Court File No. DC-24-00000007-00JR

***ONTARIO***
**SUPERIOR COURT OF JUSTICE**
**DIVISIONAL COURT**

B E T W E E N :

THE ONTARIO HEALTH COALITION and
CATHERINE PARKES

Applicants

- and -

ONTARIO MINISTER OF LONG-TERM CARE

Respondent

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**AFFIDAVIT OF CATHERINE PARKES**
**(SWORN APRIL 17, 2024)**

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I, Catherine Parkes, of the Municipality of Clarington, in the Province of Ontario, **MAKE OATH AND SAY:**

1. I am the daughter of a former resident of Orchard Villa, a long-term care home run by Southbridge Care Homes at 1955 Valley Farm Road in Pickering, Ontario. My father resided in Orchard Villa from November 2019 to April 15, 2020 when he passed away during wave 1 of the COVID-19 pandemic. In the past few years have become increasingly involved in long-term care advocacy in Ontario. For these reasons, I have direct knowledge of the matters to which I depose in this affidavit. Where the information in this affidavit is not based on my direct knowledge, but is based upon information and belief from other sources, I have stated the source of that information and I believe all that information to be true.

**Background**

2. In 2019, my family and I found that my father's care was becoming urgent with slips and falls that led to multiple trips to the hospital. His physical state had become fragile, even though his cognitive abilities remained intact. My father received an assessment by Local Health Integration Networks (LHIN) who determined that his needs were critical, and he was placed on a long-term care home (LTCH) waiting list. When choosing which homes to fill out on his forms I did my best to research which LTCH would suit him and had a number of homes chosen. However, I was told by LHIN that due to wait times, I would have to reduce the list to three homes, one of which was Orchard Villa. Orchard Villa's on-line incident reports were not favourable but I felt pressured by LHIN to list a home with the shortest wait list, which was Orchard Villa. In November 2019 my father was accepted in to the home within days and moved in within 24 hours of his acceptance.

3. My initial impression of Orchard Villa was that it was not well kept. I didn't mind that fixtures were dated, but I could clearly see that it wasn't clean. I immediately regretted listing Orchard Villa on my father's list of homes, but at that stage, our only other option was to refuse to move him in and then have him move to the bottom of a long waiting list for another home.

4. Prior to the pandemic I visited my father two to three times a week. During our Saturday visits I would sit with him and his tablemates as they ate their lunch. I witnessed the poor quality of food, the constant state of uncleanliness in the home and the shifts, both day and night, with minimal staff present.

5. During the first month of my father's stay at the home, he was the victim of staff-to-resident abuse, which my father was able to communicate to me moments after it happened. I arrived at the

home, addressed the situation and followed up with a meeting with the Director of Care. To my knowledge that meeting and my complaint was never forwarded to the Ministry of Long-Term Care. I can find no record of it in the on-line incident reports. Further, there was never any follow-up with me directly and I had to continue to press the issue myself to find out the results, which were that the staff member in question had simply been moved to another section of the home.

6. During February and March of 2020 COVID-19 was being detected throughout Canada. I paid special attention when the first stories of COVID-19 were reported in long-term care homes in Quebec. On March 19, 2020 a media report stated that COVID-19 had been detected at the Pinecrest long-term care home in Bobcaygeon, Ontario. My thoughts naturally turned to the welfare of my father as COVID-19 seemed to be creeping closer to his long-term care home.

7. During the first few months of my father's stay, I discovered that his catheter bag was filled with a dark coffee-coloured substance. I don't know how long it had been that way or why no one had noticed it earlier, but I had him sent to the hospital only to discover he was in acute kidney failure due to lack of hydration, hence the coffee colour of the catheter bag. Just three days prior I had noticed red streaks in my father's catheter bag and upon mentioning it to the registered nurse at Orchard Villa I was assured that it was simply a bit of blood from changing his catheter. Not being a part of the medical profession, I took the RN at her word, but days later as I spoke with the doctor at Lakeridge Health I realized that the red streaks had been the first sign of dehydration and a subsequent urinary tract infection that had gone on unchecked by Orchard Villa staff. Thankfully, my father recovered and the solution was that I was told to bring cups to my father's room and fill them with water myself so that he could sip water. That solution was fine for when

I was there, but I expressed my concern about his inability to reach the water on his nightstand and was never given an answer.

8. In January, 2020 my father and I attended a meeting with one of his medical specialists at Lakeridge Health in Oshawa. My father had months before received weeks of radiation for a spot of melanoma on his leg. During this follow-up meeting the doctor said the words "Mr. Parkes, you will not die of cancer, you will die of old age." They had stopped the progression of his melanoma and he was recovering well.

9. Because COVID-19 had been ravaging long-term care homes in Quebec and Ontario for two months I had hope that Orchard Villa was preparing to keep their residents safe. I was reading in the news that some long-term care homes were taking extreme measure to protect their residents, with some staff members even sleeping on-site to prevent infection from reaching their residents. I thought with two months forewarning surely Orchard Villa would have been better equipped to deal with what was coming, but Orchard Villa was not prepared and the ensuing result was not only disastrous, but also life-ending and for those family members left behind in the wake of their loved-ones death, life-altering.

10. During wave one of the pandemic family members were locked out of long-term care homes in Ontario. The Ontario government had issued a mandated lock down of all long-term care homes in an attempt to prevent COVID-19 from entering the homes. Fortunately, my father had a personal telephone line installed beside his bed, so I was able to communicate with him daily even though I wasn't able to see him in person during this time. On April 11, 2020 I was celebrating my birthday and called my father to speak with him. On that day his voice had become very weak and the only words he could manage to say were "I love you." I had spoken to my father the previous

day and he was his normal lively self, so I knew something was wrong. I hung up with my father and called Timothy Omere, the RN on my father's ward. Timothy told me that my father had a slight fever, but that it wasn't high enough for him to receive a COVID-19 test. The following day, April 12, 2020 my oldest brother was the only person able to reach my father via telephone. Although my father was able to answer the telephone, he could not speak to my brother. On Monday, April 13, 2020 I tried calling my father several times at around 7:00 a.m., but the phone was never picked up. I called his ward and the phone was answered by Prince, who was also a registered nurse at Orchard Villa. I voiced my concerns about my father's declining health and told Prince that I wanted my father tested for COVID-19 that day, regardless of the level of his fever. During this conversation I asked Prince how things were fairing in the home and he told me it was very bad, that there was hardly any staff on hand and that they didn't have enough personal protective equipment. I asked Prince how I could help and he recommended that I speak to management and let them know the situation and how concerned I was. I called management, and spoke to Beverly Williams, the director of care. Beverly assured me that my father was fine, she read his file and told me he had eaten half a sandwich just the day before. Beverly said that the home was well staffed and had enough PPE. Despite Beverly's assurances, I realized that my father was very ill and asked that one of my family members or myself be allowed in to Orchard Villa to see my father and to help him, but Beverly told me that it wouldn't be possible. Later in the day on April 13, 2020, I called Orchard Villa again and spoke with the assistant director of care and requested that my father be put on oxygen, but I was told that they didn't have enough oxygen machines and so that request was denied.

11. On April 14, 2020, unable to reach my father by phone, I managed to contact a personal support worker on my father's ward. I asked her how my father was doing as he wasn't answering

his phone. She informed me that she was brand new and didn't know my father in his usual state. I told her my father was normally very alert, jovial and always willing to answer his phone. She then told me that my father was in a very bad state. I hadn't laid eyes on my father in four weeks and the PSW's words sparked panic in me. I asked if I could please park outside the home under my father's window so that I could see him, and she complied. I raced to Orchard Villa and stepped outside of my car, which was parked just below my father's second story window. I was vaguely aware of two other people standing twenty feet to my right, discussing how things were fairing in the home. I called the PSW again and she hung up and came to the window. She waved, indicating it was okay to call my father's private phone line, which was located beside his bed. She answered the phone and raised my father's bed up so that I could see him through the window. I was horrified and heartbroken at what I saw. Just the day before the only words my father could utter were "I love you, I love you, I love you," but now I saw him laying on his back, his arms at his side and a blanket pulled up to his waist, wearing his flannel black and grey plaid shirt, and he wasn't moving. The PSW held the phone to my father's ear and I told him it was me. Normally, every time my father heard my voice or saw me walk in to a room his face would light up and he would give me the biggest smile, but this time he was non-responsive. I began to sob and begged him to say something to me, but he was silent. I could hear his breathing faint and laboured and I told him how much I loved him. I told him that I would help him and to please hold on, that I would do something right away and get him out of the home. I kept telling him that I loved him over and over. The phone call lasted no more than five minutes.

12. As soon as I returned from seeing my father, I began calling management at Orchard Villa. The phone went unanswered, but I kept dialing until the call was finally picked up by the assistant director of care. I told her that I had just viewed my father through his window and that I wanted

him sent to the hospital immediately. The assistant director told me that they were not accepting LTC residents at the hospitals; she said that paramedics wouldn't be wiling to come in to the home to put him in an ambulance. I said I would come and put him in the ambulance and she said that even if I did, he would be turned away from the emergency room and sent back to Orchard Villa, and did I really want to put my father through that in his state? In the end, my request to have him sent to the hospital was denied as well.

13. Frustrated at being denied every avenue to help my father I decided to wait until the next day when I knew a certain staff member would be on the floor. The staff member was a registered nurse who had taken a liking to my father, and with whom I had built a friendly rapport in regards to my father's care. I knew if I asked this one staff member to send my father to the hospital then it would be done. The RN's shift started at 3:00 p.m. the following day, April 15, 2020.

14. At 12:00 p.m. on April 15, 2020 I received a phone call from the same assistant director of care that I had spoken to the day before. She informed me that my father had died and asked me when I was going to have his body removed from the home and when I was going to come and collect his things. In my state of shock I told her that I would have to call my brothers and make arrangements for my father's body, to which she replied "You mean you don't already have a plan to remove him and for his funeral?" I was shocked again, but I remember replying, "I didn't expect him to die, so no, I don't have plans already made."

15. My father, who was hours away from a trip to the hospital, had died alone.

16. My father was one of the first to die in Orchard Villa during the pandemic and I realized quickly what a tragedy this would turn out to be. Prior to, and immediately following my father's

death I had been in contact with several government officials. I raised alarm bells to every level of government I could think of, emailing and conducting phone calls with municipal, provincial and federal representatives. Despite the desperation of myself and other families like me, staff members of Lakeridge Health were not sent in to the home until April 22, 2020. The Canadian Armed Forces also entered the home on April 28, 2020, but had to wait three days, until a complete cleanse of the home had been completed before they were able to fully enter Orchard Villa.

17. I watched the news as staff from Lakeridge Health were sent in, and soon saw on the news that the Canadian Armed Forces were being sent in to Orchard Villa as well. By the time the military entered the home I thought nothing could surprise me regarding my father's long-term care home, but then the military report on the five worst long-term care homes were released, one of them being Orchard Villa. There were a few things that surprised me about the military report, but more than anything a feeling of dread washed over me and stuck, as it did with many of the family members. The realization that against all hope, our knowledge of the failures by Orchard Villa were now documented by an authority higher than us. The detailing of cockroaches, filth, the feeding of residents who were laying down and then choked leading to their death, the lack of staff, lack of food, lack of hydration, all of these things were simply a heightened version of what we had seen prior to the pandemic. Without allowing us in the home to fill the gap for our loved ones, these failures by Orchard Villa had become deadly.

18. After Orchard Villa went in to lockdown on March 14, 2020, information coming from the home was difficult to come by. Many of the Orchard Villa families turned to social media and we began chatting on the Messenger app. It became a way to share any tidbits of information any of us could find, as well as a way to support each other. With this chat I found that I had become a

member of a group of sorts; a group of families bonded together by tragedy and trauma. We united and call ourselves The Families of Orchard Villa, but what we really are is a group who grabbed on to each other tightly during some of the worst moments of our lives, we became a family of casualties of Orchard Villa.

19. In the months following the release of the military report The Families of Orchard Villa publicly requested that the provincial government allow for an independent, third-party evaluation of what happened in long-term care homes in Ontario during the pandemic. The provincial government opted to conduct an independent commission instead, with a panel chosen by those in power. While my group was not pleased with the decision to not keep this non-partisan, we did participate by speaking with the commissioners for a full day on October 23, 2020. During our meeting with the commissioners we gave our testimonies, which involved our experiences before, during and after the pandemic. These testimonies tell of a long-term care home that was in dire straits before COVID swept through the home. A transcript of that meeting is marked as **Exhibit "A"** to this affidavit.

20. The pandemic was an unusual time for funerals, especially in the earliest months of the disease. My father's funeral was limited to ten family members, masked and separated from each other. We had an open casket, but even then we were kept from the casket at a ten-foot distance. At the end of our visitation, the other nine members of my family left me a moment alone with my father. My father and I were close, and his care had been my main priority for over three years. The first thing I noticed when viewing my father at the funeral home was how drastically changed he was from the few short weeks since I had last been with him. My father looked shockingly thin, his suit several sizes too large for him. He had signs of starvation and obvious dehydration that

even the mortician was unable to disguise. I said goodbye and I wept for his loss, but also for the clear visualization before me of what he had suffered during the last weeks of his life.

21. After my father's death I received an outpouring of messages from people whose life my father had touched. I heard accounts of how, when he had worked at the T. Eaton Company, he had discovered large boxes of shoes being thrown away, and how he took them to give them to those who needed them. I heard that, as he was in a managerial position, he gave jobs to people who were unable to find work elsewhere, and how that changed the course of their lives. I heard that even during the lockdown in Orchard Villa, my father used his resources to reach out to other family members so that he could give them updates on how their loved-ones were doing in the home. None of this surprised me, as my father had shown my siblings and I how to help others in need, and he did so by example. I can remember how he spent months every summer labouring to fix equipment that was used at a summer camp for underprivileged children in need, how he let down-and-out friends live in the spare bedroom of our family home when they had nowhere else to go. Even during his time in Orchard Villa there would be moments like the time he called me to tell me that his roommate was laying down and was choking, and that despite repeated attempts to contact staff by pressing the emergency call button, no one was coming. He called me because he knew I would do something, which I did, and his roommate was tended to quickly thereafter. My father was not a man who helped other in order to receive accolades. On the contrary, he helped and never spoke of it afterwards. Both my father and my mother instilled in my siblings and myself the same morals that required us to help when we see need. My father's attitude was if someone reached out for help, then you should extend your hand back to them. He also lived by the mindset that, when it came to neglect or abuse, when you see something, say something.

22. I know for certain that, moving forward, no family member or loved-one of mine will ever reside under the roof of Orchard Villa, but I can hear my father even yet saying that it's not enough. I can hear him saying, "You have seen it, you must say it." For this reason, I have been speaking for nearly four years.

**Correspondence with MLTC and the MLTC Consultation on July 15, 2021**

23. On June 25, 2021, I submitted an email to the MLTC regarding Southbridge Care Homes Inc.'s request for an extra 87 beds and a 30-year extension to their license for Orchard Villa LTCH in Pickering. A copy of my email is at Tab 94C of Volume 21 of the Record of Decision in this matter, and is marked as **Exhibit "B"** to this affidavit.

24. After receiving the notice of the public consultation concerning the Southbridge proposal to build a 320 bed long-term care home on the current Orchard Villa site, I attended MLTC's public teleconference consultation on July 15, 2021.

25. The public consultation began with a presentation by two representatives from Southbridge focussed on the new building and features regarding the new building. None of the information referred to in Southbridge's presentation was made available online prior to the public consultation, nor was it made publicly available after the consultation.

26. The Ministry representative at the meeting then directed members of the public to focus their comments and questions on the information presented by the Southbridge representatives about the proposed new building, and not on Orchard Villa's history and the many deaths that had occurred. In particular, the Ministry representative sought to focus the consultation on the new building and its features, and not the past conduct, the experiences of residents or families at

Orchard Villa, or on concerns the public had about Southbridge receiving 87 extra beds and a 30-year extension to their license. Throughout the consultation, I observed that Ministry representative repeatedly interrupted speakers who sought to comment on Southbridge's past conduct in relation to events at Orchard Villa, stating that the scope of the consultation was limited to the proposed project not the company's record. As a result, members of the public were prevented from speaking about issues they wanted to raise with the Ministry and Southbridge.

27. Another significant issue with the consultation was that the teleconference lines were jammed because so many family members and/or members of the public were trying to participate to explain their concerns with Southbridge to the Ministry. The Ministry had also decided to limit the consultation to only one hour for reasons I am not aware of. I repeatedly tried to get an opportunity to speak but was not able to for 45 minutes. Finally, I was only able to speak at the public consultation because another speaker, Natalie Mehra, conferenced me in at the end of her submission. I was one of the last people to speak and understand that there were many others who did not get the opportunity to speak during this consultation as they were stuck on hold on the teleconference. During my submission, I noted that many families had not had the opportunity to speak at the consultation and requested a second consultation occur, in person, so that everyone who wanted to make a submission would be able to.

28. I have reviewed the notes of the public consultation produced at Tab 94V of Volume 22 of the Record of Decision in this matter. My statements are described in part in those notes on p. 7022 of the record. The notes do not capture the entirety of my statements.

**The MLTC Consultation on October 17, 2022**

29. In the Fall of 2022, a notice posted the Ministry's website noted that a public consultation had been conducted in 2021 but as a result of a corporate restructuring by Southbridge, a further consultation into the licence would be held. A copy of the notice I reviewed is located at Tab 88, Volume 18 of the Record of Decision.

30. I participated in this consultation and a copy of my October 17, 2022 email submission is produced at Tab 88DD of Volume 18 of the Record of Decision, and is marked as **Exhibit "C"** to this affidavit.

31. This consultation was not conducted in public. Rather interested parties were invited to make written submissions. I did not receive any response from MLTC to my email submission.

32. After this consultation, I did not receive any other information from the MLTC. I was not notified of the decision made by the Director concerning the Application, nor did I receive any reasons for the decision. In December 2023, I learned from Natalie Mehra that notice of the Director's decision to approve the Southbridge proposal had been posted to the Ministry's website.

33. I make this affidavit in support of the application for judicial review and for no other or improper purpose.

SWORN REMOTELY via videoconference before me by CATHERINE PARKES, stated as being located in the Municipality of Clarington in the province of Ontario, on April 17, 2024 in accordance with 0. Reg 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:
Catherine Parkes
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**CATHERINE PARKES**

Commissioner for Taking Affidavits

Geetha Philipupillai LSO# 74741S

1385-3411-9435, v. 1

This is Exhibit “A” referred to in
the Affidavit of CATHERINE
PARKES sworn before me this
17th day of April, 2024

A Commissioner for Taking Affidavits

# Long Term Care Covid-19 Commission Mtg.

Meeting with Families of Orchard Villa
on Friday, October 23, 2020


77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held via Zoom, with all participants attending remotely, on the 23rd day of October, 2020, 4:00 p.m. to 5:00 p.m.

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BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner;
Angela Coke, Commissioner;
Dr. Jack Kitts, Commissioner.

PRESENTERS:

Cathy Parkes, Families of Orchard Villa Member;
Carolin Wells, Families of Orchard Villa Member;
Fred Cramer, Families of Orchard Villa Member;
Marie Tripp, Families of Orchard Villa Member;
Simon Nisbet, Families of Orchard Villa Member;

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
Ida Bianchi, Counsel, Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Policy Unit, Long-Term Care Commission Secretariat;

Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;
Kate McGrann, Counsel, Long-Term Care Commission Secretariat;
Laurel Reid, Families of Orchard Villa Member;
Lisa Theis, Families of Orchard Villa Member;
Elisabeth Van Sickle, Families of Orchard Villa Member;
Catherine Legere, Families of Orchard Villa Member;
Rob Glen, Families of Orchard Villa Member;
Bill Tobias, Families of Orchard Villa Member;
Pam Townley, Families of Orchard Villa Member;
Cathy Gayman, Families of Orchard Villa Member;
Marion Feeney, Families of Orchard Villa Member;
Veejay Leswal, Families of Orchard Villa Member;
Dorothy Scavuzzo, Families of Orchard Villa Member;
Jessica Boily, Families of Orchard Villa Member;
Pamela Bendell, Families of Orchard Villa Member;

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 4:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Good afternoon. Commissioner Jack Kitts has joined us and Commissioner Coke.

Well, are you waiting for anybody else?

CAROLIN WELLS: Cathy is going to moderate, and Simon.

SIMON NISBET: Hello.

CAROLIN WELLS: Simon and Marie, I guess.

LISA THEIS: Simon is here.

CAROLIN WELLS: Oh, yeah. There's Cathy. And Fred is there, yeah.

FRED CRAMER: Yeah.

CAROLIN WELLS: So I think that's everybody then, right?

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CAROLIN WELLS: Fred, Marie, Simon. Yeah, everybody's here, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, then if maybe I can just start us off and then your moderator can take over, and we can have this conversation.

As you may or may not know, we did release the first interim report today. We jumped the gun a bit, but we're in a hurry.

We felt a sense of obligation to speak as quickly as we could primarily, I guess, because we were created in the middle of something. It wasn't a situation where something was over and we were looking back at it.

We were created in the middle of it, and we felt the need to make some preliminary recommendations as quickly as we could and then take a more traditional approach. The traditional approach is an investigation and some hearing or proceeding to show the public the results of that investigation and then recommendations.

If you take the traditional approach where the event has already occurred and you're looking back at it, you can take two or two and a half years to see it resolve. And, of course, we didn't think that that would be much good to anybody in a situation where we're in the middle of something. To report that far down the road just seemed not to be a good idea.

So we did report, and I want to thank you for the submissions that we received, which we

did read. But we're not finished. We're just starting, actually.

And so it's really important that we understand your perspective on this because that grounds what we're doing in reality, otherwise we get caught up in a lot of slide decks and aspirational thinking and so on, but we miss the actual reality of what happened.

So we're very grateful for you meeting with us, and we really would like to hear what you have to say. The only couple things is we like to ask questions as we go along, which means we would interrupt with a question. It's not that we're rude. It's just that we find that works better than trying to go back after, at the end of something, and bring people back to something they said and ask them a question. So if that's okay with you, that's the way we would like to proceed.

And secondly, we've allocated the time we've allocated, so if -- probably break for about ten minutes in about an hour or so depending on where we are and where you are and in terms of what you're saying.

So with that, we're ready when you are.

CATHY PARKES: Okay. Thank you. My

name is Cathy Parkes. It's showing as "Catherine," but --

COMMISSIONER FRANK MARROCCO (CHAIR): Hello, Catherine.

CATHY PARKES: Hi.

COMMISSIONER FRANK MARROCCO (CHAIR): Cathy.

CATHY PARKES: Yeah, either one works.

So I'll be the moderator today, and we've actually taken the time to formulate our questions together and scripted it.

But we also are all on the same page so, of course, feel free to ask questions at any time and stop any of us. We're like-minded in our thoughts towards this.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CATHY PARKES: Okay. So I just wanted to say thank you, first of all, for meeting with us today. Those of us here are just a small representation of a group who goes by the name "Families of Orchard Villa" by way of where our families lived.

We're here representing approximately 250 people all who have been affected by the recent

events in long-term care. Our group was formed out of necessity. As the COVID-19 outbreak was declared at Orchard Villa, we found we were receiving little to no information from the home about our loved ones.

So we gathered on social media and found that together we each brought a bit of information that gave us a larger picture about what was going on in the home.

As the group grew in numbers, we began sharing our stories. And we discovered that, although the finer details would differ, the loss and struggle of our loved ones shared too many similarities.

Our families' stories tell the reality of a severe lack of communication discovering that our loved ones suffered extreme neglect, dehydration, and were denied the right to basic care.

I'm very thankful to be a part of the Families of Orchard Villa group. Together we've decided who will speak here today.

We also have several members of the group who will not be vocal, but they are here with invested interest in these hearings and to support

those of us speaking because that's the kind of group that we've become.

We've read the interim recommendations put out today, and while some of the recommendations you've put forward may overlap with what we are going to say, we feel that it's important and enough that they bear repeating.

We have five speakers who will speak --

(TECHNICAL INTERRUPTION)

Oh, somebody's echoing.

We have five speakers who will speak at various times throughout our presentation, and we welcome any questions that may come up.

Our speakers today our Carolin Wells; Fred Cramer; Marie Tripp; Simon Nisbet; and myself, Cathy Parkes.

So I'll start off, and we're just going to go through, basically, our list of concerns.

COMMISSIONER FRANK MARROCCO (CHAIR): And I just want to say, Cathy, before you -- don't worry if some of it overlaps with what we said because some of what we said overlapped with what other people said.

CATHY PARKES: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

And we were just trying to add our voice to that, so don't be concerned about that.

CATHY PARKES: Okay. Thank you. So current regulations indicate that if a resident is not being nourished and hydrated, their power of attorney must be notified, but this regulation was not adhered to during the lockdown.

We feel that almost every death could have had a different outcome if the families and POAs were informed and allowed to send the residents to hospital, which many of us weren't.

We insist that if a resident's health status becomes perilous, the home must inform the POA or caregiver and must send the resident to the hospital regardless of a do-not-resuscitate status.

And next is Carolin Wells.

CAROLIN WELLS: So I'm Carolin Wells. My father was James Shankland Fleming, and he passed away April the 9th of this year at Orchard Villa, obviously, and he was 88 years of age.

So Number 2: We have noticed from observation of our family members and from medical records that many residents have been denied treatment for non-COVID related ailments during the pandemic -- for example, UTIs, bedsores, falls,

scrapes, bruises.

Some of these issues, such as UTIs, have significant impact on an elderly person's health. Others such as bedsores, falls, and bruises highlight the substandard care and attention that was provided particularly during the shutdown.

We recommend that appropriate medical attention -- including access to doctors, treatment, hospitalizations, and notification of POAs -- sorry, that they should not be denied during the pandemic.

CATHY PARKES: And then our next speaker is Marie Tripp.

MARIE TRIPP: Good day. The military report -- and we, the families that have served -- that many infected and dying residents did not receive oxygen due to the fact that the life-saving equipment was not properly maintained.

We recommend that the oxygen be available for every resident should they need it or failing the availability of oxygen that each resident be sent to the hospital to receive care.

CAROLIN WELLS: Okay. So infection control and personal protective equipment: At the

beginning of the pandemic and before the outbreak at Orchard Villa, we observed that there was an absence of infection control procedures at the front door and throughout the building.

The only infection control observed was a table with hand sanitizer and a sign-in sheet in the front lobby that was not monitored. We believe this contributed to COVID being brought into the home. We would like to see contact management and tracing enforced.

CATHY PARKES: Thank you, Carolin.

And next is Simon Nisbet.

SIMON NISBET: Hi. My name is Simon Nisbet. My mother, Doreen Nisbet, resided in Orchard Villa 2017 until May 3rd, 2020, at which time I was able to have her relocated to the hospital where she arrived in very poor health. She is a survivor of Orchard Villa and continues to reside in a long-term care system.

Thank you for meeting with us today.

I'll continue with the infection control and PPE points. Once the pandemic was declared, Orchard Villa should have had plans for isolation.

Once COVID-19 was confirmed in the

home, family members became aware that there was no cohorting or isolation procedures being followed. Family members are aware that COVID-19-positive and negative residents were kept in the same room even though the management of the home claimed they had been separated.

We are asking for a mandate that each long-term care home have a secure, isolated space for residents and track the virus during outbreak. This would also include dedicated staff for isolation wards.

Cathy?

CATHY PARKES: Thanks, Simon. The Ministry of Long-Term Care identified, two years ago, that four-bed rooms were to be done away with. But Orchard Villa has many rooms where residents are living four residents to a room.

We do not feel that this lands itself to a quality of life on its own, and we feel the standards of having four residents to a room led to many infections and, therefore, deaths.

In addition, the rooms that are specified as semi-private are so cramped that often furniture has to be moved to allow a resident to exit the room in their wheelchair.

We would like to see the abolishment of four-bed rooms in all long-term care homes in Ontario as soon as possible.

And now on to Fred Cramer.

FRED CRAMER: Hello. My name is Fred Cramer, and my mother, Ruth Cramer, lived at Orchard Villa from September 3rd, 2019, until her death on April 19th, 2020, due to COVID-19.

After the lockdown on March 14th, residents continued to dine together in large groups. They also continued to congregate in the lobby for entertainment purposes. They continued -- up to and including April 9th, 2020 -- after Orchard Villa had reported the first case of COVID-19 in the home.

We recommend that you will ensure meals be served at multiple settings to obtain proper social distancing guidelines. We also recommend that large gathering for entertainment purposes be restricted when social distancing is not possible.

Carolin?

CAROLIN WELLS: Yeah. Number 8: We observed a consistent lack of social distancing and masking of those smoking outside. We recommend that a separate smoking section be required away

from main entrances and exits as well as hallways.

We recommend that smokers who are COVID-positive be closely monitored and kept at a distance when smoking and/or using common areas to enter or exit the building.

CATHY PARKES: And, Carolin, it's you again, Number 9.

CAROLIN WELLS: We are aware that residents who wander due to their health status were allowed to enter rooms that were not their own therefore raising the potential for spreading the virus.

We feel that there needs to be humane safety protocols for residents who wander especially those who are in a security-controlled ward but are still able to travel to and enter other residents' rooms.

CATHY PARKES: And now we move on to staffing with Fred.

FRED CRAMER: Okay. Prior to the pandemic, we were aware that staffing levels were always below standards. We saw this daily as we visited.

During the beginning of the lockdown, many of us were told by Orchard Villa staff that

they were extremely shorthanded and therefore unable to care for residents in the manner they deserved.

This was especially true during the evening and overnight shifts. We were aware that the residents went without food, hydration, medication, and basic care.

We recommend a standardized plan for staff/resident ratios inside and outside of an outbreak.

And I've got the next one, too, here. We would like to see certified, standardized training for all staff in Ontario including infection control and use of PPE as well as ethics and duty to report.

We'd also like annual retraining to ensure all staff is continuing in their understanding of these protocols.

Carolin?

CAROLIN WELLS: Yeah. So 12: We recommend better quality of employment for staff which includes better pay, benefits, the requirement that a staff member may only work in one home at a time.

We also recommended incentives to

educators that will raise enrollment in necessary long-term care staffing fields such as nursing, personal support workers, nutrition, and physical therapy care.

CATHY PARKES: And, Marie, on to you.

MARIE TRIPP: Okay. I'm sorry. I didn't introduce myself. My name is Marie Tripp. My mother was Mary Walsh. She entered Providence Villa in April 2019, and she passed away April 20th, 2020, from COVID.

Okay. Due to the lack of staffing during the pandemic, we recommend an assessment and comparison between staff scheduling and the staff swipe-card system which will indicate staffing numbers during the pandemic.

In addition, we ask that this information be validated between payroll and the accounts payable system to inform on actual staffing. We would like this information to be made public.

CAROLIN WELLS: Okay. 14 --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you there for a minute, Ms. Tripp? What you're saying is you want to know who was paid to work when and --

MARIE TRIPP: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- make that so that will tell you how many people were working per shift, et cetera, on the theory that if they paid them, they worked, and if they didn't pay them, they didn't work?

MARIE TRIPP: Correct.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

CAROLIN WELLS: So 14: We are aware that doctors rarely entered the home during the pandemic, and if they did, the information they relayed to families was not helpful.

We recommend an assessment of staff physicians to determine if they were on site, and if not, why.

SIMON NISBET: So moving on to information issues. Every family member endured a severe lack of information during the lockdown which was also highlighted in a military report on Orchard Villa.

At best, communications from the home were sporadic and inconsistent, but most often, they were nonexistent, and the information that was conveyed was incorrect often indicating numbers of

infected residents that contained conflicting information that was presented in both the media and on the Durham Region outbreak website.

We recommend a standard of communication between long-term care homes and family during outbreaks. We would like to see one or two staff members whose sole responsibility is to keep the families appraised of their loved ones' health and mental health status including timely phone communications and allowing for video conferencing between family and their loved ones.

This would include ensuring that every home has multiple tablets on hand to provide the necessity. We would like to see this position filled by a third party impartial and separate from the long-term care home staff.

Cathy?

CATHY PARKES: Thanks, Simon. Number 16: We would like to see an assessment of kitchen staffing during the pandemic, food supplies, and distribution of meals to residents during the pandemic, and we would like these assignments to be made public.

Fred?

FRED CRAMER: I have Number 17. Many

of us have obtained our loved ones' charts and have found gaping holes from as early as the lockdown on March 14th, 2020.

We recommend the review of all charts in the charting system at Orchard Villa to determine if standard charting requirements were met. We would like this information to be made public.

And I've got the next one, Number 18.

Not being allowed to see our family members was and continues to be very damaging. We were forced to rely on staff providing this information about our loved ones which was often false.

We recommend that in-room cameras become standard for every resident in long-term care homes which allow family members to have visual contact with their loved ones.

MARIE TRIPP: Number 19, legal: We are aware of some certificates -- I'm sorry. We are aware that some certificates have other causes of death even though the resident was COVID-19-positive.

We would like all death certificates from the beginning of the lockdown to the present

date be reviewed and, where necessary, be revised to include COVID-19 as the cause of death.

Number 20: We're concerned about the documentation and signing off of all death certificates during the pandemic.

It is our understanding that, during the months of March 2020 to present day, there were multiple deaths pronounced by staff that did not hold the required medical licenses to pronounce death.

We recommend the investigation of death certificates and appropriate actions be taken if there are findings that a registered physician or registered nurse did not fill out a certificate.

Simon?

SIMON NISBET: We are aware that residents were not being properly nourished prior to and especially during the pandemic. The military report on the five long-term care homes stated that residents were either not fed or the food or refreshments were placed out of reach of residents.

We were also aware that, prior to the pandemic, Orchard Villa residents' meal budget was $7 a day. That's $2.33 a meal.

We recommend more nutritional meals served according to Canada's Food Guide with an increased meal budget. It should be made mandatory that family be notified immediately if a resident is not consuming food or water to normal standards.

Cathy?

CATHY PARKES: During the pandemic, several family members were banned from being present with their loved ones during their final moments of life, including myself.

We strongly insist that family members be allowed to be present with their loved ones, regardless of COVID status, if the resident is deemed to be at the end of life and, in allowing this, that the home will also provide the family members with full personal protective equipment upon entering the residence.

Marie?

MARIE TRIPP: Yes. Number 23: We were concerned about the high level of personal property loss experienced in long-term care. Wedding rings, personal items, and other valuables were misplaced, never found, or damaged beyond repair. We would like the Commission to address this.

And Number 24: We would like to know

why management of Orchard Villa did not call the Durham Regional Police to advise on each death of a resident as is required by law.

SIMON NISBET: Inspections: We are aware that the amount of RQIs dropped dramatically in 2018 which has allowed long-term care homes to fall below standards of care.

We have also heard statements from long-term care ministers that RQIs are always done without notice to the home. However, we know this not to be accurate.

We recommend the immediate reinstatement of yearly RQIs. Each long-term care home in Ontario should receive at least one or two RQIs annually without the home being advised in advance. These should be comprehensive inspections involving a team of nursing, dietary, and environmental inspectors among others.

We further recommend that inspection reports require follow-up requirements by the Ministry of Long-Term Care inspectors. We would like to see the voluntary plan of correction be removed as a requirement from each home and that stricter responses from each home become mandatory with more effective sanctions to ensure compliance.

Fred?

FRED CRAMER: Funding allocations: We recommended the investigation of how for-profit homes allocate the funds received by the provincial government. We would like this information to be made public.

Simon?

SIMON NISBET: Hygiene:

Thanks, Fred.

We are aware the residents were left in soil garments and bedding for several days at a time even when they did not require these garments prior to the pandemic.

We recommend an investigation into the rise in urinary tract infections and bedsore infections during the pandemic.

As documented through records from the Canadian military, Orchard Villa was experiencing pest control issues in several areas of the home.

We recommend that a standard interval of deep cleaning, pest control, and regular disinfecting of services be adopted. We recommend that the documentation regarding pest control and deep cleaning be made public and that there be a schedule for future deep cleaning and pest control.

The certificate of inspection should be posted in a similar fashion to the restaurant pass system. The certification should be posted for visitors to see.

During the initial shutdown of Orchard Villa, the care received was substandard and led to a further decline of residents' health and cognitive function which fell well below the standards outlined in the Long-Term Care Act of 2007.

We feel that these standards should not be sacrificed during an outbreak. This would include but not be limited to mandatory requirements: that they be turned in their beds regularly to prevent bedsores; daily bed changing; daily cleansing; the ability to be safely toileted; a minimum standard of care for dental hygiene for each resident; a minimum standard for foot care for each resident -- this has been an ongoing problem within and outside of the pandemic time lines -- at minimum, two showers or baths per week; air quality inspections --

Oh, sorry. This is Carolin.

CAROLIN WELLS: That's okay.

CATHY PARKES: That's okay. Simon, did

you want to finish up? That last part was yours, and then Carolin can do the next one.

SIMON NISBET: Oh, I'm sorry. I have a typo here. Air quality inspections implemented weekly or biweekly during outbreaks.

CATHY PARKES: Okay. And then, Carolin, do you want to take the mental health one?

CAROLIN WELLS: Sure. I'll take the mental health. So Number 30: Residents were denied access to the outdoors for weeks or months. This denial increased the feeling of isolation, had negative affects on our family members' health.

We recommend an implementation of resident rotations out of doors for fresh air in a secured environment during outbreaks.

Should I continue there? Yeah?

CATHY PARKES: No. We'll let Simon take that one.

CAROLIN WELLS: Okay.

SIMON NISBET: Thanks, Cathy.

CATHY PARKES: Yeah.

SIMON NISBET: We have witnessed a decline in mental health along with the physical effect it has had on some of our loved ones. Often residents were left in bed for days at a time. The

residents were also denied mental stimulation.

We recommend an assessment and solution to residents enduring months of isolation as well as attempting to place residents in rooms with like-minded residents or those in similar cultural backgrounds.

We would like to see increased support from recreation, social work, or activity staff to address isolations, fears, and related mental health concerns.

And onto residents without advocates -- and I could tell you my mom, on a regular basis, would tell me "if this is like this for me, Simon, what must it be like for people that don't have people coming in?" Some individuals at Orchard Villa have no family or power of attorneys.

We know from experience how important our advocacy efforts and hands-on assistance have been in ensuring that even basic care needs for our family members are and were met.

We recommend that if a resident does not have an immediate family, friend, or power of attorney or a designated contact, that a level of staffing be provided to ensure that these residents' needs are being met.

Furthermore, we recommend the implementation of a group whose sole purpose is to update the residents' well being and the health status in the absence of family, friend, or power of attorney advocate.

Marie?

MARIE TRIPP: Thank you. Retirement living: Although we are speaking to long-term care residents today, we're also mindful that the outbreak in the long-term care side of Orchard Villa had a devastating impact on the Orchard Villa retirement community that is on the west side of the building.

The retirement section of the home was not included in many of the measures that were taken to protect the long-term care residents. We are aware that the staff and residents often commingled between the two sections.

We recommend that, if any long-term care home is housed under the same roof as a retirement home, that all retirement residents and staff be treated with the same urgent care equally. Thank you.

CATHY PARKES: So that's the end of our points. I did also just want to say that my father

was also a resident of Orchard Villa. He went in in November of 2019 and passed away April the 15th, 2020. His name was Paul William Russell Parkes.

So while our real list of concerns is actually quite a bit longer than this, the points that you've heard were spoken because we feel it most urgent and needed immediate action.

We would be remiss if we didn't also speak to our worry that a culture of fear exists among the staff at long-term care homes. This fear put on the staff by owners and management has kept the province from hearing the most important details of what has occurred in our long-term care homes aside from the residents' own stories.

We would like to see long-term care staff being given the respect they deserve and to create an environment where they are free to speak the truth of what they have witnessed.

COMMISSIONER FRANK MARROCCO (CHAIR): Cathy, can I stop you there for a minute?

Do you think they would come forward if they thought there was some confidentiality associated with what they were saying?

CATHY PARKES: Yes. I've actually been approached anonymously in person, though, by staff

who knew my father, who knew the man who shared the room with him. And they had things to say to me that they were just too afraid to say because there are internal documents that are being circulated within the home from management and from owners telling them not to speak even though I believe that's not right.

But, you know, it's worded in such a way that it just implies "you shouldn't be speaking." And yet they really want to speak. I mean, these staff members loved our families. They saw them every day. And to have to watch them die that way was upsetting, and they want to talk, but they're terrified.

COMMISSIONER FRANK MARROCCO (CHAIR): See, that's very interesting to me. We've heard from others, like ONA, that the staff really were fond of the people they were looking after.

And was that generally the impression of the families that are here, that the staff had formed some affection for the people they were caring for?

CATHY PARKES: Yes. And, of course -- everyone's nodding -- there's certain staff members who your family members had a tighter bond with.

And I mean, I was only there for -- my dad was there for five months, and I became friends with the staff members and learned to trust them and talk about their personal lives and created a bond with them. And I could see who my father really connected with.

So yes, it becomes like a -- when you have to leave your family in the care of someone else, you need to build that relationship with them and that bond with them, and oftentimes we did.

COMMISSIONER FRANK MARROCCO (CHAIR): Did anybody notice problems before COVID? I'm interested in the observations of that nature that anyone might have made.

CATHY PARKES: Who wants to go first?

Yeah. I mean, I'll say first that, in the brief time that my father was there, we dealt with chronic UTIs, renal failure due to him not being cleaned properly and changed properly, falls, scrapes, bruises, left without eating for 48 hours, staff to resident abuse that was reported. And I never saw it on an incident report, but I certainly did report it to management. And that was in five months.

I know there are people who have had

family members in there a lot longer than my dad, and it's been going on for quite a long time. I think Carolin could probably speak to that.

Carolin, your mic is off.

CAROLIN WELLS: Okay. There we go. Yes, there were definitely signs, big time. So my dad was admitted April 9th, 2018 -- oh, sorry, no, November 5th, 2018.

And the next day we got a call that he had a lesion on his arm. He fell the day he was admitted.

On November 15th, he fell out of bed, and he hit his right elbow.

November 27th, he had a skin tear on his right hand. He was in the TV room and tried to stand.

He was found out in the parking lot. And my dad could not walk. He was in a wheelchair. He had had a major stroke. So he was found out in the parking lot.

I'll just list three things -- or five things that were quite significant. I put it in my -- you know, when I spoke to you before.

There were allegations of sexual abuse, my father being the victim. I don't have the

details now. My mom's the POA, but she certainly -- it got found -- it was unfounded, but there were allegations of it.

He fell out of the his wheelchair in the shower. There should have been two PSWs in there. There was only one, and he needed a lift, which they did not use.

He had an eye injury here. He needed medical intervention and needed to be sent to the hospital.

And I'll say this: When they go to the hospital, is it scares them. I'm sure you probably know that it scares them. It's different. There's different people around. Just that going and coming is a big issue.

But I'm actually glad he was sent because there's lots of times he should have been sent and he was not, and I'll get to that.

Anyways, and my dad was found in another resident's room one time. My dad was not incontinent, so it bothered him that he had to wear a diaper. They found them in there. His diaper was off, and he had -- if you think of the foot pedals on the bottom of the wheelchair, they can be taken off.

So when they're taken off, there's, like, a steel kind of -- hollow, steel tube. He fell on that, and it went inside him and into his rectum, and he had to go to the hospital and get internal stitches and on his, obviously, outside.

The last one -- and this is very telling -- very telling -- about them being prepared/not prepared. I went to visit him. He had a cough, and he sounded very hoarse. I couldn't understand what it was, and then I heard something about them saying "you know, it might be pneumonia."

I think they finally sent him -- or I can't remember if it was my mom or them. When he got to the hospital, they said he was so dehydrated that when they did the x-ray on his chest, they could not see the pneumonia. They couldn't see the fluid because he was so dry.

He had sores all over his face and his mouth from the dehydration. He was septic, totally -- he was septic, and his kidneys totally shut down.

They said the gunk that came out of him from his urinary tract was unbelievable. I'm amazed that he made it, but he did, and he was back

at Orchard Villa shortly after that. I think it was maybe a couple of months after that when COVID came.

But, you know, to even sit there and wonder whether to send them to the hospital -- I don't understand. A lot of times they put it in the hands of the loved ones, right? And my mom's a pretty quiet person, and she was looking to the doctors to make the decision, and that was an obvious one. He almost died.

CATHY PARKES: Yeah. And we had the same where we weren't told about his UTI until it actually became so serious --

CAROLIN WELLS: Yeah.

CATHY PARKES: -- that he was going into renal failure. And when we speak about -- the dehydration is so prevalent. You know, you walk into a long-term care home, and the temperatures are unbelievably high.

And I understand, in the winter, they're doing this because, you know, you get cold as you get older. You kind of lose some of that body heat. But they're not hydrating them enough to deal with how incredibly -- it's like a sauna in there.

And so my father would often say -- and he was by a window -- that he was just hot, overheated, sweating, and couldn't handle it, but yet they're not bringing them water.

So this is part of the reason -- this and, of course, having to wear, you know, adult garments is the reason why you're dealing with so many UTIs and why a lot of people end up in hospital with dehydration. That seems to happen quite a bit.

Does anybody else want to share their stories about --

Catherine? Unmute.

LISA THEIS: Yes. It's Lisa. Thank you.

CATHY PARKES: Oh, Lisa. I'm sorry. You're --

LISA THEIS: Oh, no, we look a lot alike.

There's three things that happened when my dad was at Orchard Villa. When he went into Orchard Villa in November of 2018 -- he said he was settling in, and at his three month review, we sat with the nurse staff and someone from nutrition and a PSW representative and a nurse.

And we started to discuss Dad's medical condition. And I said, "well, his AFib --" and the nurse looks at me with a blank stare. "I didn't know he had AFib."

And then I said "he also has a condition that when he moves from lying down to standing up or sitting to lying down, his blood pressure drops rapidly." And they said "we don't have that in his file."

So I panicked because the physician had been making medical changes to his pharmaceutical based on the information that they had. So I went back to the table with the nurse after the meeting, and we went through my dad's record that had been transferred over from his GP, and every single medical condition I had spoke to in the meeting was in the report. Nobody had read it.

And the next time I saw the physician in charge, I said "are his records now accurate?" And he looked down and said "yes, they are, ma'am."

Another time I spoke to a nurse because they weren't transferring my dad properly, and she said to me: "I tell them all the time to transfer him by the lift, but they just won't do what I ask."

The other incident was dad got some pressure sores on his bottom because his seat on his wheelchair had deflated. And every day, a PSW was supposed to check that it was still inflated before they put him in his chair. And he had gone two weeks sitting on metal, they figured, because no one had checked to see that his seat was inflated.

So it's the basic -- the very basic things and the very dire things that aren't being looked after. And they just -- I think it goes back to -- once again, it's not that they don't want to do these things. They don't have enough staff.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Thank you. Thank you.

Well, Cathy, were those all the recommendations?

CATHY PARKES: Those were. I just wanted to read the last little part of what we had here.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, sure. Go ahead.

CATHY PARKES: Okay. Our faith has been shaken during the past year. We've had to sit

helplessly as we watched our family members become gravely ill and often die.

To us, this is not a question of where to point fingers or debating on a public forum. This has affected our lives forever.

We know that we must all face the loss of our elderly loved ones at some point, but the grieving that has come with knowing how they died and how they suffered has come at a cost that can't be put into words.

Our sincere hope is that, by speaking, we will somehow affect a change. We appreciate the recommendations you're putting together and that you're doing. And for those that we still have with us, we feel we have to speak for our spouse, for our loved ones, and for our future generations.

Our ultimate and united goal is to see the end of for-profit care in Ontario.

And that's all. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, unless the commissioners have any questions that I didn't ask --

FRED CRAMER: Can I just add a little something about my mom too?

COMMISSIONER FRANK MARROCCO (CHAIR):

Go ahead. Sorry, I didn't mean to cut --

FRED CRAMER: No, I didn't get in there quick enough there. My mom, the first day she went to Orchard Villa, they were not ready for us. And so we had to wait around. And they took my mom down to her room, and they had nobody take her off the gurney to do a patient transfer.

She is in a wheelchair, and she had two people assist. And we waited, and the transport people said they don't normally take the resident off the gurney. But in this case, they did.

My mom, she was laying -- well, actually, the bed wasn't even made. It was just a plain mattress there. So found some sheets. That was a little bit of a chore.

They put her down on the bed. She didn't look too comfortable. We got taken in the office and did her paperwork. And at that time, we said about not giving my mom a flu shot. She had violate reactions, and she was in the hospital for days at a time back years ago. And they had it in the charts, "no flu shot."

I just found out recently she did have a flu shot. Now, luckily it didn't have any reaction -- I don't think so. There's nothing in

the notes.

But just something that was in the notes, "do not give flu shot. She has reactions." But they gave it anyway, and they didn't tell me.

She had three falls as well. She had two falls out of bed, and then the third fall was really bad. She was right in front of the nursing station, and she fell flat on her face and broke the tip of her nose, and it was right in front of the nursing station.

So one question I had: Why couldn't they buckle up the seat belt on the wheelchair? And they said they can't do that because it's a restraint.

I found out later -- and it's in a wheelchair that can be unbuckled like a seat belt in a car -- that it is acceptable. So I think that if she would have had her seat belt on, she probably would not have fallen. And she was in the hospital for about -- I think it was about six or seven months, and the nurses there kept saying "buckle up; buckle up."

You know, so I wondered why in the hospital they stressed to buckle her up, but at Orchard Villa, they said they can't do that.

What else was there? The falls and just the -- at dinner time/lunch time, everybody was crowded. It's just so many people. They just start bumping into each other. The tables are small, and the residents are back to back.

Most people were in wheelchairs, and they didn't have enough room for the wheelchairs to be back to back or even side to side. It was really overcrowded, and that, really, should be one of the things addressed. Either two sitting times, or something has to be done there.

And up to COVID, you know, we saw these things. During COVID, I don't know what happened. I know she did have some bedsores as well that kept continually -- looking after continually. So I don't know if, during COVID, they do that for -- because the staffing levels were less. I'm not sure.

But there were some bonds, I kind of said. We got to know some of the PSWs, some of the nurses. They were great.

Some of the other ones you had to sort of play their game a little bit. They were not very nice, but you had to really sort of do some sort of -- like a little -- click with them, and

then they would help you a bit more.

But just overall, even before COVID hit, there was just, I think, a lack of staffing. That's pretty well about all we know is.

COMMISSIONER FRANK MARROCCO (CHAIR): It's Carolin, is it?

Yeah, you're on -- there you go.

CAROLIN WELLS: Oh, sorry. I was just going to say, too, then they would blame it on the nurses. Like, administration would blame it on the nurses and the PSWs, and they would say "oh, don't to them," you know? And there was a real -- you know, it was from top down. That's what I always say, "top down."

CATHY PARKES: There was a real divide between management and PSW and nursing staff, a real divide, and lack of communication and lack of coordination. That was always a problem.

CAROLIN WELLS: Yes. Like, when my dad fell in the shower and she told me that the PSW was put off work for a week or two without pay, like, she -- Beverley, the director of care, thought that I'd be pleased with that.

I wasn't pleased with that because sure, she shouldn't have done that, but they're

also almost forced to do it, right? Like I said, there's a -- like you guys were saying, there's a climate of fear. Like, they have to get the showers done. If they don't get the showers done, they get in trouble.

I wasn't happy that that woman lost a week's pay when she's probably not getting paid that much. I just wanted my father to be treated the proper way so he wouldn't get hurt. But there was a lot of issues.

And another thing I was going to say, this codex -- am I saying it right? Did everybody find the codex -- was it codex? -- when Lisa was talking -- because my dad had AFib. He had a whole bunch of things.

And you'd ask about it, and they kept telling us "oh, they're supposed to read it before each shift. They're supposed to read that. They're supposed to know about that."

But they didn't. There was tons of times when they didn't. We'd go for meetings, yearly meetings. My dad was freezing the whole time. "Please just put a sweater on him all the time." "Please give him his hanky that's comforting for him, and he's got allergies." But

they just wouldn't follow through. So that's all.

MARIE TRIPP: Sorry, can I jump in for a minute?

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

MARIE TRIPP: Thank you. Marie Tripp. My mom was Mary Walsh. As stated, she was in there, in Orchard Villa, one year.

In that one year, there was two separate investigations. One led to a nurse being suspended for six months; the DOC, Beverley's assistant, asked to resign; and retraining of all staff. That was on one side.

Mom got transferred at my demand to another wing. Over there, there was still the problems, improper transferring. Mom's getting bruised.

I go to Beverley again. Now, what Beverley investigates -- and blaming the PSWs and the nurses.

She was having them all retrained once again and then deemed my mother a three-person transfer. It was hard enough getting two people, two PSWs. Now Beverley did this, three.

I asked for that to be changed back to

two. She would not do it. I stood outside my mother's room without the people knowing I was there and saying "we can't get anybody else. Nobody wants to come in here. All they do is complain."

So it's the management from there down, as everybody keeps saying. I just had to get that in there because two investigations in one year with suspensions, asking to resign, and then a second one. They just were clearly appeasing myself. That's all they were doing. Thank you.

CATHERINE LEGERE: I just want to say something too. I think my sister, Lisa, spoke to three things that have happened with Dad.

Also, we found that there was an overuse of -- well, considered, I guess, chemical restraints. So Dad didn't always respond in a positive way when he was getting his personal care, and we kept trying to tell them how to engage with him.

He was a very chatty, social person. And if you kind of joked around with him, then you could get him, you know, to engage. Or if you just explained to him what you were doing, he would be fine.

But consistently, we found that that wasn't happening. And what they would do is they were more keen to give him some kind of a tranquilizer or sedative. I'm not sure what it was, but they would give him a medication just to calm him down rather than sort of approach him in a more humane way. That was another problem we had.

CATHY PARKES: If I could just quickly say -- I'm just getting some messages. For those of you who joined but weren't sort of speakers today, yes, please, feel free to speak.

I was being asked if it's okay if everyone speaks. Anyone can.

So, Pamela, if you have something to say...

You might be muted.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I think --

CATHY PARKES: I guess not.

PAMELA BENDELL: Yeah, I'm there. Is that okay? Can you hear me now?

CATHY PARKES: Yes.

PAMELA BENDELL: Okay. My name is Pamela Bendell. My mother, June Bendell, passed away on May 8th of this year. My parents were in

Ottawa, which is a retirement section, 2007 and 2008.

My mother was evicted because she ran away. We put her in another long-term care facility in Scarborough.

My dad passed away there, and I brought my mom back to Orchard Villa in July 2009. So she's been there a long time.

The adulate, I used to work in the facility in the '80s. I understand the operation of a private versus public facility. My mother had a horrific time. She was nonverbal. To go through that many years, 11 years, you would be here for the rest of the night.

I will bring it up close to the pandemic. If you remember the military report of a woman being fed or a resident being fed lying down and aspirated, that was my mother.

My mother shouldn't have been lying down. My mother was nonverbal. My mother could not feed herself. Hasn't been able to for about four years.

I have no idea what happened to her after March 8th, was my last visit with her. I do have a resident inside that would send me videos

and update me on what was going on.

My mother lost a considerable amount of weight, but yet the nursing home would tell me that she was eating at 75 percent capacity. I said "she would eat at 100 percent if she's fed, so where did you get your 75 percent capacity?"

My mother had black eyes. I was in with Beverley and Jason just before COVID because they dropped the patient lifter on my mother's knee and smashed her knee.

My mother had UTI infections. You talk about annual reports with the family. We would hear that my mother was getting a shower one night and a bath another night.

Someone had changed her reporting. She had not been in a tub or a shower for four years.

MARIE TRIPP: Oh!

PAMELA BENDELL: My mother had a broken toe -- because when she was in a recliner -- because she was rigid -- she had Lewy body dementia and Parkinson's.

Because she was rigid, when they turned a corner, they broke her toe against a door frame.

Also, she had -- I said about her black eyes; she had a broken toe; she had a shattered

knee.

When you talk about top down, yes, I heard someone was going to be disciplined. They just played one against the other.

And I happen to know one of the PSWs because I used to work with her years ago, and she was fabulous.

We had hired someone for eight years to go into the facility three times a week to ensure, when I was working or away, that my mom was being fed.

There was one other thing that -- oh, well, there's so many things. But at the end, when my mother died, I was on the phone when she was dying because she was choking.

And I had the doctor on one phone. I had my brother on my cellphone, and he was narrating it through.

And I was asking "could I come? Is she going to go to the hospital?"

The coroner reached out to me and put my mother's death was accidental. I since found out he's changed the report to say that she died of COVID. My mother didn't have COVID. So there's an investigation into that. It's been lie after lie

after lie after lie.

And, Cathy, when you said about the effect on us, it's unimaginable. Night after night, I think about my mother lying in a bed, can't speak, can't eat, can't do anything.

And I was getting emails saying she was eating at 75 percent, 80 -- everything was fine. She was being bathed.

No. Terrible. So that's what I have to say.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, this is very helpful for us as, as was said. It helps us stay grounded. And we --

Yes, Cathy?

CATHY PARKES: Oh, sorry. I didn't mean to interrupt you. Go ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): No, no. What were you going to say?

CATHY PARKES: Well, I was going to say this term of "they ate 75 percent of their meal," we need to encourage that to stop because if we're looking at half of the sandwich and "they've eaten 75 percent of it," that's not accurate to their nutritional needs daily.

And those terms don't work because that

is what was happening especially during April and May. There wasn't kitchen staff, and they were being served sandwiches. So eating 75 percent of the sandwich can't possibly be helping in the way that it should.

And I also want to speak to the point that I had a real problem myself with not only a lack of communication but then the communication that I was getting was absolutely false.

The day I saw my father before he died, he was comatose. I saw him through his window. I was told he was sitting up and eating 75 percent of his meal that day, and yet they couldn't get water into him to give him his medication.

So the charting wasn't being done. Old information was being given. My father's fever was much higher than they were reporting on April the 13th, two days before he passed away, but they didn't have accurate information.

They were holding off on swabbing and testing for COVID until a resident's temperature reached a certain level. That can't happen. That was awful. I had to demand that my father have a COVID test.

So what little information we were

getting was absolutely false, and that's really concerning.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you very much for sharing this. We are, you know, accessible through the counsel and the people you've been dealing with.

You know, it's not as if, once this interview is over, there's no way of getting ahold of us or, you know, asking us or contacting us if you feel the need to or if there's something you're curious about.

But I want to thank you for coming, and I want to thank you for the organized way. I appreciate this last bit of conversation, which I generated with that question, but your submission was so orderly. It's very easy to follow, and we understand what recommendations you're making.

We will probably issue further reports. We're still working on that and what that will look like. We're still trying to decide, but we do have a bit of an idea of what we're going to do next.

And I want to thank you all again.

CATHY PARKES: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): And with that, I'll say good evening, and you know

where to find us. If you've got some information you think would be helpful, please --

PAMELA BENDELL: Can I just close by saying, sorry, I have photographs, if you'd like photographs. I would be willing to share them to you, if you'd like to see the proof I have.

COMMISSIONER FRANK MARROCCO (CHAIR): I think that would be helpful. I don't know if it was Ida or -- whoever you were dealing with that made the arrangements, that would be the best way to get them to us.

PAMELA BENDELL: Absolutely. But I just want you to know there's photographs available, and I'm sure I'm not the only family member that has --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, you know, we're not prosecuting, but we will get into this a bit, I think. And that sort of thing can be quite helpful depending on what people tell us.

CATHY PARKES: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Good evening, everybody.

-- Adjourned at 4:56 p.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 25th day of October, 2020.

_____

NEESONS, A VERITEXT COMPANY
PER: MCKAYA MCDONALD, CSR
CHARTERED SHORTHAND REPORTER

This is Exhibit “B” referred to in
the Affidavit of CATHERINE
PARKES sworn before me this
17th day of April, 2024

A Commissioner for Taking Affidavits

# Tab 94C

**Daya, Kyle (MLTC)**

**From:** @MOH-G-LTC Homes Licensing
**Sent:** June 28, 2021 7:54 AM
**To:** Namatalla, Shreen (MLTC)
**Subject:** FW: Project #21-026

-----Original Message-----
From: Catherine Parkes <cparkes@hotmail.com>
Sent: June 25, 2021 12:04 PM
To: @MOH-G-LTC Homes Licensing <LTCHomes.Licensing@ontario.ca>
Subject: Project #21-026

CAUTION -- EXTERNAL E-MAIL - Do not click links or open attachments unless you recognize the sender.

Good morning,

I am writing to address Southbridge Care Homes Inc.'s request for an extra 87 beds and a 30 year extension to their license for Orchard Villa Long-Term Care Home (LTCH) in Pickering, Ontario.

My father, Paul Parkes, was a resident at Orchard Villa in 2019 and 2020, where he passed away from acute respiratory failure and COVID-19. Before my father moved in to the home I was aware that Orchard Villa LTCH had a less than exemplary track record as I had read through their incident reports on the Ministry of Long-Term Care's (MOLTC) website. It is obvious that the lack of accountability and continued failures to comply by the home directly lead to the disaster that took place during wave 1 of COVID-19. The fact that Orchard Villa notified your department of an outbreak as early as March 28, 2020, but did not inform families until April 8, 2020 and did not ask for help until April 17, 2020 all the while telling family members that they had everything under control lead to the death of more than 70 residents. It is inexcusable.

My father spent the last six days of his life in a state of confusion, with a fever, without access to food or water, denied oxygen, denied the ability to have his family by his side and most importantly was denied the right to go to the hospital for life-saving care. My father died alone under horrible conditions and it is something that haunts me daily.

I am shocked to see the the critical incident reports published on the MOLTC's website for July, September, October of 2020 and January and April of 2021 continues to depict the absolute failure at achieving infection, prevention and control protocols, in some instances with staff stating that they have no training at all. I am shocked that there is a lack of personal protective equipment (PPE) and that staff members are moving from room to room without donning their PPE. It is clear to me that Orchard Villa and its owners Southbridge Care Homes Inc, as well as Extendicare, have learned nothing from the tragic loss of life over the past 15 months.

I do not want to see an extra 87 beds and a 30 year license granted to a home and it's owners for continued failures on their part; not only would this be an insult to family members like myself, but a grave message to any current or future residents who have the misfortune of finding themselves in

Orchard Villa LTCH. I am asking that the request for the extension and extra beds be denied and that the home either moves to a municipally or provincially run non-profit ownership.

Thank you,
Cathy Parkes

This is Exhibit “C” referred to in
the Affidavit of CATHERINE
PARKES sworn before me this
17th day of April, 2024

A Commissioner for Taking Affidavits

# Tab 88DD

## Chan, Josiah (He/Him) (MAG)

**From:** Catherine Parkes <cparkes@hotmail.com>
**Sent:** October 17, 2022 4:01 PM
**To:** @MOH-G-LTC Homes Licensing
**Subject:** Orchard Villa — Project #23-034



Good afternoon,

I am writing to contribute my feedback on the licence proposal by Southbridge Care Homes for a 30-year licence and an extra 87 (for a total of 320) beds in Pickering, Ontario.

My father was a victim of neglect in this home and passed away during wave one of the COVID-19 pandemic, but even prior to that I witnessed the disorganization, uncleanliness and lack of care provided in this home. Orchard Villa's online incident reports, provided by the Ministry of Long-Term Care, read as a history of repeated failures regardless of the warnings they have been given, and this is both with the help of Extendicare and as Southbridge Care on their own.

This long-term care home has one of the highest death rates in Ontario during COVID, and continues to have repeated failures in all the ways that would make this a safe, reliable home. Southbridge has a proven track record of failure, and a 30-year licence or any extra beds must be denied. This cannot simply be about numbers of beds, but rather quality of care. Southbridge has not provided quality of care in this home.

The fact that it has taken you this long to deny them has been an insult to all of the families who has tragically lost a loved one in that home, including myself. Conditions in the home since 2020 have not improved.

I am requesting a denial of the licence proposal.

Thank you,
Cathy Parkes

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|---|---|---|---|
| OHC, et al.<br>Applicants | and | MINISTER OF LONG TERM CARE<br>Respondent | Court File No: DC-24-00000007-00JR |

***ONTARIO***
**SUPERIOR COURT OF JUSTICE**

Proceeding commenced at TORONTO

**AFFIDAVIT OF CATHERINE PARKES**

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