

Ontario Health Coalition

Submission to the Facilitator, Shirlee Sharkey

Review of Staffing and Care Standards for Long-Term Care Homes

January 31, 2008

Who We Are

The Ontario Health Coalition is a network of more than 400 grassroots community organizations representing virtually all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to health care and healthy communities. To this end, we seek to provide to member organizations and the broader public ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly-funded, publicly-administered health care system. We work to honour and strengthen the principles of the Canada Health Act.

Our members include over 50 local health coalitions in communities across the province; local health action committees; health professionals' organizations; physicians that support medicare such as the Medical Reform Group; medical students' groups that support medicare; non-profit service providers; health sector unions; women's groups such as the National Action Committee on the Status of Women, the Older Women's Network, Canadian Pensioners Concerned, Immigrant Women's Health Centre, Voices of Positive Women; seniors' groups including the Ontario Coalition of Senior Citizens Organizations, CAW retirees, Alliance of Seniors to Protect Social Programs, CareWatch, Concerned Friends, long term care family and residents' councils; low income and homeless peoples' organizations including Low Income Families Together, Food Share of Metro Toronto, Ontario Coalition Against Poverty; social service organizations; workers' advocacy organizations; ethnic and multiracial minorities; the Ontario Federation of Labour; and other organizations such as the Canadian Council of South Asian Seniors (Ont.), the Association of Neurologically Disabled, Ontario Coalition for Social Justice, Social Planning Council of Metro Toronto, Native Women's Resource Centre, Aids Action Now, Birth Control and Venereal Disease Centre, the Canadian Federation of Students (Ontario division), Oxfam Canada and the Injured Workers Resource Centre, among others.

We work in partnership with the Canadian Health Coalition and provide provincial coordination of community-based health coalitions.

Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario M3C 1Y8
tel: 416-441-2502
fax: 416-441-4073
email: ohc@sympatico.ca
www.ontariohealthcoalition.ca

Table of Contents

<u>Introduction</u>	pp. 4
<u>Priority Recommendation</u>	pp. 5
<u>Section I: Assessing the State of Care, Regulation and Accountability in Ontario's LTC Homes</u>	
Reports from our Members	pp. 6
Increasing Acuity	pp. 7
Cross-Canada Care Levels	pp. 8
Actual Care Levels vs. Recommended Levels	pp. 9
Staffing Shortages	pp. 10
Accident, Injury and Violence Rates	pp. 11
Poor Practices Reported	pp. 13
Status of Accountability	pp. 14
Incongruity between Acuity and Funding	pp. 15
<u>Section II: The Case for a Regulated Care Standard</u>	
Genesis of Regulated Care Standards	pp. 16
Best Practice Research	pp. 17
Which Classifications Should Be Covered	pp. 19
For-Profit Density and Regulation	pp. 20
<u>Section III: Additional Human Resource and Quality of Care Issues</u>	
pp. 23	
<u>Appendix I: Key Issues in Long Term Care Facilities: Sept. 2006</u>	pp. 25
<u>Appendix II: Ottawa Citizen Series: The Case for Regulation</u>	pp. 27

Introduction

The Ontario Health Coalition has, in consultation with seniors' groups, nurses' organizations, physicians, community coalitions, unions, members of residents' and families' councils, come to a consensus set of key recommendations regarding quality of life and quality of care in long term care homes. Chief among our concerns is the lack of daily care for residents, and inadequate accountability for the levels of care provided by operators. Though many aspects of the physical structure of the homes are regulated, the daily care levels have been left without equivalent regulatory and compliance regimes. Yet inadequate nursing and personal support care levels have resulted in significant problems of access, creating a multi-tiered system based on wealth rather than need. Crushing workloads, stress, inadequate supports, lack of control, a punitive culture, rationing of supplies and inadequate resources have contributed to conditions that are creating harm to residents, stress and undue financial burden on families, and exacerbated staffing shortages across the sector.

Through successive years of significant funding increases to the LTC home sector, we have not found a commensurate increase in daily hands-on care provision. The vast majority of funding increases have gone towards an increase in the size of the sector rather than to improving the amount of daily care for existing residents and addressing the pressing quality of care issues.

There is a need to redirect funding and policy attention to quality of care issues. Care workers regularly report to us that they are unable to meet health and safety and professional standards at current staffing levels. Residents report unsafe or inadequate living conditions, lack of palliative care, and deeply disturbing concerns about quality of care, outcomes and quality of life. Families echo stories of a culture of fear, guilt, stress, and inadequate care.

Priority recommendation

Based on the evidence from the best practice research and our own comprehensive consultations with stakeholders, we have identified our priority recommendation to improve care standards and outcomes in LTC homes as follows:

A care standard, in regulation under Bill 140 that would set a minimum staffing level of 3.5 hours of hands-on care per resident per day for LTC homes. The minimum would be attached to the average CMM - the average acuity - and therefore correlate to the assessed acuity of each home. As recommended in the research and best practices, the standard would cover direct care staff including RNs, RPNs, and PSWs/HCAs, excluding administrative staff. It would be attached to the Nursing and Personal Care envelope - excluding incontinence supplies. It would reflect worked hours as opposed to paid hours. It would be subject to a compliance and enforcement regime.

Thus, our recommendation suggests that as the CMM ranged from 75.1 to 105.12 in 2006, the average home (CMM 96.33) would be required to provide 3.5 hours per day. A CMM 75.1 home would be required to provide 2.73 worked hours of care per resident per day. A CMM 105.12 home would be required to provide 3.82 worked hours of care per resident per day.* The homes would retain the flexibility to assess the range of care staff within the Nursing and Personal Care envelope (RNs, RPNs, PSWs) would provide the care, excluding Administrative staff. Thus, funding would be aligned to assessed care needs and the required care levels that flow from the assessed needs. This regulated care standard would need to be subject to an effective compliance and enforcement regime.

Please see our additional recommendations in Section III and Appendix I.

* The formula would be adjusted to work under the new classification system once it is adopted across the sector.

SECTION I: ASSESSING THE STATE OF CARE, REGULATION AND ACCOUNTABILITY IN ONTARIO'S LTC HOMES

Reports from our members

The Ontario Health Coalition has conducted three cross-province consultations on care in LTC homes since 2001. These included one round of broad public hearings, another round of public forums and discussions, and a round of in-depth interviews conducted from 2006 - 2008. More than 1,600 people attended the two rounds of public hearings and forums, and approximately 40 people were interviewed in the latest round of in-depth interviews.

Through our extensive consultation with member groups, residents, family members, volunteers, careworkers and facility operators, a common theme emerged. The care levels in LTC homes are inadequate to ensure the provision of a decent and dignified quality of life. To those who live, help out or work in the homes, this is not "a numbers game" - as it is glibly termed by some policy makers. It is about care and it is an access issue. Inadequate levels of care have led to people hiring in their own care staff, if they can afford it, while residents with few family supports or lower income go without. Perhaps most seriously, we found that current care levels are inadequate to protect both residents and staff from harm.

Everywhere in Ontario we heard from frustrated caregivers, residents and family members who cannot give the care they want or cannot access the care they need. From urban to rural areas, north to south, people are identifying that heavier care residents now live in the homes. Staff feel inequipped to appropriately care for residents with cognitive difficulties and behavioural problems. Careworkers feel alienated from the charting process - terming it "charting for dollars" because they do not see a connection between funding increases and improved staffing. Yet downloading of heavier care patients from mental health facilities and hospitals continues. Across the province, younger people with disabilities are being moved into LTC facilities because of inadequate homecare and community supports. The increasing care needs have not been met with a regulatory and compliance regime to support residents and staff.

On the other hand, we have heard stories of incredible compassion. Careworkers are angry, or they end up in tears, when describing their feelings of guilt and inadequacy for providing less care than they know residents need. Family members tell us of volunteering hours each day, every day, to provide assistance for residents without family support. Personal support workers bring in clothes, work extra hours, do hundreds of extra "little" things to try to improve the quality of life for residents. Residents tell us of advocating for each other, and helping out when possible. The human resources - paid, volunteer, family - overwhelmingly report going "the extra mile" to make the experience of living in LTC homes better.

These findings are not localized. While sound facility management and lots of volunteers can compensate to some extent for the inadequacies, they cannot provide the levels of care across the province that are a minimum requirement to protect from harm. The evidence is that the lack of care is so widespread as to be a systemic problem that requires a change in public policy to address it.

Increasing acuity

- Resident acuity in Ontario's LTC homes has increased by 29.7% since Classification was implemented in 1992 as a result of the redefinition of complex continuing care, shorter lengths of stay in hospitals, ageing, and the downloading of mental health patients from hospitals. The 2007 Provincial CMM was 98.13, an increase of 1.87% from 96.33 in 2006. (Memorandum to Charitable, Municipal and Nursing Home Operators from Health Data Branch, MOHLTC, December 2007). This increase reflects only the measured needs according to the Alberta Classification system, which, as has been recognized by government, does not adequately recognize the complexities of care required by residents with cognitive, emotional and behavioural problems.
- By 2007, 74% of Ontario's 51,440 LTC residents classified that year were classified as Category F (the second highest acuity category). This represents a substantial increase in acuity over the last decade.
- It is now generally accepted that 60 - 80% of residents have some form of cognitive impairment. In 2005, 140,000 Ontarians had Alzheimer disease or related dementia. The number is expected to double to 307,000 in the next 25 years (Alzheimer Society of Ontario, Position Paper on Casa Verde Recommendations, September 2005.) In an earlier study conducted by PriceWaterhouse Coopers in 2001, 53% of Ontario's LTC residents were diagnosed with Alzheimer/dementia resulting in requirements for improved special training, evaluation and monitoring.
- The same study noted relatively high rates of Alzheimer, stroke, arthritis and significantly higher levels of cognitive impairment, impairment in activities of daily living, depression, and mental health disturbances/problems. (PriceWaterhouse Coopers, Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators. January 11, 2001.)
- Across the province, care workers report that people with serious behavioural problems, psychogeriatric patients, and younger adults with disabilities are being moved into LTC homes with increasing frequency in the last half decade. These residents have complex care needs that result in repeated reports of inadequate training, inadequate staffing levels, improper placement and violence.

Prevalence of Dementia and Alzheimer's Disease, Physical Problems and Other Diagnoses

	Ontario LTC	Sask.	Manitoba	Michigan	Maine	Mississippi	South Dakota	Sweden	Finland	Nether lands
Dementia/ Alzheimer's	53%	62%	41%	47%	50%	57%	44%	19%	65%	34%
Diabetes	19%	12%	17%	24%	20%	22%	18%	9%	6%	9%
CHF	11%	18%	13%	27%	21%	24%	30%	19%	8%	22%
Stroke	22%	18%	16%	24%	22%	25%	21%	4%	23%	13%
Arthritis	30%	32%	28%	32%	26%	34%	39%	7%	4%	17%
End Stage Disease	1%	0.2%	0.2%	1%	1%	0.4%	0.8%	0.6%	22%	0.8%
Parkinson's	6%	6%	7%	6%	7%	6%	7%	6%	3%	4%
Cancer	9%	11%	3%	11%	9%	6%	11%	6%	2%	6%
PVD	4%	3%	2%	12%	10%	9%	6%	2%	1%	3%
Osteoporosis	7%	13%	5%	14%	11%	10%	11%	4%	2%	5%
COPD	1%	4%	2%	19%	19%	14%	13%	3%	3%	7%
AHD	12%	7%	4%	19%	18%	19%	17%	7%	7%	11%

From PriceWaterhouse Coopers 2001 Report.

Ontario Has Second Worst Staffing Levels in Canada

This data covers all hours of care, including non-direct hands on care. Thus, it does not separate out the direct daily care provided under the Nursing and Personal Care envelope by the RN, RPN and PSW staff. But it illustrates, in broad terms, how Ontario is doing relative to the rest of the country.

- According to Statistics Canada, total paid hours per resident-day in residential care facilities in Ontario was 3.3 in 1997/98 with a small increase to 3.8 in 2005/06. According to this data, we are second last across the country for total hours per resident day. Only British Columbia has fewer hours per resident-day and the gap between Ontario and the rest of the country is widening significantly. (StatsCan "Accumulated paid hours during year per resident-day in residential care facilities, by principal characteristic of the predominant group of residents and size of facility, Canada, provinces and territories, annual (number))

Total LTC Facility Paid Hours Per Resident Day By Province/Territory (includes all staff)
from lowest to highest (at starting date)

Prov/Terr	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06
BC	3.3	3.5	3.6	3.6	3.6	3.6	3.5	3.5	3.7
Ontario	3.3	3.4	3.4	3.4	3.4	3.5	3.6	3.7	3.8
PEI	3.8	3.7	4.2	4.1	4.1	4.1	4.1	4.0	4.2
NB	3.9	3.9	4.0	4.1	4.2	4.2	4.3	4.2	4.2
NFLD	4.4	4.6	4.2	4.2	4.5	4.6	4.3	4.6	4.8
ALTA	4.6	4.7	4.8	4.9	5.2	5.3	5.0	5.2	5.1
NS	4.7	4.7	5.0	5.2	5.3	5.6	5.6	5.6	5.7
SASK	4.8	4.7	5.1	5.4	5.4	5.6	5.4	5.7	5.7
MAN	4.9	4.7	4.7	5.0	5.0	5.1	5.1	5.1	5.2
QUE	5.2	5.3	5.5	5.8	6.0	6.0	6.0	6.9	6.6
Territories	5.3	5.3	6.1	6.2	6.4	6.8	6.4	6.9	7.5

Ontario's Hours of Care Do Not Meet Evidence-Based Recommendations for Minimum Hours

- According to MOHLTC figures, average worked hours per resident day for direct care staff categories from 2004 - 2006 shows 2.375 HPRD in 2004 and 2.573 HPRD in 2006. (Letter from Dan Bryant, Program Advisor, Access and Privacy Office MOHLTC to Shelley Martel MPP Nickel Belt, March 14, 2007.) Yet, as described fully in Section II, these levels do not meet minimum thresholds to prevent from harm and are far short of maximum thresholds to improve outcomes.

Hours per resident day (average):

Phases	Paid Hours					Worked Hours				
	1	2	3	4	5	1	2	3	4	5
Nurse Practitioner	0.0002	0.0001	0.0001	0.0001	0.0001	0.0002	0.0001	0.0001	0.0001	0.0001
Clinical Nurse Specialist	0.0003	0.0003	0.0003	0.0003	0.0003	0.0002	0.0002	0.0003	0.0003	0.0003
Infection Control Practitioner	0.0005	0.0005	0.0005	0.0005	0.0007	0.0004	0.0005	0.0005	0.0005	0.0007
Registered Nurse	0.341	0.354	0.363	0.366	0.364	0.312	0.319	0.332	0.331	0.331
Registered Practical Nurse	0.361	0.376	0.380	0.388	0.395	0.329	0.335	0.344	0.345	0.354
Personal Support Workers	1.9	1.972	2.046	2.071	2.081	1.725	1.760	1.852	1.844	1.877
Total	2.611	2.710	2.798	2.836	2.851	2.375	2.421	2.538	2.529	2.573

Note: "worked hours" is defined as including breaks, but excluding vacation, statutory holidays, sick time, education, bereavement, and other paid absences. The phases reflect quarterly reporting by facilities up to the final quarter (#5) ended March 2006.

Ontario's LTC Homes Are Regularly Working Short-Staffed

In our consultations, staffing shortages were reported as the most significant issue among workers, families and residents. Across Ontario, staff report that it is regular practice not to replace absent careworkers, they are almost always working "short". Residents and families report that they feel bad for overworked staff, hire in their own help if they can afford it, and worry about residents who don't have additional "hired-in" assistance. These findings are supported by evidence from a study done for CUPE by Dr. Pat Armstrong and Dr. Tamara Daly in "There Are Not Enough Hands: Conditions in Ontario's Long Term Care Homes" (2004) who warn that shortages are likely to get worse:

- Like many studies, the survey identifies staff shortages as the central problem and the survey indicates that shortages in every occupational category are critical to care. While shortages in nursing, therapy and personal care staff are vitally important, so too are shortages in laundry, dietary, clerical, recreational, housekeeping and maintenance staff. If the dietary and housekeeping staff are not there, nursing staff end up doing cleaning and feeding.
- The survey found that future shortages result not only from the pay inequities and poor conditions that Monique Smith identified in her report, but also from the aging of the workforce. A majority of the workers surveyed were 45 and older, and one in five have worked in long-term care homes for over 20 years. Inadequacies in formal staffing levels are exacerbated by a failure to replace absent staff members.
- From the report: "We asked workers to indicate whether specified tasks were completed or left undone in the seven-day period prior to responding to the survey. What we found is disturbing and goes far beyond a lack of baths, appropriate food and recreation.... Nearly 60 percent of the time workers don't have the time to provide emotional support (59.8%), while walking and exercising of residents is not done more than half the time (52.3%). More than 40 percent of the time, recording, foot care, and providing support to co-workers is left undone.... More than 20 percent of the time, turning of residents, bed changing, room and bathroom cleaning, learning necessary skills and other unspecified tasks remain to be done. Bathing and building maintenance are left undone nearly 20 percent of the time. Nearly 15 percent of the time (14.7%), workers are unable to attend to clothing changing. Finally, referral to outside medical support is left undone more than 10 percent of the time. Nearly ten percent of the time (8.5%), feeding is left undone...."
- A further study, published in 2007, found that 43.8% of PSWs reported working short-staffed *on a daily basis*. (A.Banarjee et. al. "Out of Control: Violence Against Personal Support Workers in Long Term Care" 2007.)

Ontario's LTC Homes Violence, Accident and Injury Rates are Untenable

The evidence of high rates of accident, injury and violence for both staff and residents in Ontario's LTC homes is significant. Though the MOHLTC has recognized and taken steps to alleviate harm and neglect of residents, the data suggest that the MOHLTC needs to recognize LTC homes as unsafe work places also. The research points to a strong link between violence, accident, injury and workload and conditions in the homes, as well as training and special care units which we have expressed support for in addition to regulated staffing standards.

- In their 2004 study, professors Armstrong and Daly found "... Alarming rates of violence among residents and against workers and of both illness and injury. Within the most recent three-month period, almost three-quarters of workers have experienced some form of violence directed at them from one or more individual residents (73.3%). The combination of rising acuity, inadequate staffing and facilities creates conditions that are dangerous for workers's health. A stunning number (96.7%) in our survey reported having been ill or injured as a result of work in the past five years (1999 - 2003). More than 50% report that work caused illness or injury more than 11 times during this time period." (There Are Not Enough Hands: Conditions in Ontario's Long Term Care Facilities, 2004)
- In a 2007 study of personal support workers in Ontario, Manitoba and Nova Scotia these findings were echoed. 89.7% of the personal support workers indicated that they had experienced some form of physical violence from residents and family members. 43% reported that physical violence occurred virtually every day. The physical violence experienced typically includes hitting, punching, biting, grabbing, pulling hair, twisting wrists, poking, spitting, pinching and throwing objects. (Banerjee A, Daly T, Amstronm H, Armstrong P, LaFrance S and Szebehely M. "Out of Control: Violence against Personal Support Workers in Long Term Care" York University & Carleton University, November 20, 2007.
- In 2004 violent residents attacked other residents 864 times and attacked staff 264 times, a ten-fold increase in five years.(CBC News. April 19, 2005.)
- In 1999 there were 101 assaults in the homes. (Ottawa Citizen. October 21, 2006.)
- There have been 11 homicides in Ontario nursing homes since 1999 and 3,000 reported attacks. (Ontario Nurses' Association. Submission to Coroner's Inquest into deaths of Ezz-El-Dine El-Roubi and Pedro Lopez at Casa Verde Health Centre.)
- Ontario health care and social assistance workers reported 5,333 violent incidents between the years 1997 and 2004, out of 12,383 reported by all workers, for an average of 1.21 incidents per 1,000 health and social assistance workers, compared to 0.17 incidents per 1,000 workers in other industries. (CBC News. April 25, 2006.)
- Annually, Ontario health care and social assistance workers lost 24.5 days per 1,000 workers due to violence, compared to 4 lost days per 1,000 workers in all other sectors.(CBC News. April 25, 2006.)
- Neil Boyd, a criminology professor at Simon Fraser University who studied physical abuse in the health care sector, says abuse of workers occurs most frequently in long-term-care facilities, where residents have disabilities such as brain injuries, age-related dementia and chronic progressive diseases. (CMAJ 1998;159:983-5)

Recent research shows that the link between staffing injuries and staffing levels is measurable:

- In a study examining injury and staffing data for three U.S. states: Maryland, West Virginia and Ohio, researchers found that for each additional hour of nursing care provided, injury rates for nurses and nurses' aides fell by nearly 16%. In other words, for every unit increase in staffing, worker injury rates decrease by two injuries per 100 full time workers.

(Professors Alison Trinkoff, Meg Johantgen, University of Maryland and Dr. Carlos Muntaner University of Toronto, American Journal of Public Health, July 1,2005)

- Further studies show the correlation between working conditions (including workload) and violence, and the decrease in violence against caregivers as a result of special care units and training interventions:
 - Banarjee A et al. 2007.
 - Guss V, McCann J, eldelman P, Farran CJ. "Job Stress Among Nursing Home Certified Working Assistants: Comparisons of Empowered and Nonempowered Work Environments" Alzheimer's Care Quarterly. 2004.
 - Morgan DG, Stewart NJ, D'Arcy KC, Werezak LJ. "Evaluating rural nursing home environments: dementia special care units versus integrated facilities" Aging and Mental Health. 2004.
 - Gates D, Fitzwater E, Meyer U. "Violence against caregivers in nursing homes: expected, tolerated, and accepted" Journal of Gerontological Nursing. 1999.
 - Morgan DG, Stewart NJ, D'Arcy KC, Forbes D, Lawson J. "Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units" Journal of Psychiatric and Mental Health Nursing. 2005.
 - Gates D, Fitzwater E, Telintelo S, Succop P, Sommers MS. "Preventing Assaults Pilot Study" Journal of American Medical Directors Association. 2002.

Poor Practices in Ontario's LTC Homes On the Record

The ostensible reason for the requirement that residents pay a portion of the costs in nursing homes is that they are paying for accommodation. Government subsidies are supposed to cover the care needs for residents. But over the last decade, media and public reports show a litany of complaints and even scandals in Ontario's long term care facilities. In addition to the coverage of infectious disease outbreaks and the well-publicized deaths in Casa Verde, reports show a consistent pattern of inadequate care, problems with regulation and enforcement, and ineffectual financial accountability. These stories point to a need for improved regulation of care, and accountability for the use of public funds which are supposed to provide care in Ontario's nursing homes. Restoration of public confidence requires improved transparency about actual care levels, such as public posting of staffing levels and strict requirements to provide enough hands-on care.

- In 2000, the Canadian Press reported that documents obtained through a Freedom of Information request revealed that regular inspections had dropped close to 40% between 1996 and 1999. (Canadian Press, October 23, 2000. *'Dangerous' gaps in Ontario nursing home checks.*) In some instances, facilities were not inspected for three years, a clear violation of government policy. Inspectors had been reassigned to work on evaluating bids for new long-term care beds and had no time to carry out inspections. When inspections did actually take place they were not the three- to seven-day examinations mandated by the Ministry. Instead they were quick and often cursory reviews. The government responded quickly to this public embarrassment by hiring new inspectors and returning the old ones to their jobs. However, even after this, and after the requirement to reinstate surprise inspections, workers have reported to us facility "tip offs" about inspections with management bringing in extra staff and major "clean ups" just before inspectors arrive.
- In 2001, *The Toronto Sun* published a 16-page special report on long-term care entitled "Elderly Care Crisis", a moving and disturbing expose of inadequate care, stretched staffing and a non-functioning inspection and compliance regime.
- In 2003, The Ottawa Citizen published an investigative series on Ontario's LTC facilities, finding:
 - Major bankruptcies across several Ontario LTC chains
 - Ontario LTC homes awarded to multinational companies under investigation for poor practices resulting in death in the U.S.
 - Caregivers and family members overstretched in their attempts to provide adequate care
 - Excessive profit taking(The series is appended here.)
- In 2003, The Toronto Star published a series by Moira Welsh on Nursing Homes detailing neglect resulting in the death of resident due to a bedsore. The report painted a disturbing picture of inadequate care, regulation and enforcement and resulted in improvements to the inspection regime. However, the inadequacies in staffing levels persist.

Ontario's LTC Homes Have Inadequate Accountability Mechanisms: Inaction on the provincial auditor's recommendations

The provincial auditor in 1995 and 2002 noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PriceWaterhouse Coopers Report, and inadequate tracking of contagious disease outbreaks. The questions raised about funding and accountability are serious. At the time the Toronto Star published its series on nursing homes highlighting the death of a resident due to inadequate care, Extencicare was reporting record profits from its Canadian operations (in Ontario and Alberta) to its shareholders.

In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. However, no substantive action was taken to deal with the lack of accountability regarding whether or not assessed needs of residents were being met. In the minutes of the Standing Committee on Public Accounts, it is reported that the government has been collecting actual staffing data since 1995. However, this information was denied to us on request, and a Freedom of Information request was eventually placed by NDP Health Critic Shelley Martel. In response, the MOHLTC provided staffing information up to March 2006. Despite repeated assurances that up-to-date information would be provided in 2007, there has been no release of the newer numbers. If the auditor's complaint that there is no assessment to determine the adequacy of funding to meet assessed need has been resolved, that report is not available publicly. No staffing standards have been created. The Ministry has never updated nor has it addressed the findings of the 2001 PriceWaterhouse Coopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs including depression, cognitive impairment and behavioural problems.

Incongruity between measurements of acuity and outcomes for funding increases

The government mandates homes to use an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool. The assessments enable facilities and the government to determine the “case mix”. The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity, those with heavier care needs are deemed to have higher acuity. The funding the home receives for nursing and personal support care (feeding, bathing, nursing etc.) is based on the level of acuity in the home. However, there is no expected amount of care that is attached to the average level of acuity, and there is no assessment of outcomes to measure the effectiveness of either the assessment tool or the increased funding. Moreover, though funding is increased as the average acuity has gone up, the funding increase is not tied to actual increased provision of care.

Staff now cynically refer to the documentation required for the assessment tools as “documenting for dollars”. Staff attitudes reflect alienation from the documentation process as they see no connection between it and workload. An array of reports and media exposes, and testimony of families and care staff, have shown that there are serious inadequacies in care provision, despite increased reporting on care needs. Bathing, repositioning, referrals to medical care, even feeding, are left undone because there is not enough care time. This shortfall has serious health and quality of life implications for residents and staff.

We are recommending a care standard that would provide a clear connection between assessments, funding and amount of care. A care standard would be a major step towards closing the loop on measured accountability, funding, and outcomes. It would set an expected level of care, weighted by the assessed acuity of the residents in the home. This would provide one of the most important tools in assessment of appropriate funding, measuring outcomes that result from increases in funding, and provide greatly improved opportunities for accountability.

SECTION II: THE CASE FOR A REGULATED MINIMUM CARE STANDARD

The Genesis of Regulated Care Standards

The for-profit long term care industry is multinational and many of the chains operating in Ontario also operate in the U.S. The United States has had a robust public discussion about reform in long term care over the last decade and a half. Scandals, lawsuits, and horrific tales of neglect have captured the attention of politicians and have resulted in major research and reform to improve care levels and accountability for public funding. Most states moved to minimum care standards in this period. Efforts to achieve a federal minimum staffing standard were especially pronounced in the final years of the Clinton Administration. This debate and discussion has emerged as a significant piece in long term care reform across Canada.

Even a perfunctory search of the U.S. experience yields a litany of abuses not unlike the bankruptcies, profiteering, stories of neglect, and scandals we have seen in Ontario in the last decade and a half. The US Congress, pressed for ever more funding from the industry, has mandated very intensive research into funding levels and care standards.

Resulting from the escalating reports of poor practices, incessant campaigns for increased funding by operators, Congress mandated the U.S. Health Care Financing Administration to conduct “best practice” research into the staffing and care issues. Over a decade, researchers used rigorous methodology including time motion studies and multivariate analysis to arrive at evidence-based recommendations regarding care requirements. There is no evidence to conclude that this is “a numbers game”. Researchers used best practice methodology to measure as accurately as possible the levels of care required to improve outcomes for residents. If the government of Ontario chooses to reject these findings, it cannot do so without full explanation and evidence.

Findings of the Best Practice Research

The report commissioned by Congress found that there were care thresholds below which poor quality of care outcomes were measurably increased and thresholds above which care outcomes do not measurably improve. Our recommendation is based on these findings which are the best practice in research on this issue to date. Notably, study authors found:

1. They were able to demonstrate staffing levels (or thresholds) below which facilities were at substantially greater risk for quality problems (approx. 3 hours per resident per day of RN, RPN and PSW equiv's)
2. They were able to demonstrate staffing levels that were identified as minimum standards for an average acuity at 3.45 hours per resident per day (RN, RPN, PSW equiv's).
3. They were able to identify thresholds above which additional staffing would not provide demonstrable improvements in outcomes at 4.1- 4.95 hours per resident per day (RN, RPN, PSW equiv's).
4. The minimum staffing levels appeared to be sensitive to case mix, requiring a system to classify all facilities into different categories.
5. They reported that residents in understaffed facilities are at a greater risk of preventable health conditions including pneumonia, urinary tract infection, sepsis, congestive heart failure and dehydration.

(U.S. Health Care Financing Administration "Report to Congress: Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes" Phase I and II reports.)

- The Institute of Medicine (IOM) report *Improving the Quality of Long-term Care* (2001) recommended the development of minimum care levels integrated with case mix adjusted standards. It found increasing acuity of nursing home residents and recommended "[F]ederal staffing levels must be made more specific and that the minimum level of staffing has to be raised and adjusted in accord with the case-mix of residents. The objective should be to bring those facilities with low staffing levels up to an acceptable level and to have all facilities adjust staffing levels appropriately to meet the needs of their residents, by taking case-mix into account."
- The Coroner's Jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.
- A recent study published in the *American Journal of Public Health* (July 1, 2005) by researchers from the University of Toronto and University of Maryland found that for each hour of care, injury rates for nurses and nurses' aides fall by nearly 16%. For every unit increase in staffing, worker injury rates decrease by two injuries per 100 full time workers. Study authors concluded that more hours of care provided per patient, the fewer the workplace caregiver injuries, which leads to better care. (Medical News Today (medicalnewstoday.com).
- A recent Canadian literature review found an evidence-based relationship between overall staffing levels and quality of care measured by a number of outcome indicators and

concluded that minimum staffing levels are necessary to avoid adverse outcomes. This same review found that the direct care staff, including RN, RPN, and Aides contribute to quality of care. (Murphy, JM "Residential Care Quality: A review of the literature on nurse and personal care staffing and quality of care" Nursing Directorate of the British Columbia Ministry of Health, November 2006)

- In a study of the experience of dying, researchers found that the most influential factors affecting this experience are: lack of attention to the cultural needs of the residents; cognitive status of the residents; inadequate staffing. (Kayser-Jones J. "The experience of dying: an ethnographic nursing home study" Gerontologist, 2002)
- In her testimony before the U.S. Senate Committee on Finance, Professor Catherine Hawes reported on her findings that 85% of nurse aide registry directors maintain that staffing shortages, too few staff and poor staff-to-resident ratios are the main cause of abuse and neglect in nursing homes. Guilt and stress were found to be significant causes of high turnover. She recommended increased staffing levels and special care units. (Hawes, C, Professor and Director of the Southwest Rural Health Research Centre, School of Rural Public Health, Texas A & M University System Health Science Center. "Testimony before U.S. Senate Committee on Finance, ed. Washington, DC" Senate Committee on Finance, June 18, 2002)

It is based on findings of these reports, and the smaller studies correlating quality, outcomes and care standards of the staff mix in question, that we have made our recommendation to adopt a minimum care standard in Ontario.

Who Should Be Covered in A Care Standard

Though the question of which classifications should be covered in a care standard has been raised repeatedly by Ontario's MOHLTC there is little confusion in the literature regarding care standards. Almost all the literature studies the impact on outcomes of direct care staff - RN, RPN and PSW or equivalent classifications. As outlined in the previous section, the effect on care outcomes has been demonstrated for these classifications. While shortages in all categories affect the ability of direct care staff to provide care, and while all the health professionals and support services are important, the pressing need is for regulation in the daily direct care for residents. It should be recognized, furthermore, that Ontario already has staffing standards for a variety of classifications (see chart below). Thus, our priority recommendation that a regulated care standard cover RN, RPN and PSW classifications in the nursing and personal care envelope, is based on the consensus of a broad coalition of seniors' advocacy organizations, family and resident advocates, workers, unions, health professionals and academics as well as the research outlined above.

Classifications with Existing Minimum Staffing Standards in Ontario's LTC Homes
Administrator
Director of Nursing
Food Services Supervisor
Therapy Services Coordinator
Registered Dietician
Recreation and Leisure Services Staffing

For-Profit Ownership Increases Requirements for Regulation

For-profit nursing homes are required by investors to maximizing the profit and growth potentials of their companies. The investors in Extencicare, Chartwell or the others, seek to maximize the rate of return on their investment and to pursue a growth strategy that maximizes return down the road. That means profit has to be found from the mix of government (public) funding and private fees that residents pay.

In Ontario's Long Term Care Homes there are several funding envelopes, including:

- nursing and personal care
- programs and support services
- accommodation
- raw food

Only in the accommodation envelope do the facilities keep funding if they do not spend it all. In the nursing & personal care and programs & services envelopes the homes must return funding received from the government if it exceeds what they spend. In the for-profit facilities this means that the accommodation envelope is the one from which they can take profits (in addition to streams of revenue for capital). This is the envelope also into which premiums charged for private and semi-private beds go.

Over the years, the operators have done a number of things to shift costs from the accommodation envelope into the nursing and personal support envelope, including moving incontinence supplies, moving costs for building cameras and surveillance equipment, and shifting the work of accommodation staff to personal support staff. The fewer the costs in the accommodation envelope, the more room for profit-taking. In recent years, it was recommended that the operators move incontinence supplies and surveillance and security costs back into the accommodation envelope so that nursing and personal care funds are not siphoned off into these other items. This has not yet been done.

The operators have also conducted public campaigns and lobbying to increase the amount of funding for capital and in the accommodation envelope. The fee increases for residents adopted by the Harris-Eves Conservative government go into the accommodation envelope.

The for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope, even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing home industry are in direct conflict with the public interest in accessible and affordable care.

Research from well-over a decade of experience in the United States shows that care in non-profit and public long term care homes is superior to that of for-profit homes.

- When releasing his recent study revealing better performance in non-profit versus for-profit nursing homes, University of Toronto PhD candidate Michael Hillmer noted that the difference, "could be as simple as them being required to put any profits back into the homes." His study found non-profits performed better, especially in measures of patient care, than for-profits. Findings in the for-profits included higher rates of pressure ulcers (bed

sores) and use of psychoactive medications to subdue patients and more use of restraints. (Hillmer, Michael et al. Study is published in Medical Care Research and Review, April 2005.)

- His conclusions were echoed in the June 2005 release of the University of Toronto, University of Maryland study on caregiver injuries and staffing levels in nursing homes. Lead researcher Dr. Carles Muntaner state, "Reductions in staffing ratios and numbers of staff hours lead to lower quality of care. At the end of the day, it's a policy option, but the consequences are clear. If you try to squeeze the budget to maximize profits, it creates the dangerous situation we see in the United States." (medicalnewstoday.com)

From the Canadian Medical Association Journal Commentary, January 2, 2007:

There is now increasing evidence that the for-profit and not-for-profit sectors in Canada make different spending decisions:

- In an Ontario study, government-operated facilities were found to provide more hours of direct patient care per resident than for-profit facilities, although the public-sector facilities also care for residents with greater health needs. Berta W, LaPorte A, Valdemanis V. Observations on institutional long-term care in Ontario: 1996–2002. *Can J Aging* 2005;24:70-84.
- In British Columbia, not-for-profit facilities were also found to provide more hours of direct patient care per resident than for-profit facilities. McGregor MJ, Cohen M, McGrail KM, et al. Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *CMAJ* 2005;172:645-9.
- Although this was not the primary question under study, Shapiro and Tate found that, in Manitoba, for-profit long-term care facilities had higher rates of acute care hospital admission of residents because of several quality-of-care related diagnoses than did not-for-profit facilities. Shapiro E, Tate RB. Monitoring the outcomes of quality of care in nursing homes using administrative data. *Can J Aging* 1995;14:755-68.

For-Profit and Not-For-Profit Ownership: LTC Comparison Across Jurisdictions

Province	Public/Not-for-profit*	Private for-profit
British Columbia	68.3%	31.7%
Saskatchewan	96.2%	5.8%
Manitoba	84%	15%
Ontario	48.4%	51.6%
New Brunswick	100%	0%
Nova Scotia	72%	28%

**Public/not-for-profit include provincial and municipal government LTC facilities and LTC facilities seen by not-for-profit societies.*

(Hospital Employees' Union, April 2002. Statistics collected from the Ministry of Health in British Columbia, Saskatchewan and Manitoba, CUPE in New Brunswick and Nova Scotia, The Seniors Secretariat at the Ministry of Citizenship Culture and Recreation in Ontario.)

Ontario's long-term care lobby has achieved successes in deregulation, only some of which have been reversed. Consider the following:

- ELIMINATED – Requirement to provide a minimum 2.25 hours of care per resident per day in nursing homes. Eliminated by the Harris government. Not reinstated.
- ELIMINATED - Reporting on actual staffing levels to the Ministry of Health. Eliminated by the Harris government. Reinstated starting in 2005, information on actual staffing levels has been disclosed publicly only after a Freedom of Information request by NDP Health Critic Shelley Martel. Figures have only been disclosed up to March 2006.
- ELIMINATED - Requirement in the Service Agreement to adhere to planned or budgeted levels of staffing. Eliminated by the Harris government.
- ELIMINATED - Requirement to increase the average staffing per resident as a condition for eligibility for new funding. Eliminated by the McGuinty government.
- ELIMINATED – Requirement to have a registered nurse on duty 24 hours per day, seven days per week in nursing homes. Eliminated by the Harris government. Reinstated.
- ELIMINATED – Requirement to return 50% of surcharges for “preferred” accommodation to the Ministry. Eliminated by the Harris government. Not reinstated.
- REVERSED - Proportion of beds required to be held as basic accommodation was initially regulated at 60%, then it was reduced to 50%, then it was further reduced to 40% by the Rae government. This means that 60% of beds are now charged at premium rates, increasing the amount of profit to be taken from the “Accommodation Envelope” into which these user charges for residents go.
- COSTS SHIFTED TO INCREASE PROFITABILITY - The government allowed operators to move costs for incontinence supplies, moving, building cameras and surveillance equipment, and accommodation staff, from the accommodation envelope into the nursing and personal care envelope.

In the U.S. also, it is reported that the for-profit industry has lobbied against care standards. (Devore, E. “Issue Brief: Nursing Home Staffing Standards” Washington DC: Health Policy Tracking Service, June 28, 2002) Yet under the Clinton Administration, the trend was towards more stringent regulation of care standards. It was not until the Bush Administration that this trend has been slowed.

Prior to regulation of care standards, U.S. jurisdictions relied heavily on litigation to accomplish some accountability for harm and neglect in the for-profit homes. The industry has responded by a change in ownership patterns which may carry some lessons for the future in Ontario. Investment firms with Byzantine ownership structures have bought out chains, making the establishment of responsibility in litigation almost impossible. (Duhigg, Charles “More Profit and Less Nursing at Many Homes” New York Times, September 23, 2007) This trend should serve as a warning in Canada and points to a need to create more accountability, transparency, reporting and enforcement, rather than less.

SECTION III: ADDITIONAL HUMAN RESOURCE AND QUALITY OF CARE ISSUES

In our consultations including the two rounds of public hearings and forums, in-depth interviews, and meetings with our member organizations and stakeholder groups, a set of recommendations regarding additional human resource and quality of care issues has been raised. In addition, the family advocates have asked us to identify some clear recommendations pertaining to “quality of life” - a language and focus that is very important to them. The following recommendations are based on these consultations. In addition, we would like to draw your attention to our set of ten priority recommendations in Appendix I: “Key Issues in Long Term Care Homes Policy Statement September 2006” which is based on the consensus of our consultations up to that date.

Priority Consensus Recommendation Impacting Quality of Life, Quality of Care and Human Resources:

A regulated care standard as outlined in the earlier sections of this submission.

Additional Recommendations:

1. Appropriate care settings, special care units, review downloading

The Ontario Health Coalition recognizes the need for long term care homes. In addition, we support the ability of people to choose, whenever possible, the setting for their care. We are concerned about the continued downloading of heavy care patients from mental health facilities into long term care homes which cannot provide appropriately for the complex needs of these residents. We support the re-establishment of public and non-profit long-term homecare to allow seniors the option of aging in place and a range of non-profit and public supportive living environments for the younger persons with chronic care needs or disabilities. The movement of people into long term care homes should not be used as a tool to maximize bed occupancy to maximize funding or profit-taking by operators.

In addition to reviewing the download of heavy care patients from hospitals, the government must fund and set standards for public and non-profit specialty units for persons with cognitive impairment who have been assessed as potentially aggressive and staff them with sufficient numbers of appropriately trained care workers. The movement of patients out of hospitals must be based on an evidence-based assessment of care outcomes and needs, not used as a tool for cost-cutting and for-profit privatization.

2. Development of a Health Human Resource Strategy as a priority policy

Staffing shortages across classifications are impacting quality of care and human resources recruitment and retention. It must be a policy priority to develop a health human resources plan to address the shortages for the long term. Such a plan must address the working conditions that contribute to turnover and recruitment problems in long term care homes, including:

- addressing workload through regulating staffing standards, ensuring replacement for absences, and addressing shortages
- providing training interventions and special care units to reduce violence and injury
- providing wage parity between hospital, long term care facility and homecare sectors
- ensuring adequate supplies
- building an understanding of the team and the importance of the different roles of hands-on care staff
- improving scheduling control and other measures to empower staff

3. Provide time and opportunities for staff to talk with residents for social and rehabilitation purposes, and recognize this activity as vital for quality of life for both residents and staff.

Long term care homes are all-too-frequently referred to as “warehouses” in recognition of the lack of care. The Ontario Health Coalition believes that the goals of care in nursing homes should be to improve the health and social conditions of residents as well as to provide quality end-of-life care. Both of these goals rely on adequate staffing, training, communications, sound management practices, staff empowerment, adequate supplies. But they also rely on recognizing the vital importance of time for gentleness, talking and communications, and human contact between staff, families and residents.

4. Update the findings of the 2001 PriceWaterhouse Cooper’s Report into staffing and acuity levels in Ontario’s nursing homes as per the Coroner’s Jury Recommendations in the Casa Verde homicide. This report should not replace nor delay immediate institution of regulated care standards as per our priority recommendation.

Coroner’s Recommendation: That the MOHLTC retain PricewaterhouseCoopers, or a similar consultant, to update the January 2001 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario Long Term Care facilities given the significant number of Ontario residents with cognitive impairment and complex care needs in LTC facilities.... (Recommendation #28, Office of the Chief Coroner of Ontario, Recommendations of the Coroner’s Jury in the deaths of EL ROUBI, Ezzeldine and LOPEZ, Pedro, 2005)

APPENDIX I

Ontario Health Coalition Key Issues in Long Term Care Homes September 2006

Adequate funding must be provided for ongoing supportive home and community care to offer seniors, persons with disabilities and those with chronic illnesses the opportunity to live in the community as long as possible.

1) A province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per day per resident. This is to reach the goal of prevention of risk, it is not an optimum. Increases in staffing should be shared proportionately among all members of the health care team. The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers.

2) A provincial funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding for the required staffing ratio set out in #1 and strong accountability as to how that money is spent.

3) The continuance of the new completely random surprise inspection regime with an adequate number of inspectors to respond to complaints within a reasonable amount of time. Any assessment process must include talking with representatives from residents and family councils where they exist and speaking to nursing and personal care staff.

4) A ratio of 60% of facility beds for non-preferred accommodation and 40% for preferred accommodation should be reinstated. No increase in out-of-pocket fees for beds beyond inflation.

5) All long term care facility beds receive public funding. The legislation must include strong message of support for public and non-profit delivery of care. All new capacity should be built in public and non-profit homes. Operators that transfer their licenses must transfer them to public or non-profit ownership only.

6) Family councils should be recognized in the legislation with official recognition of their right to advocate. Families must be guaranteed access to the information required to hold facilities accountable. Complaints by family members must trigger an automatic inspection within two weeks of receipt of the complaint. In the case of abuse, the inspection must be immediate. Inspectors should be mandated to meet with family and resident councils where they exist. The Ministry should continue to provide funding and support to establish and continue family councils through the office of the elder care ombudsperson. There must be whistle-blower protection for residents, families and staff that speak out about poor practices in the homes.

7) There must be clear and enforced guidelines in the legislation limiting the use of physical,

chemical and environmental restraints on residents. Restraints should only be used for the purpose of preventing harm. There must be a clear decision-making process, notification of families, and restraints-as-last-resort policies.

8) Program standards must be reviewed and improved and enforced through the inspection regime set out in #3. More attention must be paid to homes that are non-compliant and strong and effective sanctions must be imposed on homes that are consistently non-compliant with significant care standards including non-renewal of the license to operate.

9) The training opportunities for front-line staff, administrators, and Compliance Advisors must be improved to ensure consistency and an understanding of how to provide residents and staff a safe, secure and compassionate environment.

10) Consultation on adequate regulation of retirement homes should be instituted.

Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario M3C 1Y8
tel: 416-441-2502
fax: 416-441-4073
email: ohc@sympatico.ca

APPENDIX II:

Ottawa Citizen Series on Long Term Care Facilities: The Case for Improved Regulation

The following series by Paul McKay appeared in the [Ottawa Citizen](#) from April 26 to May 1, 2003:

[Part 1 Cut-rate care](#)

[Part 2 The missing millions of a nursing home empire](#)

[Part 3 Mining Florida's seniors for gold](#)

[Part 4 Taxpayers finance construction boom](#)

[Part 5 Out of mind, out of sight](#)

[Part 6 How to fix the system](#)

The Ottawa Citizen (April 26, 2003)

Ontario's Nursing Home Crisis — Part 1

By Paul McKay

Cut-rate care:

How much does Ontario pay to feed and shelter our oldest, most frail citizens? About half what it pays for jail inmates. Paul McKay kicks off a six-part probe of nursing homes in Ontario.

\$4.49 a day. That's barely enough to buy one breakfast special. Or a soup-and-sandwich combo for lunch. Or a single glass of restaurant wine.

Yet that must buy three daily meals for each of the 63,000 seniors who live in Ontario's long-term care facilities, which include nursing homes and chronic-care institutions for those who need extensive medical help.

The provincial food allowance of \$4.49 a day per resident, allotted to each of Ontario's 530 long-term care facilities, has increased by only 23 cents during the past decade.

To cover all other expenses – lodging, food preparation and delivery, nursing care and physical therapy, laundry services, building maintenance, utilities and administration costs – the province pays an additional \$65 a day per resident, for a total of \$70.

Even inmates don't have it so bad. Ontario pays twice as much per day – about \$140 – to feed, house and protect those in jails, detention centres and drunk tanks.

Ontario's funding formula is low even when measured against that of some American states with comparable long-term care populations: In Florida, the government allots \$137 U.S. per resident per day for 53,000 seniors in nursing homes there – double the level in Ontario.

The vast majority of seniors in long-term care facilities are in nursing homes, where they, or their families, have to supplement the provincial allotment, paying a set maximum of \$41 per day for an

ordinary ward placement, \$49 for a semi-private room, or \$59 or more for a private room (there is no provincial cap on private room rates).

Advocates for seniors, municipal governments, charities and private owners of Ontario's nursing homes are unanimous: Provincial funding for facility residents is scandalously – even dangerously – low.

The figures are especially alarming since such residents represent the most frail of the province's elderly, and have significant care needs.

Of the 63,000 people in Ontario's long-term facilities, 53 per cent suffer from dementia or Alzheimer's, 48 per cent need help with basic activities such as walking or dressing, 22 per cent have had strokes, 30 per cent have arthritis, 19 per cent, diabetes, and 11 per cent suffer chronic heart failure.

Last summer, the province announced that long-term care fees paid by all but the most indigent residents will rise by 15 per cent over the next three years. Those increases will take a bigger bite out of the fixed-pension payments most seniors depend on.

Pleas for an extra 50 cents daily to buy food – 17 cents per meal — were greeted with silence from Queen's Park until a pre-election budget promise was made weeks ago. It would increase annual spending on long-term care by \$100 million, bringing annual provincial spending to \$1.8 billion. That increase of \$4.35 daily per resident is expected to cover higher costs not only for food, but for care and programs as well.

In the meanwhile, facility operators are struggling to make ends meet. "This is unconscionable. No one can buy the food for three decent meals a day on \$4.49," says Donna Rubin, executive director of Ontario's oldest seniors' advocacy association, the Ontario Association of Non-Profit Homes and

Services. The organization represents municipal, charity or faith-based operators of long term-care facilities, which house 25,000 people.

"Society wants us to properly feed, house and care for these people. We want to. We are ready to. But we can't on the (provincial) operating funds we have."

Karen Sullivan, Ms. Rubin's counterpart at the Ontario Long-Term Care Association, which represents privately owned nursing and long-term care homes, is equally adamant.

"Our residents often have special diet needs – for diabetes, heart disease, weight gain or weight loss. Most of their food has to be pureed, ground or mashed. We have to offer them choices, and rightly so. But that can't properly be done on \$5 per day for one meal, let alone three. Not even with bulk food purchases among our members.

"We've been pleading with the current government for another 50 cents a day (for food), but there's no sign of that happening any time soon."

Ms. Rubin and Ms. Sullivan cite damning evidence that many of the province's long-term care residents are getting cut-rate care – evidence from a 2001 consultants' study paid for by the Ontario government.

Prepared by PricewaterhouseCoopers, it concluded that, in professional nursing care and therapy levels, Ontario long-term facilities ranked at the bottom among 11 comparable Canadian provinces, American states and European countries.

The study stressed that most residents are not getting as much care and therapy as they need to cope with age-related ailments such as Alzheimer's, dementia, stroke, multiple chronic illnesses and depression. It also left no doubt that lack of care makes the symptoms of these diseases worse.

On average, Ontario seniors at nursing homes see an on-site registered nurse – who typically supervises 60 residents on a day shift and 100 residents on a night shift – barely 15 minutes a day. That ranked last on the study's list, which included Maine, Mississippi, Saskatchewan, Michigan and Manitoba.

For the combined time residents get per day with registered nurses and health-care aides, Ontario again ranked last. Seniors in Maine and Mississippi received an average of four hours a day of quality care. Long-term care residents in Saskatchewan, South Dakota, Michigan and the Netherlands all got more than three hours per day. Ontario's average was two hours per day, mostly with attendants who had fewer qualifications and were paid less.

The report also found that:

- 68 per cent of long-term care residents in Ontario did not receive any nursing rehabilitation to increase muscle strength and flexibility, while 24 per cent received only one session per week.
- 67 per cent had "adequate range of motion potential" – they could walk and do other activities independently – yet only half of those seniors received exercise assistance so they could maintain that independence.
- Ontario long-term care residents had the highest levels of mental health problems (especially depression) of all jurisdictions studied, yet fewer than six per cent received counselling. Instead, one-third were given anti-psychotic drugs or restraints.

In 1998 the provincial government jettisoned a mandatory minimum of 2.25 hours of nursing care a day per resident; there is now no minimum at all. It also dropped a requirement that long-term facilities have at least one nurse on staff at all hours.

Last July, Premier Ernie Eves promised \$100 million in new funds annually to improve nursing staff levels at long-term care homes. The increase was to fund 2,400 additional nurses and personal aides.

But the Ontario Nurses Association says some of the initial funds in 16 facilities surveyed have been used instead to reduce the debts of private facilities, replace lost municipal funding, pay administrators, or purchase supplies for incontinent patients.

"It's very frustrating for our nurses," says association president Barb Wahl. "There are far too few in the long-term care sector. One nurse is responsible, in some cases, for more than 100 residents at night." About 8,000 of the province's 44,000 nurses work in long-term care facilities.

"We are pressuring the government to make sure the money flows to where it was promised – not to an elevator operator or paying down a private operator's deficit. We need more money for bedside nursing, as promised," says Ms. Wahl.

She says the government must reinstate the minimum level of nursing-care hours per resident, as well as the rule that at least one nurse be on duty at all times in long-term care homes.

"That is critical. You don't just have problems during the day. Any number of problems can arise at night. There should be a registered nurse there on the premises, not on call, 24 hours a day. But even that's not enough for hundreds of patients. There are some nurses working alone on three wings, on three different levels. That's a nightmare. It isn't even possible for her to look at every patient, let alone give them care."

In December, provincial auditor-general Erik Peters criticized the Ministry of Health for its handling of long-term care facilities – and its failure to fix problems identified in 1995. "The ministry had still not developed either standards to measure the efficiency of facilities in providing quality care, or models for staff mixes for providing nursing and personal care, and therefore did not have a sufficient basis for determining appropriate levels of funding," he wrote.

"In addition, the ministry had not addressed the results of the 2001 (PricewaterhouseCoopers) report that noted that residents of Ontario's long-term care facilities 'receive less nursing and therapy services than (those in) similar jurisdictions with similar populations.' "

"The people of Ontario can't let this go, says Ms. Wahl. "They need to push their MPPs to make sure that staffing is increased. A ranking of last place is totally unacceptable," she adds, referring to the consultants' report.

Budget cuts to hospitals have made the need for quality care at nursing homes even more compelling, she says. "We're very concerned because the patients in nursing homes now ... are often just discharged from hospitals. They require much more care than the average patient from the past."

The PricewaterhouseCoopers report warned that failure to properly fund Ontario's long-term care system – which accounts for about eight per cent of the Health Ministry budget – will wreak greater human and fiscal damage in the long term.

"Improvements in the functional and self-care abilities of long-term care patients can enhance quality of resident life. Furthermore, costly complications can be prevented that can also reduce the overall costs to the health system, and the strain on caregivers and families. Central to this is to have a suitable quantity of nursing and therapy care available based on the needs of the resident population."

Everyone in the long-term care sector agrees the critical remedy is more nursing care. Everyone agrees that will cost much more than the combined \$1.7 billion the Ontario government and the \$800 million nursing-home residents now pay in fees each year. Everyone also agrees the crisis will be far more acute in 20 years, when an additional one million Ontarians will reach age 65, and the number of those over 85 will increase four-fold.

Yet no one is volunteering now to pay the full freight for seniors on fixed incomes.

Donna Rubin told a legislature committee in January it would cost an additional \$430 million in annual operating funds to achieve the minimum standards benchmarked in the 2001 consultants' report. That does not include capital funds for new facilities to meet the expected increase in demand for spaces.

Even with the \$100 million commitment last year, Ms. Rubin says, Ontario's funding shortfall is still \$18 a day per resident. If the recent promise of another \$100 million is ratified before an expected election call, the shortfall would still amount to \$13 a day per resident.

"We are putting every penny we get into care. We don't take out a slice of profit, and we take in most of the poorest seniors. So many of our homes depend on charities, municipalities, foundations and religious orders to kick in sometimes \$400,000 or \$500,000 a year," says Ms. Rubin.

"But many are now at the giving limit. So we're forced to feed people on pocket change, as we have for years. If we pay more for food, it comes out of nursing, or personal care, or programming. This is deplorable — a crisis."

Private facilities, which two decades ago accounted for only a third of those in Ontario, were recently awarded two-thirds of the 20,000 new beds approved by the province. They receive the same core operating subsidy of \$70 per day as non-profit homes.

Karen Sullivan contends her members make no profit on the provincial subsidies. Instead, she says, they earn their profits by charging higher fees to wealthier residents who can afford private rooms, and by buying food and other supplies in bulk and setting lower wage scales for staff.

Her association wants the Eves government to increase the long-term care operating budget by \$261 million annually.

"We are falling behind – to the point where we are now at the bottom. We have members who own facilities in other provinces and the U.S.

"Ontario seniors get an hour less nursing each day than in Saskatchewan. They get two hours less than in Mississippi. There they get more (government) funding for care on the floor, and programming."

Pointing to the 2001 consultants' report, she says "we know that means better nutrition, nursing care, and mental health.

"The results (of the study) were dramatic. They shocked even us. But no one has questioned the methodology, or the data.

"It was done by an independent consultant, paid for by the (Ontario) government. It compared apples to apples. No one at the Ministry of Health has challenged any of it."

Paul McKay is a Citizen reporter. His email address is: pmckay@thecitizen.canwest.com

=====

The Ottawa Citizen (April 27, 2003)

Ontario's Nursing Home Crisis — Part 2

By Paul McKay

The missing millions of a nursing home empire:

The family behind two decades of retirement home bankruptcies in Ontario, Florida, Kansas and Nevada always goes for broke – literally. Paul McKay reports.

On the same December day Ontario's auditor general rebuked the government in his 2002 report for failing to adequately monitor nursing homes, the Royal Crest Lifecare chain of 17 nursing and retirement homes irrevocably sank into bankruptcy.

There was barely a ripple of media coverage, yet the Hamilton-based company owed \$179 million when its sole owners, Aldo and John Martino, quietly filed affidavits declaring personal assets of only \$10,000 each.

The 5,329 Royal Crest creditors still don't know where all the money went. They include major banks, insurance companies, and mortgage lenders owed \$156 million for dozens of defaulted loans on 17 southern Ontario properties. The facilities have a book value of only \$53 million.

Taxpayers also took a big hit. Ontario's finance and health ministries are owed \$15.5 million and the province's worker's safety insurance agency \$3.2 million. Canada Customs and Revenue is owed \$7.4 million for taxes Royal Crest deducted from employees, but never paid to the federal government.

The Martino chain also owes \$1.5 million in pension funds deducted from thousands of employee paycheques, yet never forwarded to their union. Millions more are owed to water and power utilities, food and laundry suppliers, law firms, accountants, even landscaping crews.

If not for a generous offer by the major creditors, some fixed-income seniors residing in the Royal Crest facilities – including the estates of deceased residents – would have lost money from personal accounts meant for future room fees, toiletries, hairdressing or social events.

That money was missing when the biggest nursing home bankruptcy in Ontario history occurred late last year.

The second biggest occurred a decade earlier, when sister Annette Martino walked away from her own chain of Ontario nursing and retirement homes – and \$43 million in debts owed to banks, suppliers, government agencies and union pension funds. Also missing were monies taken without authority from accounts of seniors in some of her Ultra-Care homes.

That bankruptcy followed a decade of run-ins with health officials from Sarnia to Marmora in Eastern Ontario over chronic understaffing and sometimes sordid conditions. In one case, a senior was found with feces and live maggots in her shoes.

When safety code and sanitary renovations were ordered, the bills often went unpaid. When creditors closed in, Ms. Martino tied the claims up in courts while buying new nursing homes with highly leveraged loans.

Yet her personal tastes were decidedly regal. At the height of her nursing home reign, Annette Martino lived in a hilltop rural mansion near Lindsay with a pool and tennis court. She wore furs and emeralds to art galleries and social events, driving a Jaguar convertible for pleasure, and a stately Bentley to beguile prospective bankers.

Never lacking panache, Annette Martino almost persuaded her creditors to accept an eleventh-hour deal to avert bankruptcy in 1991. A numbered company offered to pay a few cents on each dollar of the millions owed, pay \$3 million for a 49 per cent interest, and leave Annette Martino the majority owner of her faltering Ultra-Care chain in Ontario. The deal was rejected when the court-appointed receiver discovered the owners of the "white knight" company were her brothers, Aldo and John.

The failed bid would have made Aldo, John and Annette Martino's proposed merger the largest nursing home conglomerate in the province. Yet even then Royal Crest's finances were precarious. By 1996, court records show, the company was selling "distress shares" to avoid sinking into insolvency. Several deficit-ridden years later, the Royal Crest chain came to its own ruinous end.

Aside from \$179 million in debts, Royal Crest lost its main food supplier last September after months of unpaid invoices. Then a provincial labour arbitrator ruled the Ontario health ministry should take over paying wages, union dues, vacation pay and taxes to employees in 11 Royal Crest homes. There were millions in missing deductions. The arbitrator concluded the Martinos could not totally disregard the union security clause in the collective agreement, and that it appeared something more sinister may be motivating the employer's actions.

Then the Ontario Ministry of Health moved to revoke the licence of the Martinos' Oakville nursing home for repeated failures to comply with safety and care regulations. Just prior to the crash, new admissions to two other Royal Crest nursing homes in suburban Toronto were suspended.

Meanwhile, apparently insolvent but unchastened, Annette Martino headed south to Florida and began assembling a new empire of homes for the aged and the mentally ill. By 1999, she had a flashy red Jaguar, a 42-foot yacht, and lived in the 9,800-square-foot historic Rutland mansion, formerly St. Petersburg's premier Prohibition-era nightclub.

But soon another army of creditors, collectively owed \$32 million U.S., was howling. When the dust settled, 15 more health care facilities were bankrupt.

Court records in Florida, and an expose by St. Petersburg Times reporter Kris Hundley, showed Martino's operations had garnered some \$24 million U.S. in federal Medicare funds.

According to affidavits from several former employees, many payments were billed for phantom patients and programs, using bogus U.S. social insurance numbers. Annette Martino obtained huge mortgages to buy her \$1.4 million U.S. mansion, and even acquire new Florida nursing homes while others were in already in receivership.

Now fighting rear-guard court actions against her many Florida creditors, Martino has disappeared. Her waterfront mansion has been stripped of furniture. The Olympic-sized pool is drained and stained a dirty brown. Guest and bath houses are boarded up, and wind-damaged tree limbs litter the property. With Spanish moss hanging from nearby trees, and an ornate iron entrance gate now rusting on the unkempt lawn, the Rutland estate has an air of ante bellum failure – and Annette Martino is once again gone with the wind.

Ontario court records show the Martino brothers also owe the U.S. Internal Revenue Service \$2.6 million for unpaid taxes. They are also facing U.S. creditors for reported bankruptcies of homes for the aged in Kansas and Nevada. A Royal Crest company was registered in Florida, but remains dormant. The Martino brothers did not respond to interview requests by the Citizen.

The Martino bankruptcy debacles throw into sharp relief the increasingly acute problem of protecting vulnerable seniors from under-funded, predatory or incompetent owners.

In Ontario, the demographics – and costs of care – are already daunting. There are 63,000 residents in 530 long-term care facilities. Last year, the province paid \$1.7 billion in subsidies; residents paid almost \$800 million more in accommodation charges.

Those resident numbers are expected to double in the next two decades, as the crest of the baby boom generation reaches post-retirement age.

The Ontario population aged 65 or older will soar to 2.7 million, up from 1.4 million in 1996. About 75 per cent of nursing home residents are female. Their average age is 86, and many suffer from chronic medical conditions, Alzheimer's and dementia.

Waiting lists for nursing home beds typically exceed two years. Recent provincial tenders to add 20,000 new long-term care beds, and refurbish existing facilities to add another 16,000, are expected barely to meet demand by 2006.

Despite all this, virtually no one in the provincial government has been paying much attention to the problems in the nursing home industry, according to Ontario auditor-general Erik Peters. In a report delivered late last year, he found:

- * No Ontario nursing home had a valid operating licence at the time of his 2002 audit. Several licences had expired years earlier. One had expired in 1994;
- * Financial information submitted by facilities was not sufficient to confirm government subsidies were properly allocated;
- * A Ministry of Health enforcement unit for addressing nursing home complaints was disbanded in 1999;
- * There was no process for targeting inspections for facilities with a history of failing to meet standards;
- * Between 1997 and 1999, fewer than half of Ontario's long-term care facilities were inspected annually. All were inspected in 2001, but the results were not properly reviewed to ensure compliance with safety and care standards;
- * The Health Ministry had not addressed the results of a 2001 consulting report that found residents of Ontario's long-term care facilities receive less nursing and therapy services than several comparable provinces, U.S. states and European countries like Sweden;
- * And the Health Ministry was not adequately tracking outbreaks of contagious diseases.

The 17 Royal Crest operations have 2,400 beds; 1,748 qualified for guaranteed provincial nursing home subsidies for more than a decade. The homes are now in the hands of a court-appointed trustee, which has retained the Extencicare Inc. nursing home chain to operate them until they are sold.

"We will soon be going to the market to divest them," says Kevin Brennan, a vice-president with Ernst and Young. "They will be marketed aggressively, and we expect to get bids from companies all across the continent."

His report to the Royal Crest creditors leaves little doubt that even the biggest, most powerful creditors (including the provincial and federal governments) will likely recoup only a small fraction of the debts owed. Aside from the nursing home properties, appraisers calculated the chain had only \$2.7 million in inventory and equipment, and \$280,000 in viable accounts receivable. There likely won't even be pennies for unsecured creditors.

The nursing home crunch is occurring all across the continent – producing desperate entrants, some predator companies eyeing guaranteed government payments per bed, and appalling examples of financial fraud and neglect for many frail, vulnerable residents.

The largest private nursing home chain in the United States, Beverley Enterprises, recently pleaded guilty to criminal charges for defrauding the federal Medicare fund. The company had been charged with filing phony cost reports totaling \$460 million U.S.

It paid a \$5 million U.S. fine on the criminal charges, and \$170 million U.S. as a civil penalty. It was also ordered to sell 10 of its nursing homes in five states.

In 2001, an Arkansas jury awarded \$78 million U.S. to the children of a 93-year old patient who died of dehydration in a nursing home operated by Diversicare Management, a subsidiary of the third largest U.S. nursing home chain. Last year, the company was sued for Medicaid fraud and neglecting patients by that state. Diversicare was owned by Advocat Inc., which sold its nursing homes in four Canadian provinces to another U.S. conglomerate soon after the judgement.

In 1999, a Florida jury found Extencicare Inc. guilty of negligence in the death of a patient who died of malnutrition, and falsifying related care records. It awarded \$20 million U.S. against Extencicare – the highest such judgement in Florida history.

Citing high litigation risks and insurance premiums, Extencicare soon after sold all its nursing homes in Florida and Texas. It is Ontario's second largest nursing home chain, and is now interim operator of the former Martino chain.

Citing tribunal hearings into prior complaints of sub-standard care at the Martino nursing home in Oakville, health ministry spokesman John Letherby declined to comment on the Royal Crest bankruptcy. He did say that recently the "quality of care in those nursing homes has improved immensely, dramatically."

Paul McKay is a Citizen reporter. His email address is: pmckay@thecitizen.canwest.com

=====

The Ottawa Citizen (April 28, 2003)

Ontario's Nursing Home Crisis — Part 3

By Paul McKay

Mining Florida's seniors for gold:

Negligence, fraud, serial bankruptcies, billion-dollar criminal and civil fines. It's the seamy side of nursing home care in the U.S. And, as Paul McKay discovers, it has disturbing links to Ontario.

When Annette Martino vanished from Ontario a decade ago, she left behind a bankrupt nursing home empire, \$43 million in defaulted debts, seniors suffering from substandard care and an opulent rural hideaway sold to stave off creditors.

Her Jaguar disappeared down Interstate 75. Within five years, the scene was replayed in coastal Florida counties surrounding St. Petersburg and Tampa. More than a dozen health care operations were bankrupt, creditors were crowding courthouse steps, and another of her grand mansions was facing foreclosure.

She had lots of company. In the 1990s, Florida nursing homes were among the worst on the continent. Abetted by a see-no-evil state government, weak standards, minimal inspections and no-strings federal subsidies, predators used Wall Street merger-and-acquisition tactics to buy or build homes for the aged and infirm.

The largest U.S. conglomerates surged into the sunshine mecca for seniors, picking up properties that came with guaranteed federal per diems for almost 80,000 qualifying residents. So did Annette Martino, and the Ontario-based Extendicare nursing home chain.

For a while, Ms. Martino and others like her mined federal Medicare and Medicaid dollars. Then Washington woke up. Federal auditors began finding what proved to be billions in fraudulent billing claims.

Meanwhile, some say, another species of shark converged on the Florida nursing home scene – sleek, silk-shirted litigation lawyers like Tampa-based Bennie Lazzara. Soon after, the Florida nursing home industry and its insurers declared his law firm, Wilkes and McHugh, their No. 1 enemy.

His courtroom adversaries, nursing home lobbyists, and some state politicians have called Mr. Lazzara a parasite. A pirate. A hired hit man. A Rolex Robin Hood. Even an anti-Christ. Yet others have praised him as an 11th-hour angel – albeit with one eye on lucrative contingency fees – who took on a rapacious, unregulated business and began cleaning it up.

"We see here the worst of the worst," says the gravel-voiced, elegantly attired Mr. Lazzara, sizing up his interviewer with a penetrating gaze. "I can't condemn every nursing home operator. But the people who come to us are those who've had abusive or negligent treatment – when the care provided has been abysmal.

"The worst are the giant, publicly traded nursing home chains. They are putting profits and their bottom line ahead of what they should be putting into the medical care of their residents."

Mr. Lazzara contends that his Tampa-based law firm, housing four dozen attorneys on several floors of a gleaming glass office tower, is fighting for social justice.

"From our experience, the care is worst where there haven't been many lawsuits, or enforcement of regulations. When cases are brought before juries, the care improves. That's what happened in Florida. We became the enforcement."

His adversaries scoff at Mr. Lazzara's professed concern, noting his law firm typically claims up to 40 per cent of multimillion-dollar negligence awards.

"When the dust settles on these cases, who wins?" counters Ed Towey, spokesman for Florida's 700 nursing and assisted living home operators. "It's not the seniors, the nursing staff, or even the nursing home operators. It's the lawyers."

What isn't in doubt is that Mr. Lazzara and his partners win most of their cases. Now private nursing home operators in Florida, Arkansas, Tennessee, Texas and California quake when they show up – because juries are nailing those found guilty.

Two years ago, a Florida jury stung Extencicare with the largest nursing home negligence penalty in state history – \$20 million U.S. — after hearing a chilling account of the final months of retired truck driver Charles McCorkle.

According to court evidence, the 67-year-old Alzheimer's victim was virtually abandoned inside the pastel-pink walls of the Colonial Care Center in suburban St. Petersburg. Relatives found him emaciated, dehydrated, riddled with bed sores that exposed bone, and lying in his own wastes. He died months after.

The Florida jury also heard that Extencicare staff later altered Mr. McCorkle's treatment charts to disguise a month-long gap in entries verifying care. Apparently determined to send Extencicare's Canadian directors and Florida regulators a message no one could miss, the jury awarded the victim's relatives \$3 million in compensatory damages, and \$17 million in punitive damages. (All numbers in U.S. dollars.)

That message hit home. Extencicare sold all of its 16 Florida nursing homes for \$60 million, and paid an undisclosed settlement. In a subsequent financial report, the company said it had placed \$25 million in a reserve for pending damage awards, and also sold its Texas properties "due to the increased frequency of claims and settlement amounts, related primarily to Florida and Texas."

The jury got it right, says Mr. Lazzara.

"It was our position at the McCorkle trial that Extencicare was trying to set the bar of care very, very low. They defended the case on the basis this was acceptable care. They never said, 'We messed up here. It was an isolated incident. We're sorry.' Instead, they called experts to say the care they gave was fine."

"The jury (members) were outraged by what they heard. The company cared more about revenues than Mr. McCorkle. The evidence was that Extencicare neglected him so badly that he could never recover. Later, they back-charted treatment for him (for dates) when he wasn't even there."

The McCorkle judgment came on the heels of a \$15-million award in 1999 against an unrelated company in Florida, following the death of an elderly man who fell 30 times, then died of untreated ulcers and malnutrition. Bennie Lazzara's law firm won that case, too.

That same year, a jury hit another private Florida nursing home operator with a \$10-million judgment, after an elderly woman lost most of her leg following an untreated minor toe infection. In still other cases, nursing home staff was caught convening "charting parties" – mass revisions of resident treatment records – after lawsuits were filed.

These haven't been isolated cases. Mr. Lazzara's law firm has won hundreds of smaller judgments against private Florida nursing homes, and has 500 more pending.

But dozens of lesser Florida law firms openly troll for clients from the front and back covers of telephone books, during broadcasts of college basketball games and on highway billboards. They too are winning awards against nursing homes – and driving their insurance premiums upward. Other law

firms, hired by nursing home chains and the companies that insure them, earn a living repelling those claims in court.

"Some awards are dramatic. They set records in Florida," concedes Mr. Towey. "But the larger problem is the sheer volume of them. Now it costs \$12,000 per year per bed for insurance. Since 95 per cent of nursing home revenues are from Medicaid and Medicare, that's taxpayer's money going to pay lawyers and insurance companies when it should go to the elderly."

Yet the most serious consequence of the fierce legal fighting in Florida may be the collateral damage it has caused.

By 2001, one in five Florida nursing homes was in bankruptcy protection, and dozens were reportedly sinking into insolvency each month. Citing the negligence awards and skyrocketing insurance premiums, big chains were selling out.

Some moved to places where it appeared regulations were weaker and lawyers like Bennie Lazzara didn't dine out on their deep pockets.

That didn't last long. Mr. Lazzara and his law partners were soon literally on their case in Arkansas, Alabama, Georgia, Texas, Tennessee and California. Wilkes and McHugh branch offices spread across the Deep South. New lawyers were hired.

In 2001, the firm won a \$78.4-million jury award after a 93-year-old woman died of complications stemming from her dehydrated condition in an Arkansas nursing home. Her sons were awarded \$63 million in punitive damages. The nursing home was part of a chain controlled by Advocat Inc., and its subsidiary, Diversicare. It also owned nursing homes in four Canadian provinces (including Ontario), which were sold soon after.

"This was a very conservative area in Arkansas," says Mr. Lazzara, part of that legal team. "But when people sat in a trial for two weeks and heard what happened in that nursing home, that verdict resulted."

"Companies like Diversicare and Extendicare blame everyone but themselves. They have blamed the poor resident for being sick. They blame families for not being more attentive. They blame doctors or nurses. It's easy to blame trial attorneys – nobody likes us. But it's juries that are coming up with these verdicts."

That \$78.4-million negligence judgment, the largest in Arkansas history, followed five other unrelated nursing home cases in the state that exceeded \$1 million in penalties.

One involved a jury award of \$12.3 million, prompting the owner to sell its state nursing homes to a California broker, which then leased them to the Arkansas division of Diversicare. Last year, already facing the \$78.4-million negligence judgment, Diversicare was hit with a lawsuit by the state attorney general for repeatedly failing to properly care for its residents.

"The filing is indicative of the consequences other nursing homes can expect if they don't fulfil the requests demanded by this office," the Arkansas attorney general said.

Meanwhile, several of the largest U.S. private nursing and retirement home chains, and their home care affiliates, were facing a formidable adversary on their opposite flank – the U.S. federal Justice Department.

Beverly Enterprises, the largest nursing home operator in the U.S., pleaded guilty to criminal charges for defrauding the federal Medicare system. It paid a \$5-million fine on the criminal charge, and agreed to a \$170-million civil penalty after it was charged with filing \$460 million in inflated or phoney billings. Ten of the Beverly Enterprises nursing homes involved were ordered sold. The chain has since voluntarily sold another 49 nursing homes in Florida.

"They were the biggest in Florida and they just got up and left," says Mr. Towey. "Extendicare, a Canadian company, has been gone for a year. Genesis, now our largest chain, has put its homes up for sale and will likely be gone by the summer. Florida is now the worst place in the nation to be in this business."

Another Florida company, operating as Kimberley Home Health Corp., pleaded guilty to federal criminal and civil charges for kickback schemes and defrauding Medicare programs. It paid a \$10-million criminal fine, and a \$51-million civil penalty.

The charges stemmed from the collusion of its parent company, Olsten Corp., with the largest private hospital chain in the U.S., Hospital Corporation of America (HCA). In December, HCA agreed to pay a \$631-million civil penalty for defrauding Medicare. That brought HCA's combined criminal and civil penalties to \$1.7 billion in a period dating back a decade. It operates nine private hospitals in the Tampa Bay area, and 180 in two dozen U.S. states and Europe. They generated gross revenues of \$18 billion in 2001.

The recent slate of negligence and fraud charges has jolted the private sector segment of the U.S. nursing home industry, which accounts for two thirds of the 1.6 million beds nationally. Those beds represent combined government and private payments of \$87 billion.

As the Annette Martino case showed, there was little to stop her and her Canadian partner from acquiring U.S. health care facilities. No background checks were made. No federal or state officials checked her credentials or controversial track record in Ontario. Key Medicare and Medicaid billing approvals were granted on bogus social security numbers.

There is also little to prevent U.S. corporate bad actors from relocating to Canada or acquiring the wreckage left by counterparts north of the border -- including, once again, the Martino family.

In December, Ms. Martino's two Ontario-based brothers signed documents confirming they and their Royal Crest chain of 17 private nursing and retirement homes had debts of \$179 million. The Royal Crest facilities are now under the authority of a court-appointed bankruptcy trustee. The interim operator is Extendicare Inc.

The former Martino family chain is currently on the auction block. Prospective owners from across North America are being invited to bid on the 17 Ontario properties. The main creditors and provincial Health Ministry must approve the sales to new owners.

Back in Florida, the legal upheavals of the past decade haven't abated. In 2001, three of every five nursing homes were facing lawsuits, many for negligence. According to Mr. Towey, one in five Florida nursing homes had no liability insurance; one in three had only self-coverage.

Since then, state regulators have made liability insurance mandatory to maintain operating licences -- and the average annual insurance cost per bed has doubled. There are now fewer buyers or new builders, which portends a pending crunch in the supply of additional nursing home beds.

"The volume of lawsuits hasn't let up. We are getting two or three new ones per day," says Mr. Towey. "That drives up insurance, which is mandatory. So you have many homes which might pay \$150,000 per year for insurance, with only \$100,000 in coverage. That protects no one – not the seniors, and not even the financial lenders to the nursing homes."

Tragically, none of this upheaval has helped provide better quality care for elderly shut-ins. Instead, it has made money for their care even scarcer.

Paul McKay is a Citizen reporter. His email address is: pmckay@thecitizen.canwest.com

=====

The Ottawa Citizen (April 29, 2003)

Ontario's Nursing Home Crisis — Part 4

By Paul McKay

Taxpayers finance construction boom:

Over the next 20 years, Ontario will heavily subsidize the construction and renovation of thousands of nursing home beds in the province. As Paul McKay reports, a company controlled by the Reichmann family is the single biggest beneficiary.

When the Ontario government promised in 1998 to build 20,000 new nursing home beds across the province at a cost of \$1.2 billion, it wasn't a moment too soon.

The pledge came after a decade without new capital funds from Queen's Park for long-term care facilities. Eight-teen thousand Ontario residents were already waiting for beds. Another tidal wave of elderly entrants — plus 3,500 from downsized chronic care hospital wards – was building behind existing queues from Kanata to Kenora.

More than 15,000 existing beds did not meet modern safety, fire, health and privacy standards adopted in 1998. Almost 70 nursing homes with 7,000 beds failed to meet standards dating back to 1972. All were facing major renovation or complete reconstruction after the alarm was raised by the provincial auditor general in 1995.

Even more trouble was on the horizon. Demographic trends left little doubt the crest of seniors would keep rising fast until 2020, when a fifth of Ontario citizens will be over 65 and those over 85 will quadruple.

But the 1998 announcement to build 20,000 new beds before 2006, approved by then-Ontario finance and Superbuild agency minister Ernie Eves, called the tune without paying the piper.

The government put up no capital. Instead, it contractually obligated future Ontario governments to spend a revised amount of \$1.5 billion – from annual operating funds over the next two decades – to compensate those approved to build new nursing homes.

Under iron-clad contracts, the province promised to pay \$10.35 per bed per day for 20 years (cumulatively \$75,555 per bed) to offset new capital construction costs. The province will make the

same daily payment per bed to owners who retrofit the most decrepit nursing homes to meet modern standards. Others will recoup lesser amounts, depending on the renovations required.

All will also continue to receive daily provincial per diems for resident food, care and programs, currently \$70 per day. As well, they will collect mandatory minimum resident fees set by the provincial government, currently \$41 per day per resident for a basic ward bed. The contracts ensure:

- Two decades of guaranteed government revenues;
- More in mandatory resident fees, already slated to increase 15 per cent by 2005 for 63,000 seniors;
- More still from a government-sanctioned shift toward "preferred" residents able to pay semi-private and private room fees, and a waiver of the share formerly recouped by the province;
- That every bed will be filled with minimal vacancy rates and marketing costs;
- A steady stream of monthly cheques from one government source.

By the end of the two decades, each new and renovated facility would be largely paid for by Ontario taxpayers. Private-sector owners could then sell, lease, or convert the facilities to residential apartments.

For companies with pockets deep enough to finance nursing home construction, those terms were irresistible. For politicians like Mr. Eves, it was a way to get 20,000 new beds built fast, and thousands more renovated, while reaping the political credit and keeping \$1.5 billion off current books.

The plan worked like a charm. Builders lined up. All 20,000 beds were awarded in three phases, roughly in regions of highest demand. Nearly 16,000 more retrofits were approved.

A construction boom is now under way. Almost 200 new facilities are expected to be finished by 2006. Once their doors open, government capital and operating funds will start flowing.

The province awarded the largest allotment of new and retrofit nursing home beds to Central Care Corporation, a Tory-connected company controlled by the Toronto-based Reichmann family. Former billionaires, they once amassed a fortune larger than the Queen's, then lost most of it in the \$18-billion Olympia & York real estate crash a decade ago.

According to the Health Ministry, the Central Care Corporation was approved to receive funding for 15 new nursing homes with 1,493 beds, and 1,160 beds in existing Ontario facilities that only meet standards dating back to the 1970s. If brought up to 1998 standards, they will also qualify for full provincial capital payments of \$10.35 per bed per day – or \$200 million for the combined 2,653 beds over the next two decades.

Those beds alone represent another \$185,000 each day in Ontario government operating subsidies, or \$68 million per year, at current rates. They also generate \$41 per day per bed in average resident fees, or almost \$40 million a year. Those fees are slated to increase 15 per cent between 2002 and 2005.

Combined, the nursing home allocations to Central Care Corporation are expected to generate \$1.36 billion in provincial operating subsidies over the next two decades, and another \$800 million in resident fees. During the same period, the company will recoup more than \$200 million in capital costs

from Ontario taxpayers. (The company reports it has 788 of the 1,160 approved beds in sub-standard facilities under renovation).

Family patriarch Paul Reichmann and his son Barry are major unit holders and officers of the parent corporate vehicle, now called Retirement Residences Real Estate Income Trust (REIT). A founding trustee and the current chairman is former Ontario premier Bill Davis. A current trustee is former Davis cabinet member and Ontario treasurer, Darcy McKeough. Another is Douglas Bassett, representing the family dynasty that controls the CTV television network and has supported the Ontario Conservatives for decades.

Central Care Corp. obtained approval in 1999 to build most of the beds it was awarded, while Mr. Eves was the finance and Superbuild agency minister. It also sought more new and renovation bed allocations during Mr. Eves' year-long hiatus from politics, when he became a trustee of Retirement Residences REIT, Central Care's parent.

When he joined that board in March 2001, Mr. Eves was granted a three-year option to purchase 35,000 trust units for \$10 each, paid a \$15,000 annual retainer, and up to \$1,000 per board meeting. When he left the company in April 2002, 11,666 of the options became vested and his to exercise.

Mr. Davis still retains an option to purchase 50,000 units for \$10 each. He is paid \$30,000 annually as company chairman. Mr. McKeough has a trustee's option to purchase 45,000 units, and owned 6,000 as of last December. Company president Barry Reichmann was granted an option on 200,000 units, and a CEO salary of \$246,346 in 2001.

Company records show Mr. Eves and Mr. Davis endorsed a merger plan that year that would make the firm the biggest nursing and retirement home conglomerate in Canada. A meteoric climb in asset acquisitions, revenues, and shareholder dividends followed. The subsidiary Central Care Corp. is the corporate vehicle for new nursing homes.

The TSX-listed trust (RRR.UN) owns or operates 181 nursing and retirement homes in Canada and some U.S. states, housing 20,000 seniors. In Ontario, it operates the former Central Park Lodges and Versa-Care nursing home divisions, which have several facilities in Eastern Ontario. It also owns retirement homes such as the Colonel By complex in Ottawa, a home care division called Central Health Services, and another called Medisys Nursing Placement.

Mr. Eves resigned from Retirement Residences REIT one year ago, weeks after his successful campaign to become leader of the Ontario Conservatives. Through the Reichmanns' O & Y Properties real estate company, Mr. Eves' campaign received \$10,500, as well as \$5,000 from Versa-Care. Health Minister Tony Clement received \$43,568 from O&Y; Properties and \$5,000 from Versa-Care for his rival leadership bid last year. Jim Flaherty, who succeeded Mr. Eves as finance and Superbuild minister, received \$10,000 for his Tory leadership bid from O&Y;Properties.

In 2002, Retirement Residences REIT donated \$14,979 to the Ontario Conservative party, and \$7,750 to the provincial Liberals. In 2001, it donated \$1,040 to the Conservatives and none to the Liberals. To date in 2003, according to the company, it has donated \$2,250 to the provincial Liberals and \$900 to the Tories.

Those donations were preceded by others to the Ontario Conservatives. From 1995 to 1999, the Reichmanns' nursing and retirement home companies donated \$22,865. According to provincial records, long-term care companies donated \$336,545 to the Conservatives between 1995 and 1999, \$72,918 to the Liberals and \$2,000 to the NDP.

In addition to the donations from O&Y Properties and Versa-Care, Mr. Clement received \$18,000 from the nursing home chain Leisureworld Inc., and \$1,000 from Extendicare, Inc. to help finance his leadership race. He has been the minister for health and long-term care since January 2001.

Leisureworld, a private company, was allocated 1,895 new beds. Extendicare was awarded 1,164 new beds, and approved to renovate 449 existing beds.

No one contends anything illegal has occurred. Or that Mr. Eves or Mr. Clement personally intervened to reward donors to their political campaigns. But, critics say, two-thirds of the 20,000 new nursing home beds were awarded to private nursing home chains because the process was tilted toward those with deep pockets.

The top five municipal and charity-based nursing home proponents were awarded 2,049 new beds, while Leisureworld alone was awarded 1,895. The top five private companies were allocated 6,573 new beds.

Past financial and nursing care practices also didn't preclude the awarding of new nursing home beds.

The Reichmanns had amassed \$18 billion in debts by the time their real estate empire collapsed in the early 1990s. Their company declared a \$2- billion loss in 1991, largely tied to massive commercial office tower developments in London, New York, Toronto and Ottawa. Among the 91 creditors in the Canadian court imbroglio that followed was the Ontario government, which eventually wrote off \$14.3 million.

Eventually, the major creditors agreed to a salvage plan in which the Reichmann family relinquished many of the major properties in return for being shielded against the related debts and personal lawsuits by creditors.

Soon after, however, the creditors hired the Reichmanns to manage many of the projects, and eventually the family assembled the financing to re-acquire control of most of the same properties. Highly regarded for their entrepreneurial acumen and engineering innovations, the Reichmanns are again on the ascent with major office tower and commercial real estate projects in London, the U.S., Mexico City, Toronto, Calgary and Ottawa.

They also control the largest nursing and retirement home conglomerate in Canada. In 1994, Paul Reichmann, his son Barry, a son-in-law, and two partners purchased the Central Park Lodges nursing home chain for \$220 million. By 1997, the 12 nursing homes, comprising 1,889 beds, had been folded into an income trust entity that avoids paying corporate tax by paying out the profits as monthly dividends to shareholders, including the Reichmanns. That year, it acquired the Ontario-based Versa-Care chain of 29 nursing homes with 3,700 beds. In 1999, it acquired another 1,412 beds in Canada, and 1,354 in the U.S.

While it was assembling this new empire, and seeking to win allocations to build new nursing home beds in Ontario, tragedy struck at a Central Park Lodges nursing home in Kitchener.

A virulent strain of influenza A hit 82 residents and 49 staff, triggering the deaths of 25 seniors. It followed a Christmas party for residents, staff and relatives in December 1998. It was the single worst case of fatalities at a nursing home in recent decades.

A coroner's inquest later traced the cause to a lack of immunization, inadequate staff-ing, and delays in lab sampling and reporting the outbreak. The inquest made 25 recommendations, including

mandatory immunizations for all staff and seniors, and an infectious disease control specialist for each facility.

The company says it has exemplary hygiene and infection control practices, and more than 80 per cent of its nursing home staff and 93 per cent of residents comply with provincial immunization directives. It has also designated a registered nurse at each facility to prevent viral infections and flag potential outbreaks.

Despite the Kitchener tragedy, and provincial directives for mandatory immunizations, the recent provincial auditor general's report concluded:

"The Ministry was not adequately tracking complaints, unusual occurrences and outbreaks of contagious diseases to identify and resolve systemic problems. In 2001, of seven regions, only two regions recorded unusual occurrences, which totalled 1,900. In the same year, only four regions recorded outbreaks of contagious diseases, which totalled 219 and affected 7,500 residents and staff."

The auditor general also warned that some Health Ministry regional offices were failing to keep logs on infectious disease outbreaks.

He recommended those logs be mandatory, and that all of Ontario's 530 long-term care facilities be inspected at least once yearly.

The Reichmanns' rival in the Canadian nursing home business, Ontario-based Extencicare Inc., was allocated 1,613 new and retrofit beds by the province, even while facing a civil trial in Florida that resulted in a \$20-million U.S. jury judgment -- the largest nursing home negligence award in that state's history.

Citing high litigation risks and insurance costs, Extencicare has since sold all its facilities in Florida and Texas. It has 260 nursing and retirement homes in Canada and the U.S., with 26,000 residents, and is the interim operator of the recently bankrupt Royal Crest chain of 17 nursing and retirement homes in Ontario.

The main private players in Ontario's nursing home sector are expected to bid for those facilities.

Paul McKay can be reached at: pmckay@thecitizen.canwest.com

=====

The Ottawa Citizen (April 30, 2003)

Ontario's Nursing Home Crisis — Part 5

By Paul McKay

Out of mind, out of sight:

Ottawa's most vulnerable, voiceless seniors have a new home. But few ever visit or volunteer help, and political promises remain unfulfilled. Paul McKay reports.

Mavis Morgan is a rock of devotion – with an earthquake of anger rumbling beneath.

Every day since last July she has come to Ottawa's Peter D. Clark nursing home complex to tenderly take the hand of an elderly stranger named Ernie and help wash, dress, feed and supervise him.

She always puts in a full shift, from 11:30 a.m. until 7:30 p.m., often serving food to others, and tidying tables and kitchen counters after meals. She is there seven days a week. She doesn't get paid a nickel.

Once, Ernie was anything but a stranger. Now, except for a flicker of recognition most mornings, and the familiar handsome features, Ernie is a ghost of the man Mavis vowed to love in sickness and health almost a half century ago.

A workplace accident and a failed medical diagnosis robbed them both. Ernie suffered brain damage at age 64. He can no longer talk, walk unassisted, feed or bathe himself, or follow spoken or printed thoughts. He cannot recognize the Morgans' two grown daughters, nursing attendants, or the 48 Alzheimer's and dementia patients who pace and drift incessantly through his ward.

Inexplicably, blessedly, Ernie briefly lights up when his grandchildren appear for a visit, or a melody embedded deep in his memory gets stirred. But the rest of his life is a relentless blank, and that has now stolen half of Mavis's life, too.

She accepts that fate, and that her beloved husband will never recover.

"I think the day I brought Ernie in here was worse than it will be the day I will have to bury him," she says, fighting back tears and laying her hand on his. "I took care of him at home for six years, but it got to be too much for me alone."

Yet there are other chronic cruelties she cannot accept.

"In the first few weeks, he got hit seven times by other patients, and punched so he needed stitches on his mouth. He also got a black eye. I was just furious," she says in a voice so angry it shakes. "One patient pinned me into a cupboard one day. They didn't know what they were doing. God bless the staff who work here – they are so caring and dedicated. But there are just not enough of them."

"How can one attendant feed 12 people soup, the main meal, a drink and dessert at the same time? Or dress 12 people at once, and still keep an eye on everyone out in the halls? So that's why I'm here every day."

So are Jim Reid and Fern Bergeron, who have spouses in the same block of bright, tidy bungalows dedicated to seniors with advanced dementia and Alzheimer's. Jim's wife Vivien is a 75-year-old former Ottawa school teacher who, he recalls proudly, never missed a day of work over four decades. They have been married 45 years. Fern's wife, Cecilia, is 87. They were married in 1947.

Both men nod solemnly as Mavis takes aim at the politicians they say have betrayed those in their hour of greatest need.

"I think the government is terrible for not sending enough money to these (nursing) homes," says Mavis. "Do they not know what's happening here, to the people who worked and paid taxes all their lives?"

"I'd love to see those high muckymucks in Toronto forced to come in here, and see what's going on. That would open their eyes. They don't understand one bit what goes on in these homes."

Mavis pays \$1,993 in resident fees for her husband's accommodation each month, drawing down RRSPs because his work as an independent maintenance contractor left no pension. When those are depleted, she says, her Ottawa home will be the only asset left.

Jim and Fern say they can afford the similar monthly fees for their Alzheimer's afflicted-spouses, but the provincial share of \$70 per day provides only cut-rate care.

"Everybody here is potentially violent. Even my wife. But there's not enough money to pay for the help," says Jim.

"The big problem is not lack of good people. The staff here are very caring, absolutely excellent. I couldn't do what they do.

"The big problem is: there's not enough bodies to help. So I get mad when I see politicians with personal trainers, or the prime minister flying off in his own jet. They've got all the wrong priorities."

All three cite incidents in which they have had to help break up arguments, track down wanderers, or supervise demented residents while beleaguered staff responded to a fracas or a vanished patient. Fern discovered his wife had a broken wrist and it torments him not knowing how it occurred.

"She only speaks in gibberish, so she can't explain if she fell or was pushed," he says. "If there was more money for more staff, this could be avoided. The shortage is dangerous."

Yet the new secured special unit for those with dementia and Alzheimer's has a higher ratio of nursing and attendant care than the provincial average. Each of 48 residents receives about 45 minutes of registered nurse care time daily, compared to the Ontario nursing home average of 15 minutes.

In the U.S. states of Mississippi and Maine, combined care from RNs and aides is four hours per resident per day, compared to 2.25 hours per day at the Ottawa complex. In Florida, the new state-legislated minimum to maintain a nursing home licence is almost three hours per resident per day. There, the government financial assistance level is twice that of Ontario.

For mentally infirm residents like Ernie, the extra nursing care is due solely to financial support from the City of Ottawa. The Clark complex receives \$1 million annually out of \$3 million in property tax funds dedicated to four city-owned long-term care facilities. The city also donated land for the site, and has backed capital costs and a mortgage. (The province pays \$10.35 per bed per day to partially offset capital costs).

The trio singles out Councillor Alex Munter and Mayor Bob Chiarelli for praise. Mr. Munter, who chairs the city council health committee, is their unofficial champion. They say he is the only politician who comes by in person, and advocates on behalf of Ottawa's most vulnerable seniors.

Most have been all but consigned to oblivion. Visits are rare, even from relatives. Some have deceased spouses or are too ill themselves to visit regularly. Mavis, Jim and Fern are the exceptions.

Despite the pressing need for volunteers, and care-related items like replacement mattresses to minimize bed sores, the dementia complex has no civic club sponsors like Kiwanis or Rotary. It also receives no corporate endowments.

Noreen Langdon, a former nurse who now manages the 216-bed Clark nursing home complex, says the adjacent facility for 48 advanced dementia cases suffers most from a capricious provincial funding system.

The provincial assessors who decide grant levels never meet the afflicted residents or their caregivers. Instead, they rely on charts compiled the previous year that don't even have categories for many of the unique care needs of dementia and Alzheimer's victims.

"The tool that they use to classify the residents does not take into account the dementia cases," says Ms. Langdon, "which is now a large part of the nursing home population. That requires a higher staffing level than for people who are just physically frail."

Compounding the flawed funding formula, says head RN Shelagh McQuarrie, is a perverse system that penalizes improvements in resident health and functioning.

"We call it 'documenting for dollars.' The province gives us money based on a point system – if they can't walk, or feed themselves, or are incontinent when they arrive. But if we improve their condition with exercise programs, or nursing care, or better diets, the province takes money away the next year."

Despite this, and daily ordeals with often explosive and erratic residents, Ms. McQuarrie remains irrepressibly committed to her elderly charges. She and her staff organize bowling and movie excursions, and the monthly calendar is crammed with exercise sessions, church services, sing-alongs, bingo, tea parties and craft classes.

A staff bake sale at Christmas raised funds for a "rummage room" in which some residents spend hours trying on hats and jewelry, collecting car and house keys, typing out imaginary letters, or teaching a phantom class of school children.

One constant customer is Alice Hart, a former painter. In what might pass for a movie star's dressing room, she delightedly puts on a string of plastic pearls, throws a canary-yellow boa across her shoulders, grins into a mirror – and perhaps sees Marlene Dietrich.

That's just fine with nurse McQuarrie.

"I love them still seeing the humour in life," she laughs. "I want it to be loud and lively here, just like life is."

When Ernie first arrived, he was assaulted by oblivious adversaries, and reacted by trying to break every mirror or window in which he saw his reflection. Now he is strapped into a reclining wheeler. Jim's wife Vivien sometimes confuses him with her father, or accuses him of being a shiftless Scot. Fern's wife Cecilia can no longer compose a sentence.

Ms. McQuarrie says there is no way to measure the torment spouses like Mavis, Jim and Fern endure each day – but every dollar invested in resident care actually benefits those imprisoned in dementia and those left to watch over them.

"When we first opened, we had no idea how people like Mavis were suffering, because they were dropping off their heart and soul at our door. They were just wrecks. Now they have some relief. They know we are doing our best, and there are counselling services for them."

The trio agrees they all hit a wall of emotional exhaustion and despondency when their spouses entered the facility, but can now at least reclaim a peaceful sleep most nights.

"Everybody here is so dedicated. There's just not enough of them," says Fern, who dedicates many of his own weekdays to help his wife and others.

The lack of funding, Ms. Langdon contends, is driving nurses out of the province or out of the profession. Those that remain choose higher-paid, lower-stress hospital placements.

During a visit to the facility, councillor Munter says the provincial funding formula fails those who need help most.

"It represents a past time and place when there were lower needs. The provincial government investment in long-term care has not kept up with an aging population that lives longer and needs more help.

"Now the residents are facing big increases (for monthly accommodation fees). That cynical attempt to shake down seniors to pay for the improvements that are needed really says a lot about this government's approach to long-term care."

Professional dietitian Hilda-Anne Troupe says she is allocated 15 minutes per resident per month to evaluate their nutrition status and needs.

"That's an impossible task. There's not a nursing home in Ontario that can do it. Yet those with dementia often require more liquid proteins and nutrients because they burn off so much energy pacing and wandering.

"That leads to broken skin and bed sores, weight loss, cognitive decline, and the inability to recover from an illness. Poor nutrition also means they are constantly frustrated, irritable. It's just a vicious circle."

The daily residents' food allotment from the province of \$4.49 has increased just 23 cents in the past decade, an increase of 5.1 per cent, compared to the consumer price index increase of 21.6 per cent. To match that, 2003 per diems to cover three meals should be \$5.27.

That means instant crystals instead of real fruit juices, powdered potatoes and processed vegetables instead of fresh ones, smaller portions, more leftovers, and reducing expensive nutrition-packed supplements. According to dietitians like Ms. Troupe, those cuts in nutrition will guarantee higher health care costs down the road.

Distant politicians may have broken election promises to treat seniors fairly, but one person who won't be breaking any vows is Mavis Morgan.

"Ernie and I had 48 wonderful years. We've been lucky. Very lucky. I love helping out here, because I am a caring person, and because if it was me, I'd want somebody to treat me well. Or to treat Ernie well if I couldn't."

Paul McKay is a Citizen reporter. His e-mail is: pmckay@thecitizen.canwest.com

=====

The Ottawa Citizen (May 1, 2003)

Ontario's Nursing Home Crisis — Part 6

By Paul McKay

How to fix the system:

Ontario has a long way to go to bring its nursing homes up to basic North American standards. The task will require more money, more accountability, higher standards and constant vigilance. Paul McKay reports. The provincial auditor found that 68 Ontario nursing homes were so decrepit they failed to meet standards dating back to the 1980s.

Last in a class of 11. That's the grade Ontario gets for the overall quality of care given to 63,000 seniors living in the province's 530 long-term care facilities.

That was the central finding of a 2001 report card paid for by the provincial government. In it, PricewaterhouseCoopers compared Ontario to 10 provinces, U.S. states and European countries.

It ranked Ontario at rock bottom for nursing, physiotherapy and counseling levels – despite evidence that our seniors have some of the highest levels of age-related illnesses and mental infirmities. The province failed to lead in any of the care categories.

A parallel alarm rang late last year, when the Ontario auditor general found:

- No evidence that the ministry had addressed the results of the PricewaterhouseCoopers study.
- A dedicated nursing home inspection team was disbanded in 1999, and annual inspections dropped dramatically between 1995 and last year.
- Contagious disease outbreaks in long-term care facilities were not being properly tracked.
- There was virtually no way to verify that provincial funds meant for seniors' care were allocated as intended.

Overall funding for long-term care has not matched inflation, let alone the steady increase in seniors leaving their own homes or those being shifted from hospital beds once considered – and funded – as chronic care placements. Seniors themselves are making up the shortfall, paying almost twice as much in monthly basic accommodation fees as nursing home residents in British Columbia, Alberta, Saskatchewan, Manitoba and Quebec.

Nurse staff and wage levels also lag behind most Canadian provinces and many U.S. states, creating an incentive for new nurses to leave Ontario after years of publicly assisted training. Those who remain often must deal with 60 residents each during a day shift, and 100 or more on a night shift, while being paid an hourly wage lower than jail guards.

Nursing home inspections are increasingly infrequent, and routinely occur only after advance notice. Ontario's regulatory standard is one inspection annually, but between 1995 and 2001 barely half that level occurred. In 1999, the low point, only 200 of the province's 520 nursing homes were inspected.

In 1984, 497 charges were laid under the provincial Nursing Homes Act. In 1988, only 12 were filed. None have been filed since, though the number of residents and facilities has swelled to a historic crest.

Florida has 260 full-time inspectors for 668 facilities housing 71,000 residents. Every inspection is unannounced. By contrast, Ontario has 56 full-time staff for 530 facilities housing 63,000 seniors, but that includes nursing home "compliance advisers," dietitians, environmental advisers and one enforcement nurse.

Recent Florida legislation backs up its inspection division with higher fines, provisions for more frequent inspections for non-compliant facilities, and the suspension of new admissions or state and federal funds for delinquent operators.

"Nurse hirings have gone up because the law requires it," says Ed Towney, spokesman for Florida nursing home operators.

"It's been a two-year boom. They are coming from all over, including Canada, because it's a great time to be a nurse in Florida."

By contrast, Ontario nursing homes rank near the bottom for coveted placements because wages are 20-per-cent lower than on hospital nursing wards, the workload is heavier and more physically demanding, and there are fewer opportunities for advancement.

Florida also has another way to ensure high care levels – it publicly exposes the worst operators. Both the state and the federal agency Medicare have user-friendly Web sites that publish inspection reports – and rank – all nursing homes receiving government funds.

The Web sites allow seniors and their families to compare nursing homes before one is chosen, and let family members monitor their loved ones.

Molly McKinstry, the Florida director of nursing home inspections, says the state Web site was designed and tested for ease of use. First posted in 2001, it divides nursing homes by county, then ranks them in the same area by overall score and a five-star rating system.

Ontario has nothing comparable. There is no Web site that discloses infractions, or ranks performance and care levels. Inspections are sporadic, partly because a dedicated inspection team was disbanded in 1999, partly because there are too few inspectors, and partly because those inspectors are often assigned other tasks such as reviewing bids to build new nursing homes.

Most alarming, the provincial auditor found last year that 68 Ontario nursing homes with 7,000 beds were so decrepit they failed to meet standards dating back to the 1980s, and required complete retrofits. They were among facilities with nearly 16,000 beds requiring substantial renovations.

When inspections do occur in Ontario, the results are only posted at the facility. Sometimes they are displayed in the nursing home foyer; often they can only be read upon request during a personal visit.

It is also impossible to verify in advance the nurse-to-resident care standard, because the Ontario government dropped the former requirement (2.5 hours per resident) in 1998. Yet every Florida nursing home and those in 36 U.S. states are legally obligated to provide almost three hours of personal nursing care per resident per day – or face the loss of their operating licence or revenues from new entrants.

In Ontario, it is easier to reliably choose a quality sofa, car or appliance than a nursing home. It is easier to check by Web site an airplane arrival time than it is to see if a nursing home with hundreds of vulnerable seniors has been inspected. And there are few guarantees about the quality of care those seniors will receive.

Improving Ontario's nursing home system will require more money, more accountability, higher standards and constant vigilance. Here are six reforms needed to move Ontario near the top of the class in care for seniors:

1. Mandatory nursing care standards

As a condition of licence, Ontario should require every long-term care facility to provide a minimum of three hours of nursing care per resident per day – four hours for those with dementia or clinical chronic care status. At least one of those hours should be for registered nurse care.

The province should restore the requirement that all facilities have at least one RN on site at all hours. Failure to verify minimum care levels would result in an automatic deferral of provincial funding. Repeated failures would result in a loss of operating licence.

2. Funding nursing care

The province should increase the average per diem for nursing care per resident to \$100 from \$60, and the daily care level for those with dementia to \$120. This would still leave Ontario far behind the Florida average per diem of \$137 U.S. The food allowance for three daily meals should be raised from \$4.49 to \$7, in line with recommendations made by professional dietitians. Both should be matched to the consumer price index.

3. Mandatory inspections

All Ontario nursing homes should be inspected annually by a dedicated division led by nursing, food hygiene and fire safety experts. All inspections should be unannounced. The inspection standards should be set by a committee reporting to the provincial legislature or the auditor general.

The inspection division would represent the Health Ministry, nursing home operators, the Ontario Nurse Association and seniors' advocacy groups, and compile an annual report on inspection results.

Failure to comply with inspection orders would trigger quarterly inspections for two years and an automatic deferral of provincial revenues until the problems are rectified. The most serious problems would result in a suspension of new admissions, or a loss of licence.

4. Inspection and care level transparency

Inspection results, enforcement orders and care staffing levels of every Ontario nursing home should be posted on a Ministry of Health Web site. Modeled on the Florida or U.S. Medicare Web sites, this would help in choosing the best nursing homes, and allow relatives to monitor the performance of facilities where loved ones reside. It would also act as a discipline for indifferent or potentially negligent operators, and for the Ministry of Health to maintain an inspection process with high integrity.

Ottawa Councillor Alex Munter, chairman of the city council health committee, says he will propose that the city 's Web site include inspection compliance reports on the four nursing homes co-funded by municipal taxpayers.

The central inspection report Web site is also endorsed in principle by Ontario's private nursing home association, the association representing non-profit nursing homes, and the Ontario Nurses Association.

"The inspections aren't happening. That means the patients are at risk," says Barb Wahl, president of the Ontario Nurses Association.

5. Protecting residents from financial abuses

Florida nursing home operators must post bonds to protect residents against unscrupulous operators or bankruptcy. Funds they have deposited for rent, personal care and social activities – often totalling millions – cannot be withdrawn without written authority, and all resident accounts are covered by bonds posted by operators. If money is stolen, or the facility declares bankruptcy, the residents do not lose their money.

To help prevent fraud and financial mismanagement, the federal Medicaid authority conducts rotating audits covering one quarter of Florida nursing homes a year. Both the state and federal governments also screen applicants for new nursing home licences for past fraud, bankruptcy history, and resident care improvement orders by other state and federal regulators.

Ontario should adopt similar protection methods. It should require all private and charity or religious run nursing homes to post bonds with the province to cover potential problems such as the recent Royalcrest bankruptcy fiasco.

The Health Ministry should also adopt the Medicaid system of rotating financial audits, with the results kept strictly confidential. This would help ensure fiscal integrity at each facility, prevent abuses and act as a monitor on the \$1.7 billion Ontario taxpayers contribute as operating funds to long term care facilities each year.

Applicants for new or renewed nursing home licences should be required to disclose all previous cases (including affiliates) of bankruptcy, regulatory enforcement orders, and criminal and civil convictions for fraud or negligence. Those sections of the applications should be posted on the Health Ministry Web site before the application is considered.

6. Option to reacquire publicly financed nursing homes

Ontario recently approved awards for the construction of 20,000 new nursing home beds. Almost two-thirds were granted to private-sector operators, and the rest were approved for municipal, charity, ethnic and religious organizations.

All qualify for government capital cost recovery payments of \$10.35 per bed per day, or \$75,000 per bed during the 20-year contract period.

However, the private owners will own the facility at the end of that period, while the non-profit homes will remain owned by city agencies or community organizations. The private-sector owners are free to sell the facilities, even though the public effectively will have paid the bulk of capital costs.

This could lead to huge private windfalls on what amount to public investments. To minimize this, the province should retain the legal option to re-acquire the facilities – at the market price – if such nursing homes are sold in the future.

This would protect the public from paying \$1.5 billion for nursing home assets, then having them sold without any public revenues recovered. The sale price would be established by an independent appraisal. The owner could then choose not to sell, or the province could choose not to buy.

These reforms would provide Ontario's most vulnerable seniors – the very citizens who have productively contributed to our society for seven decades or more – the care and vigilance they deserve.

The reforms would give those paying the billions needed to provide decent care to our fast-aging population more fiscal accountability. They would also open new windows of democratic disclosure, and allow for the retention of publicly financed assets.

"The people of Ontario can't let this go," says ONA president Barb Wahl. "They need to push their MPPs to make sure staffing is increased. A ranking of last place is totally unsatisfactory."

This concludes the Citizen's special report on Ontario's crisis in nursing home care.

Paul McKay is a Citizen reporter. His e-mail is: pmckay@thecitizen.canwest.com

=====