sciences at Humber College, and taught the Advocacy In Aging course at Ryerson University and taught social work courses in the Social & Community Services degree program at the University of Guelph-Humber.

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