Court File No. _____

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

- and -

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondents

AFFIDAVIT OF NATALIE MEHRA
(Affirmed April 11, 2023)

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1. I, Natalie Mehra, of the City of Oshawa in the Province of Ontario, Make Oath and Say as follows:

2. I have been the Executive Director of the Ontario Health Coalition since September 2000. Prior to this, I served on the Board of Directors of the Health Coalition while working as the Executive Director of the Epilepsy Association in Kingston and Southeastern Ontario. Attached hereto as **Exhibit "A"** is a brief summary of my work with the Coalition.

The Ontario Health Coalition

3. The Ontario Health Coalition has a long history of public interest advocacy on matters of health care policy, programs and law that dates from the early 1980s, including having participated in the consultations that lead to the passage of the Canada Health Act in 1984. It has been deeply engaged in public interest advocacy concerning Canadian health care ever since.

4. The Ontario Health Coalition ("The Coalition" or "OHC") is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 500 member organizations and a network of Local Health Coalitions and individual members. We represent more than 750,000 Ontarians, and our members include: seniors' groups; patients' organizations; trade unions; nurses and health professional organizations; physicians; physician organizations; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

5. The Coalition's Board of Directors includes physicians, the Ontario Nurses' Association, patient advocates, trade unions, academic experts in health policy, and leaders of community organizations all of whom share a commitment to preserving and strengthening the policies and programs of Canada's publicly funded health care system. A list of current OHC directors is attached hereto as **Exhibit "B"**.

6. The Coalition is a non-partisan public interest group whose primary goal is to protect and improve our public health care system. It works to honour and strengthen the principles of the

Canada Health Act which ensure that health care is provided to all Canadians based on their needs, not their ability to pay. It is led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration.

7. The Coalition empowers the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. 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. The Coalition is an extremely collaborative organization, actively working with others to share resources and information. The Coalition's Mission and Mandate and Local Health Coalition Terms of Reference are attached hereto as **Exhibit "C."**

The Work of the Coalition

8. The Coalition is well-known by policy leaders in both Ontario and federal governments. We are routinely invited to provide testimony before legislative or parliamentary committees and have provided testimony and have proposed amendments to virtually all major Ontario health care policy and legislative initiatives over the last two decades. These have included the People's Health Care Act, 2019, the Connecting People to Home and Community Care Act 2020, and the Providing More Care, Protecting Seniors, and Building More Beds Act, 2021. We have often been successful in prompting reforms and amendments to these initiatives. A list of the Coalition's submissions to and testimony before Standing Committees of the Ontario Legislature are attached **Exhibit "D"**.

9. The Coalition is also recognized for its experience, knowledge and leadership by the media on a wide variety of health care issues, including the decline of hospital capacity and services, the terrible record of long-term care homes in Ontario, and the failures of both to meet the needs of hospital patients designated as requiring an alternate level of care (ALC). The Coalition has a record of advocacy on these issues that goes back at least 20 years and includes research reports, public hearings, and consultations on long-term care and home care.

10. The Coalition has closely tracked hospital capacity, quality of care and access to care. The Coalition further monitors data and published reports concerning these issues, and advocates for sufficient public funding to ensure a viable and equitable health care system. It has also conducted repeated rounds of hearings and public consultations on these topics, advocating for improvements to access, quality and capacity planning. A full list of our engagement and advocacy on matters around hospital beds, public health care capacity, and de-hospitalization is attached hereto as **Exhibit "E"**.

11. The Coalition has also advocated extensively on issues related to long-term care, and often engages with LTC home residents and their families who have problems with the quality of the treatment, care and safety provided in LTC homes. It has established a long-term care committee which includes family councils from across Ontario, leading academics in the long-term care field, health professionals, the Ontario Nurses' Association, unions, physicians, faith organizations, patient advocates and others. The Coalition has researched and published reports concerning the state of Ontario's long-term care homes for at least three decades and has advocated for improved hours of care, mandatory minimum levels of care, better infection control and disease prevention, more frequent inspections and for effective enforcement of care standards. It reports on access to

care, quality, safety and care levels and the ownership and staffing factors that impact these. A list outlining the Coalition's engagement in the community on issues of care in long-term care homes and its monitoring and advocacy is attached hereto as **Exhibit "F".**

12. In 2021 the Ontario Health Coalition joined forces with the Advocacy Centre for the Elderly and the Ontario Council of Hospital Unions to request that the Ontario Human Rights Commission use its public inquiry powers under section 31 of the Human Rights Code to investigate systemic discrimination based upon age against the elderly in the provision of health care in Ontario. The Commission declined to do so, despite the organizations' request for reconsideration. The submissions to and correspondence with the Commission are attached hereto as **Exhibit "G (i), (ii) and (iii)."**

The Coalition's Work to Protect and Improve Hospital Care in Ontario

13. The Coalition has worked with communities since the mid-1990s to stop hospital cuts and closures and retain and improve services. In these efforts, the Coalition has worked with thousands of residents in affected communities across Ontario.

14. For example, between January and March 2015, the Coalition convened a town hall meeting of more than 100 people in Leamington Ontario to save the local birthing unit from closure. It then organized a "Day of Action" at the Ontario Legislature and the buses needed to bring hundreds of pregnant women, midwives, and concerned community members to the Legislature to fill the legislature's public galleries and to meet with the Minister of Health and key staff. Together, the Coalition and local community were successful in saving the birthing unit.

15. In the spring of 2017, in response to plans to close the Welland hospital, the Coalition held town hall meetings, launched a petition which garnered more than 20,000 signatures, and held a "Day of Action" at the Ontario Legislature to bring Welland and area residents to go to the Legislature, fill the public galleries, and to meet with the Minister of Health and key staff in the Ministry. The Coalition and local community were again successful, this time to stop the closure of the hospital.

16. In 2015- 2016 the Coalition worked with local residents and municipal officials in Wallaceburg Ontario to stop the closure of the local hospital's emergency department. More than 1,000 local community members attended a public consultation to persuade hospital executives to stop the closure plan. The Coalition again organized a trip by local residents to the Ontario Legislature to attend in the public galleries, hold a press conference in an effort to draw attention to the Government's plans and persuade it to change course. Again, the Coalition and community were successful in protecting the emergency department from closure.

17. In spite of these successes, the trajectory of downsizing hospitals has not been reversed, which the Coalition has documented in reports relying on authoritative sources including Ontario's Auditor General, Health Quality Ontario, and the Canadian Association of Emergency Physicians[1]. It published a backgrounder documenting this decline which is attached as **Exhibit "H"**. This backgrounder relied on data published by the Canadian Institute for Health Information (CIHI) comparing hospital bed capacity, nurse staffing levels, and public hospital funding across Canada and the OECD.[2] The Coalition summarized its key findings which included that:

[1] https://www.ontariohealthcoalition.ca/wp-content/uploads/backgrounder-on-hospital-bed-shortage.pdf
[2] Idem

- Ontario had cut more hospital beds and staff than most OECD countries, and trailed other Canadian jurisdictions in public hospital funding;

- the resulting hospital bed shortage and serious overcrowding was compromising patient and staff safety; and that

- there was an urgent for Ontario to reopen hospital beds and restore capacity to safe levels.

18. That backgrounder was not the first to warn about the seriousness of declining hospital care[3] and the Coalition has continued to document this problem ever since, including in its 2022 report ("Fast Facts") relating how poorly Canada compares with other OECD countries in respect of hospital capacity, which is attached as **Exhibit "I."**

19. It is the Coalition's contention that this hollowing out of Ontario hospital capacity is a primary cause of the acute care bed shortage that Bill 7 has ostensibly been enacted to address, but that it will do little if anything to address the problem because:

1) a significant proportion of ALC patients are waiting for another level of hospital care (complex continuing care, rehabilitation, palliative care or other), or

2) patients in ALC beds are discharged to long-term care but are too complex to be accepted for admission to long-term care homes, and

3) the acute shortage of long-term care home beds means there are not enough beds for the hospital crisis admissions and people waiting in the community for long-term care,

[3] Among others see the Coalition's report for the Drummond Commission with all the data on the downsizing of hospitals and the bed crisis: https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-February-10-2012.pdf; and also see https://www.ontariohealthcoalition.ca/wp-content/uploads/final-beyond-limits-report1.pdf

meaning that ALC beds continue to fill up with people in need of care that they cannot access in long-term care.

The Coalition's Work on Long-Term Care

20. The Coalition had engaged for years in similar public education, community organizing and other efforts to influence policy and law concerning what it regards as a fundamental failure of Ontario policy, programs and law concerning long-term care. These were brought into stark relief by the horrifying suffering and death that resulted during the COVID pandemic.

21. At the beginning of the COVID-19 pandemic, the Coalition recognized the early warning signs that death rates in long-term care homes were mounting quickly. Before Public Health Ontario began compiling and publicly releasing data, the Coalition collected the outbreak reports and death rates from all of the local Public Health Units across the province and began issuing public reports to draw attention to the tragedy that was unfolding. The Coalition tracked data on the outbreaks and death rates in each of the province's long-term care homes and released the information to the public. As Public Health began to make the information available to media and the public, the Coalition analysed the data to reveal that for-profit long-term care homes had far higher death rates than public and non-profit homes. The Coalition shared their data with several large media outlets that created their own databases to report and analyse the deaths. This report is attached hereto as Exhibit **"J"**.

22. The Coalition held several press conferences with family members of residents who had died during COVID, advocating for stronger measures, improved care levels and accountability to protect the residents. In one example, the Coalition held a virtual Day of Action in which more

than 570 family members of residents and advocates 'watched' the Ontario Legislature as Opposition Parties asked questions of the Government, aided by information provided by the Coalition that had come from family members of those who were suffering, had died, or were at risk in long-term care.

23. Ontario's horrendous record in long-term care during the pandemic was subsequently the subject of the Ontario Long-Term Care COVID-19 Commission. I appeared before the Commission and my submissions to the Commission are attached hereto as **Exhibit "K."** It is the Coalitions contention that the Government has done very little to implement the recommendations of the Commission, including:

- by failing to reinstate unannounced annual comprehensive inspections of every long-term care home,[4] notwithstanding a promise by the Premier to do so[5];
- by failing to establish a minimum care standard, but instead only a "target" of 4 hours of daily hands on care by 2025. Every target to date has been missed and staffing continues to be in crisis;[6]
- by failing to establish promised accountability measures, including fines, revocation of licenses, and criminal charges[7];
- by allocating the majority of the new bed approvals to for-profit corporations, the majority of which are large chain companies, including those with the worst death rates during in the pandemic and terrible records of care over many years[8];

24. In addition to these reports, the coalition has also compiled summaries of data published by the Ontario's Home and Community Support Services concerning the waiting lists of those

[4] https://www.cbc.ca/news/canada/seniors-homes-inspections-1.5532585
[5] https://www.google.ca/amp/s/nationalpost.com/news/companies-managing-troubled-ontario-long-term-care-homes-run-dozens-more-make-millions-in-profits/wcm/3abb5653-1148-44ec-888b-5b4964f55757/amp/
[6] https://www.ontariohealthcoalition.ca/wp-content/uploads/Crisis-Unabated-final-report-1.pdf
[7] https://www.theglobeandmail.com/canada/article-long-term-care-blackadar-ontario/
[8] https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Ford-government-LTC-bed-allocations-report.pdf

seeking admission to an Ontario LTC home, which is attached hereto as **Exhibit "L."** As this data indicates, the wait-lists vary enormously, and effectively represent the difference between waiting for such admission from weeks to many years.

25. Another Coalition report, attached hereto as "**Exhibit M"** relies on public Ministry sources to document the record of inspections for each of the ten homes in each region that have the lowest wait lists and shows the number of official notices and violation notices reported for each home. As this data shows there are often many more issues of regulatory non-compliance for homes with the lowest wait lists, in other words homes to which many fewer would-be residents have applied for admission.

26. Since this Government cancelled the program of conducting annual unannounced comprehensive inspections 2018, there is much less transparency concerning regulatory compliance by LTC homes.

27. The Coalition regards Bill 7, the More Beds, Better Care Act as embodying and perpetuating this very pattern of systemic discrimination against a large group of elderly and often very ill hospital patients to deprive them of timely health care and treatment, a point the Coalition would have vigorously made and documented had the Government consulted with the public or held legislative hearings before the Bill was enacted. It our contention that Bill 7 will not only do nothing to create hospital or long-term care beds but will in fact have the perverse consequence of actually depriving many hospital patients of needed treatment and care, and will increase their suffering and hasten the deaths. The Coalition regards Bill 7 as scapegoating a cohort of the most

vulnerable residents of Ontario while sidestepping the Government's responsibility for the chronic shortages in both hospital and long-term care for people who desperately need it.

28. Having been denied any opportunity to dissuade this Government from proceeding with such an extraordinary and cruel denial of fundamental rights to consent and needed care for the elderly nearly the end of their lives, the Coalition has joined with the Advocacy Centre of the Elderly as a co-applicant in these proceedings.

29. I affirm this affidavit in support of the Applicants' application and for no other or improper purpose.

AFFIRMED BEFORE ME by Natalie Mehra of the City of Oshawa, in the Province of Ontario on April 11, 2023 in accordance with O. Reg. 431/20 Administering Oath or Declaration Remotely.

NATALIE MEHRA

Commissioner for taking affidavits

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

This is **Exhibit "A"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Natalie Mehra – biographical details – March 2023

I have been the Executive Director of the Ontario Health Coalition since September 2000. Prior to this, from 1996 – 2000 I worked as the Executive Director of the Epilepsy Association in Kingston and Southeastern Ontario after attaining a Bachelor of Arts degree at Queen's University. I have served on boards of directors for non-profit housing, patient advocacy, women's, arts, anti-poverty, equity and human rights organizations. I have authored numerous reports and chapters of books on health care and advocacy and community organizing for social change.

Board appointments:

2010 - 2017: Board Member, Canadian Health Coalition

1999 – 2000: Board Member, Ontario Health Coalition

1999 – 2000: Co Chair, Kingston Health Coalition

1998 – 2000: Board Member, Canadian Epilepsy Alliance

1998 – 2000: Co Chair, Sexual Assault Crisis Centre, Kingston

1997 – 2000: Community Representative, Kingston and District Labour Council

1995 – 2000: Coordinator, Kingston Action Network

1997 – 1999: Board Member, Progressive Independent Community Press

1998: Board Member, Kingcole Homes Inc., Non-profit housing

1996 – 1998: Collective Member, Rising Heights Hot Meal Program

1994 – 1997: Board Member/President, Kingston Artists' Association

Publications:

Contributing author to the following books--

"A Community Coalition in Defense of Public Medicare." *Paths to Union Renewal: Canadian Experience*, edited by Pradeep Kumar and Christopher Schenk, University of Toronto Press, 2006, pp. 261–76. *JSTOR*, http://www.jstor.org/stable/10.3138/j.ctt2tv439.21. Accessed 28 Mar. 2023.

"Three Waves of Health Care Corporatization in Ontario's Hospitals." *Corporatizing Canada: Making Business Out of Public Service*, edited by Jamie Brownlee, Chris Hurl and Kevin Walby, Between the Lines Press, 2018, pp. 27-42.

Reports:

No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care (July 21, 2011): https://www.ontariohealthcoalition.ca/index.php/no-vacancy-hospital-overcrowding-in-ontario-impact-on-patient-safety-and-access-to-care/

First Do No Harm: Putting Improved Access and Accountability at the Centre of Ontario's Health Care Reform Phase I Report Ontario Health Coalition (February 10, 2012): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-February-10-2012.pdf

Putting Patients At Risk: Interviews with 50 Ontario Paramedics on the Consequences of Closing Local Hospital Emergency Departments (June 18, 2009): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-June-18-2009.pdf

Toward Access and Equality: Realigning Ontario's Approach to Small and Rural Hospitals to Serve Public Values (May 17, 2010): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-May-17-2010.pdf

Violence, Insufficient Care, and Downloading of Heavy Care Patients (May 8, 2008): https://www.ontariohealthcoalition.ca/index.php/violence-insufficient-care-and-downloading-of-heavy-care-patients/

Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care (January 24, 2019): https://www.ontariohealthcoalition.ca/index.php/situation-critical-planning-access-levels-of-care-and-violence-in-ontarios-long-term-care/

Public Money, Private Profit: The Ford Government & the Privatization of the Next Generation of Ontario's Long-Term Care (Nov 29, 2021): https://www.ontariohealthcoalition.ca/index.php/report-public-money-private-profit-the-ford-government-the-privatization-of-the-next-generation-of-ontarios-long-term-care/

Caring in Crisis: Ontario's Long-Term Care PSW Shortage (Dec 9, 2019) The report is based on eight round-table meetings held across Ontario including more than 350 participants including home operators and administrators, PSWs, union representatives, family councils, seniors, college staff who develop/coordinate PSW courses, local health coalitions and other long-term care advocates: https://www.ontariohealthcoalition.ca/index.php/report-caring-in-crisis-ontarios-long-term-care-psw-shortage/

Still Waiting: An Assessment of Ontario's Home Care System After Two Decades of Restructuring (April 4, 2011): https://www.ontariohealthcoalition.ca/wp-content/uploads/Full-Report-April-4-2011.pdf

Market Competition in Ontario's Homecare: Lessons and Consequences (March 31, 2005): https://www.ontariohealthcoalition.ca/wp-content/uploads/HC-Full-Report-March-31-2005.pdf

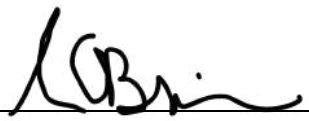
Health Accord Break Down: Costs & Consequences of the Failed 2016/17 Negotiations (October 18, 2017): https://www.ontariohealthcoalition.ca/wp-content/uploads/Health-Accord-Report.pdf Co-authored with Adrienne Silnicki.

Private Clinics & the Threat to Public Medicare in Canada (June 10, 2017): https://www.ontariohealthcoalition.ca/wp-content/uploads/final-report-1.pdf

Eroding Public Medicare: Lessons and Consequences of For-Profit Health Care Across Canada (October 6, 2008): https://www.ontariohealthcoalition.ca/index.php/private-clinics-report-eroding-public-medicare-lessons-and-consequences-of-for-profit-health-care-across-canada/

When Public Relations Trumps Public Accountability: The Evolution of Cost Overruns, Service Cuts and Cover-Up in the Brampton Hospital P3 (January 17, 2008): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-January-7-2008.pdf

This is **Exhibit "B"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Ontario Health Coalition Board of Directors

As of April 3, 2023

Doug Allan - Health Care Researcher, CUPE
Hugh Armstrong - Professor Emeritus, Carleton University
Sandra Ashcroft - Regional Director, UFCW Local 175
Vi Bui - Ontario Regional Organizer, Council of Canadians
Sandra Caleta – Coordinator, Advocates for LTC Reform
Patty Coates - President, Ontario Federation of Labour
Dr. Gordon Guyatt – Physician, Member, Canadian Doctors for Medicare
Dr. Ted Haines – Physician, Member, Hamilton Health Coalition
Sue Hotte - Chair, Niagara Health Coalition
Kellee Janzen - Health Care Director, Unifor
Mehdi Kouhestaninejad - Ontario Region Representative, Canadian Labour Congress
Sara Labelle – Chair, Hospital Professionals Division, OPSEU
Trish McAuliffe - President, National Pensioners Federation
Natalie Mehra - Executive director, Ontario Health Coalition
Maureen O'Halloran - Staff Representative, COPE Ontario
Matthew O'Reilly - Researcher, United Steelworkers
Shirley Roebuck – Retired RN, Chair, Chatham-Kent, Sarnia, Wallaceburg and Walpole Island First Nations Health Coalitions
Munib Sajjad – Community Organizer, OSSTF
Ross Sutherland – Retired RN, Co-Chair, Kingston Health Coalition
Jules Tupker - Chair, Thunder Bay Health Coalition
Erica Woods - Communications & Government Relations, Ontario Nurses' Association
Graham Webb – Lawyer & Patient Advocate
Dr. Dick Zoutman - Physician & Professor Emeritus, Queen's University

This is **Exhibit "C"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

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Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Ontario Health Coalition
Mission and Mandate
and Local Health Coalition Terms of Reference

Amended: October 14, 2010

Mission and Mandate

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. 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.

Who We Are

The Ontario Health Coalition is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 400 member organizations and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

Terms of Reference & Basis of Unity for Local Health Coalitions and Students for Medicare Chapters of the Ontario Health Coalition

The basis of unity for the Local Health Coalitions and the Ontario Health Coalition is the Ontario Health Coalition Mission and Mandate statement. Local chapters and Students for Medicare groups will work to support this mission and mandate.

Local health coalitions/SFM chapters have their own internal governance structures, including an elected chair or co chairs. Local coalitions are voluntary and ad hoc in nature, and it is understood that internal decision-making processes and governance structures are based on the needs and capacities of the local coalition.

It is also understood that in using the name "Health Coalition" or "Students for Medicare", we have a shared responsibility to reflect the values and policies of the Ontario Health Coalition.

Each year, the coalition Action Plan is set collectively at the Annual Assembly. After final approval by the Ontario Health Coalition Board, the Local Health Coalitions, student groups, and the Ontario Health Coalition work cooperatively to implement the action plan.

Local coalitions and SFM work cooperatively with the Ontario Health Coalition, with shared roles and responsibilities as follows:

- Local Health Coalitions/SFM Chapters will assign at least one person and one alternate to be principle contacts with the Ontario Health Coalition. These key contact people will have their phone number and the email address of the local coalition publicized in Ontario Health Coalition contact lists.
- Key contact people will work with the Ontario Health Coalition to try to ensure that one representative from the Local Health Coalition/SFM Chapter joins province-wide conference calls when they are requested to do so. Local contact people will check emails regularly and will act as a conduit of information between the OHC and the local group. This is important to ease quick communication across the province.
- Local Health Coalitions/SFM Chapters will send at least one and preferably two representative(s) each year to the Ontario Health Coalition Annual Assembly to give input and participate in the creation of the annual Action Plan. The OHC provides subsidies to help local groups to participate fully in this important process of strategy-setting for the year.
- Given the importance of maintaining contact lists and ensuring continuity should the volunteers in a Local Health Coalition/SFM Chapter change, all parties agree that the OHC will be responsible for data collection and management and will collect all sign up sheets from OHC sponsored or co-sponsored events to input into a central database. The OHC will provide Local Health Coalitions/SFM Chapters with their local database at regular intervals, when updated, or when asked. It is agreed that these lists are confidential and will not be shared with any other organizations, including political parties.
- Local Health Coalitions/SFM are responsible for any expenses they incur, unless there is prior agreement with the OHC director for reimbursement of these expenses.
- It is a primary goal of the Ontario Health Coalition to support and build capacity in the network of Local Health Coalitions and Students for Medicare. To that end, the Ontario Health Coalition will work continuously to publicize Local Health Coalition and student events and activities, to promote their work, to find, to build capacity within existing local groups and to build the network.
- To this end, the Local Health Coalitions and Students for Medicare will provide the Ontario Health Coalition with their regular meeting dates and dates for public events. Because it is so important to build the capacity of our grassroots network, there is an expectation that the Local Coalitions will hold regular meetings, at minimum six times per year, open to the public and publicized to all people on the database for the health coalition in that region, and the Ontario Health Coalition will aide in publicity and recruiting membership for the local coalitions and student chapters.

Ontario Health Coalition
15 Gervais Drive, Suite 201
Toronto, Ontario M3C 1Y8
Tel: 416-441-2502
Email: ohc@sympatico.ca
www.ontariohealthcoalition.ca

This is **Exhibit "D"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

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Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Ontario Health Coalition
Submissions to and testimony before Standing Committees of the Ontario Legislature

Submission to Ministry of Long-Term Care Public Consultation on New License & Expansion for Southbridge Care Homes Orchard Villa to the Director under the Fixing Long-Term Care Act, 2021
October 19, 2022
https://www.ontariohealthcoalition.ca/index.php/update-public-consultation-for-terrible-nursing-home-for-profit-orchard-villa-ltc/

Submission to the Standing Committee on the Legislative Assembly on Bill 37 Providing More Care, Protecting Seniors, and Building More Beds Act, 2021
November 29, 2021
https://www.ontariohealthcoalition.ca/index.php/submission-submission-to-the-standing-committee-on-the-legislative-assembly-on-bill-37/

Final Submission to Ontario's COVID-19 Long-Term Care Commission
February 16, 2021
https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Submission.pdf

Interim Submission to Ontario's COVID-19 Long-Term Care Commission
A Call to Conscience: The COVID-19 Crisis in Ontario's Long-Term Care Homes, What is Needed & the Government's Response Ontario Health Coalition
December 17, 2020
https://www.ontariohealthcoalition.ca/wp-content/uploads/Final-Report.pdf

Submission to the Standing Committee on Justice Policy on Bill 218 Supporting Ontario's Recovery and Municipal Elections Act, 2020
https://www.ontariohealthcoalition.ca/index.php/submission-submission-to-the-standing-committee-on-justice-policy-on-bill-218/

Submission on Bill 175, Connecting People to Home and Community Care Act 2020 to the Standing Committee on the Legislative Assembly
June 15, 2020
https://www.ontariohealthcoalition.ca/wp-content/uploads/Submission-on-Bill-175-final.pdf

Submission to the Standing Committee on Finance & Economic Affairs Ontario Pre-Budget Hearings
January 16, 2020
https://www.ontariohealthcoalition.ca/wp-content/uploads/ohc-final-submission-1.pdf

Submission to the Standing Committee on Social Policy Regarding Bill 74 The People's Health Care Act
April 1, 2019
https://www.ontariohealthcoalition.ca/wp-content/uploads/Submission-to-the-Standing-Committee-on-Social-Policy-1.pdf

Submission to the Standing Committee on International Trade, Parliament of Canada on the Trans-Pacific Partnership agreement
May 12, 2016
https://www.ontariohealthcoalition.ca/index.php/submission-speaking-out-about-protecting-health-care-from-international-trade-agreements/

Submission to the Standing Committee on Finance & Economic Affairs – Pre-Budget Hearings
January 29, 2015
https://www.ontariohealthcoalition.ca/wp-content/uploads/final-submission-January-29-2015.pdf

Submission to the Standing Committee on Social Policy Regarding the Review of the Local Health Integration Act and Regulations
February 10, 2014

Submission to the Standing Committee on Finance and Economic Affairs
March 22, 2013
https://www.ontariohealthcoalition.ca/wp-content/uploads/March-22-2013-Submission.pdf

Submission on the proposed new regulation under the Independent Health Facilities Act (IHFA), 1990 and the proposed amendment to regulation 264/07 under the Local Health System Integration Act (LHSIA)2006
October 10, 2013
https://www.ontariohealthcoalition.ca/wp-content/uploads/Oct-10-2013-Submission-re-IHFA.pdf

Submission to the Drummond Commission – Commission on the Reform of Ontario's Public Services
December 6, 2011

Submission to the Standing Committee on Finance and Economic Affairs Regarding Bill 173 (Budget Measures Act)
April 2011
https://www.ontariohealthcoalition.ca/wp-content/uploads/APRIL-29-MEDIA-RELEASE-April-May-2011.pdf

Ontario Health Coalition Submission to the Standing Committee on Social Policy Regarding Bill 21 An Act to Regulate Retirement Homes
May 10, 2010
https://www.ontariohealthcoalition.ca/wp-content/uploads/SUBMISSION-May-10-2010.pdf

Ontario Health Coalition Response to 2nd Set of Draft Regulations under Bill 140 the Long-Term Care Homes Act, 2007
October 15, 2009
https://www.ontariohealthcoalition.ca/wp-content/uploads/finalresponseltcregs09.pdf

Submission to the Ontario Auditor General on the William Osler Health Centre Brampton Public-Private Partnership (P3) Hospital Development
March 12, 2008
https://www.ontariohealthcoalition.ca/wp-content/uploads/OHC-SUBMISSION-TO-THE-AG-December-8-9-2008.pdf

Ontario Health Coalition Submission to the Facilitator, Shirlee Sharkey Review of Staffing and Care Standards for Long-Term Care Homes
January 31, 2008
https://www.ontariohealthcoalition.ca/wp-content/uploads/sharkey.pdf

Submission to the Standing Committee on Social Policy Regarding Bill 140: An Act Respecting Long-term Care Homes
January 16, 2007
https://www.ontariohealthcoalition.ca/wp-content/uploads/LTC_OHCSubmissionFinalJan16.pdf

Submission to the Standing Committee on Social Policy on Bill 102, Transparent Drug System for Patients Act, 2006
May 29, 2006
https://www.ontariohealthcoalition.ca/index.php/ontario-health-coalition-submission-to-the-standing-committee-on-social-policy-on-bill-102-transparent-drug-system-for-patients-act-2006/

Submission to the Standing Committee on Social Policy regarding Bill 36 Local Health System Integration Act
January 30, 2006
https://www.ola.org/en/legislative-business/committees/social-policy/parliament-38/transcripts/committee-transcript-2006-jan-30#P886_270500

Testimony before Standing Committee on Finance and Economic Affairs: pre-budget hearings
February 2004
https://www.ontariohealthcoalition.ca/wp-content/uploads/Submission-Feb-10-2004.pdf

Submission to the SARS Commission
November 18, 2003
https://www.ontariohealthcoalition.ca/index.php/ohcs-submission-to-the-sars-commission/

Submission to the Commission on the Future of Health Care in Canada
October 1, 2001
https://www.ontariohealthcoalition.ca/index.php/ohc-submission-to-the-commission-on-the-future-of-health-care-in-canada/

This is **Exhibit "E"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

OHC's engagement and advocacy on matters around hospital beds, public health care capacity and dehospitalization

The Ontario Health Coalition has tracked hospital capacity, quality of care and access to care for more than two decades. The Coalition monitors data and reports to document the province's funding and capacity in public health care, and advocates for sufficient public funding to ensure a viable and equitable health care system.

- Chronic Care Policy Issues (January 1999): https://www.ontariohealthcoalition.ca/wp-content/uploads/Fact-Sheet-Jan-1999.pdf
- Chronic Care Fact Sheet (May 1999): https://www.ontariohealthcoalition.ca/wp-content/uploads/Fact-Sheet-May-1999-Chronic-Care.pdf
- Patient Classification and Funding in Chronic Care Hospitals and Long Term Care Facilities (January 2000): https://www.ontariohealthcoalition.ca/wp-content/uploads/Fact-Sheet-Jan-2000.pdf
- The Emerging Crisis in Chronic Care (May 1, 2000): https://www.ontariohealthcoalition.ca/index.php/the-emerging-crisis-in-chronic-care/
- Tipping The Balance: Healthcare Restructuring and Privatization in Ontario (July 1, 2001): https://www.ontariohealthcoalition.ca/index.php/tipping-the-balance-healthcare-restructuring-and-privatization-in-ontario/
- Briefing Notes on Ontario's Hospital Cuts and Restructuring 2008/2009 (Dec 2, 2008): https://www.ontariohealthcoalition.ca/index.php/briefing-notes-on-ontarios-hospital-cuts-and-restructuring-20082009/
- No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care (July 21, 2011): https://www.ontariohealthcoalition.ca/index.php/no-vacancy-hospital-overcrowding-in-ontario-impact-on-patient-safety-and-access-to-care/
- First Do No Harm: Putting Improved Access and Accountability at the Centre of Ontario's Health Care Reform Phase I Report Ontario Health Coalition (February 10, 2012): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-February-10-2012.pdf
- The Austerity Index Part I: Health Care cuts and deficits across Ontario (Dec 5, 2012): https://www.ontariohealthcoalition.ca/index.php/the-austerity-index-part-i-health-care-cuts-and-deficits-across-ontario-2/
- "Beyond Limits": Ontario's community hospital cuts worst in Canada (April 13, 2016): https://www.ontariohealthcoalition.ca/index.php/report-ontarios-community-hospital-cuts-worst-in-canada/
- Ontario Government Responsible for Overwhelmed Hospital Emergency Departments: Critical Bed Shortages "Systemic and Pervasive" (Jan 10, 2017): https://www.ontariohealthcoalition.ca/index.php/release-backgrounder-ontario-government-responsible-for-overwhelmed-hospital-emergency-departments-critical-bed-shortages-systemic-and-pervasive/

- Time to Rebuild – recommendations for the 2018 provincial election (May 16, 2018): https://www.ontariohealthcoalition.ca/index.php/release-provincial-election-discussion-should-be-about-rebuilding-public-hospitals-long-term-care-not-efficiencies-or-lean-or-code-words-for-cuts-health-coalit/
- Mounting Health Care Cuts: Ford government cuts tracker (November 20, 2019): https://www.ontariohealthcoalition.ca/index.php/update-mounting-health-care-cuts/
- Ontario Health Coalition's Pre-Budget Submission to the Ontario Legislative Assembly: https://www.ontariohealthcoalition.ca/index.php/ontario-pre-budget-hearing-2020/
- Pre-budget brief: Ontario so far behind that emergency funding just brings us to where we should have been pre-COVID-19 (March 25, 2020): https://www.ontariohealthcoalition.ca/index.php/release-backgrounder-pre-budget-brief-ontario-so-far-behind-that-emergency-funding-just-brings-us-to-where-we-should-have-been-pre-covid-19/
- Ontario Hospital Crisis Province-Wide and By Community (Oct 24, 2022): https://www.ontariohealthcoalition.ca/index.php/report-release-ontario-hospital-crisis-province-wide-and-by-community/

The Ontario Health Coalition has conducted repeated rounds of hearings and public consultations on hospital care, publishing its results and advocating for improvements to access, quality and capacity planning.

- Putting Patients At Risk: Interviews with 50 Ontario Paramedics on the Consequences of Closing Local Hospital Emergency Departments (June 18, 2009): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-June-18-2009.pdf
- Toward Access and Equality: Realigning Ontario's Approach to Small and Rural Hospitals to Serve Public Values Results of the Ontario Health Coalition hearings on small and rural hospitals held in 12 communities across Ontario in March 2010 Submitted by the panelists to the Ontario Health Coalition (May 17, 2010): https://www.ontariohealthcoalition.ca/wp-content/uploads/FULL-REPORT-May-17-2010.pdf
- Our Hospitals, Our Communities: Report on Hospital Care Surveys in Chatham-Kent (March 20, 2017): https://www.ontariohealthcoalition.ca/index.php/our-hospitals-our-communities-report-on-hospital-care-surveys-in-chatham-kent/

- The Ontario Health Coalition monitored data surrounding the impact of COVID-19 in health care settings, including hospitals and long-term care.

  - March 12, 2021: https://www.ontariohealthcoalition.ca/index.php/report-tracking-the-spread-of-covid-19-large-outbreaks-in-health-care-settings-summary-report-over-two-thousand-dead-in-long-term-care-as-we-approach-end-of-wave-2-data-updated-to-march-3/

- There were periodic reports on COVID-19 data in hospitals and outcome settings

The Ontario Health Coalition has held repeated events and actions to stop the cuts to public hospitals and restore basic capacity planning to meet population need for care.

- 2008 – 2018: repeated "Days of Action" in which the Coalition brought in busloads of people from local communities facing emergency department closures, maternity department closures, ICU closures and loss of other vital services or entire hospitals. The Coalition arranged questions in Question Period, meetings with Health Ministers and key political staff, and press conferences. Working with local communities, the Coalition has been able to pressure successive governments to stop the closures of hospitals and their core services in many communities, including those in Welland, Fort Erie, Port Colborne, Wallaceburg, St. Joseph Island, St. Marys, Midland, Windsor, Cornwall, North Bay and others.
- October 2018: Rally of 8,000 people at the Ontario legislature https://www.ontariohealthcoalition.ca/index.php/release-thousands-demand-doug-ford-disavow-health-care-privatization-and-cuts-other-political-parties-respond-positively-to-coalitions-demand-for-services-to-be-rebuilt-restore/
- May 1, 2019: Rally of 10,000 people at the Ontario legislature https://www.ontariohealthcoalition.ca/index.php/release-more-than-10000-protest-to-tell-ford-government-to-stop-health-privatization-cuts/
- November – December 2019 mass rallies to stop the cuts to hospitals and long-term care, among other services in Chatham, Toronto, Ottawa and Sault Ste. Marie. Events were attended by more than 5,000 people.
- The Coalition has held hundreds of town hall meetings across Ontario, as well as sticker days, lobby days, municipal council resolution campaigns, launched petitions and post card campaigns, and engaged in tireless public awareness initiatives on the issues of hospital downsizing, cuts, overcrowding and offloading of patients.

This is **Exhibit "F"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

OHC's engagement and advocacy on long-term care and its engagement with long-term care residents and their families

A. Engagement in the community on issues of care in LTCs and OHC's involvement with these communities in monitoring and advocating on the quality of care in LTCs

The Ontario Health Coalition has researched the state of care in Ontario's long-term care homes for at least three decades. The Coalition reports on access to care, quality, safety and care levels and the ownership and staffing factors that impact these. The Coalition advocates to improve access to care and reduced wait times as well as care levels in the homes.

- Long Term Care – In Limbo or Worse? (March 1, 2001): https://www.ontariohealthcoalition.ca/index.php/long-term-care-in-limbo-or-worse/
- Ownership Matters: Lessons from Ontario's Long Term Care Facilities (May 27, 2002): https://www.ontariohealthcoalition.ca/index.php/ownership-matters-lessons-from-ontarios-long-term-care-facilities/
- Violence, Insufficient Care, and Downloading of Heavy Care Patients (May 8, 2008): https://www.ontariohealthcoalition.ca/index.php/violence-insufficient-care-and-downloading-of-heavy-care-patients/
- Protecting the Public Interest in Toronto's Long-Term Care Homes: A Review of the Evidence on Privatization (March 6, 2012): https://www.ontariohealthcoalition.ca/index.php/protecting-the-public-interest-in-torontos-long-term-care-homes-a-review-of-the-evidence-on-privatization/
- Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care (January 24, 2019): https://www.ontariohealthcoalition.ca/index.php/situation-critical-planning-access-levels-of-care-and-violence-in-ontarios-long-term-care/
- Ford Government Cuts to Long-Term Care Funding Risk Already Over-Stressed Care Levels (July 10, 2019): https://www.ontariohealthcoalition.ca/index.php/releaseford-government-cuts-to-long-term-care-funding-risks-already-over-stressed-care-levels/
- Investing in Care, Not Profit: Recommendations to Transform Long-Term Care in Ontario (May 20, 2021): https://www.ontariohealthcoalition.ca/index.php/report-investing-in-care-not-profit-recommendations-to-transform-long-term-care-in-ontario/
- Public Money, Private Profit: The Ford Government & the Privatization of the Next Generation of Ontario's Long-Term Care (Nov 29, 2021): https://www.ontariohealthcoalition.ca/index.php/report-public-money-private-profit-the-ford-government-the-privatization-of-the-next-generation-of-ontarios-long-term-care/

- Submission to the Standing Committee on the Legislative Assembly on Bill 37 (Nov 29, 2021): https://www.ontariohealthcoalition.ca/index.php/submission-submission-to-the-standing-committee-on-the-legislative-assembly-on-bill-37/

The Coalition has held repeated rounds of public consultations as well as surveys and round tables with staff and administrators, publishing the results and advocating for improved care levels.

- Long-Term Care: In Limbo or Worse? A report on seven public forums during February/March 2001 about the Future of Long-Term Care (May, 2001) https://www.ontariohealthcoalition.ca/wp-content/uploads/LTCforums.pdf
- Caring in Crisis: Ontario's Long-Term Care PSW Shortage (Dec 9, 2019) The report is based on eight round-table meetings held across Ontario including more than 350 participants including home operators and administrators, PSWs, union representatives, family councils, seniors, college staff who develop/coordinate PSW courses, local health coalitions and other long-term care advocates: https://www.ontariohealthcoalition.ca/index.php/report-caring-in-crisis-ontarios-long-term-care-psw-shortage/
- 95% of Ontario Long-Term Care Staff Report Staffing Shortages Leaving Basic Care Needs Unmet: Health Coalition Releases Staffing Survey Calling for Ford Government to Take Action (July 22, 2020): https://www.ontariohealthcoalition.ca/index.php/release-report-95-of-ontario-long-term-care-staff-report-staffing-shortages-leaving-basic-care-needs-unmet-health-coalition-releases-staffing-survey-calling-for-ford-government-to-take-action/
- Briefing Report: Investigating Real Registered Nurse Staffing Levels in Ontario's Long-Term Care Homes (Apr 7, 2021) - surveys of long-term care homes on nurse staffing levels: https://www.ontariohealthcoalition.ca/index.php/report-briefing-report-investigating-real-registered-nurse-staffing-levels-in-ontarios-long-term-care-homes/
- Long-Term Care Survey -Kawartha Lakes Health Coalition, Northumberland Health Coalition, and the Peterborough Health Coalition – survey of frontline staff (June 22, 2021): https://www.ontariohealthcoalition.ca/index.php/report-survey-taken-by-kawartha-lakes-health-coalition-northumberland-health-coalition-and-the-peterborough-health-coalition/
- Crisis Unabated: The Failure to Improve Dangerously Low Care Levels in Ontario's Long-Term Care Homes (May 18, 2022) – surveys of long-term care homes on overall direct-care staffing levels: https://www.ontariohealthcoalition.ca/wp-content/uploads/Crisis-Unabated-final-report-1.pdf

The Ontario Health Coalition has advocated for improved hours of care, mandatory minimum care levels, inspections and enforcement of care standards to protect residents in long-term care homes:

- Minimum Care Standards in Long Term Care Facilities Briefing Notes (Jan 31, 2007): https://www.ontariohealthcoalition.ca/index.php/minimum-care-standards-in-long-term-care-facilities-briefing-notes/
- RELEASE: McGuinty Reneging on Years of Progress in Long-Term Care Homes' Inspections & Enforcement: Betrays Longstanding Promises to Ontario Seniors (June 13, 2012)
- Fact Check & Briefing Note on Inspections in Ontario's Long-Term Care Homes (May 29, 2020): https://www.ontariohealthcoalition.ca/index.php/release-fact-check-briefing-note-on-inspections-in-ontarios-long-term-care-homes/
- Open Letter to Doug Ford signed by over 200 organizations & almost 2 million Ontarians – LTC commission & immediate measures to address the crisis in LTC (June 30, 2020) https://www.ontariohealthcoalition.ca/index.php/open-letter-open-letter-to-doug-ford-signed-by-100-orgs-1-5-million-ontarians-ltc-commission-immediate-measures/
- Rallies in 9 cities across Ontario to improve long-term care (July 2, 2020): https://www.ontariohealthcoalition.ca/index.php/release-events-actions-across-ontario-to-tell-premier-ford-that-the-priority-of-ontarians-is-to-fix-the-long-term-care-crisis-not-to-privatize-home-care/
  Rallies in 25 cities across Ontario to improve long-term care (October 8, 2020): https://www.ontariohealthcoalition.ca/index.php/release-roundup-cross-province-protest-decries-fords-inadequate-response-to-long-term-care-crisis/
  Mass livestream protest on the long-term care crisis (January 29, 2021): https://www.ontariohealthcoalition.ca/index.php/event-protest-ontarios-long-term-care-crisis/
- Coalition Responds to Long-Term Care Minister Rod Phillips' Announcement Cutting Through the PR: No Commitment to Reinstate Annual Comprehensive Inspections (October 26, 2021): https://www.ontariohealthcoalition.ca/index.php/release-coalition-responds-to-long-term-care-minister-rod-phillips-announcement-cutting-through-the-pr-no-commitment-to-reinstate-annual-comprehensive-inspections/
- Advocates Representing More Than 1 Million Canadians Call For National Standards to Improve Quality, Accountability and Take Profit Out of Long-Term Care (March 22, 2021): https://www.ontariohealthcoalition.ca/index.php/release-briefing-legal-opinion-advocates-representing-more-than-1-million-canadians-call-for-

national-standards-to-improve-quality-accountability-and-take-profit-out-of-long-term-care/

- Investing in Care, Not Profit: Recommendations to Transform Long-Term Care in Ontario (May 20, 2021): https://www.ontariohealthcoalition.ca/index.php/report-investing-in-care-not-profit-recommendations-to-transform-long-term-care-in-ontario/

B. Experience of OHC and LTC families during COVID-19 (based on OHC's direct involvement)

The Ontario Health Coalition monitored and assessed the response from the government regarding the crisis in LTC during the pandemic:

- New Directive and Guidelines for COVID-19 in Long-Term Care Homes Inadequate: Coalition Calls for Full Testing, Better Access to PPE, Respect for Human Rights in Care (April 9, 2020): https://www.ontariohealthcoalition.ca/index.php/release-new-directive-and-guidelines-for-covid-19-in-long-term-care-homes-inadequate-coalition-calls-for-full-testing-better-access-to-ppe-respect-for-human-rights-in-care/
- COVID-19 outbreaks in health settings almost doubled, death toll up by 333.7% (May 12, 2020): https://www.ontariohealthcoalition.ca/index.php/report-covid-19-outbreaks-in-health-settings-almost-doubled-death-toll-up-by-333-7/
- Health Coalition Calls for Government to Flow Urgently Needed Money to Hospitals and Long-Term Care; Staffing Announcements Far Less Than Other Provinces (Oct 2, 2020): https://www.ontariohealthcoalition.ca/index.php/health-coalition-calls-for-government-to-flow-urgently-needed-money-to-hospitals-and-long-term-care-staffing-announcements-far-less-than-other-provinces/
- OHC Raises Alarm About Ford Government's New Emergency Order Transferring Hospital ALC Patients Without Consent into LTC and Retirement Homes (April 28, 2021) https://www.ontariohealthcoalition.ca/index.php/release-ohc-raises-alarm-about-ford-governments-new-emergency-order-transferring-hospital-alc-patients-without-consent-into-ltc-and-retirement-homes/
- Ontario Auditor General Report on COVID-19 in Ontario's LTC Homes Supports Longstanding Calls for Real Change (April 28, 2021) https://www.ontariohealthcoalition.ca/index.php/release-ontario-auditor-general-report-on-covid-19-in-ontarios-ltc-homes-supports-longstanding-calls-for-real-change/

RELEASE: "We are outraged": Health Coalition slams Ford government's response to

Auditor General on LTC, No responsibility taken for the among the worst death rates

in the world (April 29, 2021) https://www.ontariohealthcoalition.ca/index.php/release-we-are-outraged-health-coalition-slams-ford-governments-response-to-auditor-

general-on-ltc-no-responsibility-taken-for-the-among-the-worst-death-rates-in-the-worl/

- Fill the Galleries to Demand Ford Take Action on LTC -- Virtual protest in which we arranged for more than 400 families of residents in LTC along with concerned citizens to virtually "fill the galleries" at the Ontario Legislature to demand action on inadequate care and astronomical death rates in the pandemic (May 11, 2022) https://www.ontariohealthcoalition.ca/index.php/event-pack-the-public-galleries-of-the-ontario-legislature/

This is **Exhibit "G"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

March 16, 2021

Ena Chadha
Chief Commissioner
Ontario Human Rights Commission
Dundas/Edward Centre 9th Floor
180 Dundas Street West
Toronto, Ontario M7A 2G5

Via email: cco@ohrc.on.ca

Dear Chief Commissioner:

We are writing to request that the Human Rights Commission use its public inquiry powers under section 31 of the *Human Rights Code* to investigate systemic discrimination based upon age against the elderly in the provision of health care in Ontario.

In particular, we submit that Ontario's long-standing policy of "de-hospitalizing" the health care system by cutting the number of public hospital beds to levels far below population need – and especially, complex-continuing care beds needed by predominantly elderly patients –, while at the same time under-resourcing long-term care homes, has had, and continues to have, a disproportionately negative effect on the province's elderly. The effect of this policy is that elderly patients are denied appropriate hospital care and discharged into circumstances in which there is inadequate provincially-funded care, thereby jeopardizing their health.

We believe that an inquiry would advance the Commission's mandate, and in particular, further the objectives of its *Policy on discrimination against older people because of age*.[1] Given the reluctance of the Ontario Human Rights Tribunal and the Courts to address systemic discrimination claims, and the scarcity of jurisprudence dealing with seniors and

[1] Ontario Human Rights Commission, *Policy on discrimination against older people because of age* (Approved 26 March, 2002; Revised by OHRC 1 February 2007).

the health care system, we submit that the Commission has a critical role to play in shining a spotlight on this pervasive form of discrimination, which affects the elderly and their families throughout Ontario.

As set out in detail below, age discrimination in the provision of health care has been an issue of grave and growing concern for several decades. Over the past several months, these chronic concerns have become tragically acute. The COVID-19 pandemic has made all too apparent inequities in access to health care, which already existed for elderly Ontarians.

According to provincial epidemiological data, as of February 27, 2021, 3,869 residents of long-term care homes in the province had died of COVID-19. This represents 55% of the total of 7,014 COVID-19 related deaths across Ontario.[2] Significant numbers of residents who succumbed to COVID-19 died in the facilities where they lived, without having been transferred to hospital. For example, Toronto Public Health found that as of April 17, 2020, only 22 of 899 residents of retirement and long-term care homes with confirmed cases of COVID-19 were being treated in hospital – or approximately 2.5%. By May 1, 2020, when there were 1,691 cases in Toronto seniors' facilities, 95 residents – or 5.6% – had been hospitalized. An investigative report by the *Ottawa Citizen* also found that the vast majority of long-term care home residents who had died since the pandemic began did not go to hospital. Using provincial data, they found that as of mid-May, only 13% of long-term care home residents over the age of 70 with COVID-19 were treated in hospital, compared with 36% of the same age group who live in the community.[3]

A new study by researchers at the University of Toronto and Public Health Ontario looks at hospitalization rates for long-term care residents with COVID-19 through the peak of the first wave and into the second wave of the pandemic. They found that in the peak months of Wave I, March and April, only 15.5% of long-term care residents with the virus were hospitalized before they died. This reached a high of 41.2% in June and July when the first wave was ending. Looking at the pandemic as a whole, and into the second wave from March to October, the study finds that the hospitalization rate for long-term care residents with COVID-19 was just 22.4%. This compares to 81.4% of people who lived in the community.[4]

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[2] Public Health Ontario, Weekly Epidemiological Summary (27 February 2021).

[3] Elizabeth Payne, "Only 13% of Ontario's long-term care COVID patients went to hospital; advocates want to know why", *Ottawa Citizen* (8 June 2020).

[4] Kenyon Wallace, "Only a fraction of long-term-care residents killed by COVID-19 were taken to hospital", *Toronto Star* (6 December 2020).

This raises the very troubling possibility that elderly residents were not hospitalized despite clear medical appropriateness/need. It may well be that in individual cases, proper considerations effectively precluded transfer. There are, however, compelling reports that even where family members, who were the residents' substitute decision-makers, requested that their loved ones be hospitalized, they had their requests denied and were told – sometimes incorrectly – that hospitals were not accepting transfers from long-term care homes.[5] Families also have reported instances where long-term care homes could not provide safe and adequate care and yet residents were not transferred to hospitals or were transferred only after grave suffering.[6] Lawyers from the Advocacy Centre for the Elderly report that they received numerous calls from families who had to compel long-term care homes to call an ambulance to transfer their loved ones to hospital during the first wave of the pandemic; that long-term care homes had used blanket no-hospitalization policies or dissuasion in contravention of residents' rights to informed consent in health care pursuant to the *Health Care Consent Act*; and that provincial policies have created

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[5] Katie Pedersen, Melissa Mancini, David Common, "Nursing home told families hospital wouldn't accept sick residents during pandemic. That wasn't true", *CBC News* (17 June 2020).

See also:

Elizabeth Payne, Andrew Duffy, "No-transfer practice at some long-term care homes denies residents rights during pandemic, say advocates", *Ottawa Citizen* (14 April 2020);

Terry Reith, "'No benefit' to sending seniors ill with COVID-19 to hospital, some nursing homes tell loved ones", *CBC News* (3 April 2020)

Elizabeth Payne, "Only 13% of Ontario's long-term care COVID patients went to hospital; advocates want to know why", *Ottawa Citizen* (8 June 2020)

Liam Casey, "Families accuse Ontario long-term care home of denying loved ones hospital trips", *Canadian Press* (18 June 2020)

[6] Chris Glover, "Family reeling as senior dies of malnutrition, not COVID-19, inside long-term care home", *CBC News* (9 June 2020).

Jill Mahoney, "What happened when families were blocked from Canada's long-term care homes", *The Globe and Mail* (3 June 2020).

Sue-Ann Levy, "$20M class-action suit filed against Schlegel Villages", *Toronto Sun* (26 Jun 2020).

Kim Zarzour, "Families sue Woodbridge Vista alleging long-term care home put profit ahead of residents" *Vaughan Citizen* (16 June 2020).

Muriel Draaisma, "Canadian military to help long-term care home struggling with COVID-19 in Vaughan", *CBC News* (7 June 2020).

a culture of “hospital avoidance”, leaving the elderly with “minimal care” while they were dying.[7]

In fact, long-term care home operators have now testified before the Ontario Long-Term Care COVID-19 Commission that they were told not to send residents to hospitals. Dr. Allan Bell, Chief and Director of Emergency Medicine at Quinte Health Care, sent a letter to regional long-term care homes informing them that hospital visits were not recommended. Fraser Wilson, Vice-President of Ontario Long-Term Care for Chartwell, a for-profit chain company, testified to the Commission that hospitals denied transfers of sick residents or returned them within hours of being sent. Maria Elias, CEO of Belmont House, a non-profit long-term care home, told the Commission that the homes were instructed not to send seniors with COVID-19 to hospital.[8]

In addition, many seniors were in fact transferred *out* of hospital care in anticipation of a wave of COVID-19 related admissions. According to a recent report from *The Globe and Mail*, between March 2 and May 3, 2020, hospitals transferred out nearly 2,200 Alternate Level of Care (“ALC”) patients, sending 1,589 to long-term care homes and 605 to retirement homes.[9] In fact, we have found that ALC patients across Ontario, the vast majority of them elderly, were transferred from public hospitals not just to long-term care but also to hotels, private for-profit retirement homes, unlicensed facilities, or even home without adequate care – in some cases in clear violation of their right to informed consent.[10] While not all of those transfers were COVID-19 related, it is clear that the cost of shoring up hospitals fell disproportionately on the elderly.

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7 Elizabeth Payne, "Only 13% of Ontario's long-term care COVID patients went to hospital; advocates want to know why", Ottawa Citizen (8 June 2020)

8 Kenyon Wallace, "Only a fraction of long-term-care residents killed by COVID-19 were taken to hospital", *Toronto Star* (6 December 2020)

9 Kelly Grant & Tu Thanh Ha, “How shoring up hospitals for COVID-19 contributed to Canada’s long-term care crisis”, *The Globe and Mail* (20 May 2020)

10 Media reports detail these transfers across the province. For example:

- **Sudbury** – 95 patients were moved out to the Clarion Hotel: Barbara Sibbald, "What happened to the hospital patients who had 'nowhere else to go'?", *CMAJ News* (15 May 2020).
- **North Bay –** 16 patients were transferred from hospital to LTC or retirement homes before the province stopped the transfers late-April. At least 7 of them were transferred to one private for-profit retirement home: Jennifer Hamilton-McCharles, “Plug pulled on hospital patient transfers”, *North Bay Nugget* (22 April 2020).
- **Lindsay/Kawartha Lakes** – Hospital reports it transferred many patients out of hospital to LTC, retirement homes or home waiting for care to clear out beds. Family reports it

Public reporting in recent months has brought much needed attention to the issue of elderly patients' access to health care services. It must be noted, however, that the provincial policy to de-hospitalize ALC patients during the first wave of the pandemic[11] simply accelerated the existing discriminatory policy of de-hospitalizing the health system by limiting hospital bed availability to levels far below population need, and discharging elderly patients regardless of medical need, appropriateness and safety.

From 1990 to 2014, more than 6,100 complex continuing care (also known as chronic care) hospital beds were closed down, thereby eliminating 54% of Ontario's chronic care hospital bed capacity.[12] At the same time, Ontario's population grew from 10.3 million in 1990 to 13.62 million in 2014 (32%) – and had grown by a further 700,000 to a total of 14.32 million by 2018. In addition, population aging has accelerated, which means that the proportion of the population that is elderly has increased. According to the most recent data, Ontario now has the fewest hospital beds per capita of any province in the country and ranks third last in number of hospital beds among all countries in the OECD.[13] Ontario's policy of cutting health care costs through de-hospitalization has been not only radical, but a profound departure from the public policy norms of peer jurisdictions.

In order to accommodate the most extreme hospital downsizing policy in the developed world, successive Ontario governments have implemented strategies to re-categorize patients with ever-increasing acuity (complexity of care needs) as being ready for discharge. The standardized designation of "Alternate Level of Care" or ALC was adopted

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felt like they were "feeding" their loved one to the virus: Roderick Benns, "RMH attempting to move more patients out of hospital to manage expected surge", *Lindsay Advocate* (4 April 2020).

- **Ottawa** - In the end, the hospitals have indeed moved patients out to this hotel and also to retirement homes: Elizabeth Payne, "Province tells hospital not to move patients into long-term care homes", *Ottawa Citizen* (17 April 2020).
- **Niagara** – Half of their 150 ALC patients were moved out in two weeks: "In It Together: 'Everyone is coming with solutions', *News & Updates from Niagara Health* (9 June 2020).

11 Ministry of Health, Ministry of Long-Term Care, Ontario Health, *COVID-19 Guidance: Use of Hotels and Retirement Homes* (2 April 2020).

12 Ontario Health Coalition, "Beds in Ontario Public Hospitals 1990 to 2014".

13 Ontario Health Coalition, "Fast Facts: Hospital Beds per 1000 population by province in 2017-2018".

Ontario Health Coalition, "Fast Facts: OECD Hospital Beds Per 1000 Population in 2017"

in 2009,[14] following widening use of the designation over the prior decade. ALC patients are not a homogeneous group but rather have unique and varied care needs. They are nevertheless routinely treated as “bed blockers” who do not require hospital care – despite provincial and hospital data showing that a significant proportion are actually in hospital waiting for another appropriate level of care in hospital, including rehabilitation, complex continuing care, and others.[15]

The drive to de-hospitalize has been facilitated by the failure of successive governments to set clear standards to protect patients who require hospital care – including complex continuing care, rehabilitative care and palliative care – and the failure to provide resources for that care. Instead, patients with these care needs have been offloaded from hospitals to an array of facilities outside of the *Public Hospitals Act.* This offloading also has the effect of removing patients from the protections of public insurance without user fees and extra billing in the *Canada Health Act*. These patients, who are predominantly and disproportionately elderly, have been sent to their own homes, retirement homes, transitional care units and hotels, sidestepping the protections that provincial and federal legislation are supposed to afford them.[16] Legal advocates for the elderly report that coercive practices to offload these patients from hospitals are among the most frequent complaints they receive.[17]

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[14] Cancer Care Ontario, “Alternate Level of Care Reference Manual, Vol 2” (January 2017) at p 13; see also Peter Nord, "Alternate level of care: Ontario addresses the long waits" (August 2009) 55(8) *Canadian Family Physician* 786

[15] Ontario Hospital Association, ALC Update (20 June 2016).

[16] These protections include the quality of care and levels of care standards, public governance, public funding of care, access to information, accreditation and accountability regimes for public hospitals under Ontario legislative and regulatory regimes. They also include the right to publicly funded care provided on equitable terms and conditions without financial barriers and the terms and conditions of public health care under the *Canada Health Act*.

[17] Advocacy Centre for the Elderly, "Discharge from Hospital to Long-Term Care: Issues in Ontario" (July 2013).

Advocacy Centre for the Elderly, "Discharge from Hospital to Long-Term Care: Issues in Ontario" (February 2014).

Carmela Fragomeni, "No law forcing you to take elderly patients home from hospital", *Hamilton Spectator* (8 April 2019).

Theresa Boyle, "Pay $1,800 a day or get out: Hospital", *Toronto Star* (22 February 2011).

Ontario Patient Ombudsman, Year Three Results, 2019.

At the same time, successive Ontario governments have under-resourced long-term care. The acuity of residents admitted to long-term care homes has increased dramatically[18] while hands-on care levels have decreased[19] – and there is no legislated ceiling as to what a long-term care home can provide. In fact, long-term care residents are funded at one-third of the rate of complex continuing care hospital patients despite equivalent levels of acuity.[20] At the same time, governments have rationed access to long-term care homes by keeping provincial bed numbers far below population need. Other ALC patients who are actually waiting for long-term care home beds cannot access appropriate care because long-term care homes are full and current wait lists number more than 38,000 people.[21] Our research has revealed that Ontario ranks second last among all provinces in the number of long-term care beds per capita.[22] Not only is Ontario's policy of de-hospitalization an outlier among peer jurisdictions, so too is the province's policy of rationing access to long-term care. As a result of these policies, ALC patients waiting for long-term care admissions have been redirected to transitional care units, retirement homes, home with inadequate home care, and to hotels which do not have the same

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[18] One way to look at the difficulty in accessing needed care is to look at the measures of acuity (complexity of care needed) on admission to long-term care. Ontario has extraordinarily high MAPLe scores on admission and they have increased significantly as follows:

> The data also shows that acuity has increased at the point of admission, meaning that residents are entering long-term care with greater needs. The MAPLe score (Method for Assigning Priority Levels) is used by care coordinators to classify clients according to their level of care needs. The MAPLe score of residents was 76% in 2010. By 2016 it had increased by 8% to 84%, a very significant leap in 6 years alone. (see file:///C:/Users/brown/Downloads/OANHSS_2016-17_Pre-Budget_Submission.pdf) Today, the vast majority (84%) of those currently admitted to long-term care homes are assessed as having high and very high needs. People with significant care needs who are not ranked as highly are unable to access long-term care.

[19] Ontario Health Coalition, *Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care* (21 January 2019).

Ontario Health Coalition, *Caring in Crisis: Ontario's Long-Term Care PSW Shortage* (9 December 2019).

Ontario Health Coalition, "95% of Ontario's Long-Term Care Homes Report Staffing Shortages Leaving Basic Care Needs Unmet" (22 July 2020).

[20] Ontario Health Coalition, *Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care* (21 January 2019).

[21] Office of the Premier, News Release, "Ontario Launches Independent Long-Term Care COVID-19 Commission" (29 July 2020).

[22] Ontario Health Coalition, "Fast Facts: Long-Term Care Beds Per 1,000 Population".

protections afforded by the legislative, inspection and regulatory regime for long-term care in Ontario.

The COVID-19 crisis has brought much-needed public attention to the deeply disturbing conditions within long-term care homes which Ontario's seniors have endured for far too long. While we think a formal public inquiry would be more suited to addressing the scope of the issue, we welcome the formation of Ontario's Long-Term Care COVID-19 Commission and look forward to its final report on the effects of COVID-19 on the province's long-term care home sector. However, this limited review of long-term care homes is only a small part of a much broader issue, which includes excessive and inappropriate de-hospitalization and rationing of long-term care.

Ontario's Long-Term Care COVID-19 Commission is intended to provide immediate answers to a relative narrow – albeit urgent – set of questions that do not include issues of systemic discrimination over the longer term. We note that the Ford government has denied the Commission's request for an extension of time to complete its work, which underscores the exigent and circumscribed nature of the review it is undertaking.

Furthermore, the fact that inappropriate de-hospitalization and rationing of long-term care disproportionately affect elderly Ontarians must not be overlooked. The factors that underlie the deplorable conditions within some long-term care homes cannot be fully or meaningfully resolved without also naming and addressing systemic, age-based discrimination in the provision of health care throughout the province. The Commission's particular expertise in relation to discrimination and equality rights is urgently needed.

1. Overview

Since the early 1990s, the Ontario Government has sought to control the rising costs of health care by downsizing its public hospitals. Using policy and funding levers, the Government has promoted "de-hospitalization": reducing the number of public hospitals and cutting 14,815 acute care and 6,109 complex continuing care beds within public hospitals. Given the resulting scarcity of hospital beds, patients with higher and higher acuity levels have had to be discharged to resolve the problem. In the initial round of hospital restructuring in the 1990s, the belief was that the health care system would adjust to these cuts by reducing hospital length of stay on one hand and by increasing reliance on home, community and long-term care on the other. Home care rolls were expanded slowly and 20,000 new long-term care beds were built from the late 1990s to the early years of this century. However, health system planning and resources never kept pace with hospital downsizing and population aging, leaving home care severely rationed. Wait lists for long-term care have numbered from 20,000-38,000 since the turn of the century.

Furthermore, hospital downsizing has continued despite significant population growth, leaving Ontario with the most radical hospital cuts in Canada and among developed nations. To accommodate extremely low levels of hospitalization, Ontario has tolerated a level of hospital overcrowding that is unheard of among our peer jurisdictions,[23] and has adopted a policy approach to offload patients into settings that are under-resourced or inappropriate to care for them. These policies have disproportionately impacted the elderly, eroding their rights to care under the *Canada Health Act* and provincial legislation.

The *Canada Health Act* expressly defines hospital care as including chronic and rehabilitative care.[24] Under the *Canada Health Act*, patients have the right to reasonable access to care on equitable terms and conditions without extra user fees and extra billing. Ontario's *Public Hospitals Act* also designates public hospitals as providing specific types of care, including chronic/complex continuing, rehabilitative, and convalescent care.[25] Under Ontario's *Health Insurance Act,* patients are covered by public health insurance in hospitals providing this full range of care[26] and under the *Public Hospitals Act,* patients in public hospitals are supposed to be protected by public governance, access to information, quality of care and public insurance regimes, as well as other public protections set out in these statutes. The policy of de-hospitalization and the adoption of measures to designate patients as ALC earlier and earlier in their hospital stays have significantly eroded patients' statutory rights.

The emergence of a new designation of certain hospital patients as "Alternate Level of Care" or ALC dates back to policy shifts in the 1990s. The definition of ALC became formalized in the 2000s and health care planners pushed for patients to be designated ALC earlier in their hospital stays in a bid to reduce patient length of stay. Today, policy makers and hospital executives routinely refer to hospitals as being "acute care facilities" despite being required to provide other levels of care, and to ALC patients as though they can and should be discharged to other settings, whether or not appropriate care is available. ALC patients, which include individuals waiting for appropriate public hospital care – including rehabilitative, complex continuing, convalescent and palliative care – are considered an undue financial drain and are routinely treated as "bed blockers". These patients and their families are subjected to pressure, coercion, and in the context of the

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23 Financial Accountability Office of Ontario, *Ontario Health Sector: A Preliminary Review of the Impact of the COVID-19 Outbreak on Hospital Capacity* (28 April 2020).

24 *Canada Health Act*, RSC 1985, c C-6.

25 RRO 1990. Reg 964: Classification of Hospitals

26 RRO 1990, Reg 552: General

current pandemic, measures to actively move them out of hospitals without consideration of their right to consent and without due regard to their care needs.

The formal definition of ALC is: "When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care [CCC], Mental Health or Rehabilitation) the patient must be designated as ALC."[27]

The discharge destinations for ALC patients include the following[28]:

- Home (with/without services/programs)
- Rehabilitation (facility/bed, internal or external)
- Complex Continuing Care (facility/bed, internal or external)
- Transitional Care Bed (internal or external)
- Long-Term Care Home
- Group Home
- Convalescent Care Bed
- Palliative Care Bed
- Retirement Home
- Shelter
- Supportive Housing

Rehabilitation, complex continuing care, transitional care, convalescent care and palliative care beds refer to care normally provided by public hospitals (despite the systematic dismantling, transfer and privatization of these services). As such, many patients designated as ALC are in fact waiting for another type of hospital care, equally legitimate as acute care, but resourced at a different level. Most others are waiting for long-term care. However, in the last 15 years, though the formal definition has remained the same, use of the ALC designation has been contorted to be treated as tantamount to meaning that the patient no longer requires hospital care and should be immediately discharged.[29]

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[27] Cancer Care Ontario, "Alternate Level of Care Reference Manual, Vol 2" (January 2017) at p 13.

[28] Cancer Care Ontario, "Alternate Level of Care Reference Manual, Vol 2" (January 2017) at p 13.

[29] See, for example:

Sabrina Jonas, "Ontario emergency rooms fill up again as COVID-19 fears ebb, patients with other illnesses return", *CBC News* (14 July 2020).

The continued push for more patients to be designated as ALC earlier in their hospital stays led to an increase in the number of patients designated as ALC. In the last 10-15 years, ALC has been described as the primary hospital "inefficiency" seized upon by policy makers in a bid to reduce hospitalization and hospital length of stay. Consequently, the Government instituted initiatives intended to reduce the numbers of so–called ALC patients, and "divert" them into community care. Since seniors account for 85% of ALC patients,[30] this has been, in effect, a plan to remove elderly patients from hospitals and to discharge them to long-term care homes, retirement homes, transitional care, other private sector settings or to their own homes, rather than allowing them to recover in hospital. Often, these premature discharges in effect do not allow elderly patients access to the health care system, giving up on their care and recovery.

The purpose of the "diversion" of ALC patients was to replace expensive forms of care (hospitals) with less expensive forms of care (home care, long-term care): to move patients to modes of care that have fewer staff, fewer services, and fewer medical resources instead of caring for them in parts of the health care system with more highly skilled staff, more services, and access to more medical resources. Since public hospitals are covered by the *Canada Health Act* and public health insurance, shrinking the scope of public hospitals effectively reduces the scope of public coverage, limiting the scope of public medicare, and primarily and disproportionately impacts the elderly.

In order to "solve" the ALC problem, hospitals and Local Health Integration Networks ("LHINs") have implemented a variety of "transitional care" programs to download patients from their roster. While this has been attempted to varying degrees over the years, only recently has it received official support from the Ontario government. These programs use retirement homes, supportive housing, and unlicensed care facilities as alternatives to the appropriate, publicly-funded health care that patients need and to which they are

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Elizabeth Payne, "Years of restraint straining Ontario's hospital system: report", *Ottawa Citizen* (20 December 2019).

Theresa Boyle, "Worst June on record for 'hallway medicine' at Ontario hospitals", *Toronto Star* (4 September 2019).

Mike Crawley, "Why Doug Ford's hospital funding will not end hallway healthcare", *CBC News* (6 October 2018).

Theresa Boyle, "Number of seniors waiting to move into long-term care homes in Ontario hits record high", *Toronto Star* (16 September 2019).

30 See, e.g. Canadian Institute for Health Information: Health Care in Canada, 2011: A Focus on Seniors and Aging, (Ottawa: CIHI, 2011) at 115 "On any given day, more than 5,200 acute care beds across Canada are occupied by ALC patients. Nearly 85% of ALC patients are age 65 or older; many (35%) are older than 85."

entitled. While these patients typically require high levels of care, usually long-term care and above, they are forced into these other types of care, which are neither resourced nor regulated in the same manner as hospitals or long-term care. For example, while long-term care homes must have at least one registered nurse on staff, none of these other facilities have that requirement, leaving residents without access to appropriate care. While patients and their families often attempt to resist transfer to these inappropriate care destinations, they are often led to believe that they have no choice but to accept, despite there being no requirement to do so.

Hospitals and LHINs use several strategies to require patients to move into these facilities. Patients and their families are not fully informed of the difference between retirement homes and long-term care homes, and are often told that they must go to a retirement home in order to apply to long-term care, as long-term care applications cannot be taken in hospital. This is untrue. They may be told that if they do not agree to go to these facilities, that they will be “discharged” on paper, and charged the “uninsured rate”, which can be thousands of dollars per day. Such pressure on patients and their families at these difficult times is overwhelming, and without proper information they often believe that they have no option but to accept transfer.[31]

In the more than two decades that these strategies have been in place, an unacceptable and disproportionate strain has been placed on seniors and their families. In the absence of sufficient hospital beds, elderly patients are mislabelled or prematurely labelled as ALC patients and pushed out of hospital before their medical condition warrants discharge or before they have had a chance to rehabilitate. And even in respect of those who could properly be termed ALC patients, the critical component of the “de-hospitalization” equation is still missing: there simply are not enough long-term care beds or home-care options available to serve the growing population of seniors for whom there are no longer hospital beds. The waitlists for long-term care and home care are wildly out-of-step with the idea that these services can compensate for shrinking hospital resources. At the same time, long-term care nurses, personal support workers and staff are dealing with increasingly complex patient care, as hospitals juggle shrinking resources and the steady growth of demand.

The end result is that seniors and their families are disproportionately paying the price for these practices and policies. They are suffering health set-backs requiring re-admission to hospital after being sent home prematurely when their medical condition requires continued hospitalization and where no adequate alternative care and accommodation is

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[31] Advocacy Centre for the Elderly, "Discharge from Hospital to Long-Term Care: Issues in Ontario" (February 2014).

available given their health condition. They are not receiving the care they need while they wait for a long-term care bed, and they are often not getting the amount or type of care their medical condition warrants once they are admitted to long-term care. They and their families are struggling to maintain their dignity as their choices – and their quality of life – diminish and their physical health deteriorates.

In the end, while it is undoubtedly the government's prerogative to design the health care system according to its priorities and its assessment of the best policies and approaches, it must do so in accordance with the legal principles enshrined in the Human Rights Code. We submit that the numerical data, the policies and the attitudes within the health care system establish systemic discrimination against the elderly. This was cast into sharp focus by the COVID-19 pandemic but is a problem of much longer standing and deeper roots. It demands further investigation by the Commission.

2. Background

The Strategy: De-Hospitalization, Alternative Level of Care, and Long-Term Care

(a) **De-hospitalization**: In the 1990s, the Ontario Health Services Restructuring Commission (HSRC) proposed, and the province executed, dramatic cuts to hospitals and hospital beds.[32] According to the Physician Hospital Care Committee, a tripartite committee of the Ontario Hospital Association, the Ontario Medical Association and the Ontario Ministry of Health and Long-Term Care, "[t]he number of acute care beds in Ontario fell by 22% as part of a hospital restructuring process during the mid to late 1990s."[33] By the end of its mandate in March 2000, the HSRC had issued final directions to 22 communities affecting 110 hospitals, amalgamated 45 hospitals into 13, and closed 29 hospital sites.[34]

The Province opened some new hospital beds in the early 2000s, but by 2006 acute and chronic bed closures had resumed and Ontario's hospital bed total sunk to a new low. From 1990-2014, Ontario closed 6,109 chronic (complex continuing care) hospital beds and 14,815 acute care hospital

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[32] Ontario Health Coalition, *No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care*, 21 July 2011, "Part 1: Failure to Plan"

[33] Physician Hospital Care Committee: Improving Access to Emergency Care: Addressing System Issues, (Ontario, 2006) at p. 44

[34] Lorraine Luski, "Hospital Restructuring in Ontario" (Toronto: Legislative Assembly of Ontario, Legislative Research Services, June 2000, updated October 2000)

beds. This represented a reduction in hospital capacity of 53% of chronic (complex continuing care) beds and 44% of acute care beds.[35]

Data from the Canadian Institute for Health Information, a Crown corporation that reports government health data, reveal that Ontario has only 2.2 hospital beds per 1,000 residents, the fewest in Canada. The average in the rest of the provinces is 3.2 per 1,000 residents, a very significant difference.[36] The OECD average number of hospital beds per 1,000 population among developed nations is 4.7 per 1,000 residents. Only two countries in the OECD – Chile and Mexico - have fewer beds *per capita* than Ontario.[37]

(b) Reliance on addressing hospital efficiencies to absorb effects of cuts: ALC, lengths of stay. The prevailing thinking is that hospitals and the health care system can compensate in part for these shrinking resources in part by using hospital resources more efficiently. The two primary means of increasing "efficiency" have been 1) reducing the length of stays in hospital; and 2) reducing ALC days.

Reduction of ALC utilization has been a high priority for health systems. Dealing with the consequences has not.[38]

As described in the previous section, an ALC patient is a person who occupies a health care bed and does not require the intensity of resources/services that come with that type of hospital bed. The definition of ALC was formalized in 2009 after being in practice for approximately a decade. Provincial policy has shifted from offloading hospital patients to long-term care and home care (1990s); to designating hospital patients as ALC (first decade of the 2000s); to pushing hospital administrators and physicians to designate more patients as ALC and to do so earlier in their length of stay (2006/7 on); and finally, to reducing the number of ALC days (approximately 2010-current).

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35 Ontario Health Coalition, "Hospital Beds Staffed and In Operation Ontario 1990-2014"

36 Ontario Health Coalition, "Hospital Beds per 1000 population by Province in 2017-2018"

37 Ontario Health Coalition, "OECD Hospital Beds per 100 population in 2017"

38 Jason M. Sutherland, PhD and R. Trafford Crump, PhD, "Exploring Alternative Level of Care (ALC) and the Role of Funding Policies: An Evolving Evidence Base for Canada", *Canadian Health Services Research Foundation*, September 2011, p. 2

In addition to reducing ALC days, reducing lengths of stay in hospital has also been an important strategy for managing shrinking hospital resources. Jane Meadus, counsel with the Advocacy Centre for the Elderly (ACE) has encountered many patients who have been instructed that the hospital only allows a certain number of days' stay for particular procedures. The result is that some individuals – disproportionately elderly – are pressured to leave hospitals before they are ready, and must seek out the services of ACE to help them navigate the system.

A 2010 report on "Senior Friendly Care in Hamilton Niagara Haldimand Brant LHIN Hospitals", created by the Regional Geriatric Program of Toronto of the Toronto Central LHIN, acknowledged:

> increasing costs of hospital care have created pressures to further reduce lengths of stay, increasing the tensions between hospital care and the needs of older patients, particularly those with more complex and chronic conditions.[39]

(c) **Reliance on Long-Term Care and Home Care**: A core strategy hospitals are using to reduce ALC days, and to reduce lengths of stay in hospital, is to move more people, more quickly, from hospital into long-term care and home-care irrespective of whether their medical condition permits it. As then-Health Minister Deb Matthews put it in 2013, even after Ontario had cut more hospital beds than anywhere else in Canada and internationally, "We are moving services from hospitals to communities."[40]

3. Applicable Legal Principles

We submit that this de-hospitalization strategy and its implementation have resulted in multiple, significant adverse effects on seniors in the province, in violation of the bar on discrimination in the provision of services in the Ontario Human Rights Code. Section 1 of the Ontario Human Rights Code provides:

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[39] Regional Geriatric Program of Toronto, "Background Document: Senior Friendly Care in Hamilton Niagara Haldimand Brant LHIN Hospitals" (9 July 2010), p. 7

[40] Richard J. Brennan, "Closing hospital beds not the answer to reforming health care, critics say", *Toronto Star* (26 February 2013)

> Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.[41]

(a) Definition of Service

An analysis of discrimination under this section begins with an analysis of what constitutes the "service".

The precise scope and definition of the "service" at issue was a central debate in *Moore v British Columbia (Education),* 2012 SCC 61 ("*Moore*"). The applicant in that case sought to define the service as "the provision of education", whereas the government argued in favour of "the provision of special education". Ultimately, Justice Abella of the Supreme Court of Canada reasoned:

> The answer, to me, is that the "service" is education generally. Defining the service only as "special education" would relieve the Province and District of their duty to ensure that no student is excluded from the benefit of the education system by virtue of their disability . . . If Jeffery [Moore] is compared only to other special needs students, full consideration cannot be given to whether he had genuine access to the education that all students in British Columbia are entitled to (paras 29-31).

Likewise, the Government of Ontario, and specifically, the Ministry of Health and Ministry of Long-Term Care, provide the funding and set the policy for the health care system in Ontario. The service in issue here is health care generally. To define the service more narrowly, for instance as the provision of hospital care, or the provision of long-term care or home care, would, in the words of Justice Abella "descend into the kind of 'separate but equal' approach which was majestically discarded in *Brown v. Board of Education of Topeka*, 347 US 483 (1954)" (*Moore*, para 30).

The scope of health care services for the purposes of this analysis can be defined with reference to the applicable provincial and federal legislation. Under the *Canada Health Act*, R.S.C., 1985, c. C-6, the primary objective of health care policy is defined in s. 3:

> It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of

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41 R.S.O. 1990, c. H.19, s. 1.

> Canada and to facilitate reasonable access to health services without financial or other barriers.

The governing principles are set out in s. 7:

> In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:
>
> (a) public administration;
> (b) comprehensiveness;
> (c) universality;
> (d) portability; and
> (e) accessibility.

Section 10 specifies what must be achieved in order to meet the requirement of universality:

> In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

Ontario has incorporated these principles into provincial law. The *Commitment to the Future of Medicare Act*, 2004, S.O. 2004, c. 5, for example, includes the following reference in the preamble:

> Confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility as provided in the Canada Health Act

(b) Prima Facie Case of Discrimination

In order to establish a *prima facie* case of discrimination in the provision of a service, a complainant must show that they have a characteristic protected from discrimination under the Code; that they experienced an adverse impact with respect to the service; and that the protected characteristic was a factor in the adverse impact (*Moore*, para 33).

In cases assessing systemic discrimination claims against the government in its provision of services, the Courts have adopted the following legal principles, of relevance to the case at hand:

- In *Moore*, Justice Abella wrote, ". . . if the evidence demonstrates that the government failed to deliver the mandate and objectives of public education such that a given student was denied meaningful access to the services based on a protected ground, this will justify a finding of *prima facie* discrimination" (para 36). [Emphasis added.]

- The BC Human Rights Tribunal in *Moore* (2005 BCHRT 580) ("*Moore*, BCHRT") recognized that it owed deference to the respondent District in delivering educational services. The District was motivated to close the Diagnostic Centre, on which Jeffery Moore and other severely disabled children like him relied, by financial constraints. At the same time, the Tribunal found that the District's failure to consider the consequences or plan for alternate accommodations together with Jeffery's need for intervention, and the fact that the Moores were told the services could not otherwise be provided by the District, constituted *prima facie* discrimination. The Supreme Court adopted this reasoning (*Moore*, para 46).

- Furthermore, the BC Human Rights Tribunal's in *Moore* found that the Government failed to adequately monitor the implementation of programs for Severely Learning Disabled students, to ensure adequacy of services and not just financial accountability. Moreover, the Government "knowingly under-funded the District . . . and refused to address this shortfall, even when it knew of the District's increasingly dire financial circumstances and that it was cutting specialized programs", based on a high-profile report detailing these problems. Both the Government's failure to properly monitor the services, and its under-funding of services for vulnerable students despite clear evidence of a problem, were critical components of the Tribunal's finding of a *prima facie* case of systemic discrimination (*Moore*, BCHRT, para 887).

- In *Eldridge v. Attorney General of British Columbia*, [1997] 3 S.C.R. 624 ("*Eldridge*"), the Supreme Court ruled: "This Court has consistently held . . . that discrimination can arise both from the adverse effects of rules of general application as well as from express distinctions flowing from the distribution of benefits" (paras 77-80).

- The Supreme Court went on in *Eldridge* to state that those who are responsible for the provision of services to the public must take positive steps to ensure

that disadvantaged persons benefit equally from those services. “The principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in the human rights field . . .”(paras 77-80).

- In *First Nations Child and Family Caring Society v. AG Canada (Minister of Indian Affairs and Northern Development Canada)* 2016 CHRT 2, (“*First Nations Child and Family Caring Society*”) the Canadian Human Rights Tribunal found that the funding formula used by First Nations Child and Family Services adversely impacted, and in some cases denied, adequate child welfare services to First Nations (para 383). In particular, the funding formula made assumptions based on population thresholds and children in care, assumptions which “ignore the real child welfare situation in many First Nations’ communities on reserve” (para 384). Funding levels were “not based on provincial/ territorial legislation or service standards”, but were instead “based on funding levels and formulas that can be inconsistent with the applicable legislation and standards” (para 388). The Tribunal found that the funding formulas “provide insufficient funding to many FNCFS [First Nations Child and Family Caring Society] Agencies to address the needs of their clientele” (para 389). This problem is exacerbated by a “lack of coordination between different programs . . . [a practice which] results in service gaps, delays or denials and, overall, adverse impacts on First Nations children and families on reserves” (para 391). The fact that the Government was aware of shortcomings in the funding formula, based on numerous reports, and had not followed the recommendations was further evidence of continued adverse impacts on the First Nations community (para 386).

- Together, these findings led to a ruling by the Tribunal that “First Nations people living on reserve and in the Yukon are *prima facie* adversely differentiated and/or denied services because of their race and/or national or ethnic origin in the provision of child and family services” (para 396). Perhaps most importantly, the Tribunal roundly rejected the government’s argument that the question of sufficiency of funding is beyond the scope of an investigation into discrimination under the *Canada Human Rights Code*. That question, in the Tribunal’s reasoning “addresses the issue of substantive equality” (para 398).

(c) Justification

The next phase of the analysis is the question of justification. The case law points to the need to have investigated alternative approaches (*British Columbia (Public Service*

Employee Relations Commission) v BCGSEU, [1999] 3 SCR 3 ("*Meiorin*", at para 65). The discriminatory conduct must be reasonably necessary to achieve a broader objective (*Moore*, SCC, para 49, citing *Ontario Human Rights Commission v Borough of Etobicoke*, [1982] 1 SCR 202, p. 208, and *Central Okanagan School District No. 23 v Renaud*, [1992] 2 SCR 970, at p. 984). In *Meiorin*, the Court described this as the employer or service provider showing "that it could not have done anything else reasonable or practical to avoid the negative impact on the individual".

4. Indicators and Aspects of Systemic Discrimination against Seniors in De-Hospitalization

Turning to the specifics of this case, in our analysis of systemic discrimination against seniors in the de-hospitalization policy, we have relied on the definition of systemic discrimination used by the Commission in its *Fact Sheet: Racism and Racial Discrimination: Systemic Discrimination*:

> Systemic discrimination can be described as patterns of behaviour, policies or practices that are part of the structures of an organization, and which create or perpetuate disadvantage (for racialized persons).
>
> The Commission is very concerned about systemic discrimination. Assessing and tackling systemic discrimination can be complex . . . [42]

In its *Policy and Guidelines on Racism and Racial Discrimination*, the Commission lists three considerations for use in "identifying and addressing systemic discrimination":

1. Numerical data;
2. Policies, practices and decision-making processes; and
3. Organizational culture.[43]

The *Policy* specifies:

> The OHRC expects organizations and institutions to use these three considerations as a basis for proactively monitoring for and, if found to exist, addressing systemic discrimination internally, i.e. with regard to human resources

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[42] Ontario Human Rights Commission, "Racism and racial discrimination: Systemic discrimination (fact sheet)".

[43] Ontario Human Rights Commission, "Policy and Guidelines on Racism and Racial Discrimination", June 2005.

and employment or externally, for example in their service delivery. In addition, if an application is filed with the Tribunal, the Commission's position is that these considerations should guide the Tribunal in its assessment of whether systemic discrimination exists within an organization or institution.

While the analysis of racial discrimination does not map precisely on to the analysis of age-based discrimination against seniors, we submit that the three indicators employed by the Commission in that analysis assist in structuring an analysis of systemic discrimination against seniors in the "de-hospitalization" policy.

Using the three indicators from the *Policy and Guidelines on Racism and Racial Discrimination*, and with reference to the case law cited above, we submit that the following analysis demonstrates the need for the Human Rights Commission to exercise its powers under s. 31 to initiate an investigation into systemic discrimination against the elderly in the provision of health services:

(a) **Numerical Data**: Statistics, on their own, establish the significant stresses that the health care system is under and which may lead to systemic victimization of the elderly in an attempt to cope with chronic shortages and underfunding. Taken together, and when combined with the policies and organizational culture, these statistics point to the existence of systemic discrimination.

(i) *High Hospital Bed Occupancy*: Ontario's hospital bed occupancy rate stands at 97.9%, the highest among industrialized countries.[44] This creates a tremendous pressure on hospitals to move people out of beds, and in particular, to move persons perceived to be ALC patients into inappropriate settings.

(ii) *Persons labelled ALC patients are mostly seniors*: In practice, targeting ALC patients for discharge from hospital amounts to targeting seniors for hospital removals. The majority of patients in ALC status are elderly, and indeed ALC patients "tend to be the most elderly in the population – age in excess of 80 years".[45] According to

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[44] Richard J. Brennan, "Closing hospital beds not the answer to reforming health care, critics say", *Toronto Star* (26 February 2013).

[45] Jason M. Sutherland, PhD and R. Trafford Crump, PhD, "Exploring Alternative Level of Care (ALC) and the Role of Funding Policies: An Evolving Evidence Base for Canada", Canadian Health Services Research Foundation, September 2011, p. 7; see also Canadian Association of Emergency Physicians (CAEP) Position Statement, "Emergency department overcrowding and access block", published in the CJEM, 2013; 15 (6), p. 363: "The majority of

the Ontario Hospital Association, “nearly 85% of all ALC patients are age 65 or older and many (35%) are age 85 and older.”

The experience of OCHU and the OHC has been that elderly patients too often are placed in an ALC category with little or no justification for this designation and based upon stereotypical views of the aged. Often, and as detailed more fully below, the patient’s age is itself a complicating factor which warrants a higher level of care than might otherwise be the case for the particular condition. As set out above, designating these patients as ALC and seeking to discharge them to increasingly inappropriate settings that are not subject to the standards and patient protections enshrined in both federal and provincial statutes erodes their rights and shrinks the scope of medicare.

(iii) *Inadequate numbers of long-term care beds*: The evidence is clear that Ontario has failed to plan to meet population need for long-term care and that rationing of access to care is planned. Currently, Ontario has the second fewest long-term care beds per capita among all provinces in Canada.[46] Despite repeated announcements of capacity expansion, in fact, the growth of long-term care beds has been just a trickle for more than 15 years, since the early 2000s. Prior to that, there was a substantial expansion of long-term care beds, with approximately 20,000 new beds added between 1998 and 2003. However, thousands of hospital beds were cut in that same period, long-term care wait lists already numbered approximately 20,000 in the late 1990s, and Ontario has experienced both population growth and a dramatic increase in the percentage of the population that is elderly.

In its 2012 report, the Auditor General noted that the number of long-term care beds in Ontario grew by only 3% over the seven years from 2004-05 to 2011-12. That means an annual average growth rate of 0.42% or 319 beds per year, which falls well short of population growth. But much more importantly, it falls far short of the growth of the relevant population – the elderly. As the Auditor General stated,

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patients in ALC status are elderly; with life expectancy increasing and the population aging this bottleneck will escalate if the problems are not addressed.”

46 Ontario Health Coalition, “Long Term Care Beds per 1000 Population”.

"[a]n increase in the number of LTC home beds of 3% during that period has not kept pace with the rising demand from an aging population."[47]

In the next period for which data is available, between 2011 and 2018, the number of long-term care beds in Ontario increased by only 0.8% while the population of Ontarians aged 75 and over grew by 20%, according to the Financial Accountability Office, an office of the Ontario Legislature.[48]

We can conclude, based on the evidence, that Ontario's health care capacity in long-term care has both fallen far behind hospital cuts and population demographic shifts; is based on a planned rationing of access to care; and is not in keeping with peer jurisdictions as our stock of long-term care beds per population has dropped to almost the bottom of the country.

(iv) *Waitlists:* As of March 2020, there were more than 38,000 Ontarians on the waitlist to access one of Ontario's approximately 78,000 beds in 630 long-term care homes.[49] According to Ministry of Health and Long-Term Care statistics, this is an increase of 18,700 Ontarians on the waitlist since May 2014.[50]

(v) *Wait times*: Ontario government data shows significant wait times for both long term care homes and home care, and these wait times have persisted at high levels for at least a decade.

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) [now AdvantAge Ontario] reported that in 2014 "[t]he overall average wait time to placement in a home is three

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47 Auditor General of Ontario, 2012 Annual Report, Ch. 3.08, p 200.

48 Financial Accountability Office of Ontario, "Long-Term Care Homes Program: A Review of the Plan to Create 15,000 New Long-Term Care Beds in Ontario" (Ontario: Queen's Printer, 2019), p 1.

49 Office of the Premier, News Release, "Ontario Launches Independent Long-Term Care COVID-19 Commission" (29 July 2020).

50 Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), "The Need is Now: Addressing Understaffing in Long Term Care", 2015 Provincial Budget Submission (December 2014).

months (89 days). Depending on priority, average wait time range from 64 days for crisis referrals (Priority 1) to 553 days for referrals to lower priority, ethno-cultural or religion-specific homes (Priority 3B)."[51]

In his 2012 report, the Auditor General reported that "the median wait times have almost tripled from 36 days in the 2004/05 fiscal year to 98 days in the 2011/12 fiscal year", and nearly one in six people on the wait list for long-term care has died while waiting.[52] As the Auditor General also noted, "Applicants in some areas of the province get into LTC homes more quickly than others. At one CCAC [Community Care Access Centre], 90% of clients were placed within 317 days, whereas at another, it took 1,100 days."[53]

From 2012/13 to 2018/19 (the most recent period for which data is available) median wait times increased again, from 133 to 147 days, according to government data.[54] Thus, the median wait time is five months, and half of the people on the wait list are waiting longer than that. In its most recent survey of long-term care wait times, conducted this summer, the Ontario Health Coalition found wait times that stretched to more than five years in some regions of the province.

While the wait time for the elderly looking for a bed in any Ontario long-term care home is lengthy, those requiring culturally specific homes often experience even longer wait times, putting additional stress on patients and their families. As an example, in February 2018 the median wait time for a bed in a long-term care facility in Ontario was 160 days; however, those waiting for a place in an ethno-culturally specific care home were faced with an average wait up to six months longer than the mainstream wait times. For some homes such as Mon Sheong Centre, Hellenic Home for the Aged and

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51 Ontario Association of Non-Profit Homes and Services for Seniors, OANHSS 2015 Provincial Budget Submission "The Need is Now: Addressing Understaffing in Long Term Care", 2015 Provincial Budget Submission (December 2014) p. 5.

52 Auditor General of Ontario, 2012 Annual Report, Ch. 3.08, p. 191.

53 Auditor General of Ontario, 2012 Annual Report, Ch. 1, p. 21.

54 Health Quality Ontario, "Wait Times for Long-Term Care Homes".

Yee Hong Centre for Geriatric Care, applicants may have waits upwards of 2,400 days. That calculates to a period greater than six years. The long-term care homes operated by Mon Sheong and Yee Hong together have over 4,000 residents on their wait lists.

(vi) *Inadequate care within long-term care homes*: In addition to shortages in the number of long-term care homes and the number of beds in long-term care homes, there is a formidable body of evidence showing long-term care homes have care levels that are inadequate to meet resident need, and severe staffing shortages that threaten the safety of residents and staff alike.

In fact, Ontario government data shows that as the complexity and heaviness of the care needs of the residents in long-term care homes have risen dramatically, the amounts of care provided have actually declined.

By all measures, levels of resident acuity have steadily risen and continue to escalate in Ontario's long-term care homes. Today, long-term care residents (really patients) are medically complex and frail – they require many medications, they have comorbidities, and they require complex nursing care. For example, residents today require peritoneal dialysis, wound treatments, palliative care, post-operative care, pain management, suctioning, and so on, all of which require complex nursing care. This care is being provided in environments that are neither physically designed for such care nor staffed with appropriate nursing staff and personal support staff in sufficient numbers to provide that care.[55]

Today, the Ontario government uses the Case Mix Index ("CMI") to assign a relative value of acuity to patients in long term care. Patients are classified into groups based on condition, complexity and needs. A relative value is then calculated to indicate the amount of resources that the resident needs.

The CMI replaced the previous resident assessment system – the Case Management Mix or "CMM" – in 2009, and no tool was developed to enable researchers to create a consistent data set

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[55] Ontario Health Coalition, *Situation Critical: Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care* (21 January 2019).

across these two systems. It is therefore challenging to fully assess rising acuity among long-term care residents. It is clear, however, that acuity levels have increased dramatically on either scale. Provincial government data shows that the CMM increased by 12.2% overall from 2004-2009 and the CMI increased by 7.63% from 2009-2016.[56] The data corroborates the accounts of those who work in long-term care, who report that rising acuity levels have created an impossible workload for front-line care staff.

The data also shows that acuity has increased at the point of admission, meaning that residents are entering long-term care with greater needs. The MAPLe score (Method for Assigning Priority Levels) is used by LHIN care coordinators to classify clients according to their level of care needs. Between 2010 and 2016, the proportion of new admissions to long-term care homes with high to very high MAPLe scores increased from 76% to 84%.[57]

The Continuing Care Reporting System (CCRS), which contains information on individuals who receive continuing care services in long-term care homes in Ontario, shows an increase in the number of long-term care residents with either "extensive" or "total" dependence on staff in order to perform activities of daily living such as bathing, dressing, toileting or eating. This data also shows a dramatic escalation of the percentage of residents whose care needs rate at the highest levels.[58]

The majority of residents in long-term care homes have a diagnosis of dementia. Dementia is associated with a decline in memory and other thinking skills. Government data reveals that 81% of individuals in long term care have some form of cognitive impairment with nearly

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[56] Statistics Canada, "Residential Care Facilities", Table 5.7 and LTC Home Level Master Sheet 2015-16, 2017-18, 2018-19 reporting from 2013-2016. Reported as fiscal year, SR Limited CMI

[57] Ontario Association of Non-Profit Homes and Services for Seniors, "Ensuring the Care is There" (January 2016).

[58] Canadian Institute for Health Information ("CIHI"), Continuing Care Reporting System Data 2012-2017 (Continuing Care Reporting System Metadata).

one-third displaying severe cognitive impairment.[59] The number of residents with dementia has been increasing at a steady rate of 1% per annum in recent years.

As many as 86% of individuals diagnosed with dementia will experience displays of aggression as the disease progresses.[60] Nearly half of residents in long-term care display aggressive behaviours,[61] and as the proportion of patients with dementia in long-term care continues to rise we can expect to see increased levels of aggressive behaviour. As psychogeriatric services in hospitals have been cut, more residents with psychogeriatric needs have been offloaded into long-term care where staffing levels are much lower and staff are not trained or equipped to manage psychogeriatric crises.

At the same time as the acuity of residents in long-term care has risen, real staffing levels, which determine the amount of care available for residents, have declined. In 2008, Ontario's long-term care staffing was an average of 2.84 worked hours per resident per day. The most recent government data showing worked hours of care shows that staffing by hands-on care staff (RNs, RPNs and PSWs) has dropped to 2.71 worked hours per resident per day, as shown in the graph below.[62]

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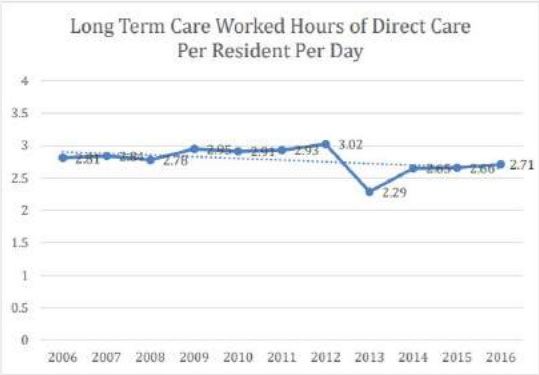
59 CIHI: Continuing Care Reporting System Data 2016-2017 (Continuing Care Reporting System Metadata).

60 Talerico, K, Evans, L, & Strumpf, N, 2002. "Mental Health Correlates of Aggression in Nursing Home Residents with Dementia", *The Gerontologist*, Volume 42, Issue 2, 1 April 2002, pp169–177.

61 CIHI: Continuing Care Reporting System Data 2016-2017 (Continuing Care Reporting System Metadata).

62 Ontario Health Coalition's calculation based on Ministry of Health and Long-Term Care Staffing Database: Ontario Long-Term Care Homes Staffing Data 2009-2016.



(vii) *Reliance on LTC for increasingly complex cases*: As hospital resources shrink and the health care system relies increasingly on LTC homes, LTC homes are housing increasingly complex cases; however, they are unable to adequately care for them. Policy has been developed to facilitate the offloading of ever more complex patients to long-term care but the resources have not been provided to ensure that they have adequate and safe care.

The average complex continuing care bed is funded by the Ontario Government at $450-500 per day.[63] Patients who require ever more care – who, in fact, have the same acuity as psychogeriatric and complex continuing care hospital patients -- are being shifted to long-term care homes that receive significantly less funding: an average of only $170.14 per day.[64]

(viii) *Inadequate long-term care and home care*: The institutions intended to receive the ALC patients are not sufficiently resourced to accommodate the health care system's increasing reliance on their services to handle individuals with complex and serious health care needs.

Consistent with the facts found in the Canadian Human Rights' Tribunal's ruling in *First Nations Child and Family Caring Society*,

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63 Rehabilitative Care Alliance, "Financial and Clinical Implications of Re-Classification" (22 January 2015).

64 Registered Nurses Association of Ontario, "Transforming long-term care to keep residents healthy and safe" (2018).

resourcing of long-term care and home-care is "not based on provincial/ territorial legislation or service standards" (para 388), and is insufficient "to address the needs of their clientele" (para 389). As was the case in *Moore*, the Government has been aware of these significant shortfalls, through multiple reports over decades. Using the language of the Supreme Court in *Moore*, the Government has failed to adequately "plan for alternate accommodations" for a vulnerable population – in this case seniors - after shrinking the available hospital resources. Taken together with the fact that seniors are the primary users of long-term care and home-care, these numbers suggest that the province has under-resourced both hospital and long-term care services which are primarily relied upon by a vulnerable, often marginalized sector of the population, on a ground prohibited under the Human Rights Code.

(ix) *High hospital re-admission rates*: Hospital re-admission rates are generally seen as an indicator of the appropriateness of care, and the appropriateness of hospital discharge policies (discussed further below). According to a study conducted by the Canadian Institute for Health Information (CIHI), the percentage of patients re-admitted to hospital has been rising steadily since 2009: 8.3, 8.6, 8.7, 8.9, 9.1.[65]

(b) **Policies, practices and decision-making processes**: In addition to these numerical indicators of disproportionate impacts on seniors flowing from the de-hospitalization strategy, there are various policies and practices which demonstrate the discriminatory impact of the province's approach.

(i) *Failure to accommodate the needs of seniors when restructuring the health care system*: When the de-hospitalization process began in the 1990s, the notion was that these changes would benefit both seniors and the sustainability of the health care system. The HSRC was clear, however, that reductions in hospital investments would need to be matched with significant investments in long-term care and community care. The HSRC repeatedly emphasized that restructuring and hospital cuts must be accompanied by substantial reinvestments in other sectors of the health system, like LTC homes. In the words of the Commission, "the HSRC recommended that reinvestment in new LTC beds be linked directly to changes in acute

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[65] Canadian Institute for Health Information (CIHI), "Trend over time: All patients readmitted to hospital (%age), 2013-14).

and complex continuing care hospitals."[66] Further, the Commission recommended that the Ministry "reconcile the appropriateness of its current planned reinvestments against the HSRC's recommendations and the experiences of stakeholder and provider groups who were directly impacted by the changes unfolding in hospitals across the province."[67]

When the government set about implementing the Commission's recommendations, however, the focus was on hospital cuts, and the investments in community care were woefully inadequate. In our submission, this is precisely the type of service cut *coupled with* a failure to adequately plan for the needs of a vulnerable population that is at the heart of the Supreme Court's finding of systemic discrimination in *Moore*. As the Supreme Court ruled in *Eldridge*, the government is under a positive duty to ensure that disadvantaged populations benefit equally from the provision of services, and in no case is that principle more important than cases in which services to vulnerable populations are being cut.

In its review of the implementation of its recommendations the HSRC harshly criticized the insufficient investments in long-term and home care, and flagged a number of key "implementation issues".[68] Among them:

(1) Complex Continuing Care: Lack of joint planning between the Ministry of Health and Long-Term Care, CCACs and affected chronic care hospitals to help re-balance services from chronic to long-term care facilities.

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66 Health Services Restructuring Commission, "Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission (1996-2000) A Legacy Report", March 2000, p. 65.

67 Health Services Restructuring Commission, "Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission (1996-2000) A Legacy Report", March 2000, p. 126.

68 Health Services Restructuring Commission, "Looking Back, Looking Forward: The Ontario Health Services Restructuring Commission (1996-2000) A Legacy Report", March 2000, p. 126.

(2) Long-term Care and Home Care reinvestments: Concerns about:

- Lack of investment of operating dollars in long-term care facilities to cope with increased acuity of residents;
- Delays in building of 'new' facility-based beds
- Lack of availability of home care. In particular, there are problems relating to quality, access, and the appropriate level of care and services required in each community to meet local needs.

Contrary to the recommendations of the Commission, the focus of the health care re-structuring was budget cuts, and not the needs of vulnerable, Code-protected populations – specifically the elderly – who rely on the services. Instead, the government re-structured the health care system without adequate regard to, and planning for, the needs of its most vulnerable users, namely seniors. As in the *First Nations Child and Family Caring Society* case, the Government has been repeatedly made aware of these shortfalls and of the impacts on seniors, but has not remedied the situation.

(ii) *Failure to assess the needs of seniors in the allocation of resources*: Successive restructuring processes have focused on achieving budget targets rather than understanding and meeting community need, and in particular the needs of seniors.

(iii) *Failure to track effects of new approach to senior care*: When the Government started out on the de-hospitalization track, it was warned by the HSRC, by independent health care advocates and by patient advocates, that hospital cuts would have significant impacts on patient care in the province, and specifically on the province's seniors. In fact, inefficiencies in the handling of senior's care in hospitals were a primary target for the transformation.

Still, the government put no measures in place to track, assess, or receive complaints about the effects of the new structure on seniors.

There has been no capacity study to guide planning for hospital beds in Ontario since the early 1990s, almost 30 years ago. Similarly,

there has been no Ministry study (at least none that has been publicly released) to guide the planning for long-term care bed capacity since the late 1990s. An FAO report released in October 2019 shows that planned LTC bed development falls far short of population need for decades to come, if policy does not change.[69] There is no publicly available tracking of the number of people who die waiting for long-term care year over year, though advocates hear of this situation fairly frequently.

Since the adoption of the designation of ALC, the Ontario Health Coalition, the Patient Ombudsman[70] and the Ontario Ombudsman[71] have reported that hospital discharges are among the most common reason for the complaints they receive from patients. Media reports commonly reveal coercive tactics being used to compel elderly patients to move out of hospitals to places where care is inadequate. Yet the province has not measured, assessed or mitigated the impact of its ALC policy on patients.

The Auditor General noted in his 2012 report that key health care outcomes from earlier discharges, such as re-admission to hospitals, are not measured.[72] Though this measure is now reported both by individual hospitals and by the province, there has been no policy change to address troubling readmission rates. There has been a systemic failure to monitor and assess the adequacy of services for a vulnerable and Code-protected group – the elderly.

As noted above, the BC Human Rights Tribunal in *Moore* made multiple adverse findings against the Government for its failure to monitor the implementation of adequate programming for Severely Learning Disabled students. The duty to monitor the adequacy of services and accommodations for vulnerable populations is in many ways the corollary to the duty, affirmed by the Supreme Court in

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69 Financial Accountability Office of Ontario, "Long-Term Care Homes Program: A Review of the Plan to Create 15,000 New Long-Term Care Beds in Ontario" (Ontario: Queen's Printer, 2019).

70 Patient Ombudsman, "Listening, Learning, Leading: Year Three Highlights".

71 Kelly Grant, "Bad hospital discharges among top complaints, Ontario watchdog finds", *The Globe and Mail* (11 May 2017).

72 Auditor General of Ontario, "2012 Annual Report, ch. 4.02".

Eldridge, of the Government to take positive steps to ensure the disadvantaged benefit equally from services.

(iv) *Impacts of Hospital Efforts at ALC reduction*: The Government has put in place a range of policies and incentives to encourage ALC reduction in hospitals.

In this context, most hospitals have their own ALC reduction goals, strategies and policies. While the policies are not, by and large, available to the public, hospital administrators often reference 'hospital policies' when enforcing these policies with patients deemed 'ALC'. It is our submission that many of these policies target seniors for differential treatment in ways that would be unfathomable for other Code protected groups, and are virtually unrelated to their actual needs and circumstances. Indeed, it appears to us that many of these policies – for example, the requirement that patients "choose" from a certain number of homes, or that bar patients from applying for long-term care in hospital at all – contravene either the *Long-Term Care Homes Act, 2007*,[73] or the *Health Care Consent Act, 1996*,[74] or both.

(1) Strongly encouraging seniors to leave hospital, despite concerns of patients, loved-ones:

The ACE reports that they receive frequent complaints from patients who are subject to pressure tactics to discharge them to inappropriate facilities, or simply send them home without adequate care. Many people approach their office because a hospital wished to discharge an elderly patient in a manner, or on a timeframe, which concerned them and caused them to fear for the welfare of the elderly patient. Further, the number of people approaching their office has risen significantly in recent years.

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73 S.O. 2007, c. 8.

74 S.O. 1996, c. 2, Sched. A.

The Ontario Health Coalition receives frequent complaints about people forced to be discharged from hospital when they are very frail, due to shortages of hospital beds.[75]

The Ontario Association of Speech Language Pathologists and Audiologists (OSLA), the Ontario Council of Hospital Unions (OCHU), and CUPE Ontario set up a 1-800 patient hotline, and monitored it for the period of a year.,. The report from the Hotline, "Pushed Out of Hospital, Abandoned at Home: After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients" chronicles the anecdotal experiences of hundreds of patients from over 30 Ontario communities.[76] The report is replete with stories of people who were themselves or had their loved ones pushed out of hospital earlier than they believed appropriate, and ended up with significant adverse health effects as a result. One particularly poignant vignette tells the story of a patient who had a hip replacement, and was sent home from hospital before adequate physiotherapy or instructions on how to handle the resulting limitations:

> "I was to be discharged at 10 am on Monday. At 9 am, two physiotherapists came. They rushed me through, how to use the bath and . . . Everything was a blur. The nurse in the background kept saying 'You have to be outta here by 10 o'clock." She was quite adamant; she said it more than once . . . I was out of there at the prescribed time, very foggy about what I was supposed to do. The very next day I ended up in emergency."[77]

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[75] Ontario Health Coalition, Release: "Hundreds of Millions in Home Care Funding Going to Profit, Duplicate Administration and 'Impossibly Complex and Bureaucratic' Home Care System: Auditor's CCAC Home Care Report", September 23, 2015.

[76] Ontario Association of Speech Language Pathologists and Audiologists (OSLA), the Ontario Council of Hospital Unions (OCHU), and CUPE Ontario "Pushed Out of Hospital, Abandoned at Home: After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients".

[77] Ontario Association of Speech Language Pathologists and Audiologists (OSLA), the Ontario Council of Hospital Unions (OCHU), and CUPE Ontario "Pushed Out of Hospital,

(2) Pressure on seniors to accept a long-term care bed that is not of their choosing:

Many ALC patients require a spot in a long-term care home, and the absence of space in an appropriate home can significantly stall their discharge from hospital. Because delays in hospital discharges can interfere with a hospital's efforts to reduce ALC numbers, patients are often subjected to coercive tactics to move them out of hospital to care facilities that are not of their choosing, sometimes far away from their home communities. The Ontario Health Coalition has received numerous complaints to that effect, and documented them in their report "No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care".[78]

The ACE reports that they are frequently approached by individuals who have been told by hospital administrators that if the individual refuses to comply with hospital policy, such as choosing a long-term care home that is not on a short list provided or refusing to take the first available bed, they will be charge a substantial *per diem* at uninsured rates ranging from $600 to many thousands of dollars.

(c) **Organizational Culture**: There are, without a doubt, scores of individuals, institutions and networks attempting to care for seniors with dignity and compassion. Still, at the highest levels, in policy-making and resource allocation, we submit that there is a pattern of approaching seniors as a drain on the system, and a burden to be managed.

This is most clearly seen in the discourse around "bed blocking". In the prevailing thinking, seniors are conceived of as "bed blockers", interrupting the efficient flow of patients through the system. This is typified by the comment of Dr. Chris Simpson, President of the Canadian Medical Association who remarked to a Toronto Star reporter: "Hospitals are congested because there are too many seniors occupying beds while

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Abandoned at Home: After Twenty Years of Budget Cuts, Ontario's Health System is Failing Patients", p. 9.

[78] Ontario Health Coalition, "No Vacancy: Hospital Overcrowding in Ontario, Impact on Patient Safety and Access to Care", Jul 21, 2011, Introduction.

waiting for long-term care or home care, both of which are in short supply."[79] He later warned: "Seniors currently eat up half of health-care costs. If nothing changes in the health system, they will account for 59% of health costs by 2031 because of their increasing numbers".[80]

This stereotypical and stigmatizing view is reflected in an article in *The Globe and Mail*, which reports, "Seniors are another problem: Sunnybrook has them stuck in more than five per cent of its beds while they wait for a spot in rehab, nursing homes or community hospitals. And Sunnybrook is not unique. There are more than 2,500 patients, known as bed-blockers, clogging up hospitals across Ontario."[81]

In recent months, a host of media reports have echoed similar sentiments, misunderstanding or having been misled about the actual meaning of the designation of ALC, and following the now routine characterization of patients occupying hospital beds as unduly using public resources.[82]

5. The Commission's Priorities and Policies: The inquiry requested here would advance key priorities in the Commission's *Litigation and Inquiry Strategy*.

The inquiry we are requesting is consistent with the Commission's statutory powers to "look into programs, policy and practices made under statute for consistency with the Code; and to "look into . . . conditions of tension or conflict in a . . . sector of the economy and to make recommendations, and encourage and co-ordinate plans, programs and activities to reduce or prevent such incidents or sources of tension or conflict"

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79 Richard J. Brennan, "Closing hospital beds not the answer to reforming health care, critics say", *Toronto Star* (26 February 2013), quote from Dr. Chris Simpson, CMA President.

80 Richard J. Brennan, "Closing hospital beds not the answer to reforming health care, critics say", *Toronto Star* (26 February 2013).

81 Sandra Martin, "The Hospital: How one hospital is dealing with Canada's aging population", *The Globe and Mail* (24 January 2014).

82 See: Laurie Fagan, "Blocked beds costing Ottawa hospitals millions", *CBC News* (9 December 2019).

Gary Chalk, "Seeking to move hospital care out of the hallways", *The Brantford Expositor* (5 February 2020).

Mike Crawley, "Some of Ontario's biggest hospitals are filled beyond capacity nearly every day, new data reveals", *CBC News* (22 January 2020).

In its *Litigation and Inquiry Strategy*, the Commission identifies the issues it considers when deciding whether to get involved in any particular case or inquiry. The issues of relevance to the inquiry requested here include:

1. Broad, systemic impact;

2. Significant issues of public policy;

3. Benefit vulnerable or marginalized people protected by the Code;

4. Shape, clarify or advance human rights law in Ontario; and,

5. Commission involvement is required because of the complexity of issue.

We submit that the human rights obligations of government with respect to health care remain under-analyzed. An inquiry into the human rights impacts of de-hospitalization and inadequate alternative care would infuse health care debates, currently focused on efficiency and cost-saving, with a human rights perspective. This, in turn, could influence funding decisions at the highest levels; focus attention on respect for dignity when individuals are moved from one form of care to another; and lead to recognition of the need for significant new investments in hospital, long-term care and home care. All of this would be of tremendous benefit to the province's growing population of the elderly, which is highly vulnerable and often neglected.

Perhaps most importantly, this is the type of discrimination that is almost certain to go un- or under-reported: the population is vulnerable, and often isolated. The fact of being shifted home, or into long-term care, exacerbates both conditions. Furthermore, they continue to rely on the public health system, and are often fearful of complaining. And the people caring for them are struggling to keep their heads above water, not often poised to litigate. Hardly anyone who is being treated in the system has a large enough perspective on the workings of the health care system to know how to challenge it. The Advocacy Centre for the Elderly reports that this type of consideration has been a concern for their organization for years, but they are so busy fielding the unmanageable number of complaints, and helping individuals navigate the system, that they simply do not have the resources to put towards this type of systemic complaint on their own. The Commission's involvement would be particularly important because the issues are so complex, and the evidence so far-reaching as to be nearly impossible for an individual claimant, or group of claimants, to raise.

6. The Time is Right

As you know, the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System recently released its final report, which sheds considerable light on the shortcomings of the existing long-term and home care systems and the pressing need for reform. The report issued by the Canadian military in May 2020, after it was called in to assist with the COVID-19 crisis, is a further indictment of policies and practices at a number of long-term care homes across the province. Other reviews will no doubt identify additional challenges and areas for improvement and reform.

While we agree that changes to the long-term and home care systems are urgently required, it is equally essential to critically examine the forces that drive vulnerable patients out of hospital and into those systems.

Despite the stated commitment of the current provincial government to end hallway medicine, the problem has only deepened. Ontario Hospital Association data show that June of 2019 was the worst month on record for hospital overcrowding since the province began collecting data in 2008. The average wait time to be admitted to a hospital from an ER was 16.3 hours, while at the same time the number of ALC patients in that month was more than 4,500 – an increase of 450 compared to June 2018.[83] Even before the current crisis emerged and COVID placed increasing demands on all aspects of the healthcare systems, hospitals were struggling to operate at or beyond 100% capacity.

The pressure to de-hospitalize ALC patients – mostly seniors – is intensifying. At the same time, the number of seniors waiting for LTC beds has climbed to a record high of 36,245 in July 2019 – an increase of 2,460 from the previous year.[84] And while the government pledged to increase the number of LTC beds by 30,000 over 10 years, progress has been effectively stalled: the number of long-stay beds grew by only 0.2% between July 2018 and July 2019, and is projected to grow by only 0.1% (a total increase of a mere 77 beds) by July 2021.[85]

7. The Path Forward

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83 Theresa Boyle, "Number of seniors waiting to move into long term care homes in Ontario hits record high", *Toronto Star* (16 September 2019).

84 Theresa Boyle, "Number of seniors waiting to move into long term care homes in Ontario hits record high", *Toronto Star* (16 September 2019).

85 Theresa Boyle, "Number of seniors waiting to move into long term care homes in Ontario hits record high", *Toronto Star* (16 September 2019).

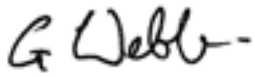
We believe an investigation into this situation, pursuant to your powers under s. 31 of the *Code*, is warranted.

In addition to the information we have provided here, we would welcome the opportunity to provide more complete submissions, should your office decide to investigate further.

Sincerely,

Michael Hurley
President
Ontario Council of Hospital Unions-CUPE

Natalie Mehra
Executive Director
Ontario Health Coalition



Graham Webb
Executive Director
Advocacy Centre for the Elderly

Ontario Human Rights Commission

Office of the Chief Commissioner

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Toronto ON M7A 2G5

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Commission Ontarienne des Droits de la Personne

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Ontario

April 13, 2021

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Dear Mr. Hurley, Ms. Mehra and Mr. Webb:

RE: Request that the OHRC conduct an inquiry on systemic discrimination against the elderly in the provision of health care in Ontario

I am writing to response to your March 16, 2021, letter requesting that the Ontario Human Rights Commission (OHRC) undertake a section 31 public interest inquiry into systemic discrimination against the elderly in the provision of healthcare in Ontario.

The information in your letter about the history and consequences of de-hospitalization and the rationing of long-term care resources raises important human rights concerns about the adverse effects experienced by older persons in their interactions with the healthcare system, especially during the current COVID-19 pandemic. As you noted,

the OHRC has previously reported on some of these same issues and the particular vulnerability of and barriers faced by older persons in the healthcare context, for example in our *Policy on discrimination against older people because of age*.

The OHRC will not be undertaking a section 31 public interest inquiry into this matter.

However, we recognize that there are significant and pressing concerns about systemic discrimination linked to healthcare, the operation of long-term care facilities and the availability of viable community alternatives to institutionalization. The OHRC is currently monitoring human rights issues in these areas.

As part of this work, the OHRC has written to the Long-Term Care COVID-19 Commission (LTC Commission) and is tracking its progress. As you know, the LTC Commission was launched to conduct an independent investigation in response to the disproportionate effects that COVID-19 has had on long-term care residents and staff.

The OHRC's August 2020 letter to the LTC Commission Chair highlighted the experience of older persons in the healthcare system, as well as the intersectional factors that bear on this issue. In that letter, the OHRC encouraged the LTC Commission to place human rights principles at the centre of its review, stressed that the residents in Ontario's long-term care facilities are particularly vulnerable to discrimination, including because of age, and urged the LTC Commission to consider the various human rights characteristics, discriminatory conditions and systemic structural forces that may underlie the issues within its mandate. We also emphasized the need to recognize how long-term care staff, especially personal support workers (PSWs) who are disproportionately racialized and/or newcomer women, experience intersectional discrimination and face compounding challenges and barriers to employment – issues which are now also the subject of a Human Rights Tribunal of Ontario application.

If you have not already done so, we urge you to provide the information in your letter to the LTC Commission to inform its final report and recommendations. Many of the issues you raise align with aspects of the LTC Commission's mandate, which includes making findings and recommendations on the pre-COVID-19 state of the long-term care system and its relationship to other aspects of the health care system. Indeed, several of the LTC Commission's interim recommendations highlight the need for better coordination between hospitals and long-term care facilities.

The OHRC has also identified discrimination against older persons as a key area of concern in our work relating to the COVID-19 pandemic. At the outset of the pandemic, the OHRC released a policy statement to guide all levels of government to adopt a human rights-based approach to managing policy, legal, regulatory, public health and emergency responses to COVID-19. Since then, the OHRC has been working to ensure that any COVID-19-related triage protocol is implemented in a way that does not discriminate against vulnerable groups, including older persons.

The OHRC appreciates the detailed and comprehensive information you provided about the history and context of Ontario's health system structuring, current practices and policies, and the effects of this system on older persons. The OHRC also acknowledges the many first-hand accounts we have received from individuals, including family members of older persons in care, nurses and personal support workers. This information and the personal narratives will be an invaluable resource for the OHRC as we continue our work in these areas.

Sincerely,

Ena Chadha, LL.B., LL.M.
Chief Commissioner

cc: Hon. Associate Chief Justice Frank N. Marrocco, Chair of the Independent Long-Term Care COVID-19 Commission
Hon. Christine Elliott, Minister of Health
Hon. Merrilee Fullerton, Minister of Long-Term Care
Hon. Doug Downey, Attorney General
OHRC Commissioners

Simran Prihar
Direct Line: 416.979.4050
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sprihar@goldblattpartners.com
Our File No. 15-49

May 21, 2021

Via E-mail (cco@ohrc.on.ca)

Ena Chadha
Chief Commissioner
Ontario Human Rights Commission
180 Dundas Street West, Suite 900
Toronto ON M7A 2G5

Dear Chief Commissioner Chadha:

Re: Request for Public Inquiry Under s. 31 of the Human Rights Code

We act for the Ontario Council of Hospital Unions (OCHU)/CUPE. We are in receipt of the attached letter dated May 6, 2021 from the Long-Term Care COVID-19 Commission, and see that you were copied. In light of this letter, we are writing to ask that you reconsider your decision not to undertake a section 31 inquiry into age discrimination in the provision of health care in Ontario.

What we are requesting is fundamentally a matter of human rights and is not restricted to the pandemic. As you noted in your April 13, 2021 letter, the information outlined in our March 16, 2021 letter to you raises important human rights concerns about the adverse treatment of the elderly in their interactions with the healthcare system. As we outlined there, this adverse treatment very much predates the COVID-19 pandemic, although the pandemic has served to highlight the worst infractions of human rights in the system.

As counsel for the Long-Term Care COVID-19 Commission notes, that Commission had a limited mandate and although they considered human rights issues as you had urged them to, it was for a much more limited purpose than that which we request in our letter. While we agree that some of the issues we outlined raise concerns relevant to the COVID-19 pandemic, what our letter shows is sustained systemic discrimination on the basis of age. This falls squarely within your mandate as the Chief Commissioner of the Human Rights Commission.

For these reasons, we ask that you reconsider your position, and undertake to open a section 31 inquiry as soon as is practicable into the serious issues raised in our March 16th letter.

Sincerely,

Simran Prihar
SP:ap/cope 343
Encl.

c.c. Michael Hurley, President, OCHU-CUPE
Natalie Mehra, Executive Director, Ontario Health Coalition
Graham Webb, Executive Director, Advocacy Centre for the Elderly

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Ontario's Long-Term Care COVID-19 Commission

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

Commission ontarienne d'enquête sur la COVID-19 dans les foyers de soins de longue durée

L'honorable Frank N. Marrocco, président
Angela Coke, commissaire
Dr Jack Kitts, commissaire

May 6th, 2021

VIA EMAIL TO: SPRIHAR@GOLDBLATTPARTNERS.COM

Simran Prihar
Goldblatt Partners
20 Dundas Street W., Suite 1039
Toronto ON M5G 2C2

Dear Ms. Prihar:

Re: COVID Long-Term Care Commission

Thank you for your correspondence of April 14, 2021, and that of the Ontario Human Rights Commission (OHRC) of April 13, 2021.

As you are aware, the COVID Long-Term Care Commission (Commission) was created to examine the causes of the spread of covid in long-term care homes and provide recommendations. The Commission delivered its report to the Minister of Long-Term Care on April 30, 2021, as required by the Terms of Reference. As a result, our Commission is now completed.

We received your correspondence and the OHRC well after the Commission had completed its investigative work. While the Commission considered some of the issues raised in your clients' complaints, they were considered for the limited purpose of the Commission and not to determine if there were breaches of the Ontario Human Rights Code.

As you noted in your correspondence to OHRC, our Commission does not have the specific mandate of the OHRC.

Our Commission heard from those including your clients regarding some of the issues in your complaint to the OHRC. However, our report was not intended to be and is not a substitute for any rights your clients might have under the Ontario Human Rights Code.

Yours very truly,

John E. Callaghan
JEC:mg

cc: Ena Chadha, LL.B., LL.M.
Chief Commissioner (via email to: cco@ohrc.on.ca

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This is **Exhibit "H"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely. .

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Ontario Health Coalition
Protecting public healthcare for all.
15 Gervais Drive, Suite 201, Toronto, Ontario M3C 1Y8 Tel: 416-441-2502 ohc@sympatico.ca
www.ontariohealthcoalition.ca

Hospital Overload: Backgrounder on Ontario's Hospital Bed Shortage

Warnings about hospital overcrowding have been repeatedly provided to Ontario's government. The following backgrounder contains recent reports and warnings about the problem from Ontario's Auditor General, Health Quality Ontario, and the Canadian Association of Emergency Physicians. It also contains data from the Canadian Institute for Health Information comparing hospital bed capacity across Canada and the OECD, comparative hospital nurse staffing levels and public hospital funding. The evidence is irrefutable. Ontario has cut more hospital beds and staff than any virtually all peer jurisdictions. Ontario has dropped to the bottom of the country in public hospital funding. The resulting hospital bed shortage and serious overcrowding situation compromises patient and staff safety. Ontario's government must urgently reopen hospital beds and restore capacity to safe levels.

The Coalition called on the Ontario government to take responsibility for planning for hospital services in our province, as is required under the Canada Health Act, including:

- Recognize that the emergency department crisis reported by hospital executives is a symptom of a systemic shortage of hospital beds that must be urgently rectified.
- Fund public hospitals to meet evidence-based measures of population need and ensuring that the funding goes to care.
- Reduce Ontario's hospital overcrowding to meet the 85% occupancy benchmark that is the internationally-accepted indicator for the safe level of crowding.
- Commit to ensuring that no patient will be left on a stretcher in a hallway or public area overnight or for days waiting for a hospital bed.

Myth-buster:

- A number of hospitals have created secondary waiting areas so that they can report that patients are moved out of emergency departments within target wait times. But patients are simply moved to areas with different names to continue waiting. Ontario's government must take steps to ensure that reporting is honest and captures the true extent of the problem.

- Government and hospital spokespeople routinely mischaracterize Alternate Level of Care (ALC) patients as the cause of hospital backlogs. In fact, according to the Ontario Hospital Association's June 30, 2016 update, approx. 2,700 of ALC patients are in acute care beds. Of these patients, one-third are waiting to be transferred to another type of hospital bed (palliative, complex continuing care, convalescent care, mental health, rehabilitation); one-third are waiting for a long-term care bed; ten percent are unknown; and the rest are waiting to be discharged to various types of home or community care. To characterize ALC patients as though they are inappropriately in hospital is erroneous. This information is being mischaracterized to cover up the shortage of hospital beds. (The OHA's ALC survey results for June 30, 2016 are here: https://www.oha.com/CurrentIssues/Issues/HSFR/Documents/ALC%20Update%20June%202016.pdf)

- Misuse of emergency departments by patients is not the cause of hospital overcrowding. People who are frightened and sick should be able to go to their local hospital for help. Patients lying on stretchers waiting for admission to hospital beds are, without question, acutely ill and are not malingering. Patients that are not acutely ill are not admitted to hospitals. (See myth buster from the Canadian Institute for Health Research: http://www.cfhi-fcass.ca/sf-docs/default-source/mythbusters/Myth-Emergency-Rm-Overcrowding-EN.pdf?sfvrsn=0)

Findings of Ontario's Auditor General

Ontario's Auditor General describes the situation in Ontario's large community hospitals in her most recent report, released on November 30. Her findings support the evidence that the Ontario Health Coalition has brought to the government repeatedly in recent years. Among the Auditor General's findings:

(Page references for the 2016 Ontario Auditor General's Report are included here.)

- The audit team describes a state of severe overcrowding in the hospitals they visited. Patients are waiting on stretchers or gurneys in hallways and other public areas, sometimes for days (page 446).
- Bed occupancy rates of greater than 85 per cent are unsafe and contribute to infections (beds are too crowded and turn over is too fast). During 2015, 60 per cent of all medicine wards in Ontario's large community hospitals have occupancy rates of greater than 85 per cent (page 431).
- The Canadian Institute for Health Information reports that Ontario hospital patients have the 2nd highest rate of potentially fatal sepsis infections in Canada (page 431).

The Auditor General describes the consequences of chronic underfunding and the failure to plan to meet population need for care:

- 1 in 10 patients requiring admission to hospital are waiting too long in emergency departments. The provincial government's target is 8 hours from triage (90 per cent of patients are supposed to be transferred to a bed withing 8 hours). But in the hospitals the audit team visited it took 23 hours for 90 per cent of the patients to be transferred to the ICU and 37 hours for transfers to other acute care wards (page 429).
- The audit team described a situation across Ontario's large community hospitals in which there are frequent and planned operating room closures. 45 per cent of large hospitals have one or more O/R closed due to funding constraints (page 450).
- There has been no improvement in wait lists for elective surgeries for the 5 years leading into this audit (pages 430-431).
- 58 per cent of hospitals ran out of money for some types of surgeries and had to defer them to the next fiscal year (page 444).
- Patients with traumatic brain injury and acute appendicitis are waiting 20 hours or more for emergency surgery (page 430).
- Wait time targets are not being met for the following types of surgeries: neurosurgery, oral and dental, thoracic, vascular, orthopedic, gynecologic, ophthalmic, cancer (page 451).

Warning from the Ontario Health Quality Council

Even Health Quality Ontario, though it studiously continues to refuse to mention Ontario's shortage of hospital beds, regardless of the evidence, included a warning about how close the system is to critical in its November 2016 report on emergency departments:

> "Patients are already lying in hallways and being seen by doctors in waiting rooms. Under current conditions, the ability of Ontario's emergency departments to care properly for patients could be seriously compromised by an occurrence as predictable as a bad flu season or as unpredictable as a SARS outbreak or a major weather event." page 3.

Position Paper from the Canadian Association of Emergency Physicians

The Canadian Association of Emergency Physicians has repeatedly warned about dangerous levels of emergency department overcrowding. Among the key causes they cite is the Canada-wide shortage of hospital beds, a situation that is more severe in Ontario than other provinces. Here is a description of the situation from their position paper on emergency department overcrowding:

> "With the shortage of hospital beds and recurring issues with acute care capacity, hospitals increasingly face a situation where more patients require admission than there are beds to accommodate them. The current approach to dealing with Access Block due to hospital crowding

involves delaying the outflow of admitted patients into appropriate inpatient areas; resulting in an excessive and unsafe use of EDs to inappropriately ‘‘warehouse’’ admitted patients, both stable and unstable, for long periods of time. This ‘‘boarding’’ of admitted patients within the ED results in EDOC and thus creates delays in seeing new patients presenting to the ED. Surveys have shown that patients attempt multiple other options prior to accessing the ED. Moreover, patients of lower acuity and urgency do not occupy acute care stretchers, require little nursing care, and typically have brief treatment times. The myth of ‘‘inappropriate use’’ should be permanently dispelled, and administrators and politicians should be encouraged to avoid attributing EDOC to ambulatory patient ED health services access…. The lack of acute care beds in Canada means that most hospitals frequently operate at unsustainable occupancy rates of higher than 95%, a level at which regular bed shortages, periodic bed crises, and hospital overcrowding are inevitable. Functioning at capacities above 95% occupancy does not allow for flexibility in the system to accommodate the natural peaks in patient volumes and admissions that will periodically occur.”
Affleck et al., CMAJ 2013, Pages 362-363.

By the Numbers: Comparative Data Shows Ontario Ranks at the Bottom in Key Indicators of Hospital Care Levels

The evidence is indisputable that Ontario’s government has cut hospital care to the lowest levels of all provinces in Canada. As illustrated in Chart 1, Ontario has the fewest hospital beds left per capita of any province, and that number is declining. In 2008-09, Ontario had 2.5 hospital beds per 1000 population, according to Canadian Institute for Health Information (CIHI) data. Today that number has dropped to 2.3 hospital beds per 1000 population. The other provinces average 3.5 hospital beds per 1000 people. The difference of 1.2 beds per 1,000 population is vast. On an aggregate per capita basis Ontario now has 16,440 less hospital beds than the average. In fact, Ontario’s government has cut more than 18,000 hospital beds since 1990 and still the cuts are continuing.

Chart 1.

Hospital Beds Per 1000 (population) By Province 2013-14	
Newfoundland & Labrador	4.6
New Brunswick	3.8
Saskatchewan	3.6
Nova Scotia	3.4
Manitoba	3.3
PEI	3.3
British Columbia	3
Alberta	2.8
Ontario	2.3
Average other provinces	3.5

Ontario Health Coalition calculations from: Canadian Institute for Health Information, *Data Table: Hospital Beds Staffed and in Operation 2013-14*. Population statistics from Canadian Institute for Health Information, *National Health Expenditures Database 2015*.

Not only has Ontario cut more hospital beds than any other province in Canada, we also now rank at the bottom of international data on hospital beds per population. Compared to 33 countries of the OECD, Ontario is third last in hospital beds per capita, followed only by Mexico and Turkey.

Chart 2.

OECD Hospital Beds Per 1000 Population 2013	
Japan	13.3
Korea	11.0
Germany	8.3
Austria	7.7
Hungary	7.0
Poland	6.6
Czech Republic	6.5
France	6.3
Belgium	6.3
Slovak Republic	5.8
Luxembourg	5.1
Estonia	5.0
Finland	4.9
Greece	4.8
Switzerland	4.7
Slovenia	4.6
Norway	3.9
Australia	3.8
Italy	3.4
Portugal	3.4
Iceland	3.2
Israel	3.1
Denmark	3.1
Spain	3.0
United States	2.9
Ireland	2.8
New Zealand	2.8
United Kingdom	2.8
Canada	2.7
Turkey	2.7
Sweden	2.6
Ontario	2.3
Chile	2.2
Mexico	1.6
OECD Average	4.8

Source: OECD, *Health Statistics 2015* at http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC

As hospital beds continue to be cut and closed down, nurses, health professionals and support staff have also been cut dramatically. Ontario has dropped to the bottom of the country in nurse to patient ratios. Data from the Canadian Institute for Health Information shows that Ontario now has the least hours of nursing care per hospital patient. Yet nurse staffing levels continue to be cut.

Chart 3.

	Nursing Inpatient Services Total Worked Hours per Weighted Case				
	2007-2008	**2008-2009**	**2009-2010**	**2010-2011**	**2011-2012**
NFLD	52.2	53.26	54.48	55.9	52.9
PEI	83.48	N/R	62.19	62.46	61.66
N. S.	56.79	57.34	U	U	54.95
N.B.	54.98	55.46	56.26	57.29	58.13
Quebec	49.73	50.06	50.82	50.73	52.47
Ontario	**44.98**	**44.76**	**43.71**	**42.81**	**42.88**
Manitoba	54.41	54.27	53.87	53.06	53.97
Saskatchewan	49.37	51.42	51.28	52.95	54.18
Alberta	54.12	54.65	54.52	54.24	54.36
B.C.	44.24	45.27	45.03	45.87	46.27
NWT	U	83.05	88.51	69.48	N/R
Yukon	48.84	48.97	50.25	56.31	54.51
Weighted Average	**48.59**	**48.8**	**48.36**	**48.2**	**48.98**

Source: Canadian Institute for Health Information, 2013.

Across Canada, patients receive 14.2 per cent more nursing care than do patients in Ontario's hospitals. Chart 3 illustrates the growing gap between Ontario and the rest of Canada in nursing hours per patient (ie. per weighted case). In 2007 – 08 Ontario's nurse staffing hours were 3.61 hours below the average of Canada per weighted case. By 2011-12, Ontario's nurse staffing hours were 6.1 hours below the average of the country. That is a 69 per cent increase in the differential in just four years. As the hospital cuts have continued and escalated since 2011-12, we can expect that gap to be even wider when more recent data becomes available.

Nine Years of Real-Dollar Cuts Mean Ontario Has Dropped to the Bottom of the Country in Hospital Funding

The above data gives a statistical overview of some key indicators of hospital service levels in Ontario compared to other jurisdictions in Canada and internationally. The following section measures hospital funding compared to other provinces in Canada. As noted above, Ontario's government has set global hospital operating funding increases below the rate of inflation for 9 consecutive years – the longest period of hospital cuts in our province's history. Until this year, hospital global funding had been frozen for four years in a row. Today, by all measures, Ontario has dropped far below the other provinces in hospital funding.

Measured on a per capita basis, the most recent data from the Canadian Institute for Health Information National Health Expenditures Database shows that Ontario ranks second-last in hospital funding. For the last few years, Ontario and Quebec have traded places for lowest ranking in the country. We are significantly below the national average. In fact, Ontario's government funds our public hospitals $501 less per person than the average of the other provinces.

Chart 4.

Public Hospital Funding Per Person, 2015 Current $	
Newfoundland & Labrador	$2,406
Alberta	$2,245
Prince Edward Island	$1,995
New Brunswick	$1,971
Nova Scotia	$1,907
Manitoba	$1,818
British Columbia	$1,797
Saskatchewan	$1,761
Ontario	$1,419
Quebec	$1,382
Average of the other provinces	$1,920
Difference between Ontario and the average of the other provinces	Ontario funds hospitals at $501 per person less

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2015*

Hospital spending per person is a clear comparison of how many resources our government is allocating to these services. To measure economic sustainability or affordability, GDP (which measures economic output) is used as the comparator. As measured as a percentage of provincial GDP, the results are the same. Ontario is second last in Canada, followed only by Saskatchewan which saw significant GDP growth in recent years. This measure shows that Ontario has room to improve hospital funding while keeping funding at sustainable levels, as long as funding goes to improving services.

Chart 5.

Public Hospital Funding as % of Provincial GDP 2015	
PEI	4.73 %
New Brunswick	4.45 %
Nova Scotia	4.31 %
Newfoundland & Labrador	3.82 %
Manitoba	3.59 %
British Columbia	3.35 %
Quebec	2.97 %
Alberta	2.67 %
Ontario	2.64 %
Saskatchewan	2.38 %
Average of the other provinces	3.59 %

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2015*

Sustainability can also be measured in terms of expenditure as a proportion of the provincial budget. In Ontario, hospital funding as a share of the provincial budget has been declining for decades. The most recent data show that we are third last among Canadian provinces for hospital spending as a proportion of total program spending. Again, the data show that we are considerably lower than the average of the other provinces and there is room to improve hospital funding to stop the cuts and restore service levels to meet population need.

Chart 6.

Public Hospital Funding as % of All Provincial Program Funding 2014	
Nova Scotia	20.72 %
British Columbia	19.44 %
New Brunswick	18.95 %
Alberta	18.91 %
Newfoundland & Labrador	18.61 %
Manitoba	17.94 %
PEI	17.56 %
Ontario	15.34 %
Saskatchewan	14.73 %
Quebec	11.16 %
Average of other provinces	17.56 %

Source: Ontario Health Coalition calculations from CIHI, *National Health Expenditures Database 2015*

Hospital Overcrowding, Cuts and Early Discharges: Impact on Patients

Ontario has not conducted a hospital bed study to measure population need and assess how many hospital beds should be planned for more than twenty years. To the extent that data is being used in planning at all, the numbers that are being used are two decades out of date. Instead of using an evidence-based planning approach, Ontario's health policy has centred on constraining hospital budgets, cutting services and reducing patient length of stay. As a result, Ontario is suffering from a shortage of hospital beds and services that is negatively affecting patients' access to care and safety.

Ontario's hospital occupancy levels are extraordinarily high. According to Ministry of Health data, by 2010 there were, on average, 30,164 inpatients[1] in Ontario's 30,810 hospital beds.[2] The provincial hospital bed occupancy rate is 97.8%, much higher than other jurisdictions. By comparison, the OECD reports an average occupancy rate for acute care beds of 75%.[3] In the United States, the average hospital occupancy rate is 68.2%.[4] Most often cited in the academic literature, a target hospital occupancy rate to reduce access blockages and improve outcomes is 85%. The consequences of hospital overcrowding warrant public attention. Within hospitals, overcrowding is associated with serious quality of care issues. Overcrowded emergency departments do not have appropriate staffing ratios for critical care or intensive care patients who require intensive monitoring by specially trained staff. Across Europe, hospital occupancy rates have been cited as a determining factor in hospital-acquired infections (HAIs), and indeed Ontario has experienced repeated waves of Hospital Acquired Infection outbreaks. Cancelled surgeries and prolonged waits are associated with poorer health outcomes. Ontario's extremely high occupancy poses a significant threat to patient safety and quality of care.

Its not the flu: it's a chronic condition

Sampling of hospital bed occupancy rates (final quarter 2013)

- Napanee/Lennox/Addington: 123%
- Sault Ste Marie area: 114%
- Toronto Hosp. for Sick Kids: 110%
- Toronto Central: 110%
- London Health Sciences Centre: 108%
- Exeter South Huron: 106%
- Burlington Joseph Brant: 106%
- Hamilton Niagara Haldimand Brant: 106%
- Niagara Health System: 104%
- Windsor Hotel Dieu Grace: 101%
- Erie St. Clair: 101%
- Oakville Halton Health: 101%
- Mississauga Halton: 101%
- The Ottawa Hospital: 101%
- Barry's Bay St Francis: 101%
- Thunder Bay Regional: 100%
- Newmarket Southlake Reg.: 100%

From Ministry of Health data accessed by Jonathan Sher, London Free Press. See: http://www.torontosun.com/2014/03/07/ont-health-ministry-data-on-hospital-overcrowding-riddled-with-errors

Emergency room overcrowding is epidemic among large and medium-sized community hospitals in Ontario, and a frequently noted factor in ER wait times is the unavailability of acute care beds.[5] In 2011, Ontario had, on average 592 patients waiting in emergency departments for admission to an inpatient bed. This represents almost 4% of Ontario's total acute care beds.[6] A study by Ontario researchers has demonstrated that long waiting times increase the risk of death and hospital readmission for patients who have been discharged from the emergency department. This study, published in the British Medical Journal looked at 22 million patient visits to Ontario emergency departments over a five year period, and found that the risk of death and hospital readmission increased with the degree of overcrowding

[1] See: http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Average+Number+of+Inpatients+on+Any+Given+Day+Ontario

[2] Ontario Hospital Association at http://www.healthsystemfacts.com/Client/OHA/HSF_LP4W_LND_WebStation.nsf/page/Beds+staffed+and+in+operation+Ontario+1990+to+large

[3] OECD "Health at a Glance 2009" page 95.

[4] National Center for Health Statistics, "Health, United States 2010", 2011, page 354.

[5] See: Forster, A.J. et al "The Effect of Hospital Occupancy on Emergency Department Length of Stay and Patient Disposition" Academic Emergency Medicine, 2003; CIHI "Understanding Emergency Department Wait Times"; B.H.Rowe et al., "Frequency, Determinants, and Impact of Overcrowding in Emergency Departments in Canada" 2006; OHA, OMA, MOHLTC, "Improving Access to Emergency Care: Addressing System Issues" 2006.

[6] Ontario Hospital Association, "ALC Study", June 2011.

at the time the patient arrived in the emergency department. The authors estimate that if the average length of stay in the emergency department was an hour less, about 150 fewer Ontarians would die each year.[7]

Not only is there a problem getting into hospitals, there is also a serious issue of patients being discharged too early and without placement in home care and in long term care homes. The Advocacy Centre for the Elderly reports that they receive frequent complaints from patients who are subject to pressure tactics to move them out of hospitals. Hospital policies may include statements that if person refuses to pick from short lists of long term care facilities that are not of their choosing, or if the patient refuses to take first available bed, then will be charged a large per diem ranging from $600 a day to $1800 a day.[8] In many cases the charges levied against patients in an attempt to move them out of hospital are unlawful.

In addition to reduced hospital beds and shorter lengths of stay for hospital patients, entire departments have been systematically cut from local hospitals. Outpatient rehabilitation, social work, laboratories and an array of outpatient services have been slashed. In many cases this care is moved far away from patients' home communities, privatized and subject to new user fees, or simply inaccessible.

Consequences of Emergency Department Overcrowding

- Patient suffering, dissatisfaction and inconvenience
- Poor patient outcomes
- Increased morbidity and mortality
- Poor quality of care
- Contribution to infectious disease outbreaks
- Violence aimed at hospital staff and physicians
- Decreased physician and nursing productivity
- Deteriorating levels of service
- Increased risk of medical error
- Negative work environments
- Negative effects on teaching and research

Source: Physician Hospital Care Committee Report to the Ministry of Health and Long-Term Care, Ontario Medical Associaiton and Ontario Hospital Association Tripartite Committee, Improving Access to Emergency Care: Addressing System Issues, August 2006.

[7] BMJ 2011; 342:d2983

[8] Wahl, Judith, Advocacy Centre for the Elderly. "ALC, Hospital Discharge, Long Term Care and Retirement Home – What Happened to the Law and Ethics ?" Power Point presentation 2011.

This is **Exhibit "I"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Ontario Health Coalition Fast Facts 2022

OECD Hospital Beds Per 1000 Population in 2020

OECD Hospital Beds Per 1000 Population 2020	
Japan	12.6*
Korea	12.7*
Germany	7.8*
Austria	7*
Hungary	6.8
Czech Republic	6.5*
Poland	6.2*
Lithuania	6.1
France	5.7*
Slovak Republic	5.7*
Belgium	5.5
Latvia	5.3*
Switzerland	4.5*
Estonia	4.5*
Slovenia	4.3*
Luxemburg	4.2
Greece	4.2**
Australia	3.8***
Portugal	3.5*
Norway	3.4*
Italy	3.2*
Spain	3*
Netherlands	2.9*
Israel	2.9
Ireland	2.9*
Iceland	2.8*
Finland	2.8*
United States	2.8**
New Zealand	2.7
Canada	2.5*
Denmark	2.5
United Kingdom	2.3
Ontario	2.3'
Chile	1.9
Mexico	1*
OECD Average	4.6

Source: OECD, *Health data 2021* https://data.oecd.org/healthegt/hospital-beds.htm

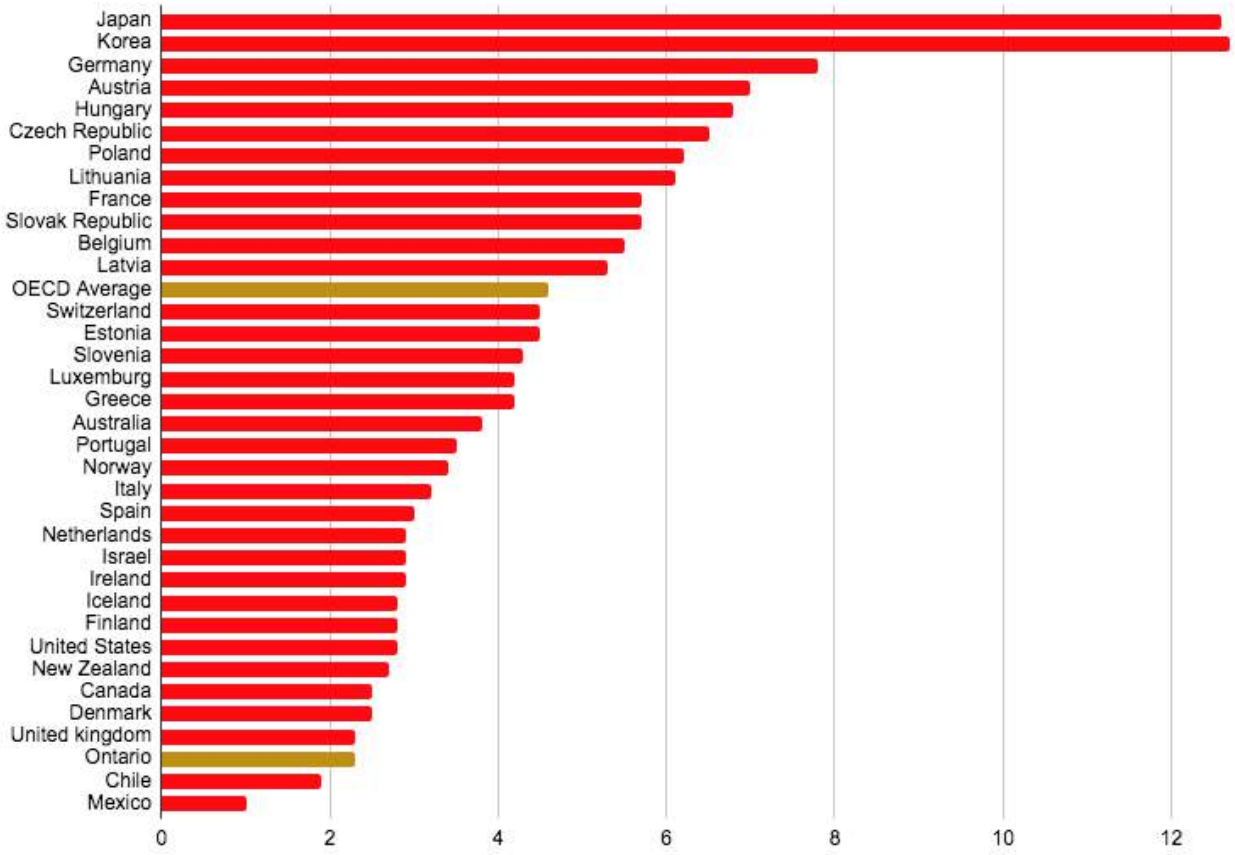
*this data is from 2020, the most recent year available.

**this data is from 2019, the most recent year available.

*** this data is from 2016, the most recent year available.

' Data calculated Ontario Health Coalition calculations: https://www.ontariohealthcoalition.ca/wp-content/uploads/Hospital-Beds-Per-1000-2021-Canada..pdf

OECD Hospital Beds Per 1000 Populations in 2021



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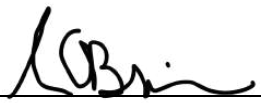
Ontario Health Coalition
Protecting public healthcare for all.

This is **Exhibit "J"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



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Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

BRIEFING NOTE: The Horrifying Truth About For-Profit Long-Term Care Homes

Posted: December 1, 2021

(December 1, 2021)

Impacts of the COVID-19 Pandemic

As of November 29, 2021, 4,023 residents died as a result of COVID-19 alone. Others died of malnutrition, dehydration, and neglect due to lack of care as COVID-19 rampaged through their long-term care (LTC) homes. Many of the COVID-19 related deaths in LTC homes are also associated with:

- Staff shortages
- Older designs of LTC homes that do not meet modern design standards
- Lack of PPE and infection control

Tragically, many residents died alone. The extraordinary and horrific death rates in for-profit LTC homes expose inadequacies of care and the differences between public and non-profit ownership and for-profit ownership. Some homes did far better though. The fact is that death rates for residents were much higher in for-profit long-term care (LTC) homes than non-profit and publicly-owned LTC homes.

LTC homes	**Death rate per 100 beds (1st wave and 2nd wave to December 2020)**
For-profit	5.2
Non-profit	2.8
Municipal (Publicly-owned)	1.35

The for-profit LTC homes in Ontario with the highest death rates are owned by Southbridge, Rykka, Sienna, and Revera. These specific corporations have a COVID-

19 death rate that is higher even than the average death rate of for-profit LTC homes.

For-profit LTC chains	Death rate per 100 beds
Southbridge	9.00
Rykka Care Centres	8.60
Sienna	6.54
Revera	6.26

Quality of Care

The elderly deserve better. Many residents require care that takes time, but currently, each resident only receives about 2.7 hours of care daily, far less than a safe level of care which would be at minimum 4-hours per resident per day.

The poor quality of care in LTC homes is worse in for-profit LTC homes.

- One study comparing the quality of care between for-profit and non-profit LTC homes found that the hours of direct care residents received in for-profit ownership was 0.34 hours less than the hours of care in non-profit ownership.
- For-profit homes have more cases of diseases and ulcers, complaints, and transfers to hospitals. Residents in for-profit LTC homes are 25% more likely to be hospitalized and 10% more likely to die.
- After a resident spends three months in a for-profit LTC home, their risk of being transferred to a hospital and dying compared to non-profit LTC homes increases to 36% and 20%, respectively.
- A study examined how ownership affects the care outcomes in LTC homes and found that residents in for-profit homes were more likely to be hospitalized with pneumonia, anemia, and dehydration than non-profit LTC homes.

Ultimately, research has shown that ownership is a significant factor in the difference in quality of care in LTC care homes, where LTC homes and their residents of for-profit ownership face poorer quality of care.

Staffing, Wages & Conditions of Care

There is no care without staff. Inadequate staffing levels are one of the many factors contributing to the high rate of COVID-19 and deaths of residents in for-profit LTC homes.

Low levels of staff have been an ongoing crisis prior to the pandemic. Unsafe staffing levels are related to the fact that staff that work in for-profit chains are paid less. For-profits also hire more casual and part-time staff to avoid providing staff benefits. At the same time, shareholders and investors receive tens of millions per month in profits. As cited in the Ontario Legislature in 2007, Karen Sullivan, the executive director of the for-profit LTC lobby group, stated that for-profit LTC homes earn profits in part from the low wages for staff and charging higher fees to residents who have private rooms.

Staff also work in multiple health care facilities to compensate for the low wages from working in LTC homes. Many staff quit because of the working conditions, low staffing levels, and unlivable wages of care. Two systemic reviews examined one Canadian study and found that staff working under for-profit ownerships had higher staff turnover compared to non-profit ownerships. Understaffing is also correlated with higher rates of injuries for staff. According to a study that examines staffing and worker injury in LTC homes, there is a proportionate relationship between staffing levels and the health and well-being of staff.

Ultimately, unsafe working environments and understaffing in for-profit LTC homes lead to the harm and deaths of residents. Care is not possible without staff, and the working conditions for staff in LTC homes are the conditions of care for the residents.

Living Conditions

More for-profit LTC homes that do not meet current design standards than non-profit and publicly owned LTC homes. These outdated buildings contributed to the higher rates of COVID-19 and deaths in for-profit LTC homes compared to non-profit LTC homes. Residents infected with COVID-19 were still being kept in the same room as healthy residents, increasing the risk for contagion. The lack of care and compassion for residents and the focus on profits from these for-profit operators is unethical and unacceptable.

In one example of a for-profit LTC home, Orchard Villa, there was a terrible outbreak with at least 70 residents who died as a result of COVID-19 alone, and others died of dehydration and malnutrition. The military, who were sent in to help, found terrible living conditions at the homes, including:

- Residents' mattresses put on the floor to prevent them from standing or walking
- Mattresses without linens
- Uncleanliness
- Living with flies and cockroaches
- Living in the smell of like rotten food
- Overcrowding
- Poor infection control

A study that examined the admission experience of residents into for-profit LTC homes compared to non-profit LTC homes found a disproportionate relationship to the quality of living conditions and stress. For-profit facilities have fewer services and provide lower comfort and security, which increases residents' stress levels.

What can you do?

- Learn more and stay updated on issues related to long-term care/chronic care: https://www.ontariohealthcoalition.ca/index.php/category/key-issues/long-term-care-chronic-care/
- Make this a key issue in the upcoming provincial election
- Contact your local MPP to raise concerns related to for-profit long-term care homes
- Find out who your local MPP is: https://www.ola.org/en/members/current
- Get involved with your local coalition
- Contact information for Ontario Health Coalition and your local coalition: https://www.ontariohealthcoalition.ca/index.php/contact-us/head-office/
- Share this briefing note widely to raise awareness

Click here for printable version

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About OHC

The Ontario Health Coalition is a network of over 400 grassroots community organizations representing virtually all areas of Ontario.

This is **Exhibit "K"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

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Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
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Expires November 15, 2024

Long Term Care Covid-19 Commission Mtg.

Ontario Health Coalition (Dr. Amit Arya and Natalie Mehra, Executive Director
on Monday, November 23, 2020

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

neesonsreporting.com | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 23rd day of November, 2020, 1:00 p.m. to 2:51 p.m.

BEFORE:

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

PRESENTERS:

Natalie Mehra, Executive Director, Ontario Health Coalition
Dr. Amit Arya, MD, CCFP (PC), FCFP, Lecturer, Division of Palliative Care, Department of Family and Community Medicine, University of Toronto
Assistant Clinical Professor, Division of Palliative Care, Faculty of Health Sciences, McMaster University

OBSERVERS:
Riley Sanders, Communications and Campaigns Coordinator, Ontario Health Coalition
Megan Lee, Campaign and Project Coordinator, Ontario Health Coalition
Salah Shadir, Administration and Operations Manager, Ontario Health Coalition

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead of the Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Kate McGrann, Counsel, Long-Term Care Commission Secretariat
Michael Finley, Counsel, Gowling WLG

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 1:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, let me introduce ourselves. I'm Frank Marrocco, Dr. Jack Kitts, Commissioner Angela Coke, and we're the Commission. Olivia Arnaud is our court reporter or our reporter.

So we're at this stage. We issued a first interim report. We may well issue a second one, and we're proceeding towards our deadline of April 30th, although that poses some difficulties for us.

So we understand what you've done. Well, at least we have a briefing note of what you've done, and it sounds very interesting from our perspective. And so we very much appreciate your sharing it with us.

We tend to ask questions as we go along, if that's all right?

NATALIE MEHRA: That's great.

DR. AMIT ARYA: Yeah, perfect.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Fine. So we will do that. I don't -- there are other people on the screen who are associated

with the Commission, but it's just us asking the questions, the three of us. So with that, we're ready when you are.

NATALIE MEHRA: Okay. Thank you. So maybe while we introduce ourselves, is it all right with you -- Riley is going to share his screen. Can he do that? And --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, sure. That's fine.

NATALIE MEHRA: Okay. And we have a PowerPoint presentation. I apologize for not sending it before. We've been sort of working to the very deadline here to finish.

COMMISSIONER FRANK MARROCCO (CHAIR): That's fine.

NATALIE MEHRA: And...

COMMISSIONER FRANK MARROCCO (CHAIR): That's not the first time that's happened. Now we don't worry about it. We can read as we go along. We'll be just fine.

NATALIE MEHRA: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Now we can see Riley's screen.

NATALIE MEHRA: Okay. And maybe, Riley, can you e-mail this over as well?

All of the links in the PowerPoint -- sorry, in the submission are live links, and they link to the various pieces of data that are relevant to that section, and the submission title here links to the submission as well.

They're up on our website, but they're not in a public part of the website. They're just available for you to access at this point.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that would be very, very helpful.

And, Riley, if you e-mail it to Alison Drummond, our executive director, I'm sure she'll make sure that it gets to where it's supposed to go.

NATALIE MEHRA: Thank you --

RILEY SANDERS: Yeah, I can deal with that.

NATALIE MEHRA: -- very much. Okay.

So this, for us, will be kind of an interim submission to you, looking at particularly because -- because the most urgent issues are that the second wave is not under control in long-term care.

And so we specifically wanted to look at conditions in the second wave, whether they have

improved or not, and what factors we think are contributing to the spread of COVID-19 now, a few elements of sort of ongoing or longer-term issues, but mainly, that's what we've focused on.

We would like to provide you with a submission that looks more broadly at the issues in long-term care as it relates to COVID-19, but we felt at this point that it was most important to kind of get the most up-to-date information and our analysis of what's happening. So that's where we're at.

Can we go to the next slide, Riley, and then if you can click on "Who We Are"?

So the Ontario Health Coalition is -- we have 400-plus member organizations. They include -- we represent more than half a million Ontarians. Our mandate is to protect public healthcare under the principles of the Canada Health Act, and the sort of foundational principles of equity and compassion that underlie the act.

And so we work to empower members of our constituent organizations in the community to engage in debate and discussion about public policy to improve public policy and improve public healthcare, and we represent the whole range of

organizations and individuals concerned about protecting public healthcare, including physician organizations, nurses, unions, seniors' organizations, Family Councils, residents, patient advocacy organizations, a whole range of ethnocultural organizations, and so on. And so we sort of have a broad coalition.

And we can go back, Riley.

We've been working for -- we've been in existence since the 1970s, and we've been working for 25 years on improving long-term care. And so we have a kind of long history of working for improvements to care levels and quality of care and quality of life in long-term care.

Amit, did you want to introduce yourself?

DR. AMIT ARYA: Yeah. So I'm Amit Arya. I'm a palliative care physician who has a special interest and practice focus in long-term care, although I also work in the hospital system, and I work in home care as well.

I have faculty appointments at the University of Toronto and McMaster University. I give workshops regularly, provincially and nationally, on systems issues in long-term care

with a specific focus on my area of expertise, which is palliative care.

I've led Rapid Response Teams on behalf of my hospitals into long-term care facilities in the first wave, and I am a board member of the Ontario Health Coalition. I'm also a member of the Ontario Health Coalition Long-Term Care Committee.

NATALIE MEHRA: Thank you. And I'm Natalie Mehra, and I'm the executive director of the Ontario Health Coalition. And our Long-Term Care Committee, which has been meeting weekly through the pandemic, includes physicians, the Advocacy Centre for the Elderly, other advocacy groups, family and residents and seniors' organizations and unions and health professionals.

Okay. So that's -- can we move on, Riley?

So I'm guessing you'll just stop us and ask if you have questions or want clarification or things like that; is that right?

COMMISSIONER FRANK MARROCCO (CHAIR): That's right.

NATALIE MEHRA: Okay. So looking -- and can you click, Riley, on the -- so looking first at the second wave versus the first wave:

What has changed and what is the current situation and what is the comparison.

So at the time that we wrote this submission, which was November the 17th, there were 100 active outbreaks in long-term care homes up from 76 at October the 31st and up from 18 at the beginning of September.

There were outbreaks during the summer but none -- and we've tracked, I should say, the outbreaks and the cases from the very beginning of the pandemic since the second week of March before Public Health started reporting, and we've tracked all the way through.

And so what we've found was that there were outbreaks in the summertime. None, except for one, had more than 5 cases; at the end of October, there were 3 active cases among residents and 18 active cases among staff in long-term care.

That has subsequently changed very dramatically, and so according to the epidemiologic data on November the 18th, there were 700 currently active cases among residents and 524 among staff.

Of those 100 outbreaks, 34 were what we would consider large outbreaks. That's an arbitrary designation, really, that we were just

counting those that had more than 10 residents and staff infected. 13 of those had more than 50, 12 had more than 99, and 4 had more than 150.

COMMISSIONER FRANK MARROCCO (CHAIR): Wow.

NATALIE MEHRA: So if we go down to the next page?

So, you know, what we can conclude from that experience at this point is that the measures that were taken in the first wave were inadequate or have been inadequate so far to stem the tide of infections in the second wave.

Once school started in particular and the case positivity rate went up in younger people to between 2 and 4 percent in September, then we saw, as the epidemiologists have predicted with a lag of a couple of weeks, the outbreaks starting among the four -- or the transmission starting to the 40-year-old-plus age group, and thus, the 70-year-old-plus age group.

And, of course, it found its way into the homes which it had done all along, but in a number of homes, they have not been able to control the spread. And so if we look at changes from Wave 1 to Wave 2...

And can we keep scrolling down there, Riley? Can you go to the chart? There we are. Can you click on that? No, it's not working?

RILEY SANDERS: No, it's not letting me expand.

NATALIE MEHRA: Can you look for the printable version and just pull it up?

RILEY SANDERS: Yeah.

NATALIE MEHRA: Okay. And then just scroll down to the chart. Okay.

So you can see the chart there.

Maybe if you can zoom in at all, Riley, that would be great.

But the first wave you can see -- now, there were problems with the Public Health data all the way along, and in our final submission, we'll give more details about the problems with the data that we found because we also were tracking every case in every home through the whole pandemic.

But the top two lines show our data and Public Health Ontario's data. There's also the Ministry of Long-Term Care database, and that data also differs from both ours and Public Health Ontario's, at times by several hundred. But they track the same sort of wave. So at least you can

see with some -- it gives a sense, anyway, of what the first wave looked like.

The red line shows the second wave, and so if you look at the second wave, what you'll see is that the growth -- I mean, it's hard to sort of figure out accurately when to say that each wave started. I think we can accurately say that the second wave started August 30th with the outbreak at Extendicare's West End Villa.

And within a couple of weeks, 11 long-term care homes in Ottawa were in outbreak. A number of those, then, were out of control, and the outbreaks started to spread in Toronto and then geographically across the region.

At this point now, by mid-November, November 17th, outbreaks are happening from border to border across the South, and they've spread into Northern Ontario as well with the first outbreak starting in Northern Ontario. And if you look at the sort of rate of increase in the second wave, you'll see that in the last three weeks, there's been an increase of approximately 1,500. 1,500 residents and staff infected.

So when we look at the first wave, that mirrors the escalation in the two and a half weeks

from March 31st to about halfway through the third week of April. And then in the two weeks from April 21st to May 5th, then the very fastest escalation we saw in the whole pandemic so far in long-term care happened from May 5th to May 19th, that two-week period where there was 2,000 positive cases in two weeks. And then it slowed down a bit to 1,500 over the four-week period from May 19th to June 16th.

So in the sort of foothills or the very beginning of the very sharpest escalation, we saw the spread mirror what we're looking at now, approximately.

So that's our assessment of where we're at at this point in the second wave.

And the main point of this is not to be alarmist at all, but the numbers are escalating every week. The number of outbreaks and the size of the outbreaks has escalated week over week, and now we're seeing the second-fastest kind of escalation that we've seen in the pandemic so far.

COMMISSIONER FRANK MARROCCO (CHAIR): Are people dying at the same rate?

NATALIE MEHRA: We haven't measured that, and the issue is that the deaths, not to be

at all glib, but they follow by several weeks.

So as you can see in the second wave, the escalation in the number of cases has happened more slowly than in the first wave. It's now, just now in the last three weeks really ramping up, and we won't be able to really see how the death rates compare to, you know, that big escalation in the first wave probably for a few weeks at this point.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: Sadly. I mean, horribly.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, no. It is -- but, anyway, thank you for the answer.

NATALIE MEHRA: Okay.

So, Riley, we can go back to the main PowerPoint, if that's okay.

So we wanted to give you a few case studies that we've done about large outbreaks in the second wave because we think that they're illustrative of what is happening in the second wave to contribute to the spread of COVID-19 now; so after the directives and guidance and policy was put in place in the first wave and through the

summer, what's happening now and what factors are contributing to the spread.

So we wanted to look more closely --

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just --

NATALIE MEHRA: Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): -- interrupt you for a second?

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): One of the things we are interested in is if there is something that should be happening now --

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- that can happen now, you know, as opposed to some long-term solution? We are very interested in that.

NATALIE MEHRA: Yes, okay. Well, I hope that this will help sort of illustrate some of the things that we think can happen now.

So this section is the case studies, and the next section is the factors -- sort of systematic look at the factors that we think are contributing to the spread.

COMMISSIONER FRANK MARROCCO (CHAIR):

All right.

NATALIE MEHRA: So if you can click, Riley, on the case studies link there? Okay.

So the one that we have the most information on is West End Villa in Ottawa, and that certainly -- that is the one that really kicked off the second wave, and if we look at -- we sort of track the outbreak in West End Villa.

So it started August the 30th, and it's not clear why the spread happened across Ottawa, in particular, so quickly. But what we have learned is that -- and so we theorized that there were a number of agency staff that work in multiple homes at the same time across Ottawa.

And we don't have anything beyond kind of anecdotal information on this, but what we do know, the chair of our board, for example, his mother is in home care in Ottawa, and she has a number of PSWs that they've hired in to provide home care for her. And a number of those PSWs work not only in home care but also in long-term care homes at the same time. They work in -- some of them work in Extendicare West End Villa and a range of other long-term care homes in Ottawa.

So in terms of concrete factors, the

loophole in the requirement that staff choose one home to work in that allows agency staff to continue to move between homes and between home care and long-term care homes, we think, is a contributing factor here. And a little further down, we'll see that in the data that's available publicly, at least one of the 45 staff by sort of mid-September that tested positive was an agency staff person.

It's not clear what other homes -- I'm going to say she; I'm assuming it's a she -- worked in and whether or not that staff person travelling between multiple homes was a contributing factor to the spread.

But what we do know is that by mid-September 11 of -- the long-term care homes in Ottawa were in outbreak, and then, of course, in West End Villa in particular but also in Starwood and Laurier Manor, the outbreaks really spread very dramatically.

And so if you scroll up a little, just charting that outbreak, started August the 30th. By September 16th, 31 residents were infected, 5 had died, and 5 staff were infected.

By September 18th, 46 residents were

infected, 6 had died, and 17 staff.

By October 18th, 84 residents, including 20 who had died, and 43 staff were infected.

By November 9th, 87 residents, including 20 who had died, and 45 staff were infected.

So we've been able to piece together what happened to some extent in that home, and I just, if it's okay, wanted to kind of walk you through what we saw, what we found.

So that first paragraph after the tracking, Riley -- sorry, you've gone down a little too quickly -- well, actually, you're right. We'll just go to the delays in testing.

So the failure over the summer by the Provincial Government to make a coherent plan for testing, ramping up testing capacity, ramping up laboratory capacity in the public hospitals and other labs across the province but particularly the public hospitals -- not all of which are even testing now to their capacity -- and in contact tracing really has been a fatal error.

And we don't think it's an exaggeration to say that it is a fatal error.

The lack of capacity once businesses and particularly once the schools reopened in September resulted in a very severe backlog of testing, of processing of the tests, and contact tracing. By the middle of October, 45 percent of the cases in Ottawa were not being contact traced, as an example; 67 percent in Toronto; about 17 percent in Peel.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you for a minute?

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): I understand the logic of what you're saying.

Is there any reason that's emerged why there wouldn't have been more of an effort at contact tracing and more of an effort to expand the capacity to turn around sample results quickly? In your work, did any reason emerge for this?

NATALIE MEHRA: No. We haven't -- we have not -- no is the simple answer. Um...

COMMISSIONER FRANK MARROCCO (CHAIR): Simple answer's okay, you know.

NATALIE MEHRA: Yeah, there just has not been any explanation for not kind of using the summer months to do it. We did see in the summer

that there was some ramp-up of hospital laboratory testing.

So not all public hospitals that can run COVID-19 tests are running COVID-19 tests, and those that can have additional capacity that could have been built and should continue to be built that has not yet been built. So that's on the laboratory side. We are --

COMMISSIONER FRANK MARROCCO (CHAIR): Can private labs do this testing?

NATALIE MEHRA: They are doing the testing, yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

NATALIE MEHRA: So, like, Dynacare --

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

NATALIE MEHRA: Yeah, they're doing the testing.

COMMISSIONER FRANK MARROCCO (CHAIR): So the province is making use of those resources?

NATALIE MEHRA: Yeah. And, in fact, they ramped up right at the very beginning back in March, April.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

NATALIE MEHRA: But not all of the public hospitals did. So in the first wave, the ramp-up of the public hospitals was sort of ad hoc. It was organized among the hospitals and Public Health themselves. The Ministry didn't sort of convene a planning table or group and make it happen.

There were a number of hospitals -- so they had a limited number of hospitals that ramped up to testing. They have to be validated. It takes a few weeks to be validated, and so on.

And then through the first wave, those hospitals and the private clinics and obviously the Public Health lab, the big Public Health lab, were ramping up their testing, but not all hospitals came online. Then, some more came online in the summer, but there was no coherent plan to sort of ramp up the laboratory capacity or the assessment centres, the testing capacity and the assessment centres, to meet what was predictably a big increase in population demand once the schools reopened and as businesses reopened as, you know, Phase 2 and Phase 3 came in. Okay.

So that impacted West End Villa, in

part, but the other thing that impacted West End Villa is that within the home itself, from the accounts of the families, testing was slow to happen. So residents who were showing symptoms didn't get tested for several days, according to the accounts from the families, and they weren't cohorted.

So even residents that were showing symptoms were not separated from residents -- even when they were sharing rooms were not separated from residents who were not showing symptoms. And we see this through the homes where there is large spread until, you know, several days later, sometimes until the family was, you know, screaming at the home, wondering why their loved one was still in a bed beside someone who was COVID-positive or had symptoms of COVID-19.

So within the home, one slow -- you know, slow testing. And throughout September, there were public reports about how many tests were pending. So once they did test, then slow test results, and then a failure of the home to cohort immediately. As soon as symptoms were present, they should be required to and inspected on cohorting, and that is not happening.

So there were several accounts from families who described this. One is Lea Maurice.

Oops. Don't go too fast, Riley.

So Lea Maurice, their grandmother was left in a room for more than 24 hours after her roommate began showing signs of COVID-19. Even after the roommate tested positive -- so the roommate wasn't actually tested for a few days. Even after she tested positive, she wasn't moved. The family had to advocate for her to move. They had to advocate for the room to be cleaned.

Finally, she was moved, and there were two other people also sharing the same bathroom with that COVID-positive patient, then, for a number of days from the time that they started showing symptoms.

COMMISSIONER FRANK MARROCCO (CHAIR): I'll ask the same question I asked before: Does a reason emerge why in September, having gone through Wave 1 and having had all those experiences, this kind of thing happens?

NATALIE MEHRA: No. In fact, throughout, the home has denied that there were problems. I mean, the only explanation that the home has made, in fairness, is that they said that

the lag in getting test results contributed to the spread in the home.

Other than that, there has not been any kind of response to the very specific cases that the families have raised in which they hadn't moved their loved ones out or sequestered the COVID-positive and the COVID-negative residents in the --

COMMISSIONER FRANK MARROCCO (CHAIR): I can understand the frustration in waiting for a result, but you have to test the person right away.

NATALIE MEHRA: Absolutely. And if they're showing symptoms, they should be separated --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah.

NATALIE MEHRA: -- immediately, regardless, while they wait for the test results.

And that didn't happen here, and it didn't happen in a number of the other homes where we've seen the big outbreaks.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: And so under the sort of array of directives and guidelines and so on,

there is kind of a network of requirements for the homes that suggests that they should cohort right away. But there's no real concrete enforcement or consequences if they don't, and they're not in a number of the homes.

So then we move on.

So poorer care, poor infection control practices were demonstrated in the home. And Public Health and government surveillance and interventions were too slow to improve them.

So on multiple occasions, actually, Public Health Ontario, Ottawa Public Health, and the Ministry of Long-Term Care Homes said that the home had sufficient PPE, that they had sufficient staff, and that they were following infection control protocols.

But those accounts are directly contradicted from families and staff with immediate knowledge, and they've given immediate -- like, concrete examples of how those haven't happened. So the Ministry and Public Health in Ottawa made those claims both on September the 11th and then again on September the 29th, but in between, this is what we heard from staff and families.

So the last paragraph on that page, a

staff person who was a whistleblower went to the Ottawa Citizen and reported that the staff -- so this is on September the 19th -- that the staff working directly with residents who had COVID-19 did not have N95 masks.

They further reported that there were two PSWs left for 60 COVID-positive residents. So one for 30 -- one PSW for 30 COVID residents on one side; one for 30 on the other side.

Again, on September 29th, Ottawa Public Health said that they had been conducting daily onsite visits, and the Ministry of Health said that they were meeting daily with the licensees, so the homeowner/operator, local public health, and public officials. From that surveillance, they said there's enough PPE that concerns about staffing shortages were being taken of, and so on.

Yet, on September the 26th, Pierette died, and in the week leading up to her death -- and this is the last paragraph on this page -- her daughter describes the conditions in which she was living:

She was dirty. There was excrement on her hands. There was excrement dried on the wall. She had not been cleaned. Her tongue was bone dry.

There were drink cartons on the table, but all but one had been left unopened. She was severely dehydrated, and she had dementia and COVID-19 and was not able to open drink cartons herself.

She had been put into a private room for isolation; however, once she was pall- -- like, once she was immediately palliative, so she was going to die within a few days, her family was allowed into the home. And what they observed was there was no staff available, residents were wandering into and out of Pierette's room even though Pierette had COVID-19 symptoms, and there were not enough staff to stop them and protect them from being exposed.

There were not enough staff to provide hydration, nutrition, human company, or basic care.

On the day of her death, which was September the 26th, Pierette's daughter tried calling the home from first thing in the morning on. She finally got a call just shy of noon, she says, from a nurse. The nurse apologized. She said that she hadn't been able to get into her mother's room because the home was so short-staffed.

So remember, this is a resident who's

dying of COVID-19, who has dementia, who can't feed herself or drink, hadn't been into the room till just before noon, and her mother was dying. So the family raced down and was able to make it just at the time of her passing.

So the accounts from the families do not match at all the accounts from Public Health and government officials that they say are based on site visits and discussions with the administrators of the homes.

What we're saying is if Public Health relied on the administrator's accounts for that home, then they shouldn't have because there was plenty of evidence to show that that home already had a bad record in terms of inadequate care. And, in fact -- and you can just scroll down, Riley -- in 2018, there had been a lawsuit -- these are actually very rare in Ontario until COVID-19 -- for systemic neglect treatment, including that the grandmother's bandaged wounds were infested with maggots.

There were inspection reports and non-compliance reports and orders over a period of several years; nine critical incident reports; ten complaints. And they described conditions,

problems with housekeeping, medication errors, unsafe or rough treatment of residents, call bells not being heard, residents not being assisted to eat, offensive odours, blood glucose levels not being checked, falls resulting in injury, all kinds -- a kind of litany of conditions that describe poor or negligent care.

And so there was plenty of evidence not to support listening to just the administrators' contentions about what the staffing and care levels were in the home and what the level of infection control was.

And it's not clear -- there's no public reporting about what kind of inspections Public Health is doing when they go into the homes that are in outbreak, but clearly they're inadequate, and our fear is that they're only talking to the administrators. We have not found staff that they're interviewing, and we haven't found residents that they're interviewing or family members to ascertain the conditions on the ground in these homes.

That's Extendicare West End Villa.

Amit, did you want to just talk about Kennedy Lodge?

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any --

NATALIE MEHRA: Oh, sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have any sense, when you describe the room in which they found -- I guess it's the mother?

NATALIE MEHRA: Pierette, yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Were they not allowed in to visit before this; is that the idea? Because you would think as soon as you went in there and saw that that you would become very agitated, to say the least.

But were they not allowed in before? Is that what the situation is; do you know?

NATALIE MEHRA: Yeah, they weren't allowed in because the home was in outbreak until Pierette was considered palliative, so immediately at risk of dying, and then they were allowed in, and it was just a few days before her death.

And as you can see, they had problems contacting the home. It was hard to get through because once there's not enough staff, there's no one to answer phones and so on as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Is that all staffing? I mean, is that the reason

that's given why this is allowed to occur? Does the home or does anybody tell you that they're just short-staffed?

NATALIE MEHRA: Well --

COMMISSIONER FRANK MARROCCO (CHAIR): That the reason for this is short-staffed?

NATALIE MEHRA: Yeah. The home is desperately short-staffed, for sure. I mean, the staff describe a level of staffing that I -- you know, I mean, I've been doing this for 25 years. We have witnessed short-staffing in long-term care homes for a long time but particularly after 2017 when, really, there emerged a crisis.

But, you know, to the level where there's one PSW for 30 COVID-positive residents, two PSWs for 60 residents, that is a -- you know, even in our long experience, we have never heard of staffing levels like that. And we're now hearing them, actually, in a number of the homes, that kind of one-for-30 situation.

That is beyond any kind of level of -- obviously, you can't really provide any care. There's no -- what kind of infection control could a PSW engage in if they have 30 residents? They're not changing PPE between people. There's no way.

There's no time. They're not -- who would be there to stop residents from wandering? There's no way to do that. You know, just all infection control that should be happening cannot happen when you're at that kind of critical shortage of staffing.

And the home itself, from what I've seen -- and I haven't seen every single statement that they've made -- they have not -- I mean, they've said all the way through that staffing is adequate, and, in fact, a later report that I saw, they said that they were overstaffed.

So, you know, the accounts from the home compared to the accounts of the families and the workers couldn't be more different.

COMMISSIONER FRANK MARROCCO (CHAIR): Where did they say that they had adequate staffing? Where was that recorded?

NATALIE MEHRA: In newspapers.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. So their public statements were to the effect that they were adequately staffed, and while there's probably no satisfactory explanation for what's been described, the idea that it's staffing appears not to have been the case because they say they were adequately staffed.

So either they're lying or they're negligent or they're incompetent at managing.

NATALIE MEHRA: Or both, yes.

DR. AMIT ARYA: Yeah. I just wanted to add to kind of, you know, validate what Natalie is saying, and it's really from my own clinical experience working in long-term care homes.

And it maybe sounds obvious, but I just wanted to put it on the record that when people are sicker, they don't need less care. They need more care, and they need more monitoring.

And especially with a disease like COVID-19 where, you know, people with dementia who live in long-term care facilities or this is a pre-existing population of people that are already quite sick and ill with other illnesses, they need very close monitoring, and they can rapidly become short of breath, their oxygen levels can drop, they can become delirious, dehydrated.

And, I mean, I would actually say you can't -- obviously, you cannot function with less staff, but I would even argue that you cannot function with the same amount of staff, which was barely adequate even before the pandemic.

COMMISSIONER FRANK MARROCCO (CHAIR):

Okay.

NATALIE MEHRA: So there's no real explanation as to why the Ministry, Public Health officials, the home -- reportedly -- and the staff and the families have such totally different accounts of what's happening.

But that pattern runs through the case examples that we've looked at and also through the staffing surveys and so on that we've done as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: And so, you know, one of the things we're concerned about is -- and this has been a case for many years -- that we've advocated that Ministry officials not rely on accounts from home administrators to ascertain the level of care in the homes.

And so for many years, we advocated that the inspections regime include interviews with residents and their families or their substitute decision-makers and staff to actually ascertain what the conditions of care are in the homes. And that was adopted in the RQI inspections that were stopped by the government in 2018.

So moving on to Kennedy Lodge, is that

okay? Go ahead, Amit.

DR. AMIT ARYA: Yeah. So just the story from Kennedy Lodge, which is somewhat consistent and indicates these issues around staffing and transparency around staffing.

I mean, November 16th, they had 31 residents who had died at Kennedy Lodge in Scarborough, which is a Revera home, and 128 residents and staff were infected. And the spokesperson for Revera claimed that staffing levels were stable and they were cohorting properly and there was enough PPE.

The Honourable Minister of Long-Term Care, Minister Fullerton, in the legislature on October 28th, also kind of echoed these comments and said there are actually no homes with critical staffing levels because help is being provided, including PPE.

And there was a journalist who then sort of was preparing an investigative report looking into that specific home, Kentucky Lodge in Scarborough, and they confirmed with the Ministry staff -- at least, the Ministry's perspective -- that homes had enough PPE and they're overstaffed, but when they interviewed the staff themselves, the

story was quite different.

So the November 17th report, sort of by PSWs, stated that because of shortages, proper infection control practices could not be followed. What that means is that they were supposed to have seven to eight frontline staff working on one floor, but unfortunately, only four were showing up to work and were not replaced.

Staff were supposed to remain on one floor but instead had to go in between floors, including units that had COVID-positive residents and COVID-negative floors. And N95 masks were there, but they weren't fit-tested, and there were shortages of sort of things that we would consider very obvious for PPE, like gloves.

And the union actually sort of confirmed this situation and said that this home already had a problem with short-staffing before the pandemic, and really, what was going on during the outbreak was far worse and that the home was described as "horribly short-staffed."

NATALIE MEHRA: So in a third case study that we just are compiling the information on, Starwood in Ottawa, another Extendicare home, the weekend before last, they're testing weekly on

Thursdays, and this is another home with an outbreak that now includes more than a hundred residents and staff.

And so Roseanne Riley (ph) told her story of her mother, who's 104 years old -- her name is Rose -- and her roommate was tested on the Thursday two weeks ago. Test result came back positive for COVID-19 on the Friday. By Sunday, Rose still had not been moved out of the room or, you know, neither Rose or the other resident -- Rose was not COVID-positive at that point, had not been moved out of the room and separated from the COVID-positive resident. By Thursday, then, of last week, Rose tested positive for COVID-19.

And so we undertook to do a staffing survey of the staff who are currently working in homes with large outbreaks specifically, to ask them what they thought was contributing to the spread of COVID-19 in the homes.

And their reports, there's a kind of wide range of conditions, and a number of them confirm these types of examples of inadequate PPE, inadequate cohorting, residents wandering, and so on, and we'll get kind of more into detail on that in a minute, if that's okay.

COMMISSIONER FRANK MARROCCO (CHAIR): Mm-hm.

NATALIE MEHRA: Okay. So that's that section.

COMMISSIONER FRANK MARROCCO (CHAIR): Can you just -- you said you did a study of staff, like --

NATALIE MEHRA: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- a survey of staff. Very briefly, but what was the methodology? How'd you do it?

NATALIE MEHRA: Well, we just worked with the unions who are in the homes where there are large outbreaks now. So "large" being defined as more than ten people.

We asked them -- so as not to kind of weight it towards one home or the other, we asked them if they could get, you know, around three staff at max in each of the homes in large outbreaks from their staff group to answer a very quick survey about, you know, are there enough staff, do you have enough PPE, are residents cohorted, are residents wandering, you know, et cetera, a list of questions which we've provided to you, and they provided answers to the questions.

We're still midway in that. So we have about, I think, 32 or so responses. We're still waiting for more to come in, today and tomorrow, and we'll write up the final study, but we can provide you with the interim results that we have at this point.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure, that would be fine. So you went to the unions; the unions went to their members in the homes where there were significant outbreaks. And you provided the questions, and one assumes the union asked the staff to answer it or ask three staff members to answer the survey, and they did?

NATALIE MEHRA: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: That's right. Okay.

So, Riley, we can go back to the main --

COMMISSIONER JACK KITTS: Natalie, before you go on, can I just ask a question? You said a couple of times that you don't really ask or don't believe the leadership in the homes.

Is that widespread, or is that -- I'm just kind of curious because, you know, the quality

control in the home is the responsibility of the executive director, director of care, and the medical director.

And are you seeing that all three are not monitoring or managing the care?

NATALIE MEHRA: Amit, maybe you want to add in on this a little bit.

Like, our experience now for decades is that there have been very serious quality problems in a number of the homes. There are, of course, homes with fantastic management, with competent management, but there are homes with really terrible, negligent management.

And it's not a small number of homes. It's a significant number of homes.

And so for all of these years, sort of tracking the inspection reports and so on, you know, we really were concerned because in the -- you know, up until about 2007 in the years in which there were inspections -- and, of course, the homes have lobbied routinely to get rid of annual, unannounced inspections, but in the years in which there were regular, unannounced inspections, the accounts of administrators about what was going on in the homes did not match what our members and

what other people were saying was happening in the homes.

So we pushed very hard for the Ministry to ensure that the inspections regime actually interviewed residents and staff. In the end, the RQI regime does require interviews of residents and substitute decision-makers and -- oh, sorry, we also advocated for Family Councils.

And I think that's a recognition from the minister at the time that there really are significant problems about how the homes report on conditions in their own homes.

COMMISSIONER JACK KITTS: So who do you think would be the most accountable body to deal with that, with the homes that a lot of people recognized doesn't have good management? Where would you pick that up?

NATALIE MEHRA: One of the things we've talked about is that -- I mean, there isn't an infection control lead in many of the homes, so in terms of infection control, you know, there actually isn't sort of a clear lead who is responsible for infection control and accountable for infection control in many of the homes.

But in terms of the general care

standards and so on, I mean, the administration has to be accountable, but in terms of actually ascertaining what's happening in the homes, the people that can tell you are the residents, the families, and the staff.

And so one just cannot -- I mean, our position is that you can't just trust the administration to tell the truth about what's happening in the homes. They don't do it.

COMMISSIONER JACK KITTS: Okay. Thank you.

NATALIE MEHRA: I don't know if you want to add anything, Amit? That's fairly blunt, I guess.

DR. AMIT ARYA: Yeah. I mean, I can just sort of say [indecipherable] management [indecipherable] that there's a lot of variability in terms of what happens in these homes at baseline.

From the physician perspective, I mean, there's many physicians -- I can share who went above and beyond during the COVID-19 pandemic and were so proactive, and I'm happy to share details about that at another point.

And then there were other situations

where, unfortunately, the physicians, you know, couldn't -- like, didn't have that skill set, you know, possibly before the pandemic. And it was very hard for them to kind of provide the higher level of acuity -- or, like, manage the higher level of acuity and complexity that was required during an outbreak.

But I'm not targeting physicians. I mean, that can apply across, you know, all areas, all disciplines working in the homes.

COMMISSIONER JACK KITTS: Okay. Thank you.

NATALIE MEHRA: We also asked -- sorry, I should just mention this. We asked -- because when the military report came out, you know, one of my questions was, well, where was the management? When these things were happening, where were the managers? Where was the director of care? Where was the administration?

And I asked the unions, where were the managements? And they said, you know, the administrative staff in many of the homes that they were in were not working onsite. They were not going into the homes during the outbreaks. They were working from home.

So I also wondered, you know, if you have so few staff on the floor, why is management not helping out? Why are they not -- why isn't it all-hands-on-deck? You know, people are dying of dehydration here. People are dying of starvation. Surely, every body that you can get in there would be in there trying to provide care, and that just wasn't the case. They left it to the one PSW, left for 30 people or 16 people or 26 people, you know, et cetera, in the homes.

And there really -- the answer was that, you know, they have their own offices. Often, they're air conditioned even when the homes are not. The administrators are not onsite.

Okay. So the factors contributing --

COMMISSIONER FRANK MARROCCO (CHAIR): So the infection control lead should be onsite?

NATALIE MEHRA: Well, on --

COMMISSIONER FRANK MARROCCO (CHAIR): Wouldn't it be satisfactory to -- and I'm not trying to put words in your mouth. Tell me if you think that's right or not, but it would seem from what you're saying that the infection control lead person should be onsite?

NATALIE MEHRA: Yes, and the

responsibilities for the infection control lead person and the accountability for them need to be clarified. So who is --

DR. AMIT ARYA: Absolutely.

NATALIE MEHRA: -- responsible and what is their accountability for that needs to be clarified because it is not clear, actually.

Sorry, Amit, did you want to say? Like, in --

DR. AMIT ARYA: Nope, nope. I was just seconding what you were saying that, yeah, absolutely, you need an infection control person onsite to monitor everything very closely, make sure the proper PPE is being used and all the staff are trained in how to use it, and residents are being cohorted.

I wanted to highlight one example from early on in the pandemic where I can give you an example the differences in support for infection control that were available in the hospital setting versus long-term care because I worked on the COVID-19 ward in the hospital.

So when I worked on the COVID-19 ward, there were two nurses who were kind of there to help me at all times before I went in to see a

patient, with donning and doffing PPE, make sure I followed all the, you know, the protocols properly, and that training was readily available.

But yet I haven't heard of any situation where, you know, say, for example, a new PSW was sent out and was working in the middle of the night with an unreasonable number of patients, as Natalie has outlined, that was offered that level of support.

NATALIE MEHRA: So, for example, like what Amit describes, in hospitals, they work in teams, and the team scrutinizes each other as they don and doff their PPE to make sure that they don't get contaminated. That does not exist in long-term care homes, not in any way, shape, or form. It just doesn't.

So, I mean, that would be an extraordinary leap forward from what we have. What we have at the moment is that they're not even donning and doffing between residents.

Okay. And --

COMMISSIONER ANGELA COKE: Can I just ask one question?

NATALIE MEHRA: Yeah.

COMMISSIONER ANGELA COKE: Just in

terms of all your observations so far, what sort of key differences you've seen between profit and not-for-profit and municipal homes in terms of their management of COVID?

NATALIE MEHRA: Well, I mean, there are very significant differences in the amount of staffing available, and particularly -- I mean, that's always been the case. And again, not every home is terrible that's for-profit; not every public or not-for-profit home is fantastic.

But generalizing across the sector, you can say without any shadow of a doubt that the staffing shortages, prior to COVID-19, were much worse in the for-profit homes than they were in the not-for-profit and the public homes.

And we can say that because we studied it, and we've provided you that study. And that echoes, you know, all of the academic research as well that has been done, the big body of academic research around powers of care.

But in addition, once COVID-19 hit, those homes that paid less -- and the for-profits pay less -- lost their workers more quickly, and once the April 22nd requirement that staff had to choose one home to work in, if they worked in

multiple homes -- staff chose where they could get more hours and where they could get higher pay, as a general rule, or where the working conditions were better. And those were the municipal and not-for-profit homes.

So in a number of the for-profit homes, in particular, we've seen staffing levels truly crumble through the first wave of the pandemic, and now in the second wave with no resilience going into the second wave because there was no capacity enhancement over the summer and no plan that was put in motion to get staff into the homes, we're seeing the very, very serious emergency, critical, critical staffing shortages in these homes with outbreaks and particularly in the for-profit homes.

And that is also echoed through our staffing surveys that we've done.

COMMISSIONER ANGELA COKE: Thank you.

NATALIE MEHRA: Okay. So looking at the factors that we think are contributing to the spread of COVID-19 in the homes.

So there have been -- in terms of directives, Directive No. 5, there has been improvement in PPE. And we have written this up, and we will send it to you once we've got it

complete and up to date. So Directive No. 5 has been amended multiple times. The most recent amendment says that:

> "Any staff person who comes within 2 metres of a person who is infected with COVID-19 should have access to an N95 mask upon their request."

The problem is that they have to request it and that it's not a requirement. It's inexplicable to us why this wouldn't be a requirement at this point and why the homes would not be inspected to that requirement.

Because what we're hearing from the staff is that either -- as in some cases, there are N95 masks available but not in their sizes or that they're being dissuaded from management from wearing N95 masks even now in the fall of 2020 after everything that we've seen.

In some homes, the training videos that are shown to staff say that N95 masks are only required when there are aerosol-generating procedures. In other homes, the management simply tells the staff that they are required. In some homes, staff have to sign out the N95 masks.

There are a whole array of ways in which the homes are rationing access to N95 masks.

And people under droplet and contact protection, they're not using N95 masks as a rule for those people, so those are people awaiting test results and so on. They're using surgical masks, or surgical masks and shields.

So although there have been improvements in access to PPE, that is a partial improvement. It's inadequate. It's at the staff's request rather than by requirement for the licensee, and it's not enforced.

In terms of the bar on -- sorry. Oh, you're on mute. There you go.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there a shortage of N95 masks in terms of the information you're getting?

NATALIE MEHRA: From the homes themselves?

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, actual physical shortage? I mean that really, though, more globally. You know how at the beginning --

NATALIE MEHRA: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- everyone was concerned they didn't have enough.

So now we move from March to, let's say, September or August, and I'm wondering from the perspective, the sources that you're accessing, is there a shortage?

NATALIE MEHRA: So, Amit, maybe you can help me here, but I remember that on our Long-Term Care Committee, the Family Councils in Sudbury were mentioning that at least one or more of their homes was having a problem getting access to N95 masks in particular, but I don't know -- and then the rest of the Family Councils were not reporting that. The staff don't know.

So that's the only one that I'm aware of. So there may be some, and I actually had asked the non-profits whether there was -- oh, yeah. I did ask some of the non-profits, and they did say that there was some stockpiling of masks that was happening. There was some problem, but it had improved, and I don't think globally, like, across the board there is a problem for the homes accessing supply.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: But there may be some

homes that for whatever -- I don't really know the reasons, have some problems accessing supply. That's particularly --

COMMISSIONER FRANK MARROCCO (CHAIR): So there's no problem -- if there's no problem accessing supplies, then if you have a shortage, it's because you haven't purchased sufficient supplies?

NATALIE MEHRA: Well, it's a cost issue. I mean, if you look at Extendicare's report to shareholders from the summer, they report the cost, the extraordinary cost of PPE is eating into their net revenue. It's a cost issue. I mean, if they ration supply, they have less expenditure.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: Okay. So bar and transfers of residents. So this is Directive No. 3, I believe.

And so in the spring, they barred the transfer of residents from hospitals, so patients from hospitals into long-term care homes that were in outbreak and people from the community into long-term care homes that were in outbreak. That was a significant improvement.

Also barred COVID-positive patients from being transferred from hospitals into long-term care homes. That was definitely an issue in the first wave and contributed to the spread in the first wave. That bar on transfers has, we think, generally worked, but there is a loophole that says that local public health officials, in agreement with the home and the hospital, can still transfer patients into homes with outbreaks.

Again, we don't know why there would be such a loophole. It's obviously very dangerous to do that, and in the directive, consent is not required for that person to be transferred. And the Advocacy Centre for the Elderly has had one case in the spring in which there was an issue of a resident being forced into a transfer, coerced into a transfer without appropriate consent into a home with outbreak.

But we're not aware of whether -- you know, we haven't heard whether that's happening anywhere else. I have not heard of it as an issue. It does, though, remain as a loophole in Directive 3.

The bar on the four-bed shared rooms, that's a definite improvement. It's in process, as

you know, through attrition and as they are cohorting.

Crisis interventions: So these are the Rapid Response Teams; military; management orders. So these are kind of the last-ditch efforts for homes that are in total crisis.

In our experience, as evidenced in, you know, Extendicare West End Villa -- sorry, I just drew a blank on it -- but also a number of the other homes in large outbreak, the orders are coming too late. Once you have, you know, more than 50 people infected, as was the case in Extendicare's West End Villa, you know, there's no reason why there shouldn't be intervention at a much lower threshold.

And they are ad hoc. At this point, it's local public health unit officials, and they have varying approaches across the province that are now making these orders, and they're late. They're ad hoc. The agreements are not the same.

In a number of cases, they've, you know, gone for sort of partnership agreements between the long-term care homes and the hospitals -- and, Amit, I don't know if you want to add in on this -- but what we're seeing is they

don't actually go in until the spread is devastating, in many cases, and then, even after that, it's not clear entirely what measures are being taken in each home and whether they're sufficient.

Because in a number of homes, they have managed to stop the outbreak. In other homes, the outbreaks continue to spread, as in Extendicare's West End Villa, for example, for a number of weeks. And, in fact, in Extendicare's West End Villa, the number of people infected doubled after the management was taken over by the Ottawa Hospital.

Did you want to add anything, Amit?

DR. AMIT ARYA: Yeah. I mean, I can just briefly add: Like, once again, a consistent theme is emerging, I feel, from my perspective and my expertise is that, you know, long-term care homes were always reliant on hospitals even before the pandemic, and then once it's [indecipherable], I commonly present and [indecipherable] to do is that, well, 65 percent of residents have transferred to hospital in their last year of life, and it's 7 percent in the last week.

There's national data from the Canadian Institute of Health Information that shows

that 21 percent of people from long-term care are transferred to hospital for palliative care, and as we talked about, some of this is a skill set and training sort of deficiency, and some of this is a sheer deficiency in staffing and the numbers of staff that are...

NATALIE MEHRA: Amit, you've cut out. Oops. He may have to dial back.

COMMISSIONER FRANK MARROCCO (CHAIR): That's right.

NATALIE MEHRA: Okay. So if that's okay, I'll just carry on, and then we'll just go back, if that's -- when he comes back in?

COMMISSIONER FRANK MARROCCO (CHAIR): Sure. That's fine.

NATALIE MEHRA: Okay. So we talked about assessment in testing capacity. I don't think I need to go through that again.

So while there were gains in the first wave, we saw lost ground, very significant lost ground once businesses and schools reopened, and there was no coherent plan to ramp-up capacity for that.

And then we saw the very, very severe backlogs in the fall. By the sort of height of the

backlogs, mid-October, there were 90,000 tests backlogged in the system, and that meant -- and the testing centres closed down for two days, and that meant a very severe backlog in tests, and obviously that affected the wait for results in long-term care homes.

Okay. So the allowance that COVID-19-positive asymptomatic staff can be required to work by their employers, you know, this one we still find quite shocking that it would be allowed in any way whatsoever. I mean, obviously from February on, information around COVID-19 being spread by asymptomatic carriers was well known around the world. Certainly, by March and April, it was well known.

But still, the allowance that employers can require COVID-positive staff to work supposedly on isolation, there is no such thing as work isolation for a PSW in a long-term care home or for an RN or an RPN. This was definitely a factor in the first wave.

We thought that it had actually been discontinued as a practice, although it is allowed in the second wave. But from our recent staffing survey and a few individual accounts from staff

that have called us, it is actually still happening in a number of homes where staff who are asymptomatic, positive but asymptomatic, are being required to go in to work. And they are not on work isolation, despite the recommendation and the protocol. So that should just be stopped. Period.

Staffing and care levels, we'll get into more detail in the next section, but I think we covered it, are worse now than they were in the first wave and certainly worse than they were prior to the pandemic.

Have we found -- did Amit come back in yet? No? I don't see him.

DR. AMIT ARYA: Yeah, sorry about that.

NATALIE MEHRA: He's here. Sorry. Thank you. Sorry, did you want to finish what you were trying to say? We lost you there.

DR. AMIT ARYA: Yeah. I don't know what happened to my hotspot. I have a hotspot right next to me, so I don't know why I got -- like, there was an issue with the connection.

But basically, I was just alluding to how long-term care facilities already had a reliance on acute care hospitals, and once again, I mean, this sort of issue around preventing

residents from going into hospital during a COVID-19 outbreak is actually quite harmful and, you know, can be deadly in certain circumstances.

I mean, of course, we have to obtain residents' consent, and there needs to be a goals of care discussion around what are the best options in that moment to make sure that resident is well looked after and are getting the best treatment for their condition, whether it's, honestly, COVID-19 or not, and that did not happen, actually.

And I hope we get some time to talk about how -- you know, hospitals are one option, but you may be aware that in Windsor, they kind of, you know, developed a third setting, a field hospital which was specifically designed for the care of residents in long-term care. And they had, for example, palliative care specialists working in the field hospital.

NATALIE MEHRA: So this is Crisis Interventions II: So everything else having failed or if staffing has crumbled to the point that basic care cannot be provided for residents and certainly not for residents who are sick with COVID-19, as well as the other conditions that they have, you know, it's our position that either the care needs

to be got into the home or the residents need to be gotten out of the home somewhere where they can be safe, be it a field hospital or a field centre, and that those need to be set up and ready to go.

The example of Windsor in the first wave, we believe -- you know, the evidence is pretty clear that it saved lives, and it meant that both the people in the field hospital and the people left in the home finally were able to get enough care, and it should be considered a model that could be used as we're in the second wave. But it's not happening.

In West End Villa, for example, by the end of September, only four residents had been moved to hospital. And as you can see from the family accounts, there was never even any question. You know, the families were never given any kind of choice, any kind of informed consent to move their loved ones out to somewhere where they could get enough care.

Obviously, this is a problem in the second wave because hospitals are open, and in Ottawa, for example, they're running at more than 100 percent capacity. And so every day that's lost is a risk to life. We need to build the capacity.

We needed to have done it through the summer. We needed to have done it prior to that.

But it needs to happen now to have either teams that are adequate to go in or a place where residents can be taken out where they can get enough care to live.

DR. AMIT ARYA: Yeah. I wanted to just add to that, that it's definitely a risk to life when basic care needs such as hydration or nutrition are not being met or residents aren't being bathed.

But it's also an equal risk to suffering of the residents, whether they're COVID-19-positive or not. We definitely know with COVID-19, once again, residents need close monitoring for symptoms such as breathlessness and agitation, for example, and they may need oxygen. They need their oxygen levels to be monitored.

They would need medication to make sure that they're not gasping for air and they're not short of breath, but they're comfortable and peaceful. Then, we need health workers that are trained in having conversations with family members and maintaining regular communication around what the treatment options really are.

So absolutely, that has to happen in the long-term care facility, but then if it can't happen, then we need to make sure that we transfer people to another place where it can and offer them that option.

NATALIE MEHRA: And then just the last two, so, you know, in terms of -- so some of the factors, we've seen some improvement. In others, like testing and contact tracing and lab capacity, we saw some improvement followed by lost ground.

But the abject failures, from our perspective, have been that there has been no coordinated systemic or systematic approach by the Ministry of Long-Term Care to dealing with outbreaks in the homes. That, in each case, at a low threshold, you know, one or two people infected because we know how quickly this virus can move, you know, these measures need to be in place.

Someone needs to be in the home, whether it's local public health or inspectors from the Ministry, or what have you. I mean, either could do it. They need to make an assessment on the ground. They need to be back in making regular assessments. They cannot just rely on the accounts by the telephone or in person by the

administrators.

They need to go and look at the condition of care, condition of life for the residents, and they need to interview them and the staff to ascertain what's happening. They need to ensure that there are strong-enough directives and guidelines and consequences for not actually providing PPE, as should be required -- should have been required months ago, but absolutely at this point, there's no excuse for not having it.

You know, they need to assess the staffing levels as the outbreak progresses and ascertain whether the residents are safe in the home or not safe in the home and have an array of options for either getting people in or getting the residents out that are available and in place to do that.

We cannot believe that we're in mid-November at this point, and that still is not in place. The measures are ad hoc. They're now being locally done. There still is no plan to actually recruit enough staff to get them into the homes. You know, that is, for us, a total kind of system failure in terms of providing a coordinated systematic response.

And following that, and Amit may want to take this one, but there really has been no accountability and no enforcement at every stage for the home operators. And so there's no real consequence for them not doing what they should be doing.

DR. AMIT ARYA: Yeah. I mean, I just wanted to add that one can't help but feel that there is an issue around divided loyalties here, and from the home's perspective, I mean, if they call in the hospital sort of based Rapid Response Team, or if it ends up that the military is in the home and so on, it could be very possible that that would open up a channel for them to be sued, right, and for them to be part of litigation. And perhaps it would affect their business image or corporate image.

But we know that we can't have conflicting loyalties at this time, and our sole loyalty should be to making sure that the residents who live in these homes are receiving, really, the best care and are receiving enough skilled care.

NATALIE MEHRA: Okay. So moving on to the next slide? Sorry, this the one that takes the longest.

So we've done a series of reports, and I won't -- I'll just take a few sentences on each between the two of us, but just to describe: We looked at staffing pre-pandemic, and there was a crisis in staffing prior to the pandemic.

We did roundtables in partnership with a union, UNIFOR. Across the province, we invited administrators, the people that run the PSW programs at the colleges, PSWs themselves, Family Councils, and we had more than 350 come to eight sets of roundtables from Thunder Bay right down to Windsor to Ottawa across -- sorry, Ottawa was not included -- but across Southern Ontario.

And what we found was that every home, without exception -- sorry, every region without exception reported that there were critical staffing shortages, PSW staffing shortages in the homes. And what that looked like was that there were not enough PSWs to start to fill all shifts. When PSWs called in, they were not replaced, and it led to critical staffing shortages across the board.

Then the pandemic hit, and after the first wave, we did a second survey, this time of direct frontline staff.

And, Amit, you're going to give the sort of quick summary of that?

DR. AMIT ARYA: Yeah. In the interest of time, I'll make it definitely quick. So basically --

NATALIE MEHRA: And [indecipherable] click on that link? Sorry. The July survey?

DR. AMIT ARYA: Yeah. So basically, the survey was done for more than 150 long-term care staff, and we asked if staffing was worse, better, or the same compared to prior to COVID-19.

And 95 percent of the staff reported that their long-term care homes were short, and 53 percent actually said that there was staffing shortages every day. 63 percent of the staff actually said that the staffing levels were worse than before COVID-19.

So what this led to, as one can sort of imagine, is that this led to neglect of the residents. It kind of led to rushed care in certain circumstances when it came to essential duties like bathing or feeding someone, and sometimes there was actually no care because they would just have to skip over bathing altogether, or there would be specifically no time for emotional

support or easing residents' depression or loneliness. Staff also reported there were more frequent falls. There was less time to reposition residents in order to prevent bed sores, for example.

And I just wanted to share one example from my own experience, which echoes the experience of people working in long-term care homes is that before the pandemic, because there was already a shortage, as Natalie talked about, we would see PSWs sort of feed three or four residents sitting together at a table, you know, at the same time, right? And sometimes, of course, family caregivers would often be present and helping as well and performing that frontline duty.

So what that meant is that depended on congregate dining, and when you can't have congregate dining because the residents are all isolating, that obviously does not allow you to save that time, and then you have to kind of do it much quicker, right? And it definitely would be the case that you would be leaving people hungry.

And the clinical experience -- and what we're hearing, actually, from family caregivers more than clinical experience is that people, you

know, have lost a lot of weight through this whole process.

NATALIE MEHRA: So in that survey, we asked what kinds of care couldn't be done, and then we've -- in the survey results which you have in the link, the most common thing when staff are short, the first thing to go is bathing and emotional support.

And then after that, it's the activities of daily living like, you know, brushing their teeth, shaving, cleaning, nail care, that kind of thing. Rushing room cleaning, and then feeding, repositioning, you know, and the other types of care that Amit said.

So in a very significant number of these surveys, we see that those very elemental pieces of care the staff were reporting could not be done. That's as of July of this year, and that's the majority of the respondents saying that these things could not be done in the homes in which they worked.

Again, in this survey, we limited it to three survey responses per home, so it wasn't weighted towards any one particular home. Okay.

So we'll go back to the next.

So then we did a repeat survey, but this one was specifically -- so we can go back to the, sorry, the main slideshow. And can you click on the bottom one?

So this is the current survey that we're doing on homes with large outbreaks now. So really, this was a bit about staffing levels, but also just about what are the conditions in the home that the staff think are contributing to the spread of COVID-19.

So we asked, is there enough staffing? Out of the responses that we have so far, and obviously the homes are in crisis, so it's a bit hard to get the responses in, but 24 of them said no, 6 said yes, and 2 said sometimes.

We asked to describe which work could not be done. So interestingly, a number of the staff who said that there was enough staff also listed a number of these things as work that can't be done. So the staff, their -- you know, low staffing has been normalized in the homes, and so the staff might say that there is enough staff, but then when you ask them what work is not getting done, they list a bunch of things that are vital pieces of care that aren't happening, and that was

the case in this study.

And when we provide you with the final, which should be later this week, we'll give you the numbers so you can get a sense of, you know, how wide-spread this is. This is just among the 34 homes with large outbreaks.

So counselling and services to families; documentation; showers and baths; feeding and hydration; transporting residents to be able to cohort them; staff breaks -- so this is care that they cannot do because they don't have enough staff -- emotional support for residents; talking to family members on the phone; giving medication; documentation; supervision.

Okay. This is an equipment issue: Not enough oxygen equipment.

Housekeeping; not enough laundry staff; answering residents' call bells so they don't get up and fall.

So then we asked a series of questions about whether -- and I apologize. We just literally put this together this morning from the last set that we got in last night, so it's very quickly done.

But we asked, do you have adequate PPE?

And so the surveys were filled in over the last week in the homes. 21 said yes. 9 said no. Even, again, not having proper access to PPE is normalized among the staff, so we asked a bunch of special, like, specific questions. We asked a "yes" or "no" question but then also specific questions to gather whether, you know, they would be -- that access to PPE is adequate according to what should be an appropriate standard, which the staff might not know.

So even among those that answered yes, they described some of the following, and the ones that just said no described these things: So they've been asked to reuse face shields; had to advocate for more N95s; they don't have proper fit-tested N95s; not enough time to change PPE between residents; discouraged in a whole array of ways from using N95s.

These are homes in outbreak, large outbreaks: Using surgical masks with COVID-19 residents; told to take their masks home and reuse them. In one case, the staff person who was a nurse couldn't get an N95 mask and had go back into her car to get a mask out of the backseat to use.

Locked up PPE. Not enough gowns; that

was fairly common. Not enough gloves.

This one was surprisingly common: No disinfectant wipes. In one home, they're using hand gel and paper towels to clean. In another home, they described the disinfectant wipes as old and dry, so they existed, but they weren't useable.

So these are current conditions, and so our question is why, you know, why are the homes not inspected to this? Why is there no accountability for the homes not providing these supplies?

We asked our COVID-19-positive residents, separated. In most of the homes, they said yes. In a few of the homes, they said no, so two. In three, they said they were at first during this outbreak, but now there are too many infected residents to be able to cohort them. And in ten, they said, yes, they're cohorted, but there's not enough staff to keep the residents from wandering into and out of each other's rooms in COVID hot zones and non-COVID hot zones.

And then we asked about, are there physical barriers to stop residents from wandering? In a few of the homes, they reported that they've removed the wheelchairs from residents' rooms so

that they can't move. I mean, that's -- that's a human rights issue. There should be enough staff to provide care for the residents. Just removing their wheelchairs so that they can't get up out of bed and go anywhere is not a solution to a COVID-19 outbreak.

Carrying on: Are there staff who are COVID-positive but asymptomatic being required to work? In seven, 7 of the staff said yes, and 22 said no. 3 didn't know.

And then we asked what other issues they thought would be contributing to the spread of COVID-19 in the homes. In a number of homes, actually, we've heard this, that they were not testing, and they were resistant to or delaying testing. So they said they had to fight for additional testing.

In one home, they described all different types of service in the building going in and out, so Rogers cable; maintenance; hairdressing services; staffing bringing it in from the community; equipment being shared between residents and not cleared properly; improper cleaning; short of qualified staff; using helpers that are not PSWs; discouragement from sending residents to the

hospital; and then problems with inadequate equipment.

Riley, can you scroll down a little bit?

And then agency staff moving in and out from coming in from various COVID hotspots, improper hygiene, and residents using shared spaces.

So those are the conditions that we're finding right now in the homes with the large outbreaks.

Okay. If we can go back to the main again? Sorry. Okay. And on to the next slide.

Amit?

DR. AMIT ARYA: Sorry, I think I'm on mute, right? So --

NATALIE MEHRA: You're on.

DR. AMIT ARYA: Yeah, I'm off mute now.

So, yeah, basically it's just kind of, you know, a slide that we need to enforce some standards of care in these homes, and some of it is around the number of staff, but some of it is around the skill and training that is not really enforced very closely in long-term care.

And basically, the same approaches to

medicine that might work in a middle-aged person with general medical training, you know, would not work in people that are seniors and especially people who have life-[indecipherable] illnesses such as dementia or heart failure and frailty, as are found in these nursing homes.

So we know that for COVID-19, specifically talking about treatment and testing, I mean, that requires that skill and knowledge where the presenting symptoms might not just be shortness of breath. It might not just be fever or cough, but it might also be falls or delirium or dehydration, right?

And we know that what we've seen is that -- I mean, perhaps this is much more of a long-term recommendation, but there is a short-term recommendation tied to this, is that we know that many of the physicians who work in long-term care tend to be older. It's a bit of an older workforce, so we need to make sure that if they cannot go in and actually see patients that need to be seen, there needs to be, you know, replacements available that can assist them and work together.

Virtual care has obviously risen up during the pandemic, and hopefully it's here to

stay, but virtual care cannot be a substitute for situations where you need an in-person assessment.

And really, it should not be about -- you know, for example, when I'm doing a virtual care assessment, it shouldn't be about my convenience, but it should be about what's in the best interest of the resident always because, as physicians, we have a fiduciary relationship with our patients.

COMMISSIONER FRANK MARROCCO (CHAIR): Is there any reason why the combination of a registered nurse practitioner and virtual care couldn't substitute for an absentee or sometimes there/sometimes not there medical director?

DR. AMIT ARYA: It's hard for me to say. I mean, I can tell you in general that there are some excellent nurse practitioners that, for example, I work with very closely in my region who are trained in geriatrics, once again, and trained in palliative care.

And, you know, we know that there is overlap in the scope of practice of physicians and nurse practitioners; they're not exactly the same.

But absolutely, I mean, I would say in many circumstances, if you had a nurse practitioner

who had the training and the skill and the time who was there onsite, they could work collaboratively with, you know, a physician who perhaps could not be there.

But the bottom line is that I can share with you as a physician. Like, I cannot just -- or I should not be delegating in ideal circumstances, you know, all my work to another health professional, and these are -- I mean, these would still be my patients, right?

And once again, I appreciate that, you know, older physicians would be afraid or scared of maybe going in to these places due to the high risk of maybe contracting COVID-19 themselves, but then if this is really what's needed to assess the residents and make sure that they get care, then it still needs to happen.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

NATALIE MEHRA: So, Amit, did you want to say anything about the other issues of the physicians? So there are the medical directors; there are other physicians working in the homes; there are issues around quality and practice.

Did you want to get into any of those

quickly?

DR. AMIT ARYA: Yeah. I mean, it kind of speaks to -- I mean, this slide is kind of focused on physicians, but I think it speaks to all skilled disciplines in long-term care where, you know, we know that the acuity and the medical complexity in the patient population is rising where, for example, I think 50 percent of residents now admitted to these homes have dementia. You know, the average age is rising, and the median prognosis in Ontario is 18 months.

Many of these residents would benefit from a palliative care approach, really, at the beginning, which doesn't mean end-of-life care, but it means integrating sort of a focus on symptom management and having early and frequent goals of care discussions with the resident, along with their substitute decision-maker, which is usually their family or family members.

But that, of course, takes skill and training, and we don't have that enforced standard of care in these homes. And I can share from a physician perspective: It doesn't exist. So what that leads to is variability.

I know many physicians that have

excellent skills in geriatrics and palliative care, and they are family physicians who have taken it upon themselves to learn more and expand their scope of practice or people with actual fellowship training beyond that.

But at the same time, there's also sort of some physicians who don't have the training and don't spend enough time with their residents and don't do, like -- you know, don't have these essential conversations. So that is a significant gap in the system that needs to be addressed, you know, as soon as possible.

NATALIE MEHRA: Okay.

DR. AMIT ARYA: Right? We wouldn't allow it in any other area of the healthcare system, right? We wouldn't allow somebody to work at the emergency department, for example, without knowing how to manage, you know, a trauma or, like, you know, being able to perform CPR, or we wouldn't allow a surgeon to be in the operating theatre without having these basic skills.

So we should really think about this in the same way in long-term care, and it's not just physicians, but nurses, nurse practitioners -- really, everyone in the intraprofessional team.

NATALIE MEHRA: Thanks. I don't know how -- I think we're running out of time. I wasn't quite sure what to do about managing the time.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we are at the 2:30 mark, but what's left for you to tell us?

NATALIE MEHRA: We just had sort of two sections.

Riley, can you flip forward one?

This really speaks to the issue of discrimination and not allowing access to hospital care for long-term care residents. That was just one piece.

And then the last piece was around the deregulation and the prioritizing of the lobby requests of the home industry over the public interests through the pandemic.

Should we go ahead? Should we -- I'm not sure what to do. Sorry.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, how long do you think it'll be?

NATALIE MEHRA: Ten minutes or so?

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, that's fine. Go ahead.

NATALIE MEHRA: Okay, okay. So I'll

just plough through quickly. Some of this you've heard, but in our written report, we'll give you more about this.

So leading in to the pandemic, obviously acuity in long-term care is a serious issue. The acuity of the residents -- that's the complexity and the heaviness of their care needs -- had increased very dramatically.

And if you can click on that link, Riley?

And so we've pulled together the most recent -- the orange link; there you go -- the most recent sort of data available up to 2019 looking at the increase in acuity of residents in the homes and then looking at the actual staffing. And what we see is a sharp, sharp increase in the acuity of the residents and an actual decline in the hands-on care levels in the homes.

It's okay. I just wanted you to see the reports so you know it's there, and you can access it.

So in this report, what we look at is the measures of acuity on admission to the homes, the MAPLe scores, which measure acuity on admission, and in Ontario, the residents are at the

highest tier of MAPLe scores on admission to the homes. The vast majority -- and this report, what we found was over 80 percent had dementia, half of those exhibit behaviours, and the level of violence is quite shocking in the homes. This is prior to the pandemic.

So there's a mix of residents now in the homes from younger people with chronic illness and disabilities, in some cases, to the frail elderly who require long-term care to people who, really, have psychogeriatric issues, which are different dementias and require different levels of training, specific training for which the home staff are not trained at all.

And so there's a resident population now that's significant with mental health issues, and then there's a resident population with dementias. There's a resident population who are frail and elderly, and there is a resident population who's young. And across the board, the acuity has increased very dramatically, but the staffing, without whom no care happens, has actually declined.

And the homes have become a dangerous place, even prior to COVID-19. And in the longer

term, there has to be a very serious look at this.

Like, Ontario has cut more hospital beds than any other province in the country, than any other developed nation. We have the fewest hospital beds per capita left of any province, by far, by a long shot, and we're at the very bottom of the OECD and the number of hospital beds per capita as well. So only -- I think it's Chile and Mexico now have few hospital beds per capita in the OECD, and we're miles behind our peer nations in Europe and so on.

And what that means is that long-term care homes have become a kind of privatized version of a chronic care hospital or, you know, a palliative care, and that whole kind of range of care as well as psychogeriatric care, and so on.

We believe that there has to be an upper limit, that you can't just continue to, forever, save costs in healthcare by off-loading ever-more complex patients into long-term care homes that are, you know, neither designed nor staffed nor have the training to provide for them; for example, a chronic care hospital bed in Ontario or a complex continuing care hospital bed in Ontario is funded at three times the rate of a

long-term care bed.

And yet the acuity levels between, you know, a chronic or complex continuing care resident and a long-term care resident would be hard to differentiate. Even though their needs are different, the actual level of support that they need is the same or, in some cases, higher.

And psychogeriatric beds were funded at a much higher level than long-term care homes, even than, you know, complex continuing care beds.

And so this sort of drive to off-load patients and then also to deny them access to hospital care when they need it really is, we think, discriminatory, and it is dangerous. And it's resulted in the highest homicide rates of anywhere in our society in long-term care homes -- that's resident-on-resident homicides -- the highest staff injury rates of any sector in our economy, and, you know, really problematic outcomes for the residents in the homes. And so that was one -- so that's prior to the pandemic.

Once we got in to the pandemic, we were pretty horrified to see that even where COVID-19 was spreading without check in the homes, even where staffing had crumbled, there was no mechanism

to ensure that residents could have access to hospital care, even when families were asking for their family members to be moved. In some cases, they were denied access to hospital care. In some cases, they were told that residents could not be transferred to hospitals, and so on.

And that culture is a very problematic culture because, really, it needs to be about what the care needs are of the residents and what the reality is of the care that's available in the home.

I don't know if you wanted to add anything, Amit, to that?

DR. AMIT ARYA: Yeah. I mean, it's a complex conversation, and you captured some of the key elements of that for sure.

I mean, you know, generally, I'll share with you: I mean, many of these seniors with dementia, for example, or these residents who are already, as I mentioned, in the last months or years of their life, they don't like to be in the hospital as a first preference because in hospitals, we know that can increase the rate of delirium. People can -- you know, they can develop deconditioning, and they're surrounded by this sort

of staff that's constantly turning over that doesn't know them.

But then what that counts on is having the proper care and support where they are, and I think for most of the residents that I know, that's what they would prefer. But then if that care and support is not available, then this is where this complex and nuanced discussion comes in that they deserve to know or their substitute decision-maker deserves to know, and then there needs to be a conversation about what would be the best next step, which we call a goals of care conversation, right?

So it's not -- like, you know, I think what Natalie is describing is paternalism where somebody else is making a decision on behalf of the resident, and there's not what we call a shared decision-making and truthful decision-making.

NATALIE MEHRA: And it's driven by attempts to cut costs, by de-hospitalization of the health system, and then by not transferring people to hospitals even when care can't be provided in other venues for them. And this, I think, has been a very serious problem during the pandemic and continues to be a very serious problem.

Riley, do you mind going back in to the main slide? Sorry. Oh, sorry, can you go back to that slide? Sorry. I'm trying to rush.

So in the pandemic, what we've seen is this acuity and the complexity of the care needs of the residents is compounded by the reticence to hospitalize; the ignoring of the right to informed consent at that time; the use of advanced care directives that are being required by homes when people are admitted, which might be two years ago, but that is not informed consent. That is not informed consent based on the unique needs of that person in the situation as it changes and as their health status changes. And at the end, what it's meant is just the failure to act to provide care for people.

In the longer term, this issue of acuity and capacity in long-term care has to be addressed. There has to be an upper limit for acuity, and the resources that are provided to long-term care need to match the actual acuity of the residents, and they do not at this point.

There cannot be continued downloading of ever-more complex and a mix of residents that are unsafe, demonstrably unsafe in the home and

cannot be provided good care in those homes. And so that needs to be addressed.

The last bed study that was done in Ontario, there was a 1994 chronic care bed study. That's the last one that sort of assessed what level chronic care was supposed to be. Nothing has been done like that since, and there has been no capacity study across the hospital system into long-term care. It's a continuum of care, as you know, to ensure that there is care provided along the continuum and that it's appropriate for the care needs of people and can actually meet those care needs.

So in the longer term, those things need to be addressed, and then this issue of advanced care planning that Amit has brought up, which is not being done; consent, which is ignored often in long-term care; and access to hospital care when people need it, which is being denied often in long-term care, are significant issues.

Sorry, Amit.

DR. AMIT ARYA: Yeah. I just wanted to very quickly, in a couple of sentences, just outline what a real-world example of that looks like, you know, in terms of the staff and the

inequity between different places.

So we can imagine, of course, end-of-life care is an important aspect of care in long-term care facilities, given the patient population. And obviously, we have to do everything to prevent COVID-19 from getting in these homes, but if COVID-19 is in the home, we don't want people to die from negligence. If people are at end of life from the virus, we still have to provide them proper care.

And to give you an example, in the hospice setting where I also work, there is one nurse for five patients in the hospice setting, and there's one PSW for ten patients.

And there's nothing close to that happening in long-term care in spite of, as was already mentioned, you know, a much higher level of complexity and need for family support.

NATALIE MEHRA: Okay. And so the last slide. Okay.

So we've provided a link to the 1999 Red Tape Submission from the OLTCA. So essentially, it captures in the kind of euphemistic language that they use, what they've been lobbying for.

But having done this for 25 years now on the board and then as the executive director of the Ontario Health Coalition, really, the public interest groups that are concerned about conditions of care in long-term care and the for-profit industry in particular have really kind of fought a pitched battle for decades now to establish a better regime of care levels, of care standards, of accountability, and enforcement.

And so I didn't want to leave without at least mentioning this to you, and we can kind of give it to you in writing in more detail, but the bottom line is that what the homes have lobbied for is to get rid of the only existing staffing standards that we have. So there is a requirement -- that are not management.

So as you know, there's a director of care and there's the medical director, but aside from that, there's the requirement that homes have one RN 24/7. It's our view that that's inadequate. That's a 40-bed home or a 400-bed home, one RN 24/7.

The homes have lobbied in recent years to get rid of that minimum care requirement. That is in the act, and we pushed to have that in the

act in 2007 because the acuity of the residents was rising so significantly and because the workforce had been -- you know, care had been off-loaded first from RNs to RPNs and then from RPNs to PSWs to the point that now the majority of the workforce is PSW, even with a, you know, rising acuity among the residents.

Under the emergency orders in March, the homes won the deregulation of that RN care standard. We think that's dangerous. I mean, in a pandemic, you would need more trained care, not less. Similarly with PSW training, in the act, there is a requirement that personal support workers provide the personal support program, which is described in the act and in the regulations: There is a requirement that the PSWs have a diploma, that they are trained PSWs.

Under the emergency orders, again passed in March, homes were allowed to replace PSWs with untrained staff and with volunteers. Again, this is dangerous. In the pandemic, you need more, not less.

And while it might be understandable that a regulation might be waived for a period of time, it cannot be that the regulations are both

waived and there is no plan, and there has been and there continues to be no plan to recruit a staff force that is trained to get them into the homes to provide enough care. And that's what happened.

So at this point, we have the worst of both worlds. We have the regulation waived, PSWs being replaced by resident support aides -- and they come under an array of titles -- and even unpaid volunteers, so people who have no training whatsoever. And yet, still no recruitment strategy to actually get PSWs into the homes.

In comparison, Québec, on June 1st, announced that it would recruit 10,000 orderlies, their equivalent to PSWs, with the full weight of government behind the recruitment plan, and within a matter of weeks, they had 67,000 applicants for 10,000 positions. They paid $21 an hour for training. They did a three-month training for them, intensive training, and they have deployed those PSWs or their equivalents into the homes now to be in place for the second wave.

Nothing like that has happened in Ontario, and we are -- they have 400 homes; we have 626 homes. So the scale of the problem in Québec was similar, although I think it was worse in

Ontario. So we need the same kind of scale of response.

What we've had instead has been kind of an ad hoc, piecemeal approach with some funding, some programs, but no robust recruitment strategy with the full weight of the Provincial Government behind it with a paid training, sped-up, intensive program and a plan to actually get a small army of PSWs into the homes to make sure that there can be enough care provided.

That is a huge failing, and it is resulting in terrible inadequacies, horrific inadequacies in care for residents in the homes.

Couple that with, now, the deregulation of the care standards, something that the homes actually lobbied for for five years leading into the pandemic, approximately five years leading into the pandemic, which they won in the emergency orders. You know, very dangerous, unsafe, and the wrong direction as compared to where we should be going.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, that -- I should tell you, we do have a hard stop at 3 o'clock.

NATALIE MEHRA: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): So if that's pretty much it, then that's it. If not, if there's something you need to conclude with, go right ahead, but we do have a hard stop at 3.

NATALIE MEHRA: Okay. Sorry. I went on too long there. So there are just a few other issues, then, that are in writing here and that we will be providing to you in writing as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you very much. Well, thank you for the presentation. We have been interested in getting this kind of a perspective, and this is extremely helpful. And thank you very much for taking the time to do this.

And we look forward to the balance of it in -- the balance of whatever it is you feel we need to know, but I can tell you some of this is very helpful.

NATALIE MEHRA: Oh, good. Okay. Thank you very much for your time, and we're sorry to have gone over.

COMMISSIONER FRANK MARROCCO (CHAIR): No, that's quite all right. Thank you very much. Bye-bye.

DR. AMIT ARYA: Thank you.

NATALIE MEHRA: Bye-bye.

DR. AMIT ARYA: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you. Bye.

COMMISSIONER JACK KITTS: Thank you.

-- Adjourned at 2:51 p.m.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, 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 23rd day of November, 2020.

_____

NEESONS, A VERITEXT COMPANY
PER: OLIVIA ARNAUD, CSR
CHARTERED SHORTHAND REPORTER

WORD INDEX

This is **Exhibit "L"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Explanatory note:

This report at long-term care wait lists in each of the 14 health regions. It lists the ten homes with the longest wait lists and the homes with the shortest wait lists. This first section shows both that there are very significant wait lists across the board but there is wide variability in the wait lists for each home with extremely long wait lists (numbering more than the total number of beds in the home) for the preferred homes and significantly lower wait lists for the homes that people do not want to go to.

Ontario Health Coalition
Numbers of People on Waitlists for Long-Term Care Homes By Health Region

February 1, 2023

Long-term care wait lists are extremely high in every health region in Ontario. Wait list data is collected and posted on the websites of each of Ontario's Health and Community Support Services organizations (HCCSSs).

This report shows the ten homes with the most people waiting and ten homes with the fewest people waiting for basic accommodation by region.

Erie St. Clair

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/ESC_LTC-Wait-Times-April-2022.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership
350	222	Huron Lodge	Public Licensee: Cooperation of the City of Windsor
284	192	Village of Aspen Lake	For-profit Licensee: R-b-j Schlegel Holdings Inc. (Schlegel Villages Inc.) ***
236	256	Village at St.Clair	For-profit Licensee: Schlegel Villages Inc.

210	140	Heron Terrace Long Term Care Community	For-profit Licensee: S&R Nursing Homes Ltd
153	96	Riverside Place	For-profit Licensee: AXR Operating (National) LP, by its general partners
136	128	Extendicare Tecumseh	For-profit Licensee: Extendicare (Canada) Inc.
136	132	Vision Nursing Home	Not-for-profit Licensee: Vision '74 Inc.
132	126	Marshall Gowland Manor	Public Licensee: The Corporation of the County of Lambton
128	150	Extendicare Southwood Lakes	For-profit Licensee: Extendicare (Canada) Inc.
112	317	Riverview Gardens	Public Licensee: The Corporation of the Municipality of Chatham-Kent

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
5	96	Sumac Lodge	For-profit Licensee: Revera Long Term Care Inc.
7	62	Watford Quality Care Centre	For-profit Licensee: Qcc Corp.
7	142	Trillium Villa Nursing Home	For-profit Licensee: S & R Nursing Homes Ltd

10	112	Franklin Gardens Long Term Care Home	For-profit Licensee: Dtoc Long Term Care Lp, By Its General Partner, Dtoc Long Term Care Mgp (A General Partnership) By Its Partners, Dtoc Long Term Care Gp Inc. And Arch Venture Holdings Inc.
11	73	Tilbury Manor Nursing Home	For-profit Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
11	103	Country Village Health Care Centre - Woodslee	For-profit Licensee: Cvh (No. 5) Lp By Its General Partners, Southbridge Health Care Gp Inc. And Southbridge Care Homes (A Limited Partnership, By Its General Partner, Southbridge Care Homes Inc.)
16	209	Berkshire Care Centre	For-profit Licensee: Rykka Care Centres LP
17	141	Banwall Gardens	For-profit Licensee: Rykka Care Centres LP
19	65	Blenheim Community Village Long-Term Care Home	For-profit Licensee: Revera Long Term Care Inc.
20	128	Fiddick's Nursing Home Limited	For-profit Licensee: Fiddick's Nursing Home Limited

South West

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/SW_LTCH-Wait-Times-April-2022.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for	**Number of licensed beds**	**Name of LTC homes**	**Ownership**

basic room			
557	160	McCormick Home	Not-for-profit Licensee: The Women's Christian Association of London
419	243	Dearness Home, Long Term Care	Public Licensee: The Corporation of the City of London
360	192	The Village of Glendale Crossing	For-profit Licensee: Homewood Corporation (Schlegel Villages Inc.) ***
353	157	McGarrell Place	For-profit Licensee: AXR Operating (National) LP, by its general partners
302	160	Woodingford Lodge - Woodstock	Public Licensee: County of Oxford
260	160	PeopleCare Oakcrossing London	For-profit Licensee: PeopleCare Communities Inc.
232	136	Valleyview Home (St Thomas)	Public Licensee: The Corporation of the City of St. Thomas
230	160	Westmount Gardens	For-profit Licensee: Steeves & Rozema Enterprises Limited
224	128	Spruce Lodge	Public

			Licensee: The Corporations of the City of Stratford, The County of Perth and The Town of St. Mary's
223	45	Greenwood Court Nursing Home	Not-for-profit Licensee: Tri-County Mennonite Homes

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
3	60	PeopleCare Stratford	For-profit Licensee: PeopleCare Stratford Inc.
14	52	Caressant Care Listowel Nursing Home	For-profit Licensee: Caressant-Care Nursing and Retirement Homes Limited
15	61	Pinecrest Manor Nursing Home - Lucknow	For-profit Licensee: Revera Long Term Care Inc.
16	60	Queensway Long Term Care Home	For-profit Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
17	69	Braemar Nursing Home	For-profit Licensee: MacGowan Nursing Homes Ltd.
21	34	Parkview Manor Health Care Centre	For-profit Licensee: Grosvenor Health Care Partnership (No. 3)

24	91	Maitland Manor	For-profit Licensee: Grosvenor Health Care Partnership (No. 3)
24	33	Fordwich Village Nursing Home	For-profit Licensee: ATK Care Inc.
26	45	Golden Dawn Senior Citizen Home Long Term Care	Not-for-profit Licensee: Golden Dawn Senior Citizen Home
27	63	Seaforth Manor - Nursing Home	For-profit Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)

Waterloo Wellington

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/WW_LTC_Wait-Times-April-2022.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership
650	263	Sunnyside Home	Public Licensee: Regional Municipality of Waterloo
455	88	Saugeen Valley Nursing Centre (Strathcona Long Term Care)	For-Profit Licensee: Sharon Farms & Enterprises Limited
435	192	The Village of Riverside Glen	For-Profit Licensee: Schlegel Villages Inc.
433	85	The Elliott Long	Not-for-Profit

		Term Residence	Licensee: Corporation of the City of Guelph
419	192	The Village at University Gates	For-Profit Licensee: Schlegel Villages Inc.
347	150	Trinity Village Care Centre	Not-for-Profit Licensee: Lutheran Homes Kitchener - Waterloo
336	95	The Village of Winston Park	For-Profit Licensee: Winston Hall Nursing Homes Limited (Schlegel Villages Inc.) ***
335	176	Wellington Terrace	Public Licensee: Corporation Of The County Of Wellington
318	160	Chartwell Westmount Long Term Care Residence	For-Profit Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc., as General Partner
303	84	Fairview Mennonite Home	Not-for-Profit Licensee: Fairview Mennonite Homes

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
8	87	Caressant Care Fergus Nursing Home	For-Profit Licensee: Caressant-Care Nursing and Retirement Homes Limited
18	80	Caressant Care Arthur Nursing Home	For-Profit Licensee: Caressant-Care Nursing and Retirement Homes Limited

26	31	Twin Oaks of Maryhill	For-Profit Licensee: Twin Oaks of Maryhill Inc.
32	67	Royal Terrace	For-Profit Licensee: Shanti Enterprises Limited
43	28	Morriston Park Nursing Home	For-Profit Licensee: Retirement Home Specialists Incorporated
45	72	Derbecker's Heritage House	For-Profit Licensee: Derbecker's Heritage House Limited
49	48	Chartwell Elmira LTC Residence	For-Profit Licensee: Chartwell Master Care Lp
51	79	Cambridge Country Manor	For-Profit Licensee: Caressant-Care Nursing and Retirement Homes Limited
55	97	Nithview Home	Not-for-Profit Licensee: Tri-County Mennonite Homes
66	92	LaPointe-Fisher Nursing Home	For-Profit Licensee: LaPointe-Fisher Nursing Home, Limited

Hamilton Niagara Haldimand Brant

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership
319	210	St. Peter's Residence at Chedoke	Not-for-Profit Licensee: St.Peter's Care Centres
307	120	The Village of Wentworth Heights	For-Profit Licensee: Oakwood Retirement Communities Inc. (Schlegel Villages Inc.)

			***
279	192	Idlewyld Manor	Not-for-Profit Licensee: Idlewyld Manor
274	222	Linhaven	Public Licensee: The Regional Municipality of Niagara
247	270	Macassa Lodge	Public Licensee: City of Hamilton
230	128	Regina Gardens	Not-for-Profit Licensee: Liuna Local 837 Nursing Home (Ancaster) Corporation
209	128	Tabor Manor	Not-for-Profit Licensee: RadiantCare
209	120	The Woodlands of Sunset	Public Licensee: The Regional Municipality of Niagara
208	160	Westhills Care Centre	For-Profit Licensee: Westhills Care Centre Inc.
204	160	The Henley House	For-Profit Licensee: Henley House Limited

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
6	68	Crescent Park Lodge	For-Profit Licensee: 955464 Ontario Limited
8	184	Grace Villa Long Term Care Home	For-Profit Licensee: Grace Villa Limited

9	80	Blackadar Continuing Care Centre	For-Profit Licensee: Blackadar Continuing Care Centre Inc.
14	101	West Park Health Centre	For-Profit Licensee: CVH (No. 1) LP
14	121	Fox Ridge	For-Profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
16	48	Kilean Lodge Nursing Home	For-Profit Licensee: Revera Long Term Care Inc.
20	60	Mount Nemo Christian Nursing Home	Not-for-Profit Licensee: Canadian Reformed Society for a Home for the Aged
21	126	Parkview Nursing Centre	For-Profit Licensee: The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner
22	151	Oakwood Park Lodge	For-Profit Licensee: Maryban Holdings Ltd
23	93	Maple Villa Long Term Care Centre	For-Profit Licensee: Dallov Holdings Limited (Better Life LTC Inc.) ***

Mississauga Halton

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/MH-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership

523	180	Village of Erin Meadows	For-Profit Licensee: Schlegel Villages Inc.
518	192	Cawthra Garden Long Term Care Community	For-Profit Licensee: Delcare LTC Inc.
499	142	Sheridan Villa Long Term Care Facility	Public Licensee: The Regional Municipality of Peel
423	192	Wesburn Manor	Public Licensee: City of Toronto
393	200	Yee Hong Centre - Mississauga	Not-for-Profit Licensee: Yee Hong Centre for Geriatric Care
381	228	Post Inn Village	Public Licensee: The Regional Municipality of Halton
368	161	The Wenleigh	For-Profit Licensee: Regency LTC operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
352	200	Allendale Long Term Care Facility	Public Licensee: The Regional Municipality of Halton
297	133	West Oak Village	For-Profit Licensee: AXR Operating (National) LP, by its general partners
286	133	Northridge Long Term Care Centre	For-Profit Licensee: AXR Operating (National) LP, by its general partners

<u>10 LTC homes with the lowest waitlist</u>

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**

18	204	Camilla Care Community	Not-for-Profit *** Licensee: Partners Community Health
19	241	Eatonville Care Centre	For-Profit Licensee: Rykka Care Centres LP
30	181	Cooksville Care Centre	For-Profit Licensee: Rykka Care Centres LP
43	90	Labdara Lithuanian Nursing Home	Not-for-Profit Licensee: Labdara Foundation
67	94	Streetsville Care Community	For-Profit Licensee: Vigour Limited Partnership on Behalf of Vigour General Partner Inc.
69	44	Mississauga Long Term Care Facility	For-Profit Licensee: Mississauga Long Term Care Facility Inc.
75	66	Dom Lipa Nursing Home	Not-for-Profit Licensee: Slovenian Linden Foundation
83	76	Erin Mills Lodge Nursing Home	For-Profit Licensee: Schlegel Villages Inc.
136	130	Extendicare Halton Hills	For-Profit Licensee: Extendicare (Canada) Inc.
158	66	Bennett Health Care Centre	Not-for-Profit Licensee: Bennett Centre Long Term Care At Bennett Village

Central West

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CW-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on	**Number of**	**Name of LTC**	

waitlist for basic room	licensed beds	homes	Ownership
529	318	Kipling Acres Long Term Care Facility	Public Licensee: City of Toronto
474	160	Tall Pines Long Term Care Centre	Public Licensee: The Regional Municipality of Peel
415	120	Village of Sandalwood Park	For-Profit Licensee: Oakwood Retirement Communities Inc. (Schlegel Villages Inc.) ***
295	160	Malton Village Long Term Care Centre	Public Licensee: The Regional Municipality of Peel
282	160	Maple Grove Care Community	For-Profit Licensee: 2063415 Ontario Limited as General Partner of 2063415 Investment LP
275	147	Woodhall Park Care Community	For-Profit Licensee: The Royale Development GP Corporation as general partner of The Royale Development LP (Specialty Care / Woodhall Park Inc.)
273	177	Peel Manor	Public Licensee: The Regional Municipality of Peel
184	95	Pine Grove Lodge	For-profit Licensee: Chartwell Master Care LP
180	150	Hawthorn Woods Care Community	For-Profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
179	128	Burton Manor	For-Profit Licensee: 1245556 Ontario Inc.

<u>10 LTC homes with the lowest waitlist</u>

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership
8	110	Humber Valley Terrace	For-Profit Licensee: Humber Valley Terrace Operating Inc.
17	181	Westside	For-Profit Licensee: Revera Long Term Care Inc.
19	146	Tullamore Care Community	For-Profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
44	78	King Nursing Home	For-Profit Licensee: King Nursing Home Limited
46	43	Shelburne Residence	For-Profit Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
108	119	Avalon Retirement Centre	For-Profit Licensee: 488491 Ontario Inc.
112	160	Deerwood Creek Care Community	For-Profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
119	64	Vera M. Davis Centre	Not-for-Profit Licensee: Peel Housing Corporation
132	224	Woodbridge Vista Care Community	For-Profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
140	138	Extendicare Brampton Long Term	For-Profit Licensee: Extendicare (Canada) Inc.

		Care Facility	

Central Toronto

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/TC-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
668	472	Baycrest Centre, Jewish Home for the Aged	Not-for-Profit Licensee: The Jewish Home For The Aged (Baycrest Hospital) ***
526	350	Kensington Gardens	Not-for-Profit Licensee: The Kensington Health Centre
495	279	Houses of Providences	Not-for-Profit Licensee: Unity Health Toronto
386	200	Chester Village	Not-for-Profit Licensee: Broadview Foundation
321	140	Belmont House	Not-for-Profit Licensee: Toronto Aged Men's and Women's Homes
249	88	Rekai Centre Wellesley Site	Not-for-Profit Licensee: The Rekai Centres
235	182	True Davidson Acres	Public Licensee: City of Toronto
222	146	Lakeshore Lodge	Public

			Licensee: City of Toronto
213	168	Isabel and Arthur Meighen Manor	Not-for-Profit Licensee: The Governing Council of the Salvation Army in Canada
204	434	Castleview Wychwood Towers (Long Term Care)	Public Licensee: City of Toronto

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
3	38	Chartwell White Eagle Long Term Care Residence	For-Profit Licensee: Chartwell Master Care LP
10	28	Garden Court Nursing Home	For-Profit Licensee: Shaparrall Limited
19	34	Suomi-Koti Toronto Nursing Home	Not-for-Profit Licensee: Toronto Finnish-Canadian Seniors Centre
29	41	Norwood Nursing Home	For-Profit Licensee: Norwood Nursing Home Limited
36	85	Ivan Franko Home (Etobicoke)	Not-for-Profit Licensee: Ukrainian Home for the Aged
39	199	The Heritage Nursing Home	For-Profit Licensee: Heritage Nursing Homes Inc.
53	18	St.Clair O'Connor Community Nursing Home	Not-for-Profit Licensee: St. Clair O'connor

			Community Inc.
59	92	Main Street Terrace	For-Profit Licensee: Revera Long Term Care Inc.
59	88	Rekai Centre Sherbourne Site	Not-for-Profit Licensee: The Rekai Centres
60	158	St. George Care Community	For-Profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

Central East

https://healthcareathome.ca/wp-content/uploads/2022/09/CE-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
2640	158	Mon Sheong Scarborough Long Term Care Centre	Not-for-Profit Licensee: Mon Sheong Foundation
2338	249	Yee Hong Centre-Scarborough Finch	Not-for-Profit Licensee: Yee Hong Centre for Geriatric Care
2308	154	Yee Hong Centre-Scarborough McNicoll	Not-for-Profit Licensee: Yee Hong Centre for Geriatric Care
1007	198	Fairview Lodge	Public Licensee: Regional Municipality of Durham
855	120	The Village of Taunton Mills	For-Profit Licensee: Oakwood Retirement Communities Inc.

854	300	Hillsdale Estates	Public Licensee: Regional Municipality of Durham
713	200	Hillsdale Terrace	Public Licensee: Regional Municipality of Durham
613	172	Chartwell WynField Long Term Care Residence	For-Profit Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
607	252	Fairhaven	Public Licensee: City and County of Peterborough
552	252	Shepherd Lodge	Not-for-Profit Licensee: Shepherd Village Inc.

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
1	136	Sunnycrest Nursing Home	Not-for-Profit Licensee: Lakeridge Health
12	32	Ehatare Nursing Home	Not-for-Profit Licensee: Estonian Relief Committee in Canada
16	202	Rockcliffe Care Community	For-Profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
17	96	Tony Stacey Centre for Veterans' Care	Not-for-Profit Licensee: Royal Canadian Legion District 'D' Care Centres
31	169	Craiglee Nursing Home	For-Profit Licensee: Craiglee Nursing Home Limited

32	157	Altamont Care Community	For-Profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
36	65	Pinecrest Nursing Home- Bobcaygeon	For-Profit Licensee: Medlaw Corporation Limited
38	233	Orchard Villa	For-Profit Licensee: CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
40	97	Hope Street Terrace	For-Profit Licensee: Cvh (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
42	54	Bon Air Long Term Care Residence	For-Profit Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.

South East

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/SE-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership
362	253	Hastings Manor for The Aged	Public Licensee: The Corporation of the County of Hastings
345	170	Rideaucrest Home	Public

			Licensee: The Corporation of the City of Kingston
324	128	Belmont Long Term Care Facility	For-Profit Licensee: Belcrest Nursing Homes Limited
321	174	Arbour Heights	For-Profit Licensee: AXR Operating (National) LP, by its General Partners
296	122	Crown Ridge Place	For-Profit Licensee: Crown Ridge Health Care Services Inc.
258	128	Fairmount Home For the Aged	Public Licensee: The Corporation of the County of Frontenac
257	168	The John M. Parrott Centre	Public Licensee: County of Lennox and Addington
245	243	Providence Manor	Not-for-Profit Licensee: Providence Care Centre
238	190	Trillium Retirement and Care Community	For-Profit Licensee: Specialty Care East Inc.
219	224	St. Lawrence Lodge	Public Licensee: The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott

<u>10 LTC homes with the lowest waitlist</u>

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC home**	**Ownership**
21	45	Kentwood Park	For-Profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership
27	60	Pine Meadow	Not-for-Profit

		Nursing Home	Licensee: Land O'Lakes Community Services
30	78	Rosebridge Manor	For-Profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership
31	47	West Lake Terrace	For-Profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership
44	97	Hallowell House	For-Profit Licensee: Revera Long Term Care Inc.
51	75	Stirling Manor Nursing Home	For-Profit Licensee: ManorCare Partners
54	49	Maplewood	For-Profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership
61	121	Perth Community Care Centre	For-Profit Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
62	60	Friendly Manor Nursing Home	For-Profit Licensee: ManorCare Partners II
63	57	E. J. Mcquigge Lodge	For-Profit Licensee: Keay Nursing Homes Inc

Champlain

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CH-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on	**Number of licensed beds**	**Name of LTC homes**	**Ownership**

waitlist for basic room			
542	450	Community Application-Perley Health Seniors Care Centre	Not-for-Profit Licensee: The Perley and Rideau Veterans' Health Centre
494	288	St. Patrick's Home	Not-for-Profit Licensee: St. Patrick's Home of Ottawa Inc.
409	161	Carleton Lodge	Public Licensee: City of Ottawa
364	254	The Glebe Centre-Ottawa	Not-for-Profit Licensee: The Glebe Centre Incorporated
327	216	Peter D. Clark Centre	Public Licensee: City of Ottawa
325	128	The Salvation Army Ottawa Grace Manor	Not-for-Profit Licensee: The Governing Council of the Salvation Army in Canada
322	160	Forest Hill	For-Profit Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
320	166	Miramichi Lodge	Public Licensee: County of Renfrew
289	224	Granite Ridge Care Community	For-Profit Licensee: Specialty Care Ottawa Inc.
285	160	Garden Terrace	For-Profit Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

<u>10 LTC homes with the lowest waitlist</u>

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership
0	450	The Perley and Rideau Veterans' Health Centre	Not-for-Profit Licensee: The Perley and Rideau Veterans' Health Centre
2	242	Extendicare Laurier Manor	For-Profit Licensee: New Orchard Lodge Limited [a Subsidiary Of Extendicare (Canada) Inc.]
5	46	Sarsfield Colonial Home	For-Profit Licensee: 2629693 Ontario Inc.
10	56	Caressant Care Bourget	For-Profit Licensee: Caressant-Care Nursing and Retirement Homes Limited
16	60	Pinecrest Plantagenet	For-Profit Licensee: CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
16	50	Tsiionkwanonhsote	Not-for-Profit Licensee: Mohawk Council of Akwesasne
19	242	Extendicare - West End Villa	For-Profit Licensee: New Orchard Lodge Limited [a Subsidiary of Extendicare (Canada) Inc.]
23	60	Lancaster Long Term Care Residence	For-Profit Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.

25	60	Champlain Long Term Care Residence	For-Profit Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
26	70	The Palace	For-Profit Licensee: CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)

Central

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CEN-LTCH-Waitlist-April2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
1641	200	Yee Hong Centre - Markham	Not-for-Profit Licensee: Yee Hong Centre for Geriatric Care
1620	192	Mon Sheong Richmond Hill LTC Centre	Not-for-Profit Licensee: Mon Sheong Foundation
904	320	Mon Sheong Stouffville	Not-for-Profit Licensee: Mon Sheong Foundation
673	168	Villa Leonardo Gambin	Not-for-Profit Licensee: Friuli Long Term Care
620	174	Valleyview Residence	Not-for-Profit Licensee: Advent Health Care Corporation
577	224	Southlake Residential Care Village	Not-for-Profit Licensee: Southlake Residential

			Care Village
565	160	Villa Colombo Seniors Centre (Vaughan)	Not-for-Profit Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.
551	391	Cummer Lodge	Public Licensee: City of Toronto
526	160	Union Villa	Not-for-Profit Licensee: Unionville Home Society
514	132	York Region Newmarket Health centre	Public Licensee: The Regional Municipality of York

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
38	249	Hawthorne Place Care Centre	For-Profit Licensee: Rykka Care Centres LP
42	100	Kristus Darzs Latvian Home	Not-for-Profit Licensee: Kristus Darzs Latvian Home
44	75	North Park Nursing Home	For-Profit Licensee: North Park Nursing Home Limited
45	36	King City Lodge Nursing Home	For-Profit Licensee: Poranganel Holdings Limited
65	136	Thompson House	Not-for-Profit Licensee: Don Mills Foundation for Seniors
68	119	River Glen Haven Nursing Home	For-Profit Licensee: ATK Care Inc.
77	252	Downsview Long	For-Profit

		Term Care Centre	Licensee: Gem Health Care Group Limited
78	170	Cheltenham Care Community	For-Profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
90	84	Willows Estate	For-Profit Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
95	152	Ukrainian Canadian Care Centre	Not-for-Profit Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation

North Simcoe Muskoka

Link**:** https://healthcareathome.ca/nsm-ltch-waitlist-april2022-en/

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
431	143	Grove Park Home for Senior Citizens	Not-for-Profit Licensee: Grove Park Home for Senior Citizens
420	160	Mill Creek Care Centre	Not-for-Profit Licensee: Mill Creek Care Centre
419	127	Victoria Village Manor	Not-for-Profit Licensee: Victoria Village Inc.
385	161	IOOF Seniors Home	Not-for-Profit Licensee: IOOF Seniors Homes Inc.
372	108	Woods Park Care Centre	For-Profit Licensee: Woods Park Care Centre Inc
357	160	The Pines	Public

			Licensee: The District of the Municipality of Muskoka
353	138	Roberta Place	For-Profit Licensee: Barrie Long Term Care Centre Inc
334	121	Trillium Manor Home for The Aged	Public Licensee: Corporation of the County of Simcoe
305	145	Leacock Care Centre	For-Profit Licensee: Orillia Long Term Care Centre Inc
289	160	Spencer House	Not-for-Profit Licensee: Spencer House Inc.

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
51	71	Creedan Valley Care Community	For-Profit Licensee: 2063412 Ontario Limited as general partner of 2063412 Investment LP
60	53	Owen Hill Care Community	For-Profit Licensee: 2063414 Ontario Limited as general partner of 2063414 Investment LP
90	89	Coleman Care Centre	For-Profit Licensee: Oakwood Retirement Communities Inc.
107	47	Collingwood Nursing Home	For-Profit Licensee: Collingwood Nursing Home Limited
107	71	Oak Terrace	For-Profit Licensee: Revera Long Term Care Inc

118	37	Stayner Care Centre	For-Profit Licensee: Stayner Care Centre Inc
119	64	Bob Rumball Home for the Deaf	Not-for-Profit Licensee: The Ontario Mission of the Deaf
126	45	Sara Vista	For-Profit Licensee: Revera Long Term Care Inc
145	182	Muskoka Shores Care Community	For-Profit Licensee: 2063412 Ontario Limited as general partner of 2063412 Investment LP
150	45	Bay Haven Nursing Home	For-Profit Licensee: Bay Haven Nursing Home Incorporated

North East

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/NE-LTCH-Waitlist-April-2022-EN.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
426	406	Pioneer Manor	Public Licensee: City of Greater Sudbury
316	128	St. Gabriel's Villa of Sudbury	Not-for-Profit Licensee: St. Joseph's Health Centre of Sudbury
295	108	Finlandia Hoivakoti	For-Profit Licensee: Finlandia Nursing Home Limited
274	176	Golden Manor	Public Licensee: The Corporation of the City

			of Timmins
259	180	Extendicare Timmins	For-Profit Licensee: Extendicare Northwestern Ontario Inc. [a Subsidiary Of Extendicare (Canada) Inc.]
230	238	Cassellholme	Public Licensee: Board of Management for the District of Nipissing East
174	160	Au Chateau	Public Licensee: Board of Management for the District of Nipissing West
174	126	Elizabeth Centre	For-Profit Licensee: Valley East Long Term Care Centre Inc.
154	128	Eastholme	Public Licensee: East District Of Parry Sound Home For The Aged
130	142	Waters Edge Care Community	For-Profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP

<u>10 LTC homes with the lowest waitlist</u>

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
2	95	Algoma Manor	Not-for-Profit Licensee: Algoma Manor Nursing Home
9	86	Extendicare Van Daele	For-Profit Licensee: New Orchard Lodge Limited [a Subsidiary Of Extendicare

			(Canada) Inc.]
11	58	Manitoulin Centennial Manor Home for The Aged	Public Licensee: Manitoulin Centennial Manor Home For The Aged Board of Management
12	98	Extendicare Kirkland Lake	For-Profit Licensee: Extendicare (Canada) Inc.
12	18	The Bignucolo Residence	Not-for-Profit Licensee: Chapleau Health Services
13	59	Wikwemikong Nursing Home	Not-for-Profit Licensee: Wikwemikong Nursing Home Limited
13	16	Lady Dunn Health Centre	Not-for-Profit Licensee: Lady Dunn Health Centre
13	20	Rosedale Centre	Not-for-Profit Licensee: Bingham Memorial Hospital
14	20	South Centennial Manor	Not-for-Profit Licensee: Anson General Hospital
16	32	Golden Birches	Not-for-Profit Licensee: North Shore Health Network

North West

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/NW-LTCH-waitlists-07-2022.pdf

10 LTC homes with the highest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**

368	150	Pioneer Ridge	Public Licensee: The Corporation Of The City Of Thunder Bay
292	128	Southbridge Pinewood Court Nursing Home	For-Profit Licensee: CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
176	448	Hogarth Riverview Manor	Not-for-Profit Licensee: St. Joseph's Care Group
139	157	Southbridge Roseview Manor Long-Term Care	For-Profit Licensee: CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
92	116	Pinecrest (Kenora)	Public Licensee: Board Of Management Of The District Of Kenora
92	97	Princess Court	Public Licensee: Kenora District Home For The Aged Board Of Management
72	21	William A. "Bill" George Extended Care	Not-for-Profit

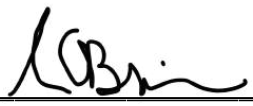
		Facility	Licensee: Sioux Lookout Meno-ya-win Health Centre
48	111	Bethammi Nursing Home	Not-for-Profit Licensee: St. Joseph's Care Group
34	22	Nipigon District Memorial Hospital- Extended Care	Not-for-Profit Licensee: Nipigon District Memorial Hospital
32	22	Wilkes Terrace	Not-for-Profit Licensee: North Of Superior Healthcare Group

10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	**Number of licensed beds**	**Name of LTC homes**	**Ownership**
8	122	Southbridge Lakehead Manor	For-Profit Licensee: Cvh (No. 9) Lp By Its General Partners, Southbridge Health Care Gp Inc. And Southbridge Care Homes (A Limited Partnership, By Its General Partner, Southbridge Care Homes Inc.)
8	26	Atikokan General Hospital- Extended Care	Not-for-Profit Licensee: Atikokan General Hospital

9	21	Rainy River Health Centre	Not-for-Profit License: Riverside Health Care Facilities Inc.
9	96	Wiigwas Elder and Senior Care	Not-for-Profit Licensee: Wiigwas Elder And Senior Care
12	12	Emo Health centre	Not-for-Profit Licensee: Riverside Health Care Facilities Inc.
12	131	Rainycrest	Not-for-Profit Licensee: Riverside Health Care Facilities Inc.
15	32	Northwood Lodge	Public Licensee: Board Of Management Of The District Of Kenora
18	9	Manitouwadge General Hospital-Extended Care	Not-for-Profit Licensee: Santé Manitouwadge Health
19	26	Geraldton District Hospital-Extended Care	Not-for-Profit Licensee: Geraldton District Hospital
32	22	Wilkes Terrace	Not-for-Profit Licensee: North Of Superior Healthcare Group

This is **Exhibit "M"** referred to in the Affidavit of **Natalie Mehra**, affirmed this 11 day of April, 2023, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.



A Commissioner for taking Affidavits etc.(*or as may be*) (pursuant to O. Reg 431/20)

Amanda Marie O'Brien, a Commissioner etc.
Province of Ontario, for Goldblatt Partners
LLP, Barristers & Solicitors
Expires November 15, 2024

Ontario Health Coalition
Numbers of Violations for the Ten Long-Term Care Homes with Lowest Waitlist in each of Ontario's Health Regions

February 1, 2023

This report contains a listing of the yearly violations in the ten LTC homes with the lowest wait lists per region.

Erie St. Clair

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/ESC_LTC-Wait-Times-April-2022.pdf

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership	Violations
5	96	Sumac Lodge	For-profit Licensee: Revera Long Term Care Inc	**2022** - Non-Compliances were not issued. **2021** - 4 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **2020** - 3 Written Notifications - 3 Voluntary Plan of Correction **2019** - 2 Written Notifications

				- 2 Voluntary Plan of Correction **2018** - 6 Written Notifications - 4 Voluntary Plan of Correction **Total violations for the past 5 years: 28**
7	62	Watford Quality Care Centre	For-profit Licensee: Qcc Corp.	**2022** - 1 Written Notifications **2021** - 18 Written Notifications - 12 Voluntary Plan of Correction - 3 Compliance Order **2020** - Non-Compliances were not issued. **2019** - 3 Written Notifications - 2 Voluntary Plan of Correction **2018** - 4 Written Notifications - 4 Voluntary Plan of Correction **Total violations for the past 5 years: 47**
7	142	Trillium Villa Nursing Home	For-profit Licensee: S & R Nursing Homes Ltd	**2022** - Non-Compliances were not issued. **2021** - Non-Compliances were not issued.

				2020 - Non-Compliances were not issued. **2019** - 2 Written Notifications - 1 Voluntary Plan of Correction **2018** - Non-Compliances were not issued. **Total violations for the past 5 years: 3**
10	112	Franklin Gardens Long Term Care Home	For-profit Licensee: DTOC Long Term Care LP, by its general partner, DTOC Long Term Care MGP (a general partnership) by its partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.	**2022** - 1 Written Notifications - 1 Voluntary Plan of Correction **2021** - 13 Written Notifications - 4 Voluntary Plan of Correction - 5 Compliance Order **2020** - 2 Written Notifications - 2 Voluntary Plan of Correction **2019** - 3 Written Notifications - 1 Voluntary Plan of Correction - 2 Compliance Order **2018** - 2 Written Notifications - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 38**

11	73	Tilbury Manor Nursing Home	For-profit Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation	**2022** - Non-Compliances were not issued. **2021** - 2 Written Notifications - 2 Compliance Order **2020** - Non-Compliances were not issued. **2019** - 1 Written Notifications **2018** - Non-Compliances were not issued. **Total violations for the past 5 years: 5**
11	103	Country Village Health Care Centre	For-profit Licensee: Cvh (No. 5) Lp By Its General Partners, Southbridge Health Care Gp Inc. And Southbridge Care Homes (A Limited Partnership, By Its General Partner, Southbridge Care Homes Inc.)	**2022** - 4 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2021** - 6 Written Notifications - 5 Voluntary Plan of Correction **2020** - 4 Written Notifications - 3 Voluntary Plan of Correction **2019** - 2 Written Notifications - 1 Compliance Order **2018** - 7 Written Notifications

				- 4 Voluntary Plan of Correction **Total violations for the past 5 years: 39**
16	209	Berkshire Care Centre	For-profit Licensee: Rykka Care Centres LP	**2022** - 6 Written Notifications **2021** - 1 Written Notifications - 1 Voluntary Plan of Correction **2020** - 8 Written Notifications - 4 Voluntary Plan of Correction - 3 Compliance Order **2019** - 19 Written Notifications - 15 Voluntary Plan of Correction - 2 Compliance Order **2018** - 13 Written Notifications - 9 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 82**
17	141	Banwell Gardens	For-profit Licensee: Rykka Care Centres LP	**2022** - 3 Written Notifications - 3 Compliance Order **2021** - 3 Written Notifications - 2 Voluntary Plan of Correction

				2020 - Non-Compliances were not issued. **2019** - 6 Written Notifications - 4 Voluntary Plan of Correction **2018** - 8 Written Notifications - 6 Voluntary Plan of Correction **Total violations for the past 5 years: 35**
19	65	Blenheim Community Village Long-Term Care Home	For-profit Licensee: Revera Long Term Care Inc	**2022** - Non-Compliances were not issued. ** **2021** - Non-Compliances were not issued. **2020** - 2 Written Notifications - 1 Voluntary Plan of Correction **2019** - Non-Compliances were not issued. **2018** - 2 Written Notifications - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 7 ****
20	128	Fiddick's Nursing Home Limited	For-profit Licensee: Fiddick's Nursing Home Limited	**2022** - 7 Written Notifications - 3 Voluntary Plan of Correction

				2021 - 5 Written Notifications - 2 Voluntary Plan of Correction - 3 Compliance Order **2020** - 5 Written Notifications - 4 Voluntary Plan of Correction **2019** - 4 Written Notifications - 1 Voluntary Plan of Correction - 2 Compliance Order **2018** - 10 Written Notifications - 7 Voluntary Plan of Correction **Total violations for the past 5 years: 53**

South West

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/SW_LTCH-Wait-Times-April-2022.pdf

Top 10 LTC home with the lowest waitlist

Number of people on waitlist for basic Room	Number of licensed beds	Name of LTC homes	Ownership	**Violations**
3	60	PeopleCare Stratford	For-profit Licensee: PeopleCare Stratford Inc.	**2022** -

				2021 - **2020** - **2019** - **2018** - **Total violations for the past 5 years:**
14	52	Caressant Care Listowel Nursing Home	For-profit Licensee: Caressant-Care Nursing and Retirement Homes Limited	**2022** - 4 Written Notifications **2021** - 9 Written Notifications - 8 Voluntary Plan of Correction - 1 Compliance Order - 1 Director Referral **2020** - 3 Written Notifications - 3 Voluntary Plan of Correction **2019** - 1 Written Notifications - 1 Voluntary Plan of Correction **2018** - 11 Written Notifications - 6 Voluntary Plan of Correction

				- 1 Compliance Order **Total violations for the past 5 years: 49**
15	61	Pinecrest Manor Nursing Home - Lucknow	For-profit Licensee: Revera Long Term Care Inc.	**2022** - Non-Compliances were not issued. **2021** - 12 Written Notifications - 6 Voluntary Plan of Correction - 6 Compliance Order **2020** - 3 Written Notifications - 2 Voluntary Plan of Correction **2019** - 5 Written Notifications - 4 Voluntary Plan of Correction **2018** - 2 Written Notifications - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 42**
16	60	Queensway Long Term Care Home	For-profit Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)	**2023** - Non-Compliances were not issued. **2022** - Non-Compliances were not issued. **2021** - Non-Compliances were not issued. **2020**

				- 4 Written Notifications - 2 Voluntary Plan of Correction **2019** - Non-Compliances were not issued. **2018** - 1 Written Notifications **Total violations for the past 5 years: 7**
17	69	Braemar Nursing Home	For-profit Licensee: MacGowan Nursing Homes Ltd.	**2022** - 4 Written Notifications - 4 Voluntary Plan of Correction **2021** - 4 Written Notifications - 4 Voluntary Plan of Correction **2020** - 6 Written Notifications - 6 Voluntary Plan of Correction **2019** - 3 Written Notifications - 1 Voluntary Plan of Correction **2018** - 1 Written Notifications - 1 Compliance Order - 1 Director Referral **Total violations for the past 5 years: 35**
21	34	Parkview Manor Health Care Centre	For-profit Licensee: Grosvenor Health Care Partnership (No. 3)	**2022** - Non-Compliances were not issued. **2021**

				- 2 Written Notifications - 1 Voluntary Plan of Correction **2020** - 1 Written Notifications - 1 Compliance Order **2019** - 1 Written Notifications - 1 Compliance Order **2018** - 8 Written Notifications - 5 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 22**
24	91	Maitland Manor	For-profit Licensee: Grosvenor Health Care Partnership (No. 3)	**2022** - 5 Written Notifications **2021** - 4 Written Notifications - 2 Voluntary Plan of Correction - 2 Compliance Order **2020** - 5 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **2019** - 23 Written Notifications - 13 Voluntary Plan of Correction

				- 7 Compliance Order **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 66**
24	33	Fordwich Village Nursing Home	For-profit Licensee: ATK Care Inc.	**2023** - 3 Written Notifications **2022** - No 2022 documents were recorded. **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2020** - 2 Written Notifications - 1 Voluntary Plan of Correction **2019** - 6 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 17**
26	45	Golden Dawn Senior Citizen Home Long Term Care	Not-for-profit Licensee: Golden Dawn Senior Citizen Home	**2022** - 12 Written Notifications - 1 Voluntary Plan of Correction

				- 2 Compliance Order "Notice of Administrative Monetary Penalty of $1100" **2021** - 8 Written Notifications - 6 Voluntary Plan of Correction - 1 Compliance Order **2020** - 4 Written Notifications - 3 Compliance Order **2019** - 11 Written Notifications - 5 Voluntary Plan of Correction - 4 Compliance Order **2018** - 1 Written Notifications - 1 Compliance Order - 1 Director Referral **Total violations for the past 5 years: 60**
27	63	Seaforth Manor - Nursing Home	For-profit Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)	**2022** - 10 Written Notifications - 1 Compliance Order **2021** - 1 Written Notifications - 1 Voluntary Plan of Correction

				2020 - Non-Compliances were not issued. **2019** - 1 Written Notifications - 1 Compliance Order **2018** - 9 Written Notifications - 6 Voluntary Plan of Correction **Total violations for the past 5 years: 30**

Waterloo Wellington

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic Room	Number of licensed beds	Name of LTC homes	Ownership	Violations
8	87	Caressant Care Fergus Nursing Home	For-profit Licensee: Caressant-Care Nursing and Retirement Homes Limited	**2022** - 12 Written Notifications **2021** - 3 Written Notifications - 2 Voluntary Plan of Correction **2020** - 11 Written Notifications - 5 Voluntary Plan of Correction - 2 Compliance Order

				2019 - 42 Written Notifications - 18 Voluntary Plan of Correction - 20 Compliance Order - 2 Director Referral "Suspension of admissions … risk of harm to health or well-being of residents in the home or persons who might be admitted" **2018** - 31 Written Notifications - 13 Voluntary Plan of Correction - 15 Compliance Order - 2 Director Referral **Total violations for the past 5 years: 178** <u>Relevant News Articles:</u> On CBC's top 30 homes with the most written notices https://www.cbc.ca/news/marketplace/ontario-care-homes-violations-seniors-abuse-1.5772707
18	80	Caressant Care Arthur Nursing Home	For-profit Licensee: Caressant-Care Nursing and Retirement Homes Limited	**2023** - Non-Compliances were not issued. **2022** - Non-Compliances were not issued. "[Order of the Director: Order requiring Management, section 157] the license has demonstrated a lack of ability and understanding of what is required to address non-compliance, sustain it, and operate the home in a manner that meets the requirements under the FLTCA and O. Reg. 246/22." **2021**

				- 6 Written Notifications - 4 Voluntary Plan of Correction - 2 Compliance Order **2020** - 1 Written Notification **2019** - 19 Written Notifications - 6 Voluntary Plan of Correction - 10 Compliance Order - 1 Director Referral **2018** - 7 Written Notifications - 5 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 62**
26	31	Twin Oaks of Maryhill	For-profit Licensee: Twin Oaks of Maryhill Inc.	**2022** - 1 Written Notification **2021** - Non-Compliances were not issued. **2020** - 3 Written Notifications - 2 Compliance Order **2019** - 9 Written Notifications - 5 Voluntary Plan of Correction **2018** - Non-Compliances were not issued.

				Total violations for the past 5 years: 20
32	67	Royal Terrace	For-profit Licensee: Shanti Enterprises Limited	**2022** - 3 Written Notifications **2021** - Non-Compliances were not issued. **2020** - 1 Written Notification - 1 Voluntary Plan of Correction **2019** - 6 Written Notifications - 3 Voluntary Plan of Correction - 2 Compliance Order **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 16**
43	28	Morriston Park Nursing Home	For-profit Licensee: Retirement Home Specialists Incorporated	**2022** - Non-Compliances were not issued. **2021** - 4 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2020** - Non-Compliances were not issued. **2019** - 1 Written Notification - 1 Voluntary Plan of Correction

				2018 - 1 Written Notification - 1 Voluntary Plan of Correction **Total violations for the past 5 years: 11**
45	72	Derbecker's Heritage House	For-profit Licensee: Derbecker's Heritage House Limited	**2022** - 1 Written Notification **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - Non-Compliances were not issued. **2019** - 1 Written Notification - 1 Voluntary Plan of Correction **2018** - Non-Compliances were not issued. **Total violations for the past 5 years: 5**
49	48	Chartwell Elmira LTC Residence	For-profit Licensee: Chartwell Master Care LP	**2022** - 2 Written Notifications - 1 Compliance Order **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - 2 Written Notifications **2019** - 2 Written Notifications - 2 Voluntary Plan of Correction

				2018 - 4 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 18**
51	79	Cambridge Country Manor	For-profit Licensee: Caressant-Care Nursing and Retirement Homes Limited	**2022** - Non-Compliances were not issued. **2021** - 7 Written Notifications - 4 Voluntary Plan of Correction - 3 Compliance Order **2020** - Non-Compliances were not issued. **2019** - 6 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **2018** - 6 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 35**
55	97	Nithview Home	Not-for-profit Licensee: Tri-County Mennonite Homes	**2022** - 11 Written Notifications - 3 Voluntary Plan of Correction - 3 Compliance Order

				2021 - 6 Written Notifications - 5 Voluntary Plan of Correction - 1 Compliance Order **2020** - 2 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2019** - 22 Written Notifications - 11 Voluntary Plan of Correction - 6 Compliance Order **2018** - 8 Written Notifications - 5 Voluntary Plan of Correction **Total violations for the past 5 years: 85**
66	92	LaPointe-Fisher Nursing Home	For-profit LaPointe-Fisher Nursing Home, Limited	**2022** - 7 Written Notifications **2021** - 10 Written Notifications - 7 Voluntary Plan of Correction - 3 Compliance Order **2020** - 11 Written Notifications - 5 Voluntary Plan of Correction - 3 Compliance Order **2019** - 30 Written Notifications

				- 12 Voluntary Plan of Correction - 14 Compliance Order - 6 Director Referral **2018** - 30 Written Notifications - 17 Voluntary Plan of Correction - 6 Compliance Order **Total violations for the past 5 years: 161** <u>Relevant News Articles:</u> On CBC's top 30 homes with the most written notices https://www.cbc.ca/news/marketplace/ontario-care-homes-violations-seniors-abuse-1.5772707

Hamilton Niagara Haldimand Brant

Link:

<u>Top 10 LTC homes with the lowest waitlist</u>

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership	Violations
6	68	Crescent Park Lodge	For-profit Licensee: 955464 Ontario Limited	**2022** - 14 Written Notifications - 4 Voluntary Plan of Correction - 6 Compliance Order **2021** - 4 Written Notifications

				- 1 Voluntary Plan of Correction **2020** - 5 Written Notifications - 5 Voluntary Plan of Correction **2019** - Non-Compliances were not issued. **2018** - 14 Written Notifications - 7 Voluntary Plan of Correction **Total violations for the past 5 years: 60**
8	184	Grace Villa Long Term Care Home	For-profit Licensee: Grace Villa Limited	**2023** - 1 Written Notification **2022** - 9 Written Notifications - 5 Voluntary Plan of Correction - 3 Compliance Order **2021** - 30 Written Notifications - 16 Voluntary Plan of Correction - 4 Compliance Order **2020** - 6 Written Notifications - 2 Voluntary Plan of Correction **2019** - 4 Written Notifications - 1 Compliance Order

				2018 - 21 Written Notifications - 6 Voluntary Plan of Correction - 3 Compliance Order **Total violations for the past 5 years: 110**
9	80	Blackadar Continuing Care Centre	For-profit Licensee: Blackadar Continuing Care Centre Inc	**2022** - 5 Written Notifications **2021** - 19 Written Notifications - 11 Voluntary Plan of Correction - 5 Compliance Order **2020** - 16 Written Notifications - 9 Voluntary Plan of Correction - 3 Compliance Order **2019** - 11 Written Notifications - 2 Voluntary Plan of Correction - 2 Compliance Order **2018** - 30 Written Notifications - 20 Voluntary Plan of Correction - 8 Compliance Order **Total violations for the past 5 years: 141**
14	101	West Park Health	For-profit	**2022**

		Centre	Licensee: CVH (No. 1) LP	- 8 Written Notifications - 3 Voluntary Plan of Correction **2021** - 17 Written Notifications - 6 Voluntary Plan of Correction - 3 Compliance Order **2020** - 13 Written Notifications - 5 Voluntary Plan of Correction - 4 Compliance Order **2019** - 12 Written Notifications - 6 Voluntary Plan of Correction - 1 Compliance Order **2018** - 17 Written Notifications - 5 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 102**
14	121	Fox Ridge	For-profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	**2023** - 2 Written Notifications - 1 Compliance Order **2022** - 6 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2021** - 10 Written Notifications

				- 5 Voluntary Plan of Correction - 2 Compliance Order **2020** - 5 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2019** - 41 Written Notifications - 22 Voluntary Plan of Correction - 11 Compliance Order **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 107**
16	48	Kilean Lodge Nursing Home	For-profit Licensee: Revera Long Term Care Inc	**2022** - 8 Written Notifications - 1 Voluntary Plan of Correction **2021** - 3 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2020** - 6 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2019** - 2 Written Notifications - 2 Voluntary Plan of Correction

				2018 - No 2018 documents were recorded. **Total violations for the past 5 years: 28**
20	60	Mount Nemo Christian Nursing Home	Not-for-profit Licensee: Canadian Reformed Society for a Home for the Aged	**2022** - 2 Written notifications **2021** - Non-Compliances were not issued. **2020** - 4 Written Notifications - 2 Voluntary Plan of Correction **2019** - 5 Written Notifications - 4 Voluntary Plan of Correction **2018** - 15 Written Notifications - 5 Voluntary Plan of Correction - 4 Compliance Order **Total violations for the past 5 years: 41**
21	126	Parkview Nursing Centre	For-profit Licensee: The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner	**2022** - Non-Compliances were not issued. **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction

				2020 - 1 Written Notification **2019** - 5 Written Notifications - 4 Voluntary Plan of Correction **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 13**
22	151	Oakwood Park Lodge	For-profit Licensee: Maryban Holdings Ltd	**2022** - 1 Written Notification **2021** - 3 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **2020** - 11 Written Notifications - 7 Voluntary Plan of Correction **2019** - 12 Written Notification - 6 Voluntary Plan of Correction - 2 Compliance Order **2018** - 10 Written Notifications - 5 Voluntary Plan of Correction - 2 Compliance Order

				Total violations for the past 5 years: 63
23	93	Maple Villa Long Term Care Centre	For-profit Licensee: Licensee: Dallov Holdings Limited (Better Life LTC Inc.)	**2022** - 3 Written Notifications **2021** - 4 Written Notifications - 4 Voluntary Plan of Correction **2020** - 5 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2019** - 6 Written Notifications - 5 Voluntary Plan of Correction **2018** - 7 Written Notifications - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 39**

Mississauga Halton

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/MH-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC homes with the lowest waitlist

Number of people on	Numbe r of	Name of LTC homes	Ownership	Violations

waitlist for basic room	licensed beds			
18	204	Camilla Care Community	Not-for-profit*** Licensee: Partners Community Health	**2022** - 17 Written Notifications - 12 Voluntary Plans for Correction **2021** - 5 Written Notifications - 2 Voluntary Plan of Correction **2020** - 42 Written Notifications - 20 Voluntary Plan of Correction - 6 Compliance Order **2019** - 11 Written Notifications - 6 Voluntary Plan of Correction - 4 Compliance Order **2018** - 18 Written Notifications - 10 Voluntary Plan of Correction - 5 Compliance Order **Total violations for the past 5 years: 158**
19	241	Eatonville Care Centre	For-profit Licensee: Rykka Care Centres LP	**2022** - 4 Written Notifications **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - 11 Written Notifications

				- 7 Voluntary Plan of Correction **2019** - 6 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2018** - Non-Compliance were not issued **Total violations for the past 5 years: 32** <u>Relevant News Articles:</u> Military had to enter due to horrible conditions. Report can be found here: https://www.documentcloud.org/documents/6928480-OP-LASER-JTFC-Observations-in-LTCF-
30	181	Cooksville Care Centre	For-profit Licensee: Rykka Care Centres LP	**2022** - 5 Written Notifications **2021** - 2 Written Notifications - 1 Compliance Order **2020** - 7 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **2019** - 6 Written Notifications - 4 Voluntary Plan of Correction

				2018 - 15 Written Notifications - 6 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 51**
43	90	Labdara Lithuanian Nursing Home	Not-for-profit Licensee: Labdara Foundation	**2022** - 9 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2021** - 2 Written Notifications **2020** - Non-Compliances were not issued. **2019** - 1 Written Notification **2018** - Non-Compliances were not issued. **Total violations for the past 5 years: 14**
67	94	Streetsville Care Community	For-profit Licensee: Vigour Limited Partnership on Behalf of Vigour General Partner Inc.	**2022** - 1 Written Notification - 1 Voluntary Plan of Correction **2021** - 4 Written Notifications - 2 Voluntary Plan of Correction

				2020 - 2 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2019** - 2 Written Notifications - 2 Voluntary Plan of Correction **2018** - 8 Written Notifications - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 27**
69	44	Mississauga Long Term Care Facility	For-profit Licensee: Mississauga Long Term Care Facility	**2022** - 11 Written Notifications - 1 Voluntary Plan of Correction - 3 Compliance Order "An Administrative Monetary Penalty (AMP) of $1100.00 is being issued." **2021** - 3 Written Notifications - 3 Voluntary Plan of Correction **2020** - 3 Written Notifications - 3 Voluntary Plan of Correction **2019** - 1 Written Notification - 1 Voluntary Plan of Correction

				2018 - 7 Written Notifications - 3 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 41**
75	66	Dom Lipa Nursing Home	Not-for-profit Licensee: Slovenian Linden Foundation	**2022** - 12 Written Notifications **2021** - 2 Written Notifications - 2 Voluntary Plan of Correction **2020** - 1 Written Notification - 1 Voluntary Plan of Correction **2019** - 2 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 22**
83	76	Erin Mills Nursing Home	For-profit Licensee: Schlegel Villages Inc	**2022** - 5 Written Notifications **2021** - Non-Compliances were not issued.

				2020 - 5 Written Notifications - 1 Compliance Order **2019** - 4 Written Notifications - 1 Voluntary Plan of Correction **2018** - 5 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 23**

136	130	Extendicare - Halton Hills	For-profit Licensee: Extendicare (Canada) Inc.	**2022** - 6 Written Notifications - 1 Voluntary Plan of Correction **2021** - 19 Written Notifications - 8 Voluntary Plan of Correction - 9 Compliance Order - 2 Director Referral **2020** - 19 Written Notifications - 9 Voluntary Plan of Correction - 5 Compliance Order - 1 Director Referral **2019** - 20 Written Notifications - 7 Voluntary Plan of Correction - 7 Compliance Order **2018** - 17 Written Notifications - 8 Voluntary Plan of Correction - 3 Compliance Order **Total violations for the past 5 years: 141** <u>Relevant News Articles:</u> On CBC's top 30 homes with the most written notices https://www.cbc.ca/news/marketplace/ontario-care-homes-violations-seniors-abuse-1.5772707
158	66	Bennett Health Care Centre	Not-for-Profit Licensee: Bennett Centre Long Term	**2022**

			Care At Bennett Village	- 1 Written Notification **2021** - 3 Written Notifications - 1 Voluntary Plan of Correction **2020** - 2 Written Notifications - 2 Voluntary Plan of Correction **2019** - 2 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2018** - 9 Written Notifications - 4 Voluntary Plan of Correction - 5 Compliance Order **Total violations for the past 5 years: 32**

Central West

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CW-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership	Violations
8	110	Humber Valley Terrace	For-profit Licensee: Humber Valley Terrace Operating Inc.	**2023** - 5 Written Notifications

				2022 - 5 Written Notifications - 5 Voluntary Plan of Correction **2021** - Non-Compliances were not issued. **2020** - 3 Written Notifications - 2 Voluntary Plan of Correction **2019** - 3 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2018** - 8 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 32**
17	181	Westside	For-profit Licensee: Revera Long Term Care Inc.	**2022** - 5 Written Notifications - 1 Compliance Order **2021** - 11 Written Notifications - 7 Voluntary Plan of Correction - 2 Compliance Order **2020** - 4 Written Notifications - 3 Voluntary Plan of Correction

				- 1 Compliance Order "Order of the Director: Mandatory Management Order, section 156." **2019** - 16 Written Notifications - 11 Voluntary Plan of Correction - 2 Compliance Order **2018** - 9 Written Notifications - 4 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 78**
19	146	Tullamore Care Community	For-profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	**2022** - 12 Written Notifications - 1 Compliance Order **2021** - 12 Written Notifications - 9 Voluntary Plan of Correction - 3 Compliance Order **2020** - 7 Written Notifications - 6 Voluntary Plan of Correction **2019** - 8 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **2018** - 29 Written Notifications - 15 Voluntary Plan of Correction

				- 6 Compliance Order **Total violations for the past 5 years: 113**
44	78	King Nursing Home	For-profit Licensee: King Nursing Home Limited	**2022** - 5 Written Notifications **2021** - 5 Written Notifications - 1 Voluntary Plan of Correction **2020** - 1 Written Notification - 1 Compliance Order **2019** - 3 Written Notifications - 3 Compliance Order **2018** - 33 Written Notifications - 16 Voluntary Plan of Correction - 11 Compliance Order - 2 Director Referral **Total violations for the past 5 years: 81**
46	43	Shelburne Residence	For-profit Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)	**2022** - Non-Compliances were not issued. **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020**

				- 5 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **2019** - 13 Written Notifications - 5 Voluntary Plan of Correction - 3 Compliance Order **2018** - 18 Written Notifications - 9 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 62**
108	119	Avalon Retirement Centre	For-profit Licensee: 488491 Ontario Inc.	**2022** - 2 Written Notifications **2021** - 3 Written Notifications - 1 Voluntary Plan of Correction **2020** - 1 Written Notification **2019** - 15 Written Notifications - 6 Voluntary Plan of Correction - 3 Compliance Order **2018** - 12 Written Notifications - 8 Voluntary Plan of Correction - 2 Compliance Order

				Total violations for the past 5 years: 53
112	160	Deerwood Creek Care Community	For-profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	**2022** - Non-Compliances were not issued. **2021** - 9 Written Notifications - 8 Voluntary Plan of Correction - 1 Compliance Order **2020** - 3 Written Notifications - 3 Voluntary Plan of Correction **2019** - 14 Written Notifications - 9 Voluntary Plan of Correction - 2 Compliance Order **2018** - 8 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 60**
119	64	Vera M. Davis Centre	Not-for-profit Licensee: Peel Housing Corporation	**2022** - 3 Written Notifications - 2 Voluntary Plan of Correction **2021** - Non-Compliances were not issued. **2020** - 1 Written Notification - 1 Voluntary Plan of Correction

				2019 - 5 Written Notifications - 1 Voluntary Plan of Correction **2018** - 3 Written Notification - 1 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 18**
132	224	Woodbridge Vista Care Community	For-profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	**2022** - 24 Written Notifications - 8 Voluntary Plan of Correction - 3 Compliance Order **2021** - 58 Written Notifications - 26 Voluntary Plan of Correction - 27 Compliances - 7 Director Referral **2020** - 17 Written Notifications - 6 Voluntary Plan of Correction - 3 Compliance Order **2019** - 13 Written Notifications - 5 Voluntary Plan of Correction - 1 Compliance Order **2018** - 12 Written Notifications - 5 Voluntary Plan of Correction

				- 5 Compliance Order **Total violations for the past 5 years: 220**
140	138	Extendicare Brampton Long Term Care Facility	For-profit Licensee: Extendicare (Canada) Inc.	**2022** - 2 Written Notifications **2021** - 7 Written Notifications - 3 Voluntary Plan of Correction - 2 Compliance Order **2020** - 1 Written Notification **2019** - 7 Written Notifications - 7 Voluntary Plan of Correction **2018** - 21 Written Notifications - 9 Voluntary Plan of Correction - 5 Compliance Order - 1 Director Referral **Total violations for the past 5 years: 65**

Central Toronto

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/TC-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC home with the lowest waitlist

Number of people on waitlist for	Number of licensed	Name of LTC homes	Ownership	**Violations**

basic Room	beds			
3	38	Chartwell White Eagle Long Term Care Residence	For-profit Licensee: chartwell Master Care LP	**2022** - 2 Written Notifications **2021** - Non-Compliances were not issued. **2020** - 4 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2019** - 1 Written Notification - 1 Voluntary Plan of Correction **2018** - 3 Written Notifications **Total violations for the past 5 years: 14**
10	28	Garden Court Nursing Home	For-Profit Licensee: Shaparrall Limited	**2022** - 8 Written Notifications - 1 Compliance Order "Administrative Monetary Penalty of $1100.00 issued for failure to comply with an order under s. 155 of the Act." **2021** - 1 Written Notification **2020** - 5 Written Notifications

				- 2 Voluntary Plan of Correction - 5 Compliance Order **2019** - 3 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2018** - 15 Written Notifications - 8 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 52**
19	34	Suomi-Koti Toronto Nursing Home	Not-for-profit Licensee: Toronto Finnish-Canadian Seniors Centre	**2022** - 1 Written Notifications - 1 Voluntary Plan of Correction **2021** - 5 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2020** - No 2020 records were documented. **2019** - 6 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **2018** - No 2018 records were documented.

				Total violations for the past 5 years: 19
29	41	Norwood Nursing Home	For-profit Licensee: Norwood nursing home limited	**2023** - 2 Written Notifications **2022** - 5 Written Notifications - 3 Voluntary Plan of Correction - 3 Compliance Order **2021** - Non-Compliances were not issued. **2020** - 8 Written Notifications - 5 Voluntary Plan of Correction - 1 Compliance Order **2019** - 1 Written Notification - 1 Voluntary Plan of Correction **2018** - 1 Written Notification - 1 Voluntary Plan of Correction **Total violations for the past 5 years: 29**
36	85	Ivan Franko Home (Etobicoke)	Not-for-profit Licensee: Ukrainian Home for the Aged	**2022** - 1 Written Notification - 1 Voluntary Plan of Correction - 2 Compliance Order **2021** - 4 Written Notifications

				- 1 Voluntary Plan of Correction - 2 Compliance Order **2020** - 7 Written Notifications - 1 Compliance Order **2019** - 4 Written Notifications **2018** - 3 Written Notifications - 1 Voluntary Plan of Correction **Total violations for the past 5 years: 27**
39	199	The Heritage Nursing Home	For-profit Licensee: Heritage Nursing Homes Inc.	**2022** - 1 Written Notification **2021** - 5 Written Notifications - 2 Voluntary Plan of Correction **2020** - 1 Written Notification - 1 Voluntary Plan of Correction **2019** - 6 Written Notifications - 4 Voluntary Plan of Correction - 2 Compliance Order **2018** - 6 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order

				Total violations for the past 5 years: 32
53	18	St. Clair O'Connor Community Nursing Home	Not-for-profit Licensee: St. Clair O'Connor Community Inc.	**2022** - 7 Written Notifications **2021** - 3 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2020** - 3 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2019** - Non-Compliances were not issued. **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 17**
59	92	Main Street Terrace	For-profit Licensee: Revera Long Term Care Inc.	**2022** - 3 Written Notifications **2021** - 4 Written Notifications - 4 Voluntary Plan of Correction **2020** - 14 Written Notifications - 12 Voluntary Plan of Correction **2019** - 6 Written Notifications

				- 3 Voluntary Plan of Correction **2018** - No 2018 documents were recorded. **Total violations for the past 5 years: 46**
59	88	Rekai Centre Sherbourne Site	Not-for-profit Licensee: The Rekai Centres	**2022** - **2021** - **2020** - **2019** - **2018** - **Total violations for the past 5 years:**
60	158	St. George Care Community	For-profit Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	**2022** - 6 Written Notifications - 4 Voluntary Plan of Correction **2021** - 10 Written Notifications - 5 Voluntary Plan of Correction - 4 Compliance Order **2020** - 3 Written Notifications - 2 Voluntary Plan of Correction

				- 1 Compliance Order **2019** - 7 Written Notifications - 6 Voluntary Plan of Correction - 1 Compliance Order **2018** - 7 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 61**

Central East

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CE-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC home with the lowest waitlist

Number of people on waitlist for basic Room	Number of licensed beds	Name of LTC homes	Ownership	**Notes**
1	136	Sunnycrest Nursing Home	Not-for-Profit Licensee: Lakeridge Health	**2022** - 23 Written Notification - 18 Voluntary Plan of Correction - 1 Compliance Orders **2021** - 6 Written Notification - 3 Voluntary Plan of Correction - 3 Compliance Orders

				2020 - 7 Written Notification - 4 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 15 Written Notification - 10 Voluntary Plan of Correction - 1 Compliance Orders **2018** - 5 Written Notification - 4 Voluntary Plan of Correction **Total violations for the past 5 years: 102**
12	32	Ehatare Nursing Home	Not-for-Profit Licensee: Estonian Relief Committee in Canada	**2022** - 1 Written Notification **2021** - Non-Compliances were not issued **2020** - Non-Compliances were not issued **2019** - 9 Written Notification - 5 Voluntary Plan of Correction **2018** - No 2018 documents uploaded **Total violations for the past 5 years: 14**
16	202	Rockcliffe Care Community	For-profit Licensee: Vigour Limited	**2022**

			Partnership on behalf of Vigour General Partner Inc	- 7 Written Notification - 5 Voluntary Plan of Correction **2021** - 5 Written Notification - 4 Voluntary Plan of Correction - 1 Compliance Orders **2020** - 9 Written Notification - 6 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 23 Written Notification - 11 Voluntary Plan of Correction - 2 Compliance Orders **2018** - 14 Written Notification - 7 Voluntary Plan of Correction - 5 Compliance Orders **Total violations for the past 5 years: 101**
17	96	Tony Stacey Centre for Veterans' Care	Not-for-profit Licensee: Royal Canadian Legion District 'D' Care Centres	**2022** - 2 Written Notification - 2 Voluntary Plan of Correction **2021** - 12 Written Notification - 8 Voluntary Plan of Correction - 3 Compliance Orders **2020** - 11 Written Notification

				- 9 Voluntary Plan of Correction - 1 Compliance Orders **2019** - 23 Written Notification - 18 Voluntary Plan of Correction - 1 Compliance Orders **2018** - 6 Written Notification - 5 Voluntary Plan of Correction **Total violations for the past 5 years: 101**
31	169	Craiglee Nursing Home	For-profit Licensee: Craiglee Nursing Home Limited	**2022** - 17 Written Notification - 4 Voluntary Plan of Correction - 1 Compliance Orders **2021** - 5 Written Notification - 3 Voluntary Plan of Correction **2020** - 19 Written Notification - 13 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 20 Written Notification - 11 Voluntary Plan of Correction - 4 Compliance Orders **2018** - 8 Written Notification - 4 Voluntary Plan of Correction

				- 3 Compliance Orders **Total violations for the past 5 years: 114**
32	157	Altamont Care Community	For-profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	**2022** - 8 Written Notification - 3 Voluntary Plan of Correction - 1 Compliance Orders **2021** - 11 Written Notification - 7 Voluntary Plan of Correction - 2 Compliance Order **2020** - 35 Written Notification - 20 Voluntary Plan of Correction - 15 Compliance Orders **2019** - 28 Written Notification - 18 Voluntary Plan of Correction - 5 Compliance Orders **2018** - 6 Written Notification - 4 Voluntary Plan of Correction - 1 Compliance Orders **Total violations for the past 5 years: 164** Military had to enter due to horrible conditions. Report can be found here:

				https://www.documentcloud.org/documents/6928480-OP-LASER-JTFC-Observations-in-LTCF-
36	65	Pinecrest Nursing Home - Bobcaygeon	For-profit Licensee: Medlaw Corporation Limited	**2022** - 4 Written Notification - 3 Voluntary Plan of Correction **2021** - 2 Written Notification - 2 Voluntary Plan of Correction **2020** - 5 Written Notification - 2 Voluntary Plan of Correction - 2 Compliance Orders **2019** - Non-Compliances were not issued **2018** - 20 Written Notification - 14 Voluntary Plan of Correction - 4 Compliance Orders **Total violations for the past 5 years: 58**
38	233	Orchard Villa	For-profit Licensee: CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)	**2022** - 7 Written Notification - 5 Voluntary Plan of Correction - 1 Compliance Orders **2021** - 13 Written Notification - 2 Voluntary Plan of Correction - 5 Compliance Orders

				2020 - 33 Written Notification - 24 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 16 Written Notification - 11 Voluntary Plan of Correction - 3 Compliance Orders **2018** - 8 Written Notification - 4 Voluntary Plan of Correction - 1 Compliance Orders **Total violations for the past 5 years: 135** On CBC's top 30 homes with the most written notices https://www.cbc.ca/news/marketplace/ontario-care-homes-violations-seniors-abuse-1.5772707 Military had to enter due to horrible conditions. Report can be found here: https://www.documentcloud.org/documents/6928480-OP-LASER-JTFC-Observations-in-LTCF-in-On.html
40	97	Hope Street Terrace	For-profit Licensee: Cvh (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its	**2022** - 4 Written Notifications **2021** - 12 Written Notification

			general partner, Southbridge Care Homes Inc.)	- 7 Voluntary Plan of Correction - 1 Compliance Orders **2020** - 12 Written Notification - 10 Voluntary Plan of Correction **2019** - 13 Written Notification - 10 Voluntary Plan of Correction - 2 Compliance Orders **2018** - 7 Written Notification - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 80**
42	54	Bon Air Long Term Care Residence	For-profit Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.	**2022** - 2 Written Notifications **2021** - 5 Written Notification - 4 Voluntary Plan of Correction **2020** - 6 Written Notification - 4 Voluntary Plan of Correction - 1 Compliance Orders **2019** - 16 Written Notification - 15 Voluntary Plan of Correction - Compliance Orders **2018** - Non-Compliances were not issued

				Total violations for the past 5 years: 53

South East

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/SE-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC home	Ownership	Violations
21	45	Kentwood Park	For-profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership	**2022** - 2 Written Notification **2021** - 4 Written Notification - 3 Voluntary Plan of Correction - 1 Compliance Orders **2020** - 2 Written Notification - 1 Voluntary Plan of Correction **2019** - 3 Written Notification - 1 Voluntary Plan of Correction **2018** - 14 Written Notification - 5 Voluntary Plan of Correction - 2 Compliance Orders - 2 Director Referrals **Total violations for the past 5 years: 40**
27	60	Pine Meadow Nursing	Not-for-profit	

		Home	Licensee: Land O'Lakes Community Services	**2022** - 3 Written Notification **2021** - Non-Compliances were not issued **2020** - Non-Compliances were not issued **2019** - 1 Written Notification - 1 Compliance Orders **2018** - 1 Written Notification - 1 Voluntary Plan of Correction **Total violations for the past 5 years: 7**
30	78	Rosebridge Manor	For-profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership	**2022** - 1 Written Notification **2021** - 2 Written Notification - 2 Voluntary Plan of Correction **2020** - 3 Written Notification - 1 Voluntary Plan of Correction **2019** - 4 Written Notification - 2 Voluntary Plan of Correction **2018** - 1 Written Notification

				Total violations for the past 5 years: 16
31	47	West Lake Terrace	For-profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership	**2023 (not included in the final count)** - Non-Compliances were not issued **2022** - 1 Written Notification **2021** - Non-Compliances were not issued **2020** - 1 Written Notification - 1 Voluntary Plan of Correction **2019** - 1 Written Notification **2018** - 1 Written Notification **Total violations for the past 5 years: 5**
44	97	Hallowell House	For-profit Licensee: Revera Long Term Care Inc	**2022** - 5 Written Notification - 4 Voluntary Plan of Correction **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - 4 Written Notification - 3 Voluntary Plan of Correction **2019** - 9 Written Notification

				- 1 Voluntary Plan of Correction - 2 Compliance Orders **2018** - 6 Written Notification - 4 Voluntary Plan of Correction **Total violations for the past 5 years: 40**
51	75	Stirling Manor Nursing Home	For-profit Licensee: ManorCare Partners	**2023 (not included in the final count)** - 5 Written Notifications **2022** - 1 Written Notification **2021** - 2 Written Notification - 1 Voluntary Plan of Correction **2020** - 1 Written Notification **2019** - 1 Written Notification **2018** - 1 Written Notification **Total violations for the past 5 years: 7**
54	49	Maplewood	For-profit Licensee: 0760444 B.C. Ltd. As General Partner on behalf of Omni Health Care Limited Partnership	**2022** - No 2022 documents uploaded **2021** - Non-Compliances were not issued **2020** - 3 Written Notification - 2 Voluntary Plans of Correction

				2019 - 6 Written Notification - 5 Voluntary Plan of Correction **2018** - 18 Written Notification - 6 Voluntary Plan of Correction - 3 Compliance Orders **Total violations for the past 5 years: 43**
61	121	Perth Community Care Centre	For-profit Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation	**2022** - 5 Written Notification - 2 Voluntary Plan of Correction - 2 Compliance Orders **2021** - 23 Written Notification - 20 Voluntary Plan of Correction - 3 Compliance Orders **2020** - 18 Written Notification - 9 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 18 Written Notification - 15 Voluntary Plan of Correction - 2 Compliance Orders **2018** - 8 Written Notification - 4 Voluntary Plan of Correction - 3 Compliance Orders **Total violations for the past 5 years: 134**

62	60	Friendly Manor Nursing Home	For-profit Licensee: ManorCare Partners II	**2022** - Non-Compliances were not issued **2021** - Non-Compliances were not issued **2020** - Non-Compliances were not issued **2019** - 2 Written Notification - 1 Voluntary Plan of Correction **2018** - 4 Written Notification - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 10**
63	57	E. J. Mcquigge Lodge	For-profit Licensee: Keay Nursing Homes Inc	**2022** - 2 Written Notification **2021** - 3 Written Notification - 2 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - Non-Compliances were not issued **2018** - Non-Compliances were not issued **Total violations for the past 5 years: 7**

Champlain

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CH-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC home with the lowest waitlist

Number of people on waitlist for basic Room	Number of licensed beds	Name of LTC homes	Ownership	**Notes**
0	450	The Perley and Rideau Veterans' Health Centre	Not-for-profit Licensee: The Perley and Rideau Veterans' Health Centre	**2022** - 5 Written Notification **2021** - 10 Written Notification - 8 Voluntary Plan of Correction **2020** - 4 Written Notification - 3 Voluntary Plan of Correction **2019** - 9 Written Notification - 6 Voluntary Plan of Correction - 1 Compliance Orders **2018** - 19 Written Notification - 7 Voluntary Plan of Correction - 2 Compliance Orders **Total violations for the past 5 years: 74**
2	242	Extendicare Laurier Manor	For-profit Licensee: New	**2022**

			Orchard Lodge Limited [a Subsidiary Of Extendicare (Canada) Inc.]	- 1 Written Notification - 1 Voluntary Plan of Correction **2021** - 7 Written Notification - 3 Voluntary Plan of Correction **2020** - 22 Written Notification - 7 Voluntary Plan of Correction - 3 Compliance Orders - 1 Director Referrals **2019** - 3 Written Notification - 3 Voluntary Plan of Correction **2018** - 18 Written Notification - 8 Voluntary Plan of Correction **Total violations for the past 5 years: 77**
5	46	Sarsfield Colonial Home	For-profit Licensee: 2629693 Ontario Inc.	**2022** - Non-Compliances were not issued **2021** - 8 Written Notification - 6 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - 1 Written Notification **2018** - 19 Written Notification

				- 10 Voluntary Plan of Correction - 4 Compliance Orders - 1 Director Referrals **Total violations for the past 5 years: 49**
10	56	Caressant Care Bourget	For-profit Licensee: Caressant-Care Nursing and Retirement Homes Limited	**2022** - 2 Written Notification **2021** - 5 Written Notification - 4 Voluntary Plan of Correction **2020** - 12 Written Notification - 3 Voluntary Plan of Correction - 1 Compliance Orders **2019** - 4 Written Notification - 3 Voluntary Plan of Correction **2018** - 4 Written Notification - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 40**
16	60	Pinecrest (Plantagenet)	For-profit Licensee: CVH (No. 4) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)	**2022** - No 2022 documents uploaded **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019**

				- Non-Compliances were not issued **2018** - 3 Written Notifications **Total violations for the past 5 years: 6**
16	50	Tsiionkwanonhsote	Not-for profit Licensee: Mohawk Council of Akwesasne	**2022** - 3 Written Notification - 3 Compliance Orders **2021** - 12 Written Notification - 4 Voluntary Plan of Correction - 5 Compliance Orders **2020** - 11 Written Notification - 2 Voluntary Plan of Correction - 5 Compliance Orders **2019** - 30 Written Notification - 20 Voluntary Plan of Correction - 8 Compliance Orders - 3 Director Referrals **2018** - 31 Written Notification - 19 Voluntary Plan of Correction - 7 Compliance Orders - 3 Director Referrals **Total violations for the past 5 years: 166**

19	242	Extendicare - West End Villa	For-profit Licensee: New Orchard Lodge Limited [a Subsidiary of Extendicare (Canada) Inc.]	**2022** - 5 Written Notification **2021** - 6 Written Notification - 4 Voluntary Plan of Correction **2020** - 6 Written Notification - 3 Voluntary Plan of Correction - 1 Compliance Order **2019** - 16 Written Notification - 8 Voluntary Plan of Correction **2018** - 12 Written Notification - 5 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 67**
23	60	Lancaster Long Term Care Residence	For-profit Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.	**2022** - Non-Compliances were not issued **2021** - 6 Written Notification - 4 Voluntary Plan of Correction - 2 Compliance Orders **2020** - 8 Written Notification - 4 Voluntary Plan of Correction

				2019 - Non-Compliances were not issued **2018** - 2 Written Notification - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 28**
25	60	Champlain Long Term Care Residence	For-profit Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.	**2022** - 1 Written Notification - 1 Voluntary Plan of Correction **2021** - 2 Written Notification - 2 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - 2 Written Notification - 2 Compliance Orders **2018** - 2 Written Notification **Total violations for the past 5 years: 12**
26	70	The Palace	For-profit Licensee: CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited	**2022** - 1 Written Notification - 1 Voluntary Plan of Correction **2021** - 1 Written Notification - 1 Voluntary Plan of Correction

			partnership, by its general partner, Southbridge Care Homes Inc.)	**2020** - 9 Written Notification - 7 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 3 Written Notification - 1 Voluntary Plan of Correction - **2018** - 5 Written Notification - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 34**

Central

Link: https://healthcareathome.ca/wp-content/uploads/2022/09/CEN-LTCH-Waitlist-April2022-EN.pdf

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership	Violations
38	249	Hawthorne Place Care Centre	For-profit Licensee: Rykka Care Centres LP	**2022** - 9 Written Notifications **2021** - 13 Written Notifications - 9 Voluntary Plans of Correction

				- 4 Compliance Orders **2020** - 33 Written Notifications - 16 Voluntary Plans of Correction - 13 Compliance Orders **2019** - 17 Written Notifications - 9 Voluntary Plans of Correction - 6 Compliance Orders **2018** - 21 Written Notifications - 7 Voluntary Plans of Correction - 3 Compliance Orders **Total violations for the past 5 years: 160** <u>Relevant News Articles:</u> Military had to enter due to horrible conditions. Report can be found here: https://www.documentcloud.org/documents/6928480-OP-LASER-JTFC-Observations-in-LTCF-
42	100	Kristus Darzs Latvian Home	Not-for-profit Licensee: Kristus Darzs Latvian Home	**2022** - 7 Written Notifications - 4 Voluntary Plans of Correction **2021** - 1 Written Notification - 1 Voluntary Plan of Correction

				2020 - 4 Written Notifications - 1 Voluntary Plan of Correction **2019** - 12 Written Notifications - 4 Voluntary Plans of Correction - 3 Compliance Orders **2018** - 3 Written Notifications - 1 Compliance Order - **Total violations for the past 5 years: 41**
44	75	North Park Nursing Home	For-profit Licensee: North Park Nursing Home Limited	**2022** - 1 Written Notifications **2021** - Non-Compliances were not issued **2020** - 4 Written Notifications - 4 Voluntary Plans of Correction **2019** - Non-Compliances were not issued **2018** - 9 Written Notifications - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 21**
45	36	King City Lodge	For-profit	

		Nursing Home	Licensee: Poranganel Holdings Limited	**2022** - Non-Compliances were not issued **2021** - 1 Written Notifications - 1 Voluntary Plan of Correction **2020** - 3 Written Notifications - 3 Voluntary Plan of Correction **2019** - Non-Compliances were not issued **2018** - 2 Written Notifications - 2 Voluntary Plan of Correction **Total violations for the past 5 years: 12**
65	136	Thompson House	Not-for-profit Licensee: Don Mills Foundation for Seniors	**2022** - 6 Written Notifications **2021** - 5 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **2020** - 1 Written Notifications - 1 Compliance Order **2019** - 6 Written Notifications - 5 Voluntary Plan of Correction - 1 Compliance Order

				2018 - 7 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 42**
68	119	River Glen Haven Nursing Home	For-profit Licensee: ATK Care Inc.	**2022** - 6 Written Notifications - 1 Compliance Order **2021** - 6 Written Notifications - 4 Voluntary Plan of Correction - 1 Compliance Order **2020** - 6 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order - 1 Director Referral **2019** - 9 Written Notifications - 4 Voluntary Plan of Correction **2018** - 19 Written Notifications - 12 Voluntary Plan of Correction - 2 Compliance Order **Total violations for the past 5 years: 75**
77	252	Downsview Long	For-profit	

		Term Care Centre	Licensee: Gem Health Care Group Limited	**2022** - 10 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2021** - 6 Written Notifications - 1 Voluntary Plan of Correction - 2 Compliance Orders **2020** - 19 Written Notifications - 9 Voluntary Plan of Correction - 5 Compliance Order - 2 Director Referral **2019** - 6 Written Notifications - 3 Voluntary Plan of Correction **2018** - 2 Written Notifications **Total violations for the past 5 years: 68**
78	170	Cheltenham Care Community	For-profit Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	**2022** - 6 Written Notifications **2021** - 1 Written Notification **2020** - 7 Written Notifications - 5 Voluntary Plan of Correction

				- 1 Compliance Order **2019** - 15 Written Notifications - 9 Voluntary Plan of Correction - 1 Compliance Order **2018** - 2 Written Notifications - 1 Voluntary Plan of Correction **Total violations for the past 5 years: 48**
90	84	The Willows Estate Nursing Home	For-profit Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership	**2022** - 5 Written Notification - 1 Compliance Order **2021** - 19 Written Notification - 8 Voluntary Plan of Correction - 12 Compliance Orders **2020** - 2 Written Notification - 2 Voluntary Plan of Correction **2019** - 20 Written Notifications - 14 Voluntary Plan of Correction **2018** - 22 Written Notification - 15 Voluntary Plan of Correction - 6 Compliance Orders

				Total violations for the past 5 years: 126
95	152	Ukrainian Canadian Care Centre	Not-for-profit Licensee: St. Demetrius (Ukrainian Catholic) Development Corporation	**2023 (not included in final count)** - 3 Written Notifications **2022** - 3 Written Notifications **2021** - 3 Written Notification - 2 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - 1 Written Notification - 1 Compliance Order **2018** - 9 Written Notification - 4 Compliance Order **Total violations for the past 5 years: 23**

North Simcoe Muskoka

Link**:** https://healthcareathome.ca/nsm-ltch-waitlist-april2022-en/

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership	Violations
51	71	Creedan Valley Care Community	For-profit Licensee: 2063412 Ontario Limited as general partner of 2063412 Investment LP	**2022** - 1 Compliance Order **2021** - 30 Written Notification - 14 Voluntary Plan of Correction - 12 Compliance Order - 1 Director Referral **2020** - 18 Written Notification - 8 Voluntary Plan of Correction - 9 Compliance Order - 4 Director Referrals **2019** - 38 Written Notifications - 13 Voluntary Plan of Correction - 26 Compliance Order - 5 Director Referrals **2018** - 31 Written Notifications - 15 Voluntary Plan of Correction - 9 Compliance Order **Total violations for the past 5 years: 234**
60	53	Owen Hill Care Community	For-profit Licensee: 2063412 Ontario Limited as	**2022**

			general partner of 2063412 Investment LP	- 3 Written Notification - 1 Voluntary Plan of Correction **2021** - 9 Written Notification - 5 Voluntary Plan of Correction - 1 Compliance Order **2020** - 2 Written Notification - 1 Voluntary Plan of Correction **2019** - 2 Written Notification - 2 Voluntary Plan of Correction **2018** - 8 Written Notification - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 37**
90	89	Coleman Care Centre	For-profit Licensee: Oakwood Retirement Communities Inc.	**2022** - 6 Written Notifications - 3 Compliance Orders **2021** - 1 Written Notification **2020** - 1 Written Notification - 1 Voluntary Plan of Correction **2019**

				- 4 Written Notifications - 2 Compliance Orders **2018** - 3 Written Notifications **Total violations for the past 5 years: 21**
107	47	Collingwood Nursing Home	For-profit Licensee: Collingwood Nursing Home Limited	**2022** - 13 Written Notifications **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction - 2 Compliance Orders **2020** - 7 Written Notifications - 5 Voluntary Plan of Correction - 2 Compliance Orders **2019** - 9 Written Notification - 7 Voluntary Plan of Correction - 1 Compliance Order **2018** - 30 Written Notifications - 17 Voluntary Plan of Correction - 10 Compliance Orders **Total violations for the past 5 years: 106**
107	71	Oak Terrace	For-profit	

			Licensee: Revera Long Term Care Inc.	**2022** - 4 Written Notifications **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction **2020** - 3 Written Notifications - 2 Voluntary Plan of Correction **2019** - 10 Written Notifications - 4 Voluntary Plan of Correction - 3 Compliance Orders **2018** - 5 Written Notifications - 3 Voluntary Plan of Correction **Total violations for the past 5 years: 37**
118	37	Stayner Care Centre	For-profit Licensee: Stayner Care Centre Inc.	**2022** - 4 Written Notifications **2021** - 1 Written Notifications - 1 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - 2 Written Notifications

				- 1 Voluntary Plan of Correction **2018** - 9 Written Notifications - 2 Voluntary Plan of Correction - 5 Compliance Orders **Total violations for the past 5 years: 25**
119	64	Bob Rumball Home for the Deaf	Not-for-profit Licensee: The Ontario Mission of the Deaf	**2022** - 5 Written Notifications - 1 Voluntary Plan of Correction **2021** - 1 Written Notifications - 1 Voluntary Plan of Correction **2020** - 3 Written Notifications - 2 Voluntary Plan of Correction - 1 Compliance Order **2019** - 5 Written Notifications - 3 Voluntary Plan of Correction - 1 Compliance Order **2018** - 13 Written Notifications - 6 Voluntary Plan of Correction - 3 Compliance Order **Total violations for the past 5 years: 45**
126	45	Sara Vista	For-profit	

			Licensee: Revera Long Term Care Inc.	**2022** - Non-Compliances were not issued **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction **2020** - 1 Written Notifications **2019** - 4 Written Notifications - 2 Voluntary Plan of Correction **2018** - 9 Written Notifications - 8 Voluntary Plan of Correction **Total violations for the past 5 years: 27**
145	182	Muskoka Shores Care Community	For-profit Licensee: 2063412 Ontario Limited as general partner of 2063412 Investment LP	**2022** - Non-Compliances were not issued **2021** - 2 Written Notifications - 1 Voluntary Plan of Correction - 1 Compliance Order **2020** - 12 Written Notification - 5 Voluntary Plan of Correction - 3 Compliance Order **2019**

				- 14 Written Notification - 10 Voluntary Plan of Correction - 3 Compliance Order **2018** - 6 Written Notification - 2 Voluntary Plan of Correction - 1 Compliance Order **Total violations for the past 5 years: 60**
150	45	Bay Haven Nursing Home	For-profit Licensee: Bay Haven Nursing Home Incorporated	**2022** - 6 Written Notification - 3 Voluntary Plans of Correction **2021** - 2 Written Notification - 2 Voluntary Plans of Correction **2020** - 3 Written Notification - 3 Voluntary Plan of Correction **2019** - 6 Written Notification - 6 Voluntary Plan of Correction **2018** - **No 2018 documents uploaded** **Total violations for the past 5 years:**

North East

Link: https://healthcareathome.ca/wp-content/uploads/2022/10/NE-LTCH-Waitlist-April-2022-EN.pdf

Top 10 LTC home with the lowest waitlist

Number of people on waitlist for basic Room	Number of licensed beds	Name of LTC homes	Ownership	**Violations**
2	95	Algoma Manor	Not-for-profit Licensee: Algoma Manor Nursing Home	**2022** - 4 Written Notification - 1 Compliance Order **2021** - 1 Written Notification **2020** - 2 Written Notification - 2 Voluntary Plan of Correction **2019** - 1 Written Notification **2018** - 6 Written Notification - 2 Voluntary Plans of Care - 1 Compliance Order **Total violations for the past 5 years: 20**
9	86	Extendicare Van Daele	For-profit Licensee: New Orchard Lodge	**2022** - 4 Written Notifications

			Limited [a Subsidiary Of Extendicare (Canada) Inc.]	- 2 Voluntary Plans of Care **2021** - 11 Written Notifications - 4 Voluntary Plans of Care - 4 Compliance Orders **2020** - 8 Written Notifications - 5 Voluntary Plans of Care - 3 Compliance Orders **2019** - 4 Written Notifications - 4 Voluntary Plans of Care **2018** - 7 Written Notifications - 4 Voluntary Plans of Care - 2 Compliance Orders **Total violations for the past 5 years: 62**
11	58	Manitoulin Centennial Manor Home for the Aged	Public Licensee: Manitoulin Centennial Manor Home For The Aged Board of Management	**2022** - 1 Written Notification **2021** - 3 Written Notifications - 2 Voluntary Plans of Care **2020** - Non-Compliances were not issued **2019**

				- 2 Written Notifications - 1 Compliance Order **2018** - 9 Written Notification - 3 Voluntary Plans of Care **Total violations for the past 5 years: 21**
12	98	Extendicare Kirkland Lake	For-profit Licensee: Extendicare (Canada) Inc.	**2022** - Non-Compliance were not issued **2021** - 5 Written Notifications - 2 Voluntary Plans of Care **2020** - 5 Written Notifications - 4 Voluntary Plans of Care **2019** - 8 Written Notification - 5 Voluntary Plans of Care **2018** - 4 Voluntary Plans of Care **Total violations for the past 5 years: 33**
12	18	The Bignucolo Residence	Not-for-profit Licensee: Chapleau Health Services	**2022** - 3 Written Notifications - 1 Compliance Orders

				2021 - 12 Written Notifications - 7 Voluntary Plans of Correction - 2 Compliance Orders **2020** - 4 Written Notifications - 4 Voluntary Plans of Correction **2019** - Non-Compliances were not issued **2018** - 1 Written Notification **Total violations for the past 5 years: 34**
13	59	Wikwemikong Nursing Home	Not-for-profit Licensee: Wikwemikong Nursing Home Limited	**2022** - Non-Compliances were not issued **2021** - 16 Written Notifications - 8 Voluntary Plans of Correction - 7 Compliance Order - 1 Director Referral **2020** - 7 Written Notifications - 6 Voluntary Plans of Correction **2019** - 10 Written Notifications - 4 Voluntary Plans of Correction - 1 Compliance Order

				2018 - 22 Written Notifications - 10 Voluntary Plans of Correction - 7 Compliance Order - 4 Director Referrals **Total violations for the past 5 years: 103**
13	16	Lady Dunn Health Centre (Wawa)	Not-for-profit Licensee: Lady Dunn Health Centre	**2022** - Non-Compliances were not issued **2021** - Non-Compliances were not issued **2020** - Non-Compliances were not issued **2019** - 1 Written Notification **2018** - 14 Written Notifications - 10 Voluntary Plans of Correction - 2 Compliance Orders - 1 Director Referral **Total violations for the past 5 years: 28**

13	20	Rosedale Centre	Not-for-profit Licensee: Bingham Memorial Hospital	**2022** - 3 Written Notifications **2021** - 4 Written Notifications - 2 Voluntary Plans of Correction **2020** - 7 Written Notifications - 7 Voluntary Plans of Correction **2019** - 2 Written Notifications - 1 Voluntary Plans of Correction **2018** - 3 Written Notifications - 3 Voluntary Plans of Correction **Total violations for the past 5 years: 32**
14	20	South Centennial Manor	Not-for-profit Licensee: Anson General Hospital	**2022** - 15 Written Notifications - 2 Voluntary Plans of Correction - 5 Compliance Orders **2021** - 6 Written Notifications - 4 Voluntary Plans of Correction **2020** - 10 Written Notifications - 3 Voluntary Plans of Correction

				- 6 Compliance Orders **2019** - 11 Written Notifications - 4 Voluntary Plans of Correction - 5 Compliance Orders **2018** - 12 Written Notifications - 3 Voluntary Plans of Correction - 4 Compliance Orders **Total violations for the past 5 years: 90**
16	32	Golden Birches	Not-for-profit Licensee: North Shore Health Network	**2022** - **2021** - **2020** - **2019** - **2018** - **Total violations for the past 5 years:**

North West

Link**:**

Top 10 LTC homes with the lowest waitlist

Number of people on waitlist for basic room	Number of licensed beds	Name of LTC homes	Ownership	Violations
8	122	Southbridge Lakehead	For-Profit Licensee: Cvh (No. 9) Lp By Its General Partners, Southbridge Health Care Gp Inc. And Southbridge Care Homes (A Limited Partnership, By Its General Partner, Southbridge Care Homes Inc.)	**2022** - 1 Written Notifications - 1 Voluntary Plans of Correction **2021** - 2 Written Notifications - 2 Voluntary Plans of Correction **2020** - 2 Written Notifications - 2 Voluntary Plans of Correction **2019** - 3 Written Notifications - 2 Voluntary Plans of Correction - 1 Compliance Order **2018** - 8 Written Notifications - 3 Voluntary Plans of Correction - 1 Compliance Order **Total violations for the past 5 years: 28**
8	26	Atikokan General Hospital	Not-for-Profit	**2022**

			Licensee: Atikokan General Hospital	- Non-Compliances were not issued **2021** - 2 Written Notifications - 2 Voluntary Plans of Correction **2020** - 6 Written Notifications - 4 Voluntary Plans of Correction **2019** - Non-Compliances were not issued **2018** - 6 Written Notifications - 3 Voluntary Plans of Correction - 1 Compliance Order **Total violations for the past 5 years: 24**
9	21	Rainy River Health Centre	Not-for-Profit License: Riverside Health Care Facilities Inc.	**2022** - 1 Written Notification **2021** - 3 Written Notifications - 3 Voluntary Plans of Correction **2020** - 3 Written Notifications - 2 Voluntary Plans of Correction - 1 Compliance Order **2019** - 3 Written Notifications

				- 3 Voluntary Plans of Correction **2018** - 8 Written Notifications - 3 Voluntary Plans of Correction **Total violations for the past 5 years: 30**
9	96	Wiigwas Elder and Senior Care	Not-for-Profit Licensee: Wiigwas Elder And Senior Care	**2022** - 1 Written Notification **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - 21 Written Notifications - 7 Voluntary Plans of Correction - 12 Compliance Orders - 2 Director Referrals **2019** - 27 Written Notifications - 19 Voluntary Plan of Correction - 3 Compliance Orders **2018** - 34 Written Notifications - 15 Voluntary Plans of Care - 7 Compliance Orders - 2 Director Referrals **Total violations for the past 5 years: 152**
12	12	Emo Health Centre	Not-for-Profit	

			Licensee: Riverside Health Care Facilities Inc.	**2022** - 1 Written Notification **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - 6 Written Notifications - 3 Voluntary Plans of Correction **2018** - 3 Written Notifications - 2 Voluntary Plans of Correction **Total violations for the past 5 years: 17**
12	131	Rainycrest	Not-for-Profit Licensee: Riverside Health Care Facilities Inc.	**2022** - Non-Compliances were not issued **2021** - 13 Written Notifications - 10 Voluntary Plan of Correction - 2 Compliance Orders **2020** - 7 Written Notifications - 3 Voluntary Plan of Correction - 2 Compliance Orders

				2019 - 31 Written Notifications - 14 Voluntary Plans of Correction - 2 Compliance Orders **2018** - 37 Written Notifications - 15 Voluntary Plan of Correction - 25 Compliance Orders - 7 Director Referrals **Total violations for the past 5 years: 168**
15	32	Northwood Lodge	Public Licensee: Board Of Management Of The District Of Kenora	**2022** - 1 Written Notification **2021** - 4 Written Notifications - 3 Voluntary Plans of Correction **2020** - 4 Written Notifications - 2 Voluntary Plans of Correction - 2 Compliance Orders **2019** - Non-Compliances were not issued **2018** - 27 Written Notifications - 17 Voluntary Plans of Correction - 3 Compliance Order **Total violations for the past 5 years: 63**

18	9	Manitouwadge General Hospital- Extended Care	Not-for-Profit Licensee: Santé Manitouwadge Health	**2022** - 2 Written Notifications **2021** - 1 Written Notification - 1 Voluntary Plan of Correction **2020** - Non-Compliances were not issued **2019** - 3 Written Notifications - 2 Voluntary Plans of Care - 1 Compliance Order **2018** - 5 Written Notifications - 3 Voluntary Plans of Care - 2 Compliance Orders **Total violations for the past 5 years: 20**
19	26	Geraldton District Hospital	Not-for-Profit Licensee: Geraldton District Hospital	**2022** - 1 Written Notification **2021** - 3 Written Notifications - 2 Voluntary Plans of Correction **2020** - Non-Compliances were not issued **2019**

				- 9 Written Notifications - 5 Voluntary Plans of Care **2018** - 1 Written Notification - 1 Voluntary Plan of Correction **Total violations for the past 5 years: 22**
32	22	Wilkes Terrace	Not-for-Profit Licensee: North Of Superior Healthcare Group	**2022** - 2 Written Notification - 1 Compliance Order **2021** - Non-Compliances were not issued **2020** - Non-Compliances were not issued **2019** - 5 Written Notifications - 4 Voluntary Plans of Correction **2018** - 5 Written Notifications - 5 Voluntary Plans of Correction **Total violations for the past 5 years: 22**

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

- and -

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINSISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondent

Court File No.

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced in Toronto

AFFIDAVIT OF
NATALIE MEHRA
(Affirmed April 11, 2023)

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ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

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