Office of the Auditor General of Ontario

COVID-19 Preparedness and Management

Special Report on Pandemic Readiness and Response in Long-Term Care

April 2021

Office of the Auditor General of Ontario

To the Honourable Speaker
of the Legislative Assembly

I am pleased to transmit my Special Report on *COVID-19 Preparedness and Management*, Chapter 5, under Section 12(1) of the *Auditor General Act*.

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Auditor General

April 2021
Toronto, Ontario

Ce document est également disponible en français.

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Reflections

The COVID-19 pandemic has presented a challenge to health experts and government decision-makers around the world that in many ways is unprecedented in its impact and complexity. Ontario health experts, frontline workers and government decision-makers have worked together to respond to the many challenges of the pandemic and its health, economic and social impacts on Ontarians.

By late March 2020, when COVID-19 had begun its ravage of long-term-care homes, it became blatantly obvious that aggressive infection prevention, detection and patient care actions were needed—and needed quickly—to prevent staggering death rates from becoming the norm across Ontario's entire long-term-care community. Unfortunately, neither the Ministry of Long-Term Care, nor the long-term-care sector was sufficiently positioned, prepared or equipped to respond to the issues created by the pandemic in an effective and expedient way. This is the subject of this report—*Chapter 5: Pandemic Readiness and Response in Long-Term Care*—one in a series of reports our Office has published on Ontario's response to COVID-19.

From a big-picture perspective, there were three underlying issues that made practical and timely action all the more challenging for the stakeholders involved. First, despite very specific observations and recommendations on preparing for future outbreaks made by the Expert Panel on SARS and Infectious Disease Control led by Dr. David Walker, the SARS Commission led by Mr. Justice Archie Campbell, our Office and others, actions taken over the years have been insufficient to ensure that we would be better prepared as a province for the 'next time'.

Secondly, ongoing and repeated concerns raised for well over a decade about systemic weaknesses in the delivery of long-term care to the elderly have not, for the most part, been adequately addressed.

Thirdly and finally, the long-term care sector's lack of integration within the healthcare sector, compounded by the timing of the reorganization of the healthcare sector, did not enable long-term-care homes to fully benefit from the needed lifesaving expertise in infection prevention and control that could have been provided to a much greater extent by public health units and hospitals.

This report contains 16 recommendations with 55 action items to address our audit findings. There should be no surprises in the content and recommendations in this report. Many of the issues

and recommendations have either been highlighted or recommended previously by this Office, or were the subject of public discussions or publications amongst the various stakeholders we met with during our audit, as well as other interested groups and individuals. Given the longstanding nature of these issues and the risks of severe outcomes, there is a need to keep decision-makers' attention focused on what needs to change, even though vaccines have helped to significantly reduce COVID-19 outbreaks and deaths in long-term care homes.

Proactively implementing the recommendations in this report, in concert with similar recommendations likely contained in the upcoming report of the Long-Term Care COVID-19 Commission, would better prepare the Ministry and the long-term-care sector for the impact of future disease outbreaks, and other significant and urgent care issues, on long-term-care home residents.

The province has committed to making improvements by increasing the provincial average direct care time provided per resident per day, and has committed to increasing beds available for long-term care. Steps are also being initiated to address personal support worker training requirements and update infection prevention and control requirements at long-term-care homes. Continued attention to the implementation of these commitments and additional recommendations would go a long way toward ensuring seniors living in Ontario's long-term-care homes are accorded the well-deserved dignity, safety and comfort that is clearly envisioned in Section 1 of the *Long-Term Care Homes Act, 2007*.

Sincerely,

Bonnie Lysyk, MBA, FCPA, FCA
Auditor General of Ontario

Special Report

Chapter 5:

Pandemic Readiness and Response in Long-Term Care

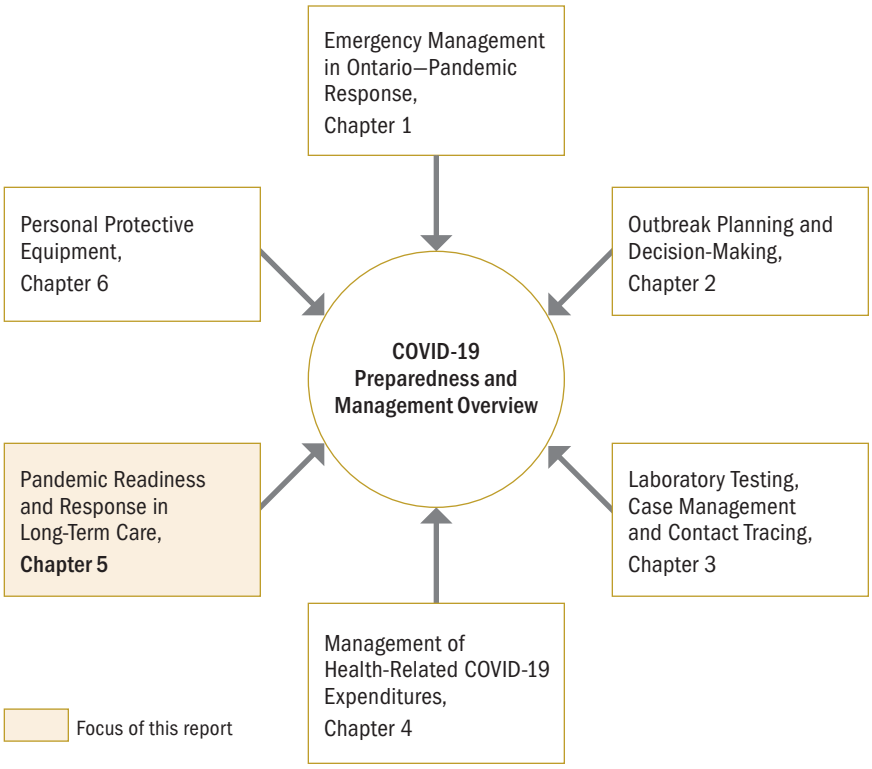
1.0 Summary

This chapter is one in a series of audits undertaken by our Office on the province's response to the Coronavirus Disease 2019 (COVID-19) pandemic (see **Figure 1**). **Chapter 5**, *Pandemic Readiness and Response in Long-Term Care*, looks at the preparedness and response of Ontario's long-term-care sector to COVID-19 between the onset of the pandemic in January 2020 (when the first case was identified in Ontario) up to December 31, 2020. Our work addresses some of the much-publicized issues surrounding the impact of COVID-19 in long-term-care homes and provides specific and pragmatic recommendations to address these issues.

This chapter covers a significant sector (one that has typically operated separately from hospitals and public health in the health-care system) that

Figure 1: Six Key Areas of the COVID-19 Audit by the Office of the Auditor General of Ontario

Prepared by the Office of the Auditor General of Ontario



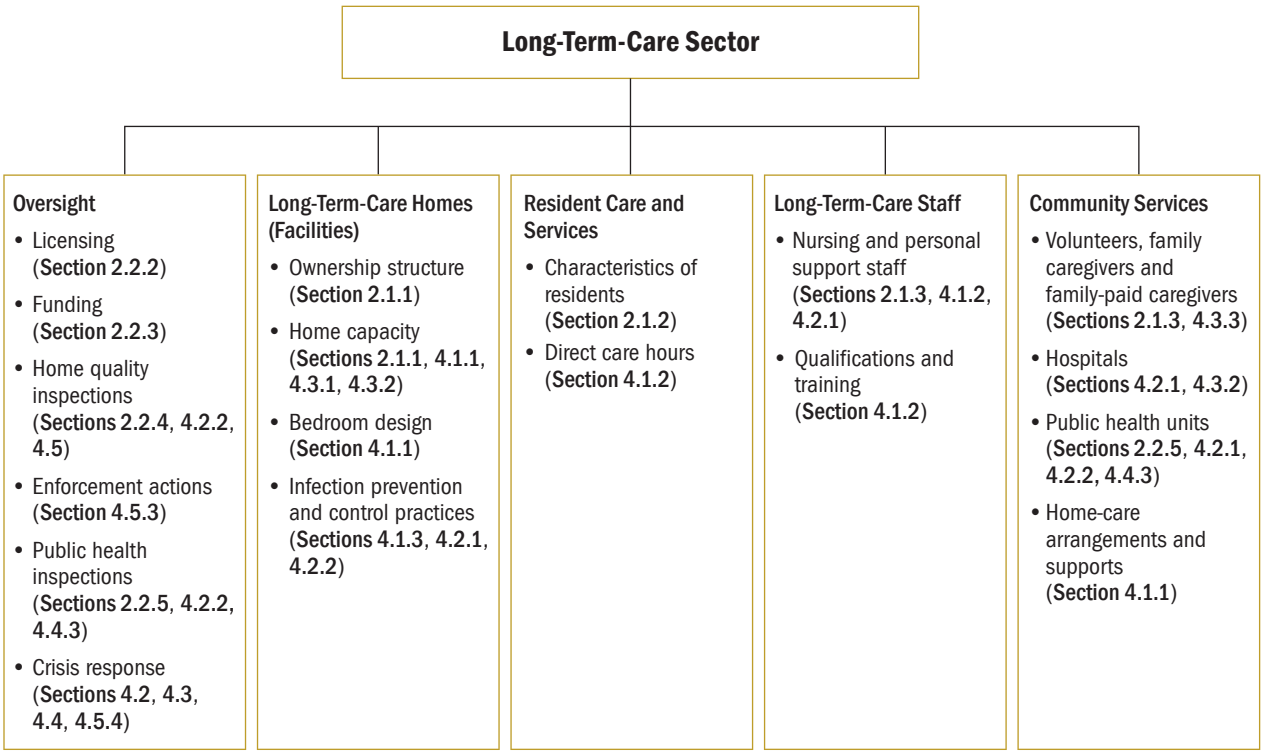
experienced severe human health impacts when COVID-19 directly affected the lives and well-being of many residents and staff in long-term-care facilities. The first cases of COVID-19 were identified in four long-term-care homes on March 17, 2020. From March 2020 to December 31, 2020, 475 or 76% of long-term-care homes in Ontario had reported cases of COVID-19 among their residents and staff.

Under Section 1 of the *Long-Term Care Homes Act, 2007*, "A long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

To satisfy this fundamental principle of the Act, the long-term-care sector has been given responsibilities in many areas (see **Figure 2**). These include providing appropriate living settings, staffing levels, quality of care, access to family support and other community services, and oversight of homes by the Ministry of Long-Term Care (Ministry).

Long-standing systemic problems in the sector were quickly and starkly amplified at the onset and during the first and second waves of the pandemic, and were contributing factors to the outbreaks and spread of COVID-19 in the long-term-care homes. Many other studies and reports, including some prior audit reports issued by our Office, have identified these long-standing systemic issues that have remained largely unresolved over the years by the province even with the increasing health-related needs of residents over the last decade. For example, as described in our *2019 Annual Report, Volume 1*, **Section 3.05**, Food and Nutrition in Long-Term-Care Homes, the needs of residents in homes have become more complex in the last 10 years, with residents relying more on personal support workers—over 85% of residents need

Figure 2: Key Areas in Long-Term Care Addressed in This Report
Prepared by the Office of the Auditor General of Ontario



extensive or 24/7 daily assistance; about one-third of residents have severely impaired cognitive abilities; and 64% have dementia.

Some of the contributing factors that we confirmed negatively impacted residents of long-term-care homes during the pandemic up to December 31, 2020 include the following:

- **Residents were living in rooms with three or four occupants.** Our analysis of self-reported COVID-19 data from homes from March 19 to August 31, 2020—the initial wave of the pandemic—found that, of all the homes where at least 30% of the home's residents became infected at the same time, almost two-thirds primarily had bedroom designs that housed three or four residents in one room. The Ministry and the Local Health Integration Networks, which are responsible for placing residents in long-term-care homes, did not know how many residents were actually housed in three- or four-bed wards when the pandemic hit the long-term-care sector in March 2020. The licences for over 26,500 beds in 257 or over 40% of the 626 long-term-care homes in Ontario are set to expire in 2025. The Ministry could not tell us how many of these beds will need to be renovated to comply with current Ministry bedroom standards that limit the number of residents sharing a room to two.
- **The transfer of patients designated as alternate level of care (ALC) from hospitals to long-term-care homes contributed to crowding in homes.** For example, in the month of March 2020, 761 transfers of patients designated as ALC were made from hospitals to long-term-care homes, 50% more than the average of 508 patients transferred per month throughout 2019. Given that homes were, on average, at 98% capacity prior to the pandemic according to the Ministry's occupancy data, these transfers of patients designated as ALC added pressure to the homes, some of which were already struggling to contain the spread of COVID-19.
- **Long-term-care homes had insufficient staff and staff training to provide appropriate care.** Our analysis of the staffing shortages reported by homes to the Ministry from March 19 to June 30, 2020 found that the staffing shortage peaked in late April, when 36 homes—ranging from a small 56-bed home to a large 300-bed home—reported critical shortages to the Ministry on the same day. A total of 76 homes reported critical staffing shortages during this period. Furthermore, the Ministry's July 2020 staffing study found that staffing shortages, even prior to the pandemic, and the rising complexity of residents' needs have resulted in gaps between personal support workers' (PSW) educational training and the working requirements at long-term-care homes. PSWs are not regulated in Ontario (and in Canada). Regulating the profession would help protect the health and safety of long-term-care home residents by setting standards of practice and putting in place accountability mechanisms for members.
- **Restricting families from visiting homes consequently eliminated a valuable source of resident care providers.** On March 30, 2020, Ontario's Chief Medical Officer of Health issued a directive that limited visitors to long-term-care homes to only essential visitors. The measure was intended to control COVID-19 outbreaks by limiting the number of people going into homes. However, this lack of contact took an emotional and physical toll on residents and their families, in many cases resulting in a deterioration in residents' physical and mental condition.
- **Infection prevention and control (IPAC) were not consistently practised in homes even prior to the COVID-19 pandemic.** Our analysis of the results of Ministry inspections between January 2015 and December 2019 found that a total of 413, or about two-thirds of all homes were cited for a total of 765 instances of non-compliance with IPAC requirements. Examples included residents leaving unlabelled

personal-care items in the sink areas of shared washrooms and staff not following proper hand hygiene during feeding. Effective IPAC practices are important given that, based on our analysis of outbreak information prior to the COVID-19 pandemic, 96.5% of homes had reported an outbreak related to acute respiratory infections, such as influenza, between January 2016 and December 2019. During that period, 42% or 264 homes reported an average of two to 13 outbreaks per year. As well, during our 2019 audit of Food and Nutrition in Long-Term-Care Homes, we noted that at the 59 homes we visited, only 76% of staff and 19% of residents were observed practising proper hand hygiene before or after a meal.

- **Long-term-care homes were initially not partnered with hospitals or public health units to benefit from their expertise in infectious disease outbreaks.** Given the limited IPAC specialists in long-term-care homes, many homes did not have the capacity to manage the COVID-19 outbreaks without external support, for example from hospitals. A September 2020 article in the *Canadian Medical Association Journal* highlighted the strong links between hospitals, long-term-care homes and public health units in British Columbia as a factor in the better outcomes in that province during the initial wave of COVID-19. As of July 8, 2020, only 347 or 55% of Ontario's 626 long-term-care homes had informal partnerships (that is, no formal agreement or memorandum of understanding) with a local hospital to allow homes to access IPAC expertise.
- **A problematic enforcement practice culminated with the Ministry completely discontinuing, in fall 2018, its proactive comprehensive inspections of homes to focus on clearing a growing backlog of critical incidents and complaints.** The number of compliance orders issued since our 2015 audit of the Ministry's inspection program increased from an average of 783 per year from 2012 to 2014 to 931 per year from 2015 to 2019. Despite this increase, the Ministry still had not implemented our 2015 recommendations aimed at addressing the issue of repeated non-compliance. In addition, in fall 2018, the Ministry discontinued annual comprehensive inspections despite the fact they had identified areas of significant non-compliance, including IPAC non-compliance.

In this report, we identify other problematic areas that are also critical to address to ensure that the residents of long-term-care homes are sufficiently protected and cared for, which is especially important when an infectious disease outbreak occurs in the facility and, in this case, in the community at the same time. These areas include:

- **A lack of structured collaboration between different government bodies and agencies on issues such as infection prevention and control inspections.** The Ministry of Long-Term Care has the mandate to inspect homes' compliance with the requirements of the *Long-Term Care Homes Act, 2007* and Regulation 79/10, but only has three staff who have IPAC expertise. On the other hand, public health units, whose staff do have the IPAC expertise, are not specifically required under the Ministry of Health's IPAC Protocol to conduct regular inspections of long-term-care homes. Currently, some public health units inspect long-term-care homes only if they receive an IPAC-related complaint about a home, while others conduct inspections on their own initiative.
- **Measures to contain COVID-19 were initially left up to home operators.** The Chief Medical Officer of Health issued his first mandatory instruction to long-term-care homes on March 22, 2020, directing homes not to permit residents to leave the home for short-stay absences and limit, *where possible* [emphasis added], the number of homes that employees were working at. When requirements were eventually issued to the long-term-care home operators, they were often unclear,

ambiguous and open to interpretation. For example, contract staff—temporary staff who are hired through employment agencies to fill vacancies—were allowed to work in multiple homes. This appeared to be inconsistent with the intent of the order to restrict long-term-care home employees from working at multiple sites.

In late 2020, there were 78,824 beds in the 626 homes across the province. As of August 31, 2020, Public Health Ontario had reported that 5,937 long-term-care home residents and 2,643 staff had contracted COVID-19; 1,815 residents and eight staff had died from it. As of that date, long-term-care home residents made up only 20.2% of total COVID-19 cases in Ontario but comprised 64.8% of all COVID-related deaths. The 1,815 residents and eight staff who died due to COVID-19 represented a 30.6% and 0.3% case fatality rate for residents and staff.

According to data from the National Institute on Ageing—a Ryerson University think tank focused on issues affecting Canada's aging population—at 40%, Ontario had the highest percentage of long-term-care and retirement homes that were affected by COVID-19 in Canada as of October 31, 2020.

September 2020 marked the beginning of a second upward trend in the daily number of new cases in long-term-care homes, averaging eight resident and four staff cases per day. As of December 31, 2020, Public Health Ontario had reported that 11,143 residents and 4,329 staff in Ontario's long-term-care homes had contracted COVID-19. An additional 985 residents died due to COVID-19 after August 31, 2020 for a total of 2,800 residents by December 31, 2020; fortunately, the number of staff deaths remained unchanged at eight.

With the arrival of vaccines, the number of COVID-19 outbreaks and deaths has been significantly reduced in the long-term-care homes, but the long-standing systemic issues that place residents at risk remain to be addressed.

Overall Conclusion

Overall, the Ministry of Long-Term Care and the long-term-care homes were not sufficiently positioned, prepared or equipped to respond to the issues created by the pandemic in an effective and expedient way. Despite ongoing concerns raised over several years prior to the pandemic, the public sector had not yet effectively addressed the systemic weaknesses in the delivery of long-term care in Ontario. As well, we noted that, unfortunately, the list of emergencies in Regulation 79/10 under the *Long-Term Care Homes Act, 2007* for which homes were required to develop an emergency response plan did not require them to be prepared for a pandemic emergency like COVID-19 before it occurred.

The Ministry's preparedness, and its ability to respond quickly and effectively, was also hampered by issues such as the long-term-care sector's lack of integration within the rest of the health-care sector, which could have provided the sector life-saving expertise on infection prevention and control from public health units.

Beginning in February 2020, the province implemented a number of measures to deal with the impact of COVID-19 in an attempt to minimize its spread. Unfortunately, some of these measures also had unintended consequences on long-term-care home residents and staff by further contributing to crowding and staffing shortages. In addition to these unintended consequences, the province delayed mandating, as opposed to recommending certain measures, did not provide clear directions to homes, and did not inspect to ensure that homes were complying with containment measures.

There should be no surprises about what is noted and recommended in this report. Many of the issues and recommendations have either been previously highlighted or made by this Office, or were spoken about publicly or discussed in publications by the various stakeholders we met with during our audit.

Implementing the recommendations in this report should better prepare the Ministry and the long-term-care sector for the impact of future infectious disease outbreaks and other care issues on the residents in long-term-care homes. But equally, if not more importantly, implementing these recommendations will go a long way to ensure that our seniors living in long-term-care homes are accorded the dignity, safety and comfort that was originally envisioned and set out in Section 1 of the *Long-Term Care Homes Act, 2007*. Chapter 6 will examine the impact of insufficient PPE on the spread of COVID-19 in long-term-care homes.

This report contains 16 recommendations with 55 action items to address our audit findings.

OVERALL RESPONSE

The Ministry of Long-Term Care (Ministry) thanks the Auditor General and her team for the recommendations. The Ministry shares the goal of ensuring long-term-care residents are afforded the dignity, safety and comfort they deserve.

Prior to COVID-19, the Ministry was undertaking steps to modernize the long-term-care sector to be more resident-centred and to provide high quality care responsive to residents' needs. The Ministry was focused on the development of new long-term-care beds and redeveloping older beds to modern design standards; addressing long-standing and systemic challenges with long-term-care staffing and addressing the recommendations from the 2019 *Public Inquiry into the Safety and Security of Residents of the Long-Term Care Homes System*.

The devastating experience and impact of COVID-19 on long-term-care residents, staff and their families and loved ones has shone a spotlight on the long-standing challenges in the sector—as well as additional issues that require urgent attention and reform.

In this context, the Ministry is currently working across three areas of focus:

- **Pandemic response:** while high rates of resident and staff vaccination have changed the current impact of COVID-19 on the long-term-care sector, the Ministry and homes need to remain vigilant to respond to ongoing and emerging outbreaks and developments over the course of the pandemic.
- **Recovery:** developing and implementing an action-oriented recovery framework to assist the sector to transition into the new normal.
- **Modernization:** redoubling efforts to support sustainable, longer-term change in areas such as staffing and capital development; improved performance, oversight and accountability; and improving quality of care, resident quality of life and public confidence.

Shortly, the Minister will be receiving the final report from the Long-Term Care COVID-19 Commission, which will have further findings and recommendations regarding the sector's experience of COVID-19, including recommendations on how to prevent the future spread of disease in long-term-care homes. In addition, the Ontario Ombudsman is undertaking an investigation into the government's oversight of long-term care during the COVID-19 pandemic. The Ministry intends to consider and integrate, as appropriate, the recommendations from the Auditor General in this report, along with the recommendations from the Commission and the Ombudsman as they become available, as it prioritizes key short-, medium- and longer-term actions to improve the long-term-care sector, making it a safer place for residents to receive the care they need and experience a high quality of life.

2.0 Background

2.1 Overview of Ontario's Long-Term-Care Sector

The 626 long-term-care homes that were operating in Ontario at the time of our review are to provide accommodation, care and other services for adults who require access to 24-hour nursing and personal care, and assistance with most or all daily activities such as eating, bathing and dressing.

The *Long-Term Care Homes Act, 2007* (Act) governs the process for placing individuals into homes and the provision of care to residents of homes. The fundamental principle of the Act is that a long-term-care home is "to be operated so that it is a place where [residents] may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

All long-term-care homes, regardless of their ownership, must comply with the requirements under the Act and its regulation, Regulation 79/10 (see **Appendix 1** for key provisions of the Act and regulation applicable to this review).

2.1.1 Long-Term-Care Homes

Homes are operated by either for-profit or not-for-profit entities (including municipalities). As shown in **Figure 3**, 57% of homes in Ontario are operated by for-profit entities. Under the Act, home operators are responsible for all aspects of operating their homes, including developing programs—such as those related to nursing and personal support, infection prevention and control (IPAC), nutrition, recreation and social activities—and acquiring the necessary supplies, equipment (including personal protective equipment (PPE)), and staff to deliver those programs. Each home must also have an interdisciplinary team responsible for implementing its IPAC program. The team must meet quarterly and invite the local medical officer of health to attend.

As of October 31, 2020, there were 78,824 beds in the 626 homes across the province. The majority of those beds were classified as long-stay (**Figure 4**), meaning that they were designed for those who require care and assistance for an indefinite period of time. Long-term-care homes may also provide short-stay beds, including interim beds for those who are awaiting placement in a long-term-care home after their hospital stay, convalescent care beds for those who require temporary intensive supports, and respite beds to provide temporary relief for caregivers.

Bed Classification Based on Occupancy

Long-term-care home beds are also categorized based on when the home was built or renovated, and whether it was built or renovated according

Figure 3: Types of Long-Term-Care Homes in Ontario, as of August 2019

Source of data: Ministry of Long-Term Care

Type of Long-Term-Care Home	# of Homes	% of Total Homes	# of Beds	% of Total Beds
For-profit homes	357	57	41,830	53
Not-for-profit homes (other than municipal homes)	169	27	20,117	26
Not-for-profit homes (municipal homes)	100	16	16,156	21
Total	**626***	**100**	**78,103**	**100**

* Does not include one home that is licensed to operate but was temporarily closed at the time of our audit due to a flood. Also does not include beds under the Extended Care Capital Assistance Program (ELDCAP), which are long-term-care beds located in and operated by acute-care hospitals. The ELDCAP was established in 1982 to expand bed capacity in small Northern Ontario communities.

Figure 4: Types of Rooms in Long-Term-Care Homes in Ontario, as of October 31, 2020

Source of data: Ministry of Long-Term Care

	Description[1]	# of Beds	% of Total Beds
Long-Stay Beds[2]			
Basic room	A two-bed room accommodating two residents with a separate ensuite washroom. Also includes ward-style rooms designed to accommodate three to four residents, as was permitted under the 1972 *Nursing Homes Act* Regulation.	35,980	45.65
Semi-private room	A one-bed room with an ensuite washroom that is shared with another one-bed room.	13,421	17.03
Private room	A one-bed room accommodating one resident with a separate ensuite washroom.	28,005	35.53
Subtotal		**77,461[3]**	**98.27[3]**
Short-Stay Beds			
Interim Beds	Created to provide increased long-term-care capacity for Alternate Level of Care (ALC) hospital patients (i.e., hospital patients who no longer require acute hospital care), and who are eligible for long-stay admission but are on a waiting list for a home.	347	0.44
Convalescent-Care Beds	For individuals recovering after surgery or serious illness who require intensive supports for a temporary period of time. Residents in these beds are expected to return to the community within 90 days.	723	0.92
Respite Beds	For individuals residing in the community whose caregivers require temporary relief from their caregiving obligations or individuals who require temporary care in order to continue to reside in the community. Residents in these beds are expected to return to their residences within 60 days after admission.	293	0.37
Subtotal		**1,363**	**1.73**
Total		**78,824**	**100**

1. Descriptions of the three types of long-stay beds are based on the *Long-Term Care Home Design Manual, 2015*, except as otherwise indicated.
2. Long-stay beds are for those residents who require 24-hour nursing care, substantial assistance with activities of daily living, and frequent supervision for an indefinite period of time. The vast majority of long-term-care home beds are long-stay.
3. The subtotal for long-stay beds does not equal the total when the number of beds in each room type (i.e. basic, semi-private, and private) are added up. The difference is due to known Ministry of Long-Term Care reporting issues. Because of this (and rounding), the individual percentages do not add up to the subtotal percentage.

to home design standards that were in place at the time of being built or renovated.

Long-term-care home design standards were first established in 1972 in a regulation under the *Nursing Homes Act*, which was repealed in July 2010, when the *Long-Term Care Homes Act, 2007* took effect. In 1999, the then Ministry of Health and Long-Term Care released new design standards in its *Long-Term Care Facility Design Manual* (Design Manual). **Figure 5** summarizes key relevant differences between the 1972 regulation and the 1999 Design Manual. The Ministry has made minor updates to the Design Manual since 1999, with the latest updates occurring in 2015. The current standards are based on the 2015 Design Manual.

The Ministry classifies long-term-care home beds into one of five classifications ranging from New (full compliance with 1999 standards) to Level D (non-compliance with 1972 and 1999 standards). **Figure 6** shows how beds that are currently in use are classified based on compliance with the 1972 Regulation and 1999 Design Manual standards and how many beds are in each classification.

The current standards—limiting rooms to house only one or two residents, with a maximum of two residents sharing one bathroom—apply to operators of new homes as well as to operators who are applying to renew their licence for existing homes. We discuss the licensing process in **Section 2.2.2**.

2.1.2 Residents of Long-Term-Care Homes

Almost 78,000 residents live in the 626 long-term-care homes, which typically operate close to capacity, across the province. Ontario's aging population will likely increase the demand for safe long-term care and/or safe home care in the next 25 years. According to Statistics Canada, the proportion of the population aged 65 and over in Ontario is projected to increase from 16.9% in 2018 to as high as 26.1% in 2043.

According to a 2019 report by the Financial Accountability Office of Ontario, in 2018/19, the median wait time for placement into a home was 152 days, or about five months. As of September 30, 2020, over 37,000 people were waiting for placement in a long-term-care home.

As described in our *2019 Annual Report, Volume 1*, **Section 3.05,** Food and Nutrition in Long-Term-Care Homes, the needs of residents in homes have become more complex in the last 10 years. For example, as noted in that report, as of March 31, 2019:

- residents had more complex health issues and were more physically frail;
- over 85% of residents needed extensive or 24/7 daily assistance;
- the majority of residents required wheelchairs or walkers, and were dependent on personal support workers to move around the home; and

Figure 5: Key Ways in Which Bedroom Design Standards in the 1972 *Nursing Home Act* Regulation and the *Long-Term Care Facility Design Manual, May 1999* Differ

Prepared by the Office of the Auditor General of Ontario

Key Area of Difference	1972 *Nursing Homes Act* Regulation	*Long-Term Care Facility Design Manual, May 1999**
The extent to which a home-like setting is established	Not applicable.	Homes are to have Resident Home Areas: smaller, self-contained units within the home that give residents more intimate and familiar living spaces and support long-term-care home staff in providing care to residents.
Existence of rooms with three or four beds	Rooms with three or four beds were allowed.	Rooms with three or four beds are not permitted. There can be no more than two beds per room.
Bedroom sizes	Single-bed rooms had at least 10.22 square metres (110 square feet) of floor space. Two-bed rooms had at least 8.36 square metres (90 square feet) of floor space per resident. Three-bed rooms had at least 8.36 square metres (90 square feet) of floor space per resident. Four-bed rooms had at least 7.43 square metres (80 square feet) of floor space per resident.	Single bed rooms must have at least 12.08 square metres (130 square feet) of floor space per resident. Two-bed rooms must have at least 10.68 square metres (115 square feet) of floor space per resident.
Sharing of resident washrooms	One washroom served up to four residents.	One washroom is to serve no more than two residents.

Note: The areas of differences listed are not exhaustive; only those areas relevant to aspects of this report are included.

* The objective of the 1999 standards was to create less institutional, more residential long-term-care homes that would provide a higher quality of life for residents. The standards applied to bedrooms that were new or renovated after May 1999.

Figure 6: Bed Classifications as Defined under Ministry of Long-Term Care Design Standards

Source of data: Ministry of Long-Term Care

Bed Classification	Description	Term of Licence[1] (Years)	Total # of Beds[2]	% of Total Beds
New bed	Complies with the *1999 Long-Term Care Facility Design Manual*, or was upgraded in accordance with the *2002 Long-Term Care "D" Retrofit Facility Design Manual*, or the *2009* or *2015 Long-Term Care Home Design Manual*.[3]	30[4]	39,508	50.6
A bed	Substantially complies with the *Long-Term Care Facility Manual, May 1999*.	25[4]	6,986	9.0
B bed	Substantially exceeds the structural standards of the 1972 *Nursing Homes Act* Regulation (1972 standards), but does not meet "A" bed criteria, which limits the room occupancy to two residents.	15	5,628	7.2
C bed	Meets the structural standards of the 1972 standards, which allowed three- and four-bed wards.	15	24,635	31.5
Upgraded D bed	Does not meet the 1972 standards but was upgraded to comply with the Ministry's 2002 D Bed Upgrade Option Guidelines. This involved spending at least $3,500 per bed on approved improvements to benefit resident health, safety or well-being.	10	1,346	1.7
Total			**78,103[5]**	**100**

1. Licences issued to municipal homes do not expire.
2. As of August 2019.
3. There were no significant changes in standards from 1999 to 2015 related to bedroom design.
4. Under the *Long-Term Care Homes Act, 2007* (Act), licences are issued for a term of 30 years or less, depending on the bed classification. In January 2015, the Act was amended to extend the term of licences for "New" and "A" beds by an additional five years, subject to the requirements of the Act.
5. Does not include beds in one home that is licensed to operate but was temporarily closed at the time of our audit due to a flood. Also does not include beds under the Extended Care Capital Assistance Program (ELDCAP), which are long-term-care beds located in and operated by acute-care hospitals. The ELDCAP was established in 1982 to expand bed capacity in small Northern Ontario communities.

- about one-third of residents had severely impaired cognitive abilities—64% had dementia (a progressive disease that affects all aspects of functioning).

Figure 7 shows a profile of long-term-care residents in Ontario from information as of March 31, 2009 and March 31, 2020. Over the last 11 years, the proportion of residents with complex care needs has increased. For example, since 2009, the proportion of residents with heart disease and dementia has increased by 14.3% and 12.5%, respectively. As of March 31, 2020, 75.9% of residents had heart disease, 63.2% had dementia (including Alzheimer's disease), 28% had diabetes, 18.3% had lung diseases such as asthma and chronic obstructive pulmonary disease, and 9.7% had cancer. The average duration of a resident's stay in long-term-care homes in Ontario was two years and eight months as of March 31, 2019—the most recent year for which this information is available.

According to a June 2020 Canadian Institute for Health Information (CIHI) report, the proportion of seniors (age 65 and older) living in long-term-care and retirement homes is higher in Canada than the average in Organisation for Economic Co-operation and Development (OECD) countries. In addition, compared with other OECD countries, residents in Canadian long-term-care and retirement homes are older, with 91% of residents over 65 years old and 74% over 80 years old (see **Figure 8**).

Figure 7: Profile of Long-Term-Care Residents in Ontario

Source of data: Canadian Institute for Health Information and Ministry of Long-Term Care

	As of March 31, 2009	As of March 31, 2020	% Change
Resident Demographics[1]			
Total # of residents	75,960	77,968	2.6
Average age of residents (years)	83	83	–
% of residents under 65 years old	6.4	6.4	–
% of residents aged 85 years or older	50.0	54.6	9.2
% of female residents	68.8	66.8	(2.9)
% of male residents	31.2	33.2	6.4
% of Residents with the Following Health Characteristics[1,2]			
Cancer	9.2	9.7	5.4
Dementia, including Alzheimer's disease	56.2	63.2	12.5
Diabetes	24.0	28.0	16.7
Heart disease[3]	66.4	75.9	14.3
Arteriosclerotic heart disease	11.8	15.6	32.2
Congestive heart failure	12.1	12.7	5.0
Hypertension	50.0	64.1	28.2
Lung disease[3]	16.0	18.3	14.4
Asthma	3.4	5.0	47.1
Emphysema/chronic obstructive pulmonary disease (COPD)	13.8	15.1	9.4
% of Residents with the Following Functioning Characteristics[1]			
Dependent or totally dependent on assistance for eating, mobility, toilet use, hygiene[4]	35.8	35.6	(0.6)
Severe impairment of cognitive performance[5]	30.7	33.6	9.4
Signs of depression[6]	28.1	27.4	(2.5)
Limited or no social engagement[7]	45.5	40.3	(11.4)
Average Duration of Resident Stay	**2 years, 7 months[8]**	**2 years, 8 months[8]**	–

1. According to the Canadian Institute for Health Information's (CIHI) Profile of Residents in Residential and Hospital-Based Continuing Care.
2. Percentages are based on total residents divided by total number of residents assessed. Patients may be assessed for multiple health-care characteristics.
3. These percentages are for residents with at least one of any type of heart or lung disease. The most prevalent types of heart or lung disease are shown in the indented rows below. Residents with more than one type of heart or lung disease are included in the percentages for each disease. For this reason, the percentages of residents with specific types of heart or lung disease add up to more than the percentage of residents with at least one type of heart or lung disease.
4. Based on a scale from 0–6, with 0 being independent and 6 being totally dependent, as per aggregate assessment scores recorded by long-term-care homes and collected by the CIHI. Includes residents that scored dependent (5) and totally dependent (6).
5. Based on a scale from 0–6, with 0 being cognitively intact and 6 being very severely impaired, as per aggregate assessment scores recorded by long-term-care homes and collected by the CIHI. Includes residents that scored moderate/severe (4), severe (5), and very severe (6) impairment.
6. Based on a scale from 0–14, with a score of 3 or greater indicating the potential presence of a depressive disorder, as per aggregate assessment scores recorded by long-term-care homes and collected by the CIHI. Includes residents scoring 3 (i.e., possible depressive disorder) or higher.
7. Based on a scale from 0–6, with 0 having the lowest social engagement and 6 being the highest social engagement, as per aggregate assessment scores recorded by long-term-care homes and collected by the CIHI. Includes residents that scored 1 or lower.
8. Average duration of resident stay as of December 31, 2011 (as per Office of the Auditor General of Ontario, *2019 Annual Report*, Volume 1, Chapter 3, **Section 3.05**, Food and Nutrition in Long-Term-Care Homes, page 296) and as of December 31, 2019 (as per the Ministry of Long-Term Care).

Figure 8: Age of Residents in Long-Term-Care and Retirement Homes in Organisation for Economic Co-operation and Development Countries

Source of data: Canadian Institute for Health Information*

	% of Residents	
	Aged 65+	**Aged 80+**
Australia	94	75
Belgium	96	78
Canada	**91**	**74**
France	90	Data not available
Germany	87	65
Hungary	68	40
Ireland	95	Data not available
Israel	92	65
Netherlands	66	48
Norway	90	68
Portugal	84	50
Slovenia	Data not available	57
Spain	87	69
United States	84	54
Average	**86**	**62**

* Data tables relating to the Canadian Institute for Health Information's June 2020 report titled *Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare With Other Countries*. These data tables provide information on the long-term-care sector in 17 countries in the Organisation for Economic Co-operation and Development countries. Data was collected as of May 25, 2020 from various international and national sources.

2.1.3 Long-Term-Care Staff

According to data from the Ministry of Long-Term Care's latest available staffing study (released in July 2020), in 2018 over 82,500 people worked in long-term-care homes in Ontario (see **Figure 9** for information on staffing, duties and qualifications). This consisted of 43% full-time employees, 45% part-time employees, and 12% casual and purchased services. An additional 12,500 people worked as cleaners and cooks, bringing the total to about 100,000 people working in the sector.

The *Long-Term Care Homes Act, 2007* (Act) requires each home to have a person in the following positions:

- an Administrator who is in charge of the home and is responsible for its overall management;
- a Director of Nursing and Personal Care who is a registered nurse who supervises and directs the nursing staff and personal care staff; and
- a Medical Director who is a physician who evaluates and addresses medical practices, clinical procedures and resident care (this individual cannot be the licensee, a person having a controlling interest in the licence or a member of the board of a corporate licensee).

Either a physician or a nurse practitioner is required to conduct a physical examination of each resident upon admission and annually. As well, at least one registered nurse needs to be on duty and present in the home at all times (this individual must be an employee of the home and a member of the regular nursing staff of the home).

The Act does not prescribe minimum staffing requirements beyond the ones just noted, but does require that homes have a staffing plan in place that provides for a staffing mix that is consistent with residents' care and safety needs.

According to data from the Ministry of Long-Term Care's 2018 staffing report, 61% of homes' employees were personal support workers (PSWs), who help residents with activities of daily living such as feeding, bathing and hygiene. Registered nursing staff—including registered practical nurses, registered nurses and nurse practitioners combined—comprised the second-largest type of staff, making up about 28% of all employees. The remaining 11% of employees provided support and administrative services.

In addition to paid employees, volunteers, residents' family members and private caregivers who are hired and paid by residents' families also help provide care and emotional support to residents, including feeding, grooming and bathing them, and helping them to exercise. According to the Ontario Caregiver Organization, there are about 3.3 million caregivers in Ontario. The Ontario Caregiver Organization is a not-for-profit organization funded by the Ministry of Health to serve as one point of access to information for individuals without medical training who provide physical

Figure 9: Staffing[1] in Long-Term-Care Homes in Ontario, 2018[2]

Source of data: Ministry of Long-Term Care

Type of Staff	Duties and Qualifications	#	% of Total Staff	Type of Employment (%)		
				Full-Time[3]	Part-Time	Casual and Purchased Services[4]
Personal support workers and health care attendants/ aides	• Assist residents with activities of daily living such as eating, bathing and walking, and perform light housekeeping duties and tasks delegated by registered health professionals. • May have a Personal Support Worker Certificate from an accredited college in Ontario. • The profession is unregulated.	49,978	61	42	48	10
Registered practical nurses (RPNs)	• Care for residents with less complex needs. • Completed a post-secondary nursing program at the college level. • Profession is regulated under the *Nursing Act, 1991* and by the College of Nurses of Ontario.	15,263	18	39	45	16
Allied health professionals and programming support staff	• Dietitians, occupational and physical therapists, social workers and others providing support and administrative services. • Qualifications and education vary according to profession.	9,405	11	60	31	9
Registered nurses (RNs)	• Care for residents with more complex needs and less predictable conditions. • Must have a bachelor's degree. • Profession is regulated under the *Nursing Act, 1991* and by the College of Nurses of Ontario.	7,846	10	40	42	18
Nurse practitioners (NPs)	• Can diagnose, prescribe medication, perform procedures, and order and interpret diagnostic tests. • Must have an advanced university education such as a master's degree or other specialty certificates. • Profession is regulated under the *Nursing Act, 1991* and by the College of Nurses of Ontario.	67	<1	63	35	2
Total		**82,559**	**100**	**43**	**45**	**12**

1. Actual number of staff (not full-time equivalent).
2. Based on the Ministry's long-term-care staffing report, which is generated from the voluntary submission of a staffing survey completed by long-term-care homes. In the latest report (2018), 602 of 626 homes submitted data.
3. For the purposes of the long-term-care staffing report, full-time is defined as an employee who is regularly scheduled for work 75 hours or more on a biweekly basis.
4. Casual employees work irregular hours and have no guaranteed hours of work, are not entitled to leave time and are not required to provide statutory notice for termination unless otherwise stated in the employment agreement.

and emotional support to a family member, partner, friend or neighbour. A November 2019 report by the Ontario Caregiver Organization and The Change Foundation—an independent health policy think tank—stated that 13% of Ontario caregivers they surveyed reported providing care to their loved one in an institution such as a long-term-care home.

2.2 Provincial Involvement with the Long-Term-Care Sector

In June 2019, the province separated the responsibilities of the former Ministry of Health and Long-Term Care into two separate ministries: the Ministry of Health and the Ministry of Long-Term Care.

The Ministry of Health sets the priorities for Ontario's health system, including both public health and health care. The Patient Ombudsman reports into the Minister of Health.

The Ministry of Long-Term Care licenses and regulates long-term-care homes, including conducting inspections required under the *Long-Term Care Homes Act, 2007*. It also provides funding, through Local Health Integration Networks (LHINs), to long-term-care homes for beds that are co-funded by residents.

Appendix 2 provides a schematic overview of Ontario's health-care system related to long-term care as of April 1, 2021.

2.2.1 Legislation

The *Long-Term Care Homes Act, 2007* (Act), which came into effect on July 1, 2010, and its Regulation 79/10, set out standards for all long-term-care homes in Ontario. The Act covers residents' rights, care and services; admission of residents; operation of homes; and funding and licensing of homes. It also provides the Ministry of Long-Term Care (Ministry) with the power to inspect homes to ensure that they are complying with the legislation and to take enforcement actions, if necessary.

The Health Protection and Promotion Act (HPPA) provides for the organization and delivery of public health programs and services, prevention of the spread of diseases, and promotion and protection of the health of Ontarians. Under the HPPA, the Ontario Chief Medical Officer of Health (who reports to the Deputy Minister of Health) may issue directives specifying precautions and procedures to be followed by health-care providers, which include long-term-care homes. Under the HPPA, local medical officers of health (who report to local municipal Boards of Health) may order institutions, such as long-term-care homes, to take specific actions for the purposes of monitoring, investigating and responding to an outbreak of communicable disease. Local public health units have the legislated ability to inspect long-term-care homes for public health-related matters, including infection prevention and control matters.

The Emergency Management and Civil Protection Act authorizes the Premier of Ontario and the Executive Council of Ontario to declare a state of emergency and issue emergency orders. It also requires, under section 6, ministries to develop emergency plans for certain types of emergencies as assigned to them by the Lieutenant Governor in Council through an Order in Council. Order in Council (OIC) 1157/2009 assigns the Minister of Health and the Minister of Long-Term Care the responsibility to develop emergency plans in respect of human health, disease and epidemics; health services during an emergency; and continuity of operations. The OIC requires that such emergency plans describe how the ministries will manage human health emergencies and ensure continued access to health services through continued engagement with partners including public health units, long-term-care facilities, and hospitals.

See **Appendix 1** for a list of key provisions of the above laws that are relevant to this report.

2.2.2 Licensing

The Ministry of Long-Term Care issues licences to long-term-care home operators under the *Long-Term Care Homes Act, 2007* for terms of up to 30 years based on bed classifications (**Figure 6**). Home operators who want to obtain a new licence or renew an existing one are required to build the new homes or renovate existing homes to comply with current design standards in the Ministry's Long-Term Care Facility Design Manual (Design Manual) (discussed in **Section 2.1.1**).

In cases where home operators renewing their licence cannot fully comply with current standards within the existing structure of the home, home operators can request permission from the Ministry to follow "Design Variance Standards" when renovating the home. For example, two-bed rooms may have 9.75 square metres of floor space instead of 10.68 square metres, as required by current standards. Design Variance Standards do not apply to new construction and only apply to renovation projects.

In 2002, 2007, 2014, and 2018 the Ministry launched bed renewal initiatives to support the renovation of Level B, C and D beds to comply with the current standards. These initiatives have been relatively unsuccessful; as shown in **Figure 6**, nearly one-third of beds are still categorized as C or D beds despite the 1999 design standards being in place for two decades. Through those initiatives, the Ministry provided construction funding subsidies to home operators once the renovations were completed.

Home operators were primarily responsible for raising the funds for the land and other capital costs of the renovation. The Ministry would then pay the home operator the subsidy—calculated on a per bed per day basis—for a period of up to 25 years. In September 2020, the Ministry updated its funding model to retroactively apply to all projects that started since June 2018. The policy now provides home operators with an upfront development grant as well as an enhanced funding subsidy—still payable over 25 years.

In July 2018, the province announced it would invest $1.75 billion to build 15,000 new beds and renovate 15,000 old beds by 2023. Subsequently, in July 2020, the province announced that the $1.75-billion investment would result in 8,000 new beds and 12,000 renovated beds by 2025. In addition, the province announced in the *2020 Ontario Budget* that it would fast track, through its Accelerated Build Pilot Program (Pilot Program), the planned construction of four long-term-care homes in Mississauga, Toronto and Ajax that are intended to have 1,280 beds ready for occupancy by early 2022. The Pilot Program intends to use modular construction (a process in which a building is constructed offsite in modules and then assembled onsite), rapid procurement, and leverage hospital lands to complete construction of the long-term-care homes years faster than traditional construction timelines.

As of September 2020, the licences for over 26,500 beds in 257 homes across the province were set to expire in 2025. The Ministry did not have information about how many of the 26,500 beds are in rooms that are designed and operated to house three or four residents.

2.2.3 Funding

In 2019/20, a total of $6 billion was collected by long-term-care homes: $4.4 billion in Ministry funding and $1.6 billion in resident co-payments. Annual provincial funding to long-term-care homes has increased by 12.8% between 2015/16 and 2019/20 (**Figure 10**). Increases averaged about 2.7% per year. The Ministry co-funds, along with residents, long-term-care home operations in Ontario as follows:

- Residents pay room and board charges based on rates set by the Ministry, which include the cost of food and other accommodation services such as housekeeping, food service, maintenance and administration. Effective July 1, 2019, the daily rate was $62.18 for basic (two- to four-bed rooms with a common washroom), $74.96 for semi-private, and $88.82 for private accommodation.

Figure 10: Provincial Funding to Long-Term-Care Homes, 2015/16–2019/20 ($ billion)

Source of data: Ministry of Long-Term Care

Fiscal Year	Amount	Change	% Change
2015/16	3.9	–	–
2016/17	4.0	0.1	2.6
2017/18	4.1	0.1	2.5
2018/19	4.3	0.2	4.9
2019/20	4.4	0.1	2.3
Total	**20.7**	**0.5**	**12.8**

- Homes receive Ministry funding through the LHINs for four categories: nursing and personal care; program and support services; raw food; and other accommodations (**Figure 11**). While most Ministry funding flows through the LHINs, some of it is provided directly by the Ministry.

The actual amount a home receives from the Ministry can vary depending on the following:

- its occupancy rate;
- the complexity of residents' medical needs, measured using the Case Mix Index—the relative measure of average resources required to provide for residents' needs; and
- how much money has been collected from resident co-payments. Although there is a daily rate set for resident co-payments, the actual amount collected from resident co-payments may be less than the daily rate set by the Ministry because the amounts charged to residents are adjusted based on their ability to pay the full rate. About 35% of residents receive financial assistance (to subsidize or cover part of their co-payments) from the Ministry to pay for accommodation.

Figure 11: Ministry of Long-Term Care Per Diem Funding Per Resident to Long-Term-Care Homes by Funding Categories, April 2020

Source of data: Ministry of Long-Term Care

Funding Category	Details	Amount ($)	Allocation (%)
Nursing and Personal Care	• Includes wages, benefits and training for direct-care staff, as well as any equipment or supplies used by direct-care staff to provide nursing and personal care to the residents. • Staff in this category include registered nurses, registered practical nurses, and personal support workers who, beyond clinical duties, provide eating assistance to residents.	102.34	57
Program and Support Services	• Includes staff, equipment and supplies used to provide services and programs to residents. • Staff in this category include Registered Dietitians, physiotherapists, occupational therapists, social workers, recreational staff and others that provide support services to residents.	12.06	7
Raw Food	• Strictly for the purchase of raw food materials, including food supplements ordered by a physician, a nurse, or a Registered Dietitian. • Includes the resident portion of food for special events (like Christmas dinners), but does not include any non-resident guests like family.	9.54[1]	5
Other Accommodations	• Includes other eligible expenditures defined in the Ministry's policy that are not included in the above categories, such as dietary services (i.e., food service workers, cooks), housekeeping services, property operations and maintenance, and general and administration services.	56.52[1]	31
Total		**180.46[2]**	**100**

1. Ministry funds up to this amount after the long-term-care home applies the residents' co-payments to this category.
2. Amount is the base rate for residents with the lowest complexity of needs. The Ministry uses a formula to adjust this base per diem rate according to the overall complexity score of the residents in the long-term-care home. For 2020/21, the Ministry provided additional per diem funding of $4.50 per resident to enhance direct-care services and support other operating costs within any of the four categories.

Some homes may also receive additional funding beyond what they receive from the Ministry and their residents. For instance, not-for-profit homes may receive additional funding through fundraising efforts, and municipal homes may receive additional funding from their municipality.

2.2.4 Ministry Inspections of Long-Term-Care Homes

The Act requires the Ministry to inspect, without prior notice, each long-term-care home at least once a year. However, the Act does not specify what type of inspection must be done, or that all aspects of each home's operations must be inspected annually.

The Act also requires the Ministry to perform inspections if it receives information from any source that certain incidents have occurred, such as improper or incompetent care of a resident, that have resulted in serious harm or significant risk of serious harm to the resident.

The Ministry's Long-Term Care Inspections Branch (**Appendix 3**) is responsible for inspecting long-term-care homes to ensure compliance with the Act and its Regulation 79/10. A centralized intake unit in Hamilton, with nine triage officers, receives and assesses each complaint and critical incident report (from any source) and determines whether an inspection is required. Complaints and critical incidents that require an inspection are referred to one of seven regional offices, which are located in London, Waterloo, Hamilton, Toronto, Sudbury, Oshawa and Ottawa. As of December 31, 2020, there were 143 inspectors across the regional offices. The number of inspectors in each regional office ranged from 17 in Waterloo to 26 in Sudbury (**Figure 12**). There was a total of 41 vacant positions across the province.

At the time of our 2015 audit of the Long-Term-Care Home Quality Inspection Program (Program), there were four types of inspections: comprehensive inspections, critical incident inspections, complaints inspections and follow-up inspections. Critical incident and complaints inspections are conducted in response to reports of critical incidents such as fire, unexpected or sudden death, or outbreaks of communicable diseases, and complaints related to care received by residents. Comprehensive inspections are proactive inspections designed to look at different aspects of a long-term-care home's operations (**Appendix 4**). **Figure 13** shows the number of long-term-care

Figure 12: Number of Inspectors by Region, as of December 31, 2020

Source of data: Ministry of Long-Term Care

Region	# of Homes	# of Beds	# of Inspectors	# of Beds per Inspector
Central East (Kingston)	88	11,783	19	620
Central West (Waterloo)	88	9,100	17	535
Hamilton	92	11,593	20	580
London	89	10,365	20	518
Ottawa	94	11,393	20	570
Sudbury	87	9,453	26	364
Toronto	88	15,142	21	721
Total	**626**	**78,829**	**143***	**551**

* Represents actual number of inspectors. There were a total of 41 vacancies across the province as of December 31, 2020: seven in Central East, eight in Central West, six each in Hamilton, London, Ottawa and Toronto, and two in Sudbury.

home inspections conducted by Ministry inspectors from 2015 to 2020.

Beginning in August 2016, the Ministry implemented a shorter, more focused comprehensive inspection approach, which we described in our 2017 follow-up report on the Program. In fall 2018, the Ministry discontinued comprehensive inspections to address its inspection backlog of complaints and critical incident reports. Since 2019, the Ministry has primarily conducted complaint and critical incident inspections.

2.2.5 Public Health Inspections of Long-Term-Care Homes

Public Health

Within the Ministry of Health, the Office of the Chief Medical Officer of Health is responsible for developing public health initiatives and monitoring public health programs that are delivered by 34 local public health units across the province.

The local public health units—each led by a local medical officer of health and accountable to a local board of health—deliver programs focused on preventing and controlling communicable diseases. The Ministry of Health and municipalities fund local public health units. From a governance perspective, local public health units do not report to Public Health Ontario or to the Chief Medical Officer of Health. However, the Chief Medical Officer of Health has the authority, under the *Health Protection and Promotion Act* (HPPA) (discussed in **Section 2.2.1**), to direct public health units to implement public health actions in response to a public health risk or emergency.

Under section 10(1) of the HPPA, every local medical officer of health has a duty to conduct inspections within their jurisdiction for the purpose

Figure 13: Numbers of Different Types of Long-Term-Care Home Inspections Conducted, 2015–2020

Source of data: Ministry of Long-Term Care

Type of Inspection	2015	2016	2017	2018	2019	2020[1]
Complaint[2]	764	756	512	611	1,055	456
Comprehensive[3]	625	611	636	370	7	0
Critical Incident[4]	615	559	394	526	1,400	696
Follow-up[5]	336	254	258	224	331	103
Other[6]	18	20	13	23	50	21
Total	**2,358**	**2,200**	**1,813**	**1,754**	**2,843**	**1,276**

1. Covers only the eight months from January 2020 to August 2020.
2. The Ministry receives complaints from residents, their family members and the public, mostly by phone (through a toll-free ServiceOntario Action Line), but also in person and by email or fax. The Ministry's centralized intake unit reviews the complaints received to decide whether an inquiry or inspection is warranted. If yes, the unit assigns a risk level to each case: from low (level 1—minimal risk) to high (level 4—immediate jeopardy and serious or significant risk of harm). The *Long-Term Care Homes Act, 2007* (Act) Act stipulates that high-risk complaints be inspected immediately, while the Ministry aims to inspect medium-risk (level 3 and 3+) complaints within 30 days. Complaint inspections normally involve one to two inspectors who use the inspection protocol(s) that best match the nature of the complaint.
3. Also known as resident quality inspections (RQIs). RQIs are proactive inspections designed to review the entire operation of a long-term-care home and involve examining issues more generally than complaint or critical incident inspections. In fall 2018, the Ministry decided to halt conducting RQIs and instead perform a greater number of complaint, critical incident and follow-up inspections in order to address the growing backlog of complaints and critical incidents that required inspection.
4. Long-term-care homes must immediately report critical incidents to the Ministry. Such incidents include fire, neglect or abuse of residents, improper care, misuse of residents' money, unlawful conduct, unexpected or sudden death, residents missing for more than three hours, missing residents who return with an injury or adverse change in condition, outbreaks of reportable or communicable diseases, and contamination of the drinking water supply. For other incidents, such as resident falls resulting in a significant change in condition that requires a hospital visit, failures of the home's security or other major systems for more than six hours, and missing medication, homes are required to inform the Ministry within one business day. Homes report critical incidents through a web-based tool called the Critical Incident System or through a pager if the incident occurs after business hours. The inspection process to address a critical incident is the same as the process for complaint inspections described above.
5. If an inspection results in a long-term-care home being issued a compliance order, the Ministry must conduct a follow-up inspection to ensure that the home has followed the order by the deadline given and that the issue has been rectified. This also includes a Director's Order follow-up inspection, which is to follow up on a compliance order that may have been issued by the Director under the Act.
6. These types of inspections may include proactive types of inspections initiated by the service area office.

of "preventing, eliminating, and decreasing the effects of health hazards." Local medical officers of health are appointed by the local board of health to manage the local public health unit. The HPPA specifically requires local medical officers of health to inspect food premises, including any food and equipment, and premises used or intended to be used as a boarding or lodging house. The HPPA does not define what constitutes a boarding or lodging house. Local public health units are not specifically required to proactively inspect long-term-care homes under the HPPA, but can issue precautionary and procedural directives regarding communicable diseases to long-term-care homes or require long-term-care homes to take corrective action to address an identified outbreak.

Also, under section 10(1) of the HPPA, Ontario's public health units are each responsible for implementing programs for infection prevention and control, which includes conducting inspections of settings associated with a risk of infectious disease transmission. These inspections are to be carried out in accordance with Ministry of Health protocols and guidelines on infection prevention and control.

The Ministry of Health sets infection prevention and control standards and policies through the Ontario Public Health Standards. These Standards, established under section 7 of the HPPA, identify the minimum expectations for public health programs and services to be delivered by each board of health (public health unit). One of those programs is infection prevention and control. Specific inspection requirements for public health units are the following:

- The Ministry of Health's 2019 Infection Prevention and Control Protocol requires every board of health to inspect all licensed child care and personal service settings at least once every 12 months. In contrast, there is no similar requirement for boards of health to conduct an annual inspection of long-term-care homes for adherence to infection prevention and control practices. However, public health units may be required to inspect a long-term-care home if they receive a complaint relating to infection prevention and control at the home. Otherwise, the protocol requires boards of health to use a "risk-based approach" to determine the priority and need for additional inspections, which could include proactive inspections of long-term-care homes within their area.
- The Ministry of Health's 2018 Institutional/Facility Outbreak Management Protocol (**Appendix 5**) requires every public health unit to assist long-term-care homes in establishing and reviewing their written outbreak response plans, at a minimum, once every two years.

2.2.6 Health Sector and the Reorganization Under Way

In March 2019, the province announced its plan to create a central agency under the Ministry of Health, called Ontario Health, to oversee health-care delivery across the province, including health care delivered in long-term-care homes.

In December 2019, the following five provincial health agencies merged with Ontario Health: Cancer Care Ontario, eHealth Ontario, HealthForce Ontario Marketing and Recruitment Agency, Health Quality Ontario, and Health Shared Services Ontario. In addition, the Minister of Health transferred 183 executive level non-home and community care employees of the 14 Local Health Integration Networks (LHINs) to Ontario Health. However, unlike the five provincial health agencies, the LHINs (Crown agencies that are responsible for co-ordinating health services at a local level) did not fully merge with Ontario Health.

Ontario Health was responsible for overseeing the operational reorganization of the 14 LHINs into five interim geographical regions. In addition, delivering home and community care is scheduled to eventually move from the LHINs to local Ontario Health Teams. First announced in December 2019, Ontario Health Teams were established with the intention to make it easier for patients to transition from one health-care provider to another—for

example, between hospitals and home-care providers—by having one patient record and one care plan. Under Ontario Health Teams, health-care providers in the same region are to work as one coordinated team.

All applications and placements in long-term-care homes in Ontario were previously arranged by the 14 LHINs (renamed Home and Community Care Support Services effective April 1, 2021). The LHINs were also responsible for distributing Ministry of Long-Term Care funding to long-term-care homes. Effective April 1, 2021, the LHINs' planning, funding and integration functions, including oversight of funding, were transferred to Ontario Health.

Until the full transition of LHINs into Ontario Health Teams is completed, LHINs, operating as Home and Community Care Support Services, will continue their day-to-day activities in their current jurisdictions, including delivering home and community care and long-term-care placement services.

In April 2019, the province also proposed changes to Ontario's public health system as part of the *2019 Ontario Budget*, including reducing the number of public health units from 35 (at the time; now only 34) to 10 by March 2021 and creating 10 new autonomous boards of health with regional and local representation. Consultations were put on hold in mid-March 2020 to allow public health to respond to the COVID-19 pandemic.

2.3 Impact of COVID-19 on Ontario Long-Term-Care Homes

2.3.1 The Global COVID-19 Pandemic

COVID-19 is one strain (type) of seven known strains of disease called coronaviruses. Like another coronavirus strain familiar to Ontarians, severe acute respiratory syndrome (SARS), it presents a danger to people's health and can lead to death in severe cases.

The most common symptoms of COVID-19 are similar to those of the flu or a cold. They include fever, a dry cough, difficulty breathing and fatigue. It is not yet clear what the long-term implications are of contracting COVID-19.

According to the World Health Organization (WHO), people over 60 years old and those with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease and cancer are at the highest risk for severe symptoms and death from COVID-19. Mortality increases with age, with the highest mortality among people over 80 years of age. Mortality also increases with the presence of comorbidities (that is, other diseases or conditions that are present at the same time as being infected with COVID-19; conditions described as comorbidities are often chronic or long-term).

According to the February 2020 report, *World Health Organization-China Joint Mission on Coronavirus Disease 2019*, which was intended to enhance understanding of the COVID-19 outbreak in China to inform international containment measures, as of February 20, 2020, the mortality rate was 13.2% for those with cardiovascular disease, 9.2% for those with diabetes, 8.4% for those with hypertension, 8% for those with chronic respiratory disease, and 7.6% for those with cancer. In comparison, the mortality rate for those with no comorbid conditions was 1.4%.

According to Statistics Canada, 54% of the over 9,500 individuals who died from COVID-19 between March 1, 2020 and July 31, 2020 in Canada were aged 85 or older. About 2,770 or 29% of these individuals were residents of Ontario long-term-care homes. The majority (90%) of the 9,500 individuals had at least one comorbid condition. The most common comorbid condition was dementia, which was present in 38% of all COVID-19-related deaths. Other common comorbidities were pneumonia (33%), hypertensive diseases (15%), heart disease (13%), respiratory failure (13%), renal failure (12%) and diabetes

(12%). In Ontario, 46% of those who died of COVID-19 had pneumonia, 36% had dementia, 16% had hypertensive diseases, 14% had diabetes and 12% had heart disease.

COVID-19 is most commonly spread from one infected person to (an)other(s) through respiratory droplets and close personal contact, as well as when someone touches an infected area and then touches their mouth, nose or eyes before washing their hands.

On January 27 and 28, 2020, Canada reported its first confirmed cases of COVID-19—a couple from Toronto who had returned from Wuhan, China. Canada's first COVID-19 death occurred in a long-term-care home in British Columbia on March 9, 2020. Two days later, on March 11, 2020, the WHO declared COVID-19 to be a pandemic—an infectious disease that has rapidly spread worldwide.

2.3.2 Case and Death Statistics in Ontario's Long-Term-Care Homes

March to August 2020

The first resident cases of COVID-19 in Ontario's long-term-care sector—two from two homes in Toronto, one from a home in Vaughan, and four from a home in Oshawa—were recorded on the Ministry of Health's Integrated Public Health Information System (iPHIS) on March 17, 2020. The first cases of COVID-19 among long-term care staff—one from a home in Oshawa, two from a home in Toronto, and five from a home in Bobcaygeon—were recorded three days later on March 20, 2020.

COVID-19 spread quickly in some long-term-care homes from March to April 2020 (see **Figure 14**). In just one month, the number of new cases increased from an average of 14 residents and eight staff per day in March to an average of 128 residents and 49 staff per day in April, peaking on April 15, when there were about 250 resident and 60 staff cases on that day (see **Figure 14**). The number of new cases began decreasing in May 2020, with an average of 44 residents and 19 staff per day, to an average low of one resident and one staff per day in August 2020. As of August 31, 2020, Public Health Ontario had reported that 5,937 residents and 2,643 staff had contracted COVID-19, and 1,815 residents and eight staff had died from it. For the purposes of this report, the initial wave of COVID-19 refers to the period up to August 31, 2020.

As of August 31, 2020, long-term-care home residents were reported to make up 20.2% of total COVID-19 cases in Ontario, but comprised 64.8% of all COVID-related deaths. The 1,815 residents and eight staff who were reported to have died due to COVID-19 represented a 30.6% and 0.3% case fatality rate for residents and staff who had contracted COVID-19.

September to December 2020

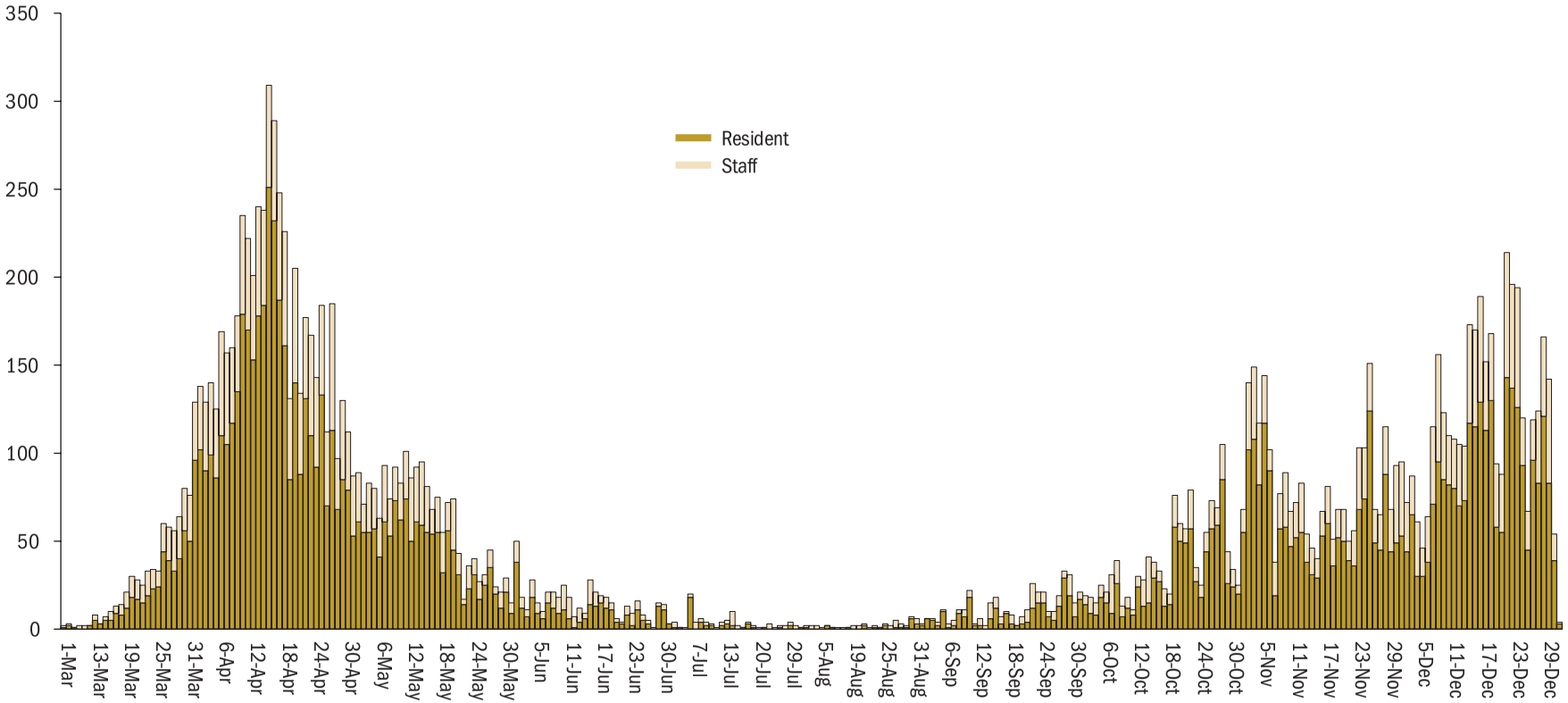
September marked the beginning of a new upward trend in the daily number of new cases, averaging eight resident and four staff cases per day. As of December 31, 2020, Public Health Ontario had reported that 11,143 residents and 4,329 staff in Ontario's long-term-care homes had contracted COVID-19, and 2,800 residents and eight staff had died from it.

According to data from the National Institute on Ageing—a Ryerson University think tank focused on issues affecting Canada's aging population—at 40%, Ontario had the highest percentage of long-term-care and retirement homes that were affected by COVID-19 in Canada as of October 31, 2020. Alberta and Quebec had the second- and third-highest percentages, with 33% and 32% of long-term-care and retirement homes in those provinces being affected by COVID-19.

See **Figure 15a** for the list of 15 long-term care homes with the highest number of resident deaths, 13 of which are operated by for-profit entities, up to December 31, 2020. These 15 homes, having only approximately 4.4% of all long-term-care home beds, accounted for 28% of all resident deaths. **Figure 15b** lists the 15 long-term-care homes with the highest number of resident cases. **Figure 16**

Figure 14: COVID-19 Cases among Long-Term-Care Home Residents and Staff by Episode Date[1], March 1, 2020–December 31, 2020[2]

Prepared by the Office of the Auditor General of Ontario based on data from Public Health Ontario's iPHIS database



1. Episode Date is an approximation of resident or staff symptom onset date.
2. Data was extracted from the Integrated Public Health Information System (IPHIS) on February 11, 2021.

Figure 15a: Fifteen Homes with Highest Number of Resident Deaths, December 31, 2020

Source of data: Ministry of Long-Term Care[1]

	Name	City	Total Bed Capacity	# of Deaths		
				Resident	Staff	Total
1	Orchard Villa[2]	Pickering	233	70	0	**70**
2	Camilla Care Community[2]	Mississauga	236	68	0	**68**
3	Downsview Long Term Care Centre[2]	North York	252	64	1	**65**
4	Carlingview Manor[2]	Ottawa	303	61	0	**61**
5	Altamont Care Community[2]	Scarborough	159	53	1	**54**
6	Tendercare Living Centre[2]	Scarborough	254	52	0	**52**
7	Forest Heights[2]	Kitchener	240	51	0	**51**
8	Hawthorne Place Care Centre[2]	North York	269	51	0	**51**
9	Extendicare Guildwood[2]	Scarborough	169	48	0	**48**
10	Isabel and Arthur Meighen Manor	Toronto	168	48	0	**48**
11	Madonna Care Community[2]	Orleans	160	46	2	**48**
12	Eatonville Care Centre[2]	Etobicoke	247	42	0	**42**
13	Midland Gardens Care Community[2]	Scarborough	299	42	0	**42**
14	Seven Oaks	Scarborough	249	41	0	**41**
15	Westside[2]	Etobicoke	242	40	0	**40**
Total			**3,480**	**777**	**4**	**781**

1. COVID-19 data is constantly being updated as the Ministry gathers more information. The numbers in this figure are based on self-reported data from homes, extracted on December 31, 2020. The data compiled as of this date may be different from publicly reported data at the time of the release of this report.
2. Home is operated by a for-profit organization.

illustrates the number and percentage of homes that had COVID-19 resident cases and those that did not, as of December 31, 2020.

2.3.3 Ontario's Initial Response to COVID-19 in Long-Term-Care Homes

Appendix 6 lists the key federal and Ontario government entities involved in responding to the COVID-19 pandemic.

On February 3, 2020, the province began recommending measures to long-term-care home operators, through guidance documents, meant to contain the spread of COVID-19. See **Appendix 7** for a chronology of Ontario's response to COVID-19 outbreaks in long-term-care homes up to December 31, 2020.

On March 14, 2020, the province formed the Long-Term Care Table—now called the Retirement Home/Long-Term Care Operations COVID Action Table—to provide advice in addressing issues related to the long-term-care sector, including testing and outbreak containment. As of December 31, 2020, the table had 63 members.

On March 22, 2020, Ontario's Chief Medical Officer of Health issued his first mandatory instruction, through Directive #3, seven weeks after the first recommended guidance. The mandatory instruction required long-term-care home operators to prohibit residents from leaving the long-term-care home to visit family and to limit the number of homes that staff work at. Until then, the guidance documents provided recommendations that home operators could implement at their own discretion. During the pandemic, Directive #3 has been the primary means by which the Chief Medical Officer of Health communicates mandatory instructions to long-term-care home operators.

Figure 15b: Fifteen Homes with Highest Number of Resident Cases, January 4, 2021

Source of data: Ministry of Long-Term Care and Ministry of Health

	Name	City	Bed Capacity	# of Resident Cases
1	Altamont Care Community	Scarborough	159	227
2	Orchard Villa	Pickering	233	206
3	Eatonville Care Centre	Etobicoke	247	188
4	Camilla Care Community	Mississauga	236	187
5	Villa Colombo Homes for the Aged	North York	160	171
6	Carlingview Manor	Ottawa	303	170
7	Forest Heights	Kitchener	240	161
8	Downsview Long Term Care Centre	North York	252	152
9	Grace Villa Nursing Home	Hamilton	184	142
10	Hawthorne Place Care Centre	North York	269	138
11	The Village at St. Clair	Windsor	256	134
12	Extendicare Starwood	Nepean	192	132
13	Midland Gardens Care Community	Scarborough	299	128
14	Extendicare Guildwood	Scarborough	169	123
15	Humber Valley Terrace	Etobicoke	158	120
Total			**3,357**	**2,379**

Figure 16: Long-Term-Care Homes with and without Reported Resident COVID-19 Cases

Prepared by the Office of the Auditor General of Ontario based on information from the Ministry of Long-Term Care*

	For-Profit Homes		Not-for-Profit Homes		All Homes	
Wave	#	%	#	%	#	%
Mar 18, 2020–Aug 31, 2020						
No reported resident cases	235	66.2	181	67.5	416	66.8
At least one resident case	120	33.8	87	32.5	207	33.2
Sep 1, 2020–Dec 31, 2020						
No reported resident cases	258	72.7	194	72.4	452	72.6
At least one resident case	97	27.3	74	27.6	171	27.4

* COVID-19 data is constantly being updated as the Ministry gathers more information. The numbers in this figure are based on self-reported data from homes, extracted on December 31, 2020. The data compiled as of this date may be different from publicly reported data at the time of the release of this report. Statistics on number of beds were provided by the Ministry of Long-Term Care.

Emergency Funding in Initial Wave of COVID-19

From March to June 2020, the province approved $526.7 million in emergency funding for the long-term-care sector as part of its initial response to the COVID-19 outbreaks in long-term-care homes. As of December 31, 2020, an estimated $470.8 million had been spent (**Figure 17**).

On September 29, 2020, the Ministry released its COVID-19 fall preparedness plan, which included the additional commitment of $540 million for infection prevention and control, along with testing and surveillance measures to protect residents, staff and caregivers. As part of the $540-million investment, $405 million was to support operations, including staffing and supplies, and up

to an eight-week supply of personal protective equipment. The funding was to be spent between October 2020 and March 2021.

Operational Support to Long-Term-Care Homes in Initial Wave of COVID-19

On April 22, 2020, the province requested the Canadian Armed Forces to help five long-term-care homes with COVID-19 outbreaks—Altamont Care Community (Scarborough), Eatonville Care Centre (Etobicoke), Hawthorne Woods Care Community (Brampton), Holland Christian Homes (Brampton) and Orchard Villa (Pickering). In June 2020, the province requested the Canadian Armed Forces to help in two additional homes—the Downsview Long-Term Care Home (Toronto) and Woodbridge Vista Care Community (Vaughan). Under Operation LASER, which ran from April to July 2020, the Canadian Armed Forces deployed teams made up of nurses, medical technicians and additional personnel to provide staffing support, help with infection prevention and control, and assist with other duties such as cleaning and food preparation. The Canadian Armed Forces delivered its interim report on the first five homes on May 26, and its final status report on all seven homes on August 14. See **Appendix 8** for a summary of observations in the Canadian Armed Forces report and the corresponding sections in this report where we discuss the issues.

On May 12, 2020, the province issued an emergency order empowering the Ministry to temporarily replace management at long-term-care homes struggling to contain COVID-19 outbreaks. On May 25, the Ministry appointed two hospitals to take over two long-term-care homes for 90 days. On May 27, the Ministry announced that it would be appointing hospitals to temporarily manage five more long-term-care homes—in Brampton, Etobicoke, North York, Pickering and Scarborough. At four of those homes, the Canadian Armed Forces had reported examples of homes not adhering to or not having infection prevention and control policies, inadequately trained staff and shortages of medical supplies, deficiencies in facilities, and concerns about standards of care.

From June 2020 to July 2020, the Ministry appointed hospitals to temporarily manage four more long-term-care homes—in Kitchener, Scarborough, Vaughan and North York.

2.3.4 Other Investigations on COVID-19 in Long-Term-Care Homes

In June 2020, Ontario's Patient Ombudsman announced that her Office planned to investigate the COVID-19 crisis in long-term-care homes. The Patient Ombudsman released her report in October 2020 with preliminary recommendations on staffing levels, visitor restrictions, infection prevention and control procedures, and communication of information. See **Appendix 8** for a summary of issues discussed in the Patient Ombudsman's preliminary report and the corresponding sections in this report where we discuss the issues.

The Patient Ombudsman, an office situated within Ontario Health, established under the authority of the *Excellent Care for All Act, 2010*, receives and looks into complaints about health-care services, including those provided in long-term-care homes. From 2016/17 to 2019/20—the most recent period for which data is available—the Patient Ombudsman received an average of 228 complaints per year related to long-term-care homes, with the largest number (22%) regarding the quality of care provided to residents.

On July 29, 2020, the province, under the authority of the *Health Protection and Promotion Act*, launched an independent commission—the Long-Term Care COVID-19 Commission (Commission)—to investigate the spread of COVID-19 within long-term-care homes; how residents, staff and families were impacted; and the adequacy of measures taken by parties, including the province, long-term-care homes and other parties, to prevent, isolate and contain the spread. The three-member Commission, led by Associate Chief Justice Frank

Figure 17: Breakdown of Ontario's Emergency Funding to Long-Term-Care Sector, March–June 2020 ($ million)

Prepared by the Office of the Auditor General of Ontario based on information from the Treasury Board Secretariat

Funding Category	Details	Amount Allocated as of Jun 30, 2020	Estimated* Amount Spent as of Dec 31, 2020
Emergency Surge Capacity	Intended to add approximately 1,560 long-term-care beds, or about a 2% increase in capacity. The increased capacity was intended to help in the prevention and treatment of COVID-19 by: • providing more single-bed rooms to isolate infected residents; and • allowing patients in hospitals who qualify for placement in long-term-care homes to be discharged to one in order to take pressure off hospitals.	21.8	4.5
Prevention and Containment	Intended to cover the immediate and extraordinary operating costs of COVID-19 screening, staffing and equipment in 613 long-term-care homes, including: • 24/7 COVID-19 screening of staff and visitors to prevent anyone ill from entering the long-term-care home; • screening of residents on an ongoing basis to contain new infections; • additional staff on all shifts to replace sick staff; and • cost of supplies related to nursing, personal care, housekeeping and laundry.	138.3	125.1
Pandemic Pay	Intended to provide eligible front-line workers—nurses, PSWs, and support staff in services such as dietary and housekeeping—with a $4-an-hour pay increase from April 24, 2020 to August 13, 2020, plus $250 per month up to a maximum of $1,000 for working at least 100 hours per month. The pandemic pay provided to long-term-care home workers was part of the larger pandemic pay initiative that included front-line workers in retirement homes, home and community care, social services congregate care settings and hospitals; and providing ambulance services (paramedics), mental health and addictions services and correctional services.	346.6	321.2
Coverage of Cost of Deferred Resident Payments	Intended to compensate long-term-care homes for the six-month deferral—from July 1, 2020 to January 1, 2021—of the scheduled 1.9% increase to residents' copayments. The six-month deferral was intended to provide temporary financial relief to long-term-care home residents and their families, as they may have been experiencing financial difficulties due to the COVID-19 pandemic.	20.0	20.0
Total		**526.7**	**470.8**

* Amounts spent as of December 31, 2020 are unaudited.

Marrocco, began hearing testimonies from stakeholders on September 2, 2020. It released a list of interim recommendations on October 23 and December 4, 2020, and is expected to deliver its final report by April 30, 2021.

3.0 Objective and Scope

3.1 Why We Are Issuing This Report

Over the last 12 years, our Office has audited various aspects of the long-term-care sector. Our audit of Infection Prevention and Control at Long-Term-Care Homes in 2009, the Long-Term-Care Home Quality Inspection Program in 2015, and most recently Food and Nutrition in Long-Term-Care Homes in 2019 found issues related to insufficient infection prevention and control (IPAC) expertise and poor IPAC practices in long-term-care homes, lack of space to allow for proper cohorting of infectious residents, and ineffective Ministry oversight of homes.

During our 2020 continuous follow-up of our 2015 audit, Long-Term-Care Home Quality Inspection Program, the COVID-19 pandemic impacted Ontario and was particularly devastating to residents and staff of certain long-term-care homes. Our objective in preparing this report was to expand our follow-up on the status of recommendations we made in our 2015 audit of the *Long-Term-Care Home Quality Inspection Program*, and assess whether the Ministry of Long-Term Care, in conjunction with long-term-care homes and other health-care-sector partners, had effective systems and procedures in place to:

- ensure that inspections of long-term-care homes proactively identify risks and issues, and resolve non-compliance with legislation, regulation, and policies;
- respond to the impacts of the COVID-19 pandemic in the long-term-care sector in a timely manner, in accordance with applicable legislation, regulation and best practices; and
- identify and implement lessons learned to inform its response to infectious disease outbreaks and pandemics.

In conducting our work, we identified criteria (see **Appendix 9**) to address our objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry reviewed and agreed with the suitability of our objective and associated criteria.

Other Special Chapters on COVID-19 Preparedness and Management

This report is one in a series of special chapters on COVID-19 preparedness and management from our Office. The objective of preparing these chapters is to inform Ontarians about lessons learned and to recommend actions to better prepare Ontario should we face another such event. See **Figure 1** identifying the other chapters.

Our upcoming special report on Personal Protective Equipment (PPE) will address the issue of PPE in long-term-care homes.

3.2 What We Did

We conducted our work from mid-June 2020 to March 2021. We obtained written representation from Ministry senior management that, effective April 27, 2021, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

To better understand the long-term-care sector and the Ministry's oversight role and activities, we:

- reviewed key relevant legislation, regulations, policies and other relevant documents and reports;
- met with senior Ministry management and staff, and interviewed a sample of inspectors from the Ministry's Long-Term Care Inspection Branch;

- analyzed financial, long-term-care home, resident and inspection data from the Ministry from January 2015 to September 2020;
- reviewed relevant past reports by our Office and the status of the Ministry's implementation of recommendations in those reports including our 2015 audit Local Health Integration Networks; and
- reviewed information and reports, such as those from the Canadian Institute for Health Information (CIHI), the Royal Society of Canada, the Canadian Patient Safety Institute, the *Canadian Medical Association Journal* and the *Journal of the American Medical Association*.

Our work to understand the impact of COVID-19 on the long-term-care sector and evaluate the province's response to it focused on the initial wave of the pandemic up to August 31, 2020. We conducted the following work:

- analyzed COVID-19 data from the Ministry and Public Health Ontario;
- reviewed directives, orders and communications from the province to the long-term-care sector;
- contacted and obtained information from a sample of long-term-care homes;
- met with senior management and staff from the Ministry, Ontario Health, Public Health Ontario;
- surveyed five of the 34 public health units in the province. The five public health units accounted for 63% of COVID-19 cases in Ontario's long-term-care homes between January 15, 2020 and February 28, 2021. They were Durham, Ottawa, Peel, Toronto and York Region;
- met with experts in the field of geriatrics and infectious diseases, as well as representatives from various stakeholder groups (**Appendix 10**);
- met with the Chief Coroner for Ontario, whom the province had appointed as Coordinator of the Provincial Outbreak Response; and
- reviewed documentation provided by the Ministry to the Long-Term Care Commission, as well as testimonies that various individuals and stakeholder groups made at the Commission from September 2, 2020 to March 10, 2021.

We also researched COVID-19 information and the response in other Canadian provinces to understand the impact of the pandemic and the measures that were implemented to manage it in the long-term-care sector in those jurisdictions. Our research also aimed to identify potential best practices.

We engaged Dr. David Walker, who chaired the province of Ontario's Expert Panel on SARS and Infectious Disease Control and the subsequent Expert Panel on the Legionnaires' Disease Outbreak in the City of Toronto, as our independent advisor to assist us with our work.

Our scope did not include assessing the Ministry of Long-Term Care's handling of specific individual complaints and critical incident reports that they received.

Data Sources

Long-term-care data, including information related to COVID-19, is captured and reported through various systems (**Appendix 11**). In late September 2020, the province announced that Ontario had entered the second wave of the COVID-19 pandemic, with the number of new cases in the province averaging 450 per day. In the long-term-care sector, there was an average of eight new resident cases and four staff cases per day that month. On December 31, 2020, 212 long-term-care homes were in an ongoing outbreak situation.

The statistics in this report are based on information reported by long-term-care homes to the Ministry of Long-Term Care, the Integrated Public Health Information System (iPHIS, now called the Case and Contact Management System), Public Health Ontario Daily Epidemiologic Summaries, publicly reported data during our fieldwork up to December 31, 2020. As with any ongoing outbreak situation, COVID-19 data is constantly being updated as the Ministry and public health officials gather more information. The data extracted represents information that was known at a certain point in time. Therefore, the data is subject to variability

depending on the date at which the underlying data was extracted. Additional factors, such as time lag in case reporting and changes in data collection methodology may further alter the data.

This report includes statistical information about the number of COVID-19 cases and deaths, as well as the measures put in place by the province during the second wave of COVID-19 up to December 31, 2020 (see **Section 2.0**).

4.0 Detailed Observations

4.1 Long-Term-Care Homes Ill-Equipped to Prevent or Minimize COVID-19 Outbreaks Because of Long-Standing Facility, Staffing and Infection Prevention and Control Issues

Our review confirmed that the following long-standing issues have not been resolved after years of little to no effective action and have negatively affected long-term-care residents' quality of life. Long-standing issues include up to four residents living in a bedroom in homes that do not meet current Ministry standards of limiting room occupancy to two residents; residents not consistently receiving the needed level of supports with daily activities of living because of insufficient staff to provide care; and residents being at risk of contracting infections because of insufficient infection prevention and control practices.

4.1.1 Many Residents Share Rooms with up to Three Other Residents, Not Meeting Residency Standards in Ministry's 1999 Long-Term Care Design Manual

Up to 257, or over 40%, of the 626 long-term-care homes in Ontario need to be renovated to comply with current bedroom standards that limit the number of residents sharing a room to two.

Licences are issued for terms of up to 30 years depending on the bedroom design (**Figure 6**). In order for home operators to obtain a licence for a new home or renew a licence for an existing one, they must build the new home or renovate existing homes in accordance with current design standards. The Ministry released its new residency standards in 1999 in its *Long-Term Care Design Manual*. However, home operators were not required to renovate an existing home until its licence expired. As such, Ontario currently has many long-term-care homes that are operating under older design standards. The licences for about 26,500 beds in 257 homes across the province are set to expire in 2025. The Ministry could not tell us how many of these beds will need to be renovated to meet the new design standards that limit room occupancy to two residents.

Our analysis of self-reported COVID-19 data from homes from March 19 to August 31, 2020 found that almost two-thirds of the homes with the most severe outbreaks during that period had primarily older bedroom designs. For the purposes of our analysis we define severe outbreak and older design as follows:

- A severe outbreak is when at least 30% of a home's residents were infected at the same time during the period we reviewed.
- A home has a primarily older bedroom design when 70% of its beds are classified as C or D beds, meaning that they were designed and operated to accommodate up to four residents in one room (**Figure 5** and **Figure 6**).

The older bedroom design allowing for up to four residents in one room contributed to crowding and insufficient physical distancing in the homes, which increased the risk of COVID-19 spreading through the home. The Ministry and the LHINs, who are responsible for placing residents in long-term-care homes, did not know how many residents were actually housed in three- or four-bed wards when the pandemic hit the long-term-care sector in March 2020.

We also noted in our analysis that 15 of the 16 homes where over half of the home's residents contracted COVID-19 in the period we reviewed (March 19 to August 31, 2020) were for-profit homes that had primarily older bedroom designs. For-profit homes housed 53% of the beds in the province (**Figure 3**), but accounted for 70% of the resident deaths from March 19 to August 31, 2020. More than half of for-profit long-term-care homes in Ontario have primarily older bedroom designs. In comparison, about 15% of non-profit and municipal homes have primarily older bedroom designs.

According to a September 2020 article in the *Canadian Medical Association Journal*, 63% of Ontario long-term-care home residents were in a shared room with one to three other residents prior to the COVID-19 pandemic. In comparison, only 24% of long-term-care home residents in British Columbia were in a shared room before COVID-19. The article indicated that, as of September 10, 2020, British Columbia had a resident infection rate of 1.7% compared with Ontario's rate of 7.6%.

On June 10, 2020, the Chief Medical Officer of Health issued a temporary directive to prohibit new residents from being placed in three- or four-bed rooms in order to allow for sufficient physical distancing among residents. The temporary directive was still in effect as of December 31, 2020.

A study published in the *Journal of the American Medical Association* in November 2020 found that residents in Ontario long-term-care homes that were "highly crowded," where the majority of residents are housed in shared bedrooms and washrooms were more than twice as likely to develop infection and die from COVID-19 than residents in homes with mainly single-occupancy rooms. The study was conducted on 618 homes where a total of 5,218 residents developed COVID-19 infections and 1,452 died of COVID-19 from March 29 to May 20, 2020.

We wanted to know whether the newer bedroom design, limiting the number of residents in a room to only two, helped prevent the spread of COVID-19 in homes that complied with the June 10, 2020 directive. We analyzed the same self-reported data from March 19 to August 31, 2020, and noted that 58 homes had at least one confirmed case of COVID-19 and were able to keep the infection rates at below 1% of residents during that period. Two-thirds of these 58 homes that were able to contain the spread of COVID-19 had primarily newer bedroom designs, meaning that about 70% of these homes' beds were classified as new beds or A beds (see **Figure 6**). In fact, the November 2020 study in the *Journal of the American Medical Association* found, through simulations, that converting all four-bed rooms to two-bed rooms could have prevented 998 or 19% of the COVID-19 infections and 263 or 18% of the COVID-19 deaths in the 618 long-term-care homes included in the study.

Planned Additional Beds Insufficient to Meet Growing Demand

As shown in **Figure 6**, one-third of beds across the province are currently classified as C or D beds, meaning that residents occupying those beds are sharing a room with up to three other residents. The risk of homes having COVID-19 cases started to be lowered with vaccine administration to residents and employees in early 2021. However, the risk of homes having other infectious disease outbreaks in the future remains.

In July 2020, the province committed to add 8,000 new and 12,000 renovated beds by 2025. However, it is unclear whether the current plan is sufficient to address the increasing demand and whether plans take into account the use of alternative options such as increasing home care services, and/or increasing the use of assisted living or retirement home accommodations in Ontario. Over 37,000 people were waiting to be placed in a long-term-care home as of September 30, 2020. In addition, Statistics Canada is projecting that the proportion of the population aged 65 and over in Ontario will increase from 16.9% in 2018 to as high as 26.1% in 2043. Ontario's aging population will,

therefore, likely increase the demand for long-term care in the next 25 years unless additional long-term care/home care strategies are put in place. The Conference Board of Canada estimated in 2017 that by 2035—when the baby boomer generation (those born between approximately 1946 and 1964) are 71 to 89 years old—238,000 Ontarians will need long-term care. In 2019, the Financial Accountability Office of Ontario estimated that the province would need to add 55,000 new long-term-care beds by 2033/34 to meet demand and that even with these additional beds, there would still be a wait list of approximately 36,900 Ontarians.

The province's ultimate long-term goal is to develop a total of 30,000 new beds and redevelop 15,000 beds by 2028. However, as of the March 2021 Budget, the province had committed to developing about 20,200 new beds and redeveloping 15,900 beds. Taking into account the over 26,500 beds for which the licences are set to expire in 2025, we calculated that, by 2028, these commitments will result in a net increase of about 9,600 beds (number of new and redeveloped beds less the number of expiring beds). This assumes that the licences, for the 10,600 expiring beds that are not yet funded to be renovated, will not be renewed.

Whether long-term-care home operators will have the ability to raise the necessary funds to cover renovation costs to their existing facilities is also uncertain. Home operators are responsible for funding the costs of renovating their homes to meet the current design standards before their licences expire. Home operators receive a construction funding subsidy from the Ministry only once the renovations are completed. In September 2020, the Ministry revised its Capital Development Funding Policy to provide development grants, ranging from 10% to 17% of total project costs, to help cover upfront costs like land and other construction expenses. Under this revised funding policy, the Ministry approved a total of $761 million in additional funding to 74 homes to create 3,957 new beds and renovate 6,796 older beds.

RECOMMENDATION 1

So that all long-term-care home facilities provide residents with accommodations that meet current Ministry of Long-Term Care standards and are places where residents live in security, safety and comfort, as envisioned in the *Long-Term Care Homes Act, 2007*, with the intent of preventing future disease outbreaks (such as respiratory infections and gastrointestinal infections), we recommend that the Ministry re-assess its long-term-care home licensing process to require home operators to renovate their facilities within a realistic, but shorter defined time frame to be in compliance with current standards, as well as when home design standards change.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry agrees that the timely upgrading of homes is important to providing residents with a safe and comfortable home. In September 2020, the Ministry concluded a call for application that solicited interest in both redevelopment and building new capacity. Shortly thereafter in November 2020 and March 2021 the Ministry made a significant investment in redeveloping or upgrading beds. To date, $2.6 billion has been committed to the redevelopment program, which includes 20,161 new beds and 15,918 redeveloped beds.

Approximately 50% of eligible beds have been approved for upgrading. Further advancement on redeveloping beds will be contingent on future funding availability. As part of the recently concluded call for applications, the Ministry was over-subscribed in terms of requests to redevelop beds compared with funding available at this time.

The Ministry, in collaboration with the federal government, through the Investing in Canada Infrastructure Program, is making

immediate investments to assist eligible homes with upgrades that will address the pandemic.

Further, the Ministry will evaluate future options/methods to upgrade physical facilities so that they are more comfortable and meet safety standards.

RECOMMENDATION 2

So that there will be sufficient beds available to meet the growing demand for long-term care (in conjunction with any future changes to home care, retirement home, and assisted living considerations), we recommend that the Ministry of Long-Term Care:

- re-assess whether its long-term plan to add approximately 45,000 new or renovated beds by 2028 (taking into account the number of expiring licences) will be sufficient to meet future demands, given the current wait-list backlogs and the projected growth in the number of individuals who will need long-term care in the next 25 years;
- assess how this plan will fit into an integrated plan with home care and alternative housing in retirement homes and assisted living facilities; and
- annually revisit its long-term plan and update as necessary, integrating other potential options and supports to providing care, such as home-based care where feasible.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry agrees that it is critical to consider how best to meet growing demand across a variety of care settings, including long-term care.

The government has committed to building 30,000 beds in a decade. In September 2020, the Ministry concluded a call for application that solicited interest in both redevelopment and building new capacity. Shortly thereafter in November 2020 and March 2021 the Ministry made a significant investment to add new capacity. To date, $2.6 billion has been committed to the development program, which includes 20,161 new beds and 15,918 redeveloped beds. This is roughly two-thirds of the Ministry commitment to add new capacity.

To supplement the supports available in their homes for people on, or eligible to be on, the long-term-care wait list, the Ministry has provided funding to 33 communities to enable them to implement a Community Paramedicine for Long-Term Care program. This initiative will help more seniors on long-term-care wait lists stay safe while living in the comfort of their own homes for a longer period of time.

Continuous assessment of the demands for long-term care and how that demand can be best met is required and the Ministry will continue to work with the Ministry of Health, the Ministry of Seniors and Accessibility and other partners to consider opportunities to best meet needs.

4.1.2 Insufficient Experienced Staff Available to Provide Needed Level of Care for Residents in Long-Term-Care Homes

We confirmed that staffing shortages, another long-standing issue that was highlighted as far back as the Ministry's staffing report in 2008, impacted the health and safety of residents in long-term-care homes during the period of our analysis. Staffing levels were insufficient to help residents with activities of daily living such as bathing, toileting, dressing and feeding to the extent needed for timely and fulsome care.

Stakeholder groups and the Ministry's own July 2020 staffing study have highlighted the serious issue of long-term-care staffing not keeping pace with the increasing demand for long-term care and the increasing complexity of residents' care needs. According to the Ministry's staffing study, a decreasing labour supply, challenging working

conditions (including pay considerations), and a negative public image, have contributed to difficulties recruiting and retaining qualified staff. The study found that, each year, about 40% of new personal support worker (PSW) graduates leave their job within one year of graduation. In addition, the Ministry estimated that about 25% of PSWs who have two or more years of experience leave the profession each year.

Our analysis of the staffing shortages reported by homes to the Ministry from March 19 to June 30, 2020 found that the staffing shortage peaked in late April, when 36 homes— ranging from a small 56-bed home to a large 300-bed home—reported critical shortages on the same day. A total of 76 homes reported critical staffing shortages during this period. Some homes reported shortages throughout March to June. The determination of a critical shortage is based on the following: the size of the home; the number of vacant shifts, especially in key roles; whether the home had exhausted all options; and impact on resident care.

According to the Ministry's July 2020 staffing study (discussed in **Section 2.1.3**), one 128-bed home reported missing 10 registered nurses during a 24-hour day. The staffing shortages were confirmed in a September 2020 Ontario Nurses' Association (ONA) survey of its members who were employed in long-term-care homes. Fifty percent of respondents indicated that staffing decreased during the pandemic. The ONA surveyed approximately 3,300 of their nurses who work in long-term-care homes. About 1,200 nurses started and partially completed the survey. Of those nurses, 766 completed the entire survey. Over 90% of respondents reported experiencing shortages in PSWs at least occasionally to frequently.

Most significantly, 43% of nurses reported occasions where there was no registered nurse on staff, which would have been a violation of the *Long-Term Care Homes Act, 2007* (Act) until the province amended its regulation. On March 20, 2020, the province amended Regulation 79/10 under the Act to provide exceptions to the regulatory requirement that at least one registered nurse—who is an employee of the home and a member of the home's nursing staff—is on duty and present in the home at all times. The amendment allows homes to fulfil the requirement by having a registered nurse who is not an employee of the home or a registered practical nurse under supervision of the Director of Nursing. As per the Ministry, this change was made to accommodate the situation where a home would not be able to have a registered nurse present.

Some stakeholders told us that staffing shortages at homes worsened when some workers refused to come to work for fear of contracting COVID-19, and when homes had difficulties hiring temporary staff to fill vacant positions. Stakeholders told us that, with fewer staff to provide care for and assist residents, the level and quality of care dropped significantly. This was confirmed by home operators who were consulted during the Ministry's staffing study. They reported missed baths, missed personal care, and a lack of toileting, among other basic care functions. They also reported that PSWs had to "cut corners to optimize the times they [had] available" because they were "often rushed." Stakeholder testimonies at the Long-Term Care COVID-19 Commission also described the impact of the staffing shortage, citing the following examples:

- only one registered nurse was on duty to care for 99 residents, which meant that the nurse could spend, at most, four-and-a-half minutes with a resident, assuming there were no interruptions from other units and no breaks, and the nurse did not perform any other work;
- only one PSW was on duty to care for 30 residents, making it difficult for the PSW to change PPE between resident visits, stop residents from wandering and enforce infection control; and
- there were only four staff on a floor where there were normally seven to eight staff, which meant that staff had to go to multiple floors, including units that had COVID-19-positive residents and units with residents who did not have COVID-19.

The results of the Ministry's inspection of Sunnycrest Nursing Home in Whitby on November 28, 2020 illustrated the significant adverse consequences of staffing shortages on resident care. A Ministry inspector visited the home in response to a report of a COVID-19 outbreak, which is considered a critical incident. Staff members told the inspector that staffing was down to less than 50% of its normal level. The inspector's review of the staffing schedule for November 28 and 29 found gaps in PSW and nursing staff on both days. The floor where most of the COVID-19-positive residents were located was the most impacted by the shortage. Nursing staff, who had to administer medications to 80 residents, were up to two hours late in administering medications, including medications such as insulin where delays pose a high risk. Staff members also told the inspector that wound dressings were not being completed due to the staffing shortage.

The September 2020 *Canadian Medical Association Journal* article cited studies conducted between June and August 2020 in nursing homes in the United States that showed low staffing and low care hours were associated with poor resident outcomes, such as higher rates of COVID-19 infection. For example, California nursing homes with total registered nurse staffing levels below the recommended minimum standard of enough nurses to provide 0.75 hours of care per resident per day were twice as likely to have COVID-19 resident infections. Conversely, among homes in Connecticut with at least one confirmed COVID-19 case, every 20-minute increase in registered nurse care per resident per day was associated with 22% fewer confirmed cases. Among those with at least one COVID-19-related death, every 20-minute increase in registered nurse care was associated with 26% fewer deaths.

While there are no minimum staffing requirements under the *Long-Term Care Homes Act, 2007* (Act) beyond those described in **Section 2.1.3**, the Act requires homes to have a staffing plan in place that provides for a staffing mix that is aligned with residents' care and safety needs.

The Act does not prescribe a minimum number of hours of direct care to be provided by nursing staff or PSWs per resident. In 2018, homes reported providing an average of 3.73 *paid* hours of care per resident per day, which amounts to an average of two hours and 18 minutes from PSWs, one hour and two minutes from RNs or RPNs, and 24 minutes from other health professionals. This is slightly lower than the average of up to four hours that many stakeholders and the Ministry's own previous staffing report from 2008 have recommended, and represents an average; meaning that some residents were receiving less than 3.73 hours of direct care per day and some were receiving more. Given the different needs of residents, it is highly likely that homes where some residents require significant levels of care may not be providing enough care time for those individuals and may also be providing less than a minimum of four hours of care for other residents.

The optimal staffing mix, staff-to-resident ratio, or hours of direct care would vary depending on the specific needs of residents. Nonetheless, establishing and enforcing per resident standards (considering their specific level of care needs) would better ensure that residents receive the minimum level of care and support they need, consistent with the fundamental principles of the Act. This is especially critical given that, as shown in **Figure 7**, residents' needs have increased over the last 10 years.

Our 2014 audit of Palliative Care found that access to palliative care services was not equitable across the province. There were no minimum education requirements for physicians or nurses who primarily provided palliative care, which could impact patient care and comfort. We recommended then that educational requirements for health-care providers providing palliative care be included in an overall palliative care policy framework for Ontario. Palliative care is an important consideration for residents in long-term-care homes.

In November 2020, the province committed to increasing the hours of direct care for long-term-care

residents to an average of four hours per day. The four-hours-per-resident per-day commitment is based on *worked* hours instead of *paid* hours (which was the basis for the 3.73 hours in the previous paragraph). Using worked hours, the 2018 average was 2.75 direct care hours by RNs, RPNs and PSWs per resident. Worked hours are hours when staff are present at the home and available for work. Paid hours include vacations, statutory holidays and benefits in addition to worked hours.

The announcement committed to increase overall funding to long-term-care homes by $500 million in 2021/22, $1 billion in 2022/23, $1.5 billion in 2023/24 and $1.9 billion in 2024/25.

Personal Support Workers' (PSWs) Education May Not Sufficiently Prepare Them for Work Environment

The Ministry's July 2020 staffing study highlighted gaps between PSWs' educational training and the working conditions in long-term-care homes. Specifically, the study notes that "educators tend to teach to the ideal environment," but PSWs face more challenging working conditions than what they are prepared for through their training. The primary reasons for the gap are the rising complexity of residents' needs and staffing shortages, which often result in PSWs being given responsibilities for which they did not receive training.

Regulation 79/10 under the *Long-Term Care Homes Act, 2007* requires that PSWs hired by long-term-care homes must have successfully completed a personal support worker program that meets the standards set out by the then Ministry of Training, Colleges and Universities, and comprises at least 600 hours of in-class instruction and practical experience combined. Neither the regulation nor the standards (called the Personal Support Worker Program Standard and the Personal Support Worker Training Standard) specify the minimum number of hours of practical experience required (out of the 600 total hours) in order to complete the program. The standards do not require students to pass a licensing exam to obtain a PSW certificate.

PSWs are not regulated in Ontario (and in Canada). Regulating the profession would help protect the health and safety of long-term-care home residents by setting standards of practice and putting in place accountability mechanisms for members when they do not abide by those standards. Given that PSWs comprise more than half of long-term-care home staff, and are responsible for the direct day-to-day care of vulnerable individuals with complex needs, these standards of practice and accountability mechanisms would help ensure that residents are receiving appropriate care. The Ministry's July 2020 staffing study suggested that consideration be given to further professionalize the PSW role within the long-term-care sector. In addition to nurses, dietitians, and pharmacists, other professions such as, foresters, land surveyors, and real estate agents are also regulated in Ontario.

Individuals can earn a PSW certificate from a community college, private career college or school board. The individual education institutions determine how their program will be delivered; the standards only list learning outcomes and performance objectives—skills that graduates of the program are expected to be able to demonstrate. For example, the standards require that graduates reliably demonstrate the ability to:

- assist clients across life span with routine activities of daily living;
- assist clients with medication in keeping with the direction of the care plan and under the monitoring of a regulated health professional;
- provide client-centred and client-directed care that is based on ethical principles, sensitive to diverse client and family values, beliefs and needs, and which follows the direction of the client care plan;
- establish and maintain helping relationships with clients and their families, reflecting open communication, professional boundaries,

employers' policies and adhering to confidentiality and privacy legislation;
- promote and maintain a safe and comfortable environment for clients, their families, self and others, including implementing infection prevention and control measures and emergency first aid procedures that are in keeping with the client care plan, policies, procedures and applicable legislation; and
- use best practices to support positive and safe behaviour in clients experiencing cognitive impairment and mental health challenges.

We reviewed the full-time PSW certificate programs in Ontario offered by all 24 community colleges and the 15 private career colleges that had the highest enrolment to determine whether there were any differences in how the PSW programs were delivered. We noted all community colleges offered two-semester programs, which run for about 24 to 30 weeks, and include 140 to 438 hours of practical experience. Programs offered at private career colleges run for about 29 to 52 weeks, totalling between 700 and 800 hours. In general, practical experience comprises about half of the total program hours. Differences in PSW programs may be due to, for example:

- the quality of instructors and instruction materials;
- location and type of practical experience (practical experience may be obtained through placements in long-term-care homes, hospitals, or other community settings);
- number of hours of instruction received in specific subject matter such as managing clients with cognitive impairments or behavioural issues; and
- availability of lab environments to facilitate simulations and demonstrations.

RECOMMENDATION 3

So that long-term-care homes can consistently have the necessary and appropriate overall staffing level and mix to provide a sufficient level and quality of care to residents, in compliance with the *Long-Term Care Homes Act, 2007* (Act), we recommend that the Ministry of Long-Term Care (Ministry):

Strategic Actions

- develop and implement a provincial staffing strategy addressing the root causes of staffing shortages in long-term-care homes as identified in the Ministry's July 2020 staffing study and as experienced during COVID-19 (including consideration of ways to further professionalize the role of PSWs, for example, by regulating the PSW profession);
- after a period of time under the new standard of a provincial average of four hours of direct care from RNs, RPNs and PSWs per resident per day, revisit its operational sufficiency to confirm that residents are receiving the necessary care given the increasing complexity of residents' needs, which can vary between individuals and between homes;
- incorporate into a staffing strategy specific short- and long-term objectives and targets related to staffing levels and staffing mix in long-term-care homes (considering the necessary training and experience of employees, including training and experience in treating dementia and providing geriatric and palliative care);

Operational Actions

- regularly monitor the effectiveness of its strategy against the established objectives and targets, and take corrective action when objectives and targets may not be met;

- develop and provide guidelines to homes regarding the appropriate staffing level and mix depending on the level of care required by residents as per the Case Mix Index;
- document the expected level of care required for a resident depending on their Case Mix Index in regulations that are reviewed and updated annually if needed, depending on the overall level of care of residents in long-term care homes; and
- require its inspectors to annually assess whether homes have staffing plans in place, as required by the Act and the reasonableness of those plans; as well as confirming that homes are operating in accordance with those plans.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry will implement the directions set out by the government in its Long-Term Care Staffing Plan released in December 2020. This Plan was informed by the July 2020 staffing study and the experience of COVID-19 in long-term-care homes.

The Plan and the government's 2021 Budget reaffirm a commitment to provide an average of four hours of daily direct care (measured as worked hours) provided by PSWs, RPNS and RNs. This increase from the 2018 level of 2.75 worked hours is a higher standard than that recommended in the 2008 study. The investment of $4.9 billion over four years will support achievement of specific year-by-year targets and the creation of the more than 27,000 new full-time equivalent positions that will be required. It will also support an additional 20% increase in direct care time from other health-care professionals such as physiotherapists and social workers.

The Ministry will develop guidance to LTC homes on staffing models, as committed in the Staffing Plan, which may include staff-to-resident ratios and/or linking the requirement for 24/7 oversight by a registered nurse to the size of the home. The Staffing Plan recognizes that each home needs some flexibility to develop staffing approaches that meet residents' specific and diverse needs. The Ministry will evaluate tying expected levels of care to Case Management Index (CMI) values for individuals or groups of residents as an effective way to support increased and appropriate care for residents. This will be undertaken in the content of the commitment in the Staffing Plan to review components of the long-term-care funding model, including CMI.

The Ministry will regularly assess progress against the short- and longer-term objectives, and annual public targets related to direct care in the Staffing Plan and has committed to regularly track progress and 'course correct' along the way.

RECOMMENDATION 4

So that the supply of Personal Support Workers (PSWs) needed is available and that PSWs are sufficiently trained to provide the necessary level and quality of care to residents, in compliance with the *Long-Term Care Homes Act, 2007*, we recommend that the Ministry of Long-Term Care:

- work with Ontario Health, the Ministry of Health and the Ministry of Labour, Training and Skills Development to establish a long-term plan for the demand and supply of PSWs in Ontario as part of a provincial long-term care staffing strategy recommended in **Recommendation 3**;

- annually monitor and revisit and update the demand and supply information of PSWs to track to the long-term plan;
- work with the Ministry of Colleges and Universities to evaluate the PSW training programs in Ontario and establish a standard training curriculum for use in the delivery of consistent training and practical experience requirements as part of its staffing strategy; and
- require inspectors to assess, as part of annual long-term-care home inspections, whether home operators are confirming that PSWs working in their homes are properly trained on current standards.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry agrees that having an appropriate supply of well-trained PSWs is critical to achieving the targets in the Long-Term Care Staffing Plan and to improve quality of care. In January 2021, the Ministry began working with the Ministry of Health, the Ministry of Colleges and Universities and the Ministry of Labour, Training and Skills Development on these issues, including the suitability of current and newly announced educational programs.

Consistent with the government's Staffing Plan, released in December 2020, work began in January 2021 to accelerate and expand education and training pathways in order to prepare and train the tens of thousands of new staff that will be required. As an initial step, the government has announced an investment of more than $115 million in 2021/22 to accelerate the training of nearly 8,200 personal support workers (PSWs) through publicly funded colleges.

As part of this work, the Ministry will work with Ministry partners to put in place:

- mechanisms to improve the suitability and quality of educational programs to prepare PSWs for work in long-term care;
- mechanisms to ensure PSWs working in homes are properly trained; and
- new initiatives as necessary.

The Ministry will work with the Ministry of Health to regularly monitor and assess the supply and demand of PSWs.

4.1.3 Infection Prevention and Control Not Effectively Entrenched in Homes Prior to COVID-19 Pandemic

Our review of information about non-COVID-related infectious disease outbreaks and Ministry inspection results confirmed concerns about the effectiveness of infection prevention and control (IPAC) practices in long-term-care homes pre-COVID, and the extent to which poor existing IPAC practices contributed to the spread of COVID-19 in homes. Ensuring that proper IPAC practices are followed is especially critical given that more than two residents are still sharing one room up to 257, or over 40%, of the homes in the province (discussed in **Section 4.1.1**).

Our analysis of outbreak information prior to the COVID-19 pandemic found that 96.5% of homes had reported an outbreak related to acute respiratory infections, such as influenza, between January 2016 and December 2019. An outbreak is defined as three cases occurring within 48 hours. Although older adults are at higher risk from respiratory infections, we noted the following concerning trends in the outbreaks reported by homes during the period we reviewed:

- 43% (271 homes) reported an outbreak every year from 2016 to 2019.
- 42% (264 homes) reported an average of two to 13 outbreaks per year from 2016 to 2019.
- 28% (176 homes) reported 10 or more outbreaks from 2016 to 2019. Seven of the 15 homes with the highest number of resident COVID-19-related deaths as of December 31, 2020 (**Figure 18**) reported 10 to 18 outbreaks from 2016 to 2019.

Figure 18: Historical Acute Respiratory Outbreaks among 15 Homes with Highest Number of Resident Deaths Related to COVID-19, as of December 31, 2020

Source of data: Ministry of Long-Term Care

			# of Acute Respiratory Outbreaks*				(2016–2019)	
	Name	City	2016	2017	2018	2019	Total # of Acute Respiratory Outbreaks	Average # of Acute Respiratory Outbreaks per Year
1	Orchard Villa	Pickering	3	7	1	2	13	3.3
2	Camilla Care Community	Mississauga	2	2	2	0	6	1.5
3	Downsview Long-Term Care Centre	North York	0	2	2	0	4	1.0
4	Carlingview Manor	Ottawa	0	0	2	2	4	1.0
5	Altamont Care Community	Scarborough	3	3	3	6	15	3.8
6	Tendercare Living Centre	Scarborough	1	4	5	7	17	4.3
7	Forest Heights	Kitchener	1	3	5	0	9	2.3
8	Hawthorne Place Care Centre	North York	0	1	0	3	4	1.0
9	Extendicare Guildwood	Scarborough	0	3	3	1	7	1.8
10	Isabel and Arthur Meighen Manor	Toronto	0	0	0	0	0	0.0
11	Madonna Care Community	Orleans	0	1	3	2	6	1.5
12	Eatonville Care Centre	Etobicoke	2	1	1	4	8	2.0
13	Midland Gardens Care Community	Scarborough	5	5	5	2	17	4.3
14	Seven Oaks	Scarborough	2	3	4	7	16	4.0
15	Westside	Etobicoke	2	2	4	5	13	3.3
Total			**21**	**37**	**40**	**41**	**139**	**n/a**

Note: Seven homes that had between 10 and 18 outbreaks in the period 2016 to 2019 are highlighted in gray.

* Each outbreak may involve one or more resident(s). The number of residents with acute respiratory infection is unknown.

The 20 homes that reported the highest number of outbreaks from 2016 to 2019 reported an average of six outbreaks per year. Among the 20 homes was Midland Gardens Care Community, which had a total of 17 outbreaks from 2016 to 2019. This home had 128 COVID-19 resident cases as of January 4, 2021. Our analysis of the results of Ministry inspection data from January 2015 to December 2019 found that a total of 413 homes, or about two-thirds of all homes, were cited for 765 instances of non-compliance with IPAC requirements. Non-compliance with IPAC requirements in the Act was the fourth-most-cited type of non-compliance in the Ministry's comprehensive inspections (**Figure 19**) that the Ministry decided to halt in the fall of 2018.

We also reviewed long-term care inspectors' inspection reports from 2015 and 2019 for all homes where at least half of their residents contracted COVID-19 and where members of the Canadian Armed Forces were temporarily deployed to provide emergency support. We found that three-quarters of these homes (Altamont Care Community, Downsview Long-Term Care Centre, Eatonville

Figure 19: Top 10 Legislative Requirements Not Met by Inspection Type, January 1, 2015–August 31, 2020

Source of data: Ministry of Long-Term Care

Rank	Legislative Requirement Not Met	Source of Legislative Requirement[1]	# of Written Notifications Issued
Comprehensive Inspection			
1	Plan of care for resident	Act (s.6)	1,595
2	Required policies and records under the Act and regulations must be followed[2]	Regulation (s.8)	992
3	Skin and wound care	Regulation (s.50)	645
4	Infection prevention and control program	Regulation (s.229)	608
5	Administration of drugs	Regulation (s.131)	541
6	Safe storage of drugs	Regulation (s.129)	526
7	Residents' Bill of Rights is respected and promoted	Act (s.3)	468
8	Policy to promote zero tolerance of abuse and neglect of residents	Act (s.20)	456
9	Accommodation services	Act (s.15)	452
10	Medication incidents and adverse drug reactions	Regulation (s.135)	410
11	Reporting certain matters to Director	Act (s.24)	410
Critical Incident System Inspection			
1	Plan of care for resident	Act (s.6)	1,186
2	Required policies and records under the Act and Regulations must be followed[2]	Regulation (s.8)	506
3	Reporting certain matters to Director	Act (s.24)	483
4	Policy to promote zero tolerance of abuse and neglect of residents	Act (s.20)	466
5	Duty to protect from abuse and neglect	Act (s.19)	458
6	Reporting of critical incidents	Regulation (s.107)	396
7	Transferring and positioning techniques	Regulation (s.36)	253
8	Licensee must investigate, respond and act on incidents	Act (s.23)	203
9	Requirements for residents with responsive behaviours	Regulation (s.53)	200
10	Administration of drugs	Regulation (s.131)	196
Complaint Inspection			
1	Plan of care for resident	Act (s.6)	1,221
2	Required policies and records under the Act and Regulations must be followed[2]	Regulation (s.8)	453
3	Skin and wound care	Regulation (s.50)	274
4	Dealing with complaints about the care of a resident or the operation of the home	Regulation (s.101)	255
5	Administration of drugs	Regulation (s.131)	235
6	Reporting certain matters to Director	Act (s.24)	217
7	Residents' Bill of Rights is respected and promoted	Act (s.3)	192
8	Duty to protect from abuse and neglect	Act (s.19)	189
9	Authorization for admission to a home (for a prospective resident)	Act (s.44)	184
10	General requirements for programs (e.g., health, recreational and social)	Regulation (s.30)	168

1. Requirements under the *Long-Term Care Homes, Act 2007* (Act) and its Regulation 79/10.
2. Comprises a range of policies and records that long-term-care homes must have in place. Policies include, for example: to promote zero tolerance of abuse and neglect; to minimize restraining of residents; that deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas; and that address the location of the supply, procedures and timing for reordering drugs, and drug administration.

Care Centre, Grace Manor, Hawthorne Place Care Centre, and Woodbridge Vista Care Community) were previously cited for one to six instances of non-compliance with IPAC requirements in the Act. Examples of such previous non-compliance included:

- residents and staff not observing proper procedures when contact precaution warnings were placed on residents' doors;
- residents leaving unlabelled personal care items such as toothbrushes, denture cups and disposable razors in the sink areas of shared washrooms; and
- staff not observing proper hand hygiene during feeding.

We raised the issue of handwashing in homes in our 2019 audit, Food and Nutrition in Long-Term-Care Homes. Given the vulnerability of residents to infectious disease, it is critical for staff to consistently wash their hands. At the 59 homes we visited during that audit, only 76% of staff and 19% of residents were observed practising proper hand hygiene directly before or after a meal. More concerning were the rates at individual homes, which varied between 0% and 35% at four of the five homes where we conducted detailed work. Our report also noted that inspections between January 2017 and March 2019 by public health inspectors at the five homes cited issues like no paper towels and no liquid soap at handwashing stations in the kitchen, food storage and dining areas.

We looked at how the five homes fared during COVID-19 for the purposes of this review. One of the five homes (Hogarth Riverview Manor in Thunder Bay) did not have any cases of COVID-19 among its residents. Of the four other homes:

- one (Tyndall Nursing Home in Mississauga) had 118 COVID-w resident cases and 34 resident deaths;
- one (Weston Terrace Care Community in Toronto) had 92 COVID-19 resident cases and 34 resident deaths;
- one (Extendicare West End Villa in Ottawa) had 84 COVID-19 resident cases and 18 resident deaths; and
- one (Hillsdale Terraces in Oshawa) had 36 COVID-19 resident cases and 13 resident deaths.

None of the five homes had staff cases. The homes in Mississauga and Toronto, which had the highest number of cases and deaths, were in hot spots in the province, where COVID-19 was more prevalent than in other regions.

The Ministry's staffing study in July 2020 noted that the rapid spread of COVID-19 in some homes suggests that many initial IPAC efforts were insufficient. This was corroborated by the IPAC assessments conducted by Public Health Ontario from March to December 2020 in 76 long-term-care homes. The IPAC assessments, performed at the request of the homes, found 222 deficiencies in IPAC practices, including improper use of personal protective equipment, lack of cleaning products, and failure to follow hand hygiene best practices.

Representatives from stakeholder groups such as the Ontario Nurses' Association (ONA) and the Ontario Personal Support Workers Association (OPSWA) informed us there is minimal and inconsistent IPAC training for staff working in long-term-care homes. According to the OPSWA, IPAC training provided by long-term-care homes to staff can vary from minimal to extensive depending on the home.

This was also confirmed in a September 2020 ONA survey of its members who were employed in long-term-care homes:

- fewer than half (47%) of respondents indicated that the IPAC training they received fully met their needs as an employee to prevent and control infection in the home;
- only 21% of respondents said they received in-person training, including how to put on and remove gowns, gloves, masks and respirators; and
- 5% of respondents reported not receiving any IPAC training at all.

Regarding IPAC programs and practices at long-term-care homes, about 9% of the respondents to the ONA survey reported that their home did not have an IPAC program prior to March 2020, despite it being a requirement under the Act. The ONA also surveyed approximately 60 nurses who were redeployed to long-term-care homes from other institutions (i.e., hospitals and LHINs). Of these redeployed nurses, 39% of respondents stated they were not satisfied with IPAC practices in their homes, and 51% reported witnessing failures to comply with IPAC best practices.

The Registered Nurses Association of Ontario had similar findings in its November 2020 survey it sent to all 626 long-term-care homes. Specifically:

- only 15% of respondents reported having a staff member fully dedicated to IPAC;
- 30% of respondents reported that their homes' IPAC leads did not have any formal IPAC training; and
- 9% of respondents indicated that they did not have a staff member responsible for overseeing IPAC practices at the home, despite it being a requirement under the Act.

Regulation 79/10 of the Act specifies the IPAC program requirements homes must meet. Homes must have a designated IPAC lead, a system to monitor and analyze symptoms of infection, an outbreak management system, a hand hygiene program and an immunization program for various infectious diseases (**Appendix 1**). However, the regulation does not specify the level of IPAC education and experience that is required of the designated IPAC lead, nor has the Ministry provided further guidance on this. In addition, the regulation states that the IPAC program must be in accordance with evidence-based or prevailing (current) practices, but the Ministry has not clearly defined what these practices are in a policy that all long-term-care home operators must adhere to.

Regulation 79/10 also does not require long-term-care homes to conduct regular exercises to simulate infectious disease outbreaks and response. The COVID-19 experiences of long-term-care homes in Kingston illustrated the value of such exercises. Prior to the pandemic, in August 2019, long-term-care homes in Kingston participated in an exercise with other health-care providers to walk through how to prepare for a severe influenza season. As of December 31, 2020, there had been a total of only seven cases of COVID-19—five staff and two residents—in the 11 long-term-care homes in Kingston.

As noted in **Section 2.1.3**, 61% of homes' employees are PSWs. However, they receive little or no IPAC training. Nurses typically receive more IPAC training, but comprise only 28% of homes' staffing complement. In his testimony at the Long-Term Care COVID-19 Commission, Dr. Gary Garber—the former Medical Director of Infection Prevention and Control at Public Health Ontario—attributed the lack of IPAC expertise at homes to staffing turnovers, stating that, "It is very difficult to maintain the level of basic IPAC expertise within the homes due to the dramatic turnovers. You could train the staff in hand hygiene, and three months later, the staff turnover was such that you'd be starting from scratch."

RECOMMENDATION 5

So that the required infection prevention and control (IPAC) programs and practices are in place and are effective in preventing and controlling infectious disease incidences and outbreaks at long-term-care homes, we recommend:

- the Ministry of Long-Term Care consult with local public health units to:
  - develop and clearly communicate IPAC directives that outline clear and detailed requirements that all long-term-care homes must incorporate in their IPAC programs, including, for example, the level of IPAC education and experience required of the home's designated IPAC

lead as well as initial and ongoing IPAC training requirements;
- develop supporting guidance documents that provide additional resources for long-term-care homes to help them meet the requirements in the *Long-Term Care Homes Act, 2007* (Act) and its regulations; and
- establish mandatory IPAC training requirements for long-term-care staff at the home level, especially those involved in providing direct care to residents, to determine and address gaps and to have them provide continual training to coincide with their staff turnover.

- the Ministry of Long-Term Care, in conjunction with the Ministry of Health:
  - require all long-term-care homes to conduct annual exercises, prior to the influenza season, that simulate infectious disease outbreaks and response;
  - require public health units to co-ordinate and participate with long-term-care homes within their jurisdictions in these annual exercises; and
  - require public health units to conduct at a minimum, annual IPAC assessments of all long-term-care homes within their jurisdictions, and provide such assessments to the Ministry of Long-Term Care; and
- the Ministry of Long-Term Care use the IPAC assessments conducted by public health units to inform its inspection process.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry agrees with the goal of ensuring long-term-care homes have suitable and effective IPAC practices in place. Collaborating with the Ministry of Health and public health experts to embed IPAC practices and protocols within all aspects of long-term care is critical to achieve positive resident outcomes.

The following responses reflect collaboration with and review from the Ministry of Health and the Office of the Chief Medical Officer of Health, Public Health.

The Ministry of Long-Term Care released a new IPAC guidance document to the sector in January 2021 that is aligned with current best practice guidance from the Provincial Infectious Diseases Advisory Committee (PIDAC). The document includes recommendations for the level of education for IPAC personnel, up to and including certification. It also addresses recommended components of evidence-based IPAC programming in homes.

As well, the Ministry of Long-Term Care is working collaboratively with the Ministry of Health and Ontario Health to establish hubs of IPAC expertise in Ontario Health Regions. Funding for the hubs was approved in 2020/21. All IPAC hub programs began in December 2020, and were in place by January 2021. Most hubs are housed in hospitals with advanced IPAC expertise. The hubs provide a range of supports to Long-Term Care Homes, including expertise, knowledge dissemination and capacity development. Hubs engage with public health units and Ontario Health at the local level.

Public Health Ontario has been a key partner supporting long-term-care homes during the pandemic, including conducting IPAC assessments and developing training and educational resources. As well, it has supported the training of the IPAC specialists who were deployed to homes.

The Ministry will review the elements of this recommendation along with any related recommendations from the LTC COVID-19 Commission, as it continues to work with Public Health Ontario, Ontario Health and other partners to review and improve IPAC practices and protocols on an ongoing basis.

4.2 Long-Term-Care Sector Largely Disconnected from Rest of Health-Care System

4.2.1 Lost Opportunity for Many Homes to Have Staffing and Infection Prevention and Control Support from Hospitals, Public Health Units

We confirmed that most long-term-care homes did not have access to potentially life-saving infection prevention and control (IPAC) expertise and support during the initial stages of the COVID-19 crisis because they were largely disconnected from other sectors of the health-care system.

Prior to the pandemic, most long-term-care homes did not have formal partnerships with local public health units and hospitals that would have enabled them to benefit from the IPAC expertise of hospital and public health unit staff. Dr. Gary Garber confirmed the disconnect between long-term-care homes and hospitals in his testimony at the Long-Term Care COVID-19 Commission, stating that, "until spring [2020], there was no real connection between hospitals and long-term-care regarding IPAC." Various stakeholder groups noted that, given the limited IPAC specialists in long-term-care homes, many homes did not have the capacity to manage the COVID-19 outbreaks without external support.

Long-term-care homes are overseen by the Ministry of Long-Term Care. Hospitals are overseen by the Ministry of Health, Ontario Health and the former LHINs, while local public health units, which are responsible for public health response, primarily report to their respective municipal governments. In comparison, long-term-care homes in British Columbia are overseen by regional health authorities that also oversee both hospitals and local public health units (see **Appendix 12**).

A September 2020 article in the *Canadian Medical Association Journal* (discussed in **Section 4.4.1**) highlighted the strong links between hospitals, long-term-care homes and public health in British Columbia as a factor in the better outcomes in that province during the initial wave of COVID-19.

Reports Highlighted Integration Gap Between Long-Term-Care and Rest of Health Sector

In 2015, our Office noted in our audit of LHINs—Local Health Integration Networks—that the then Ministry of Health and Long-Term Care had "not clearly determined what would constitute a 'fully integrated health system,' nor ha[d] it developed ways of measuring how effectively LHINs [were] performing specifically as planners, funders and integrators of health care." We recommended that the then Ministry of Health and Long-Term Care: (1) develop LHIN-specific performance targets, and (2) implement performance indicators that measure the co-ordination of health services. In our 2017 follow-up, the Ministry committed to implement these recommendations by March 2018.

When we followed up on the Ministry's commitment in 2018, we found that the Ministry had set performance indicators to measure the co-ordination of health services. The Ministry told us during our follow-up that it would not create LHIN-specific performance targets because it had established provincial-level targets that all LHINs were expected to demonstrate improvement toward. We confirmed that the indicators and targets that were set did not include anything specifying integrating health services for the long-term-care sector with the entirety of health services publicly provided in Ontario. In this time of transition from the LHIN system to a more centralized health oversight system, it is all the more important for those with oversight responsibility to act with a clear and measurable vision of health integration where Ontarians' needs for long-term care, retirement homes, assisted-living and home care are fully considered and relationships are integrated.

Subsequent reports written by others have also recently noted the disconnect between the long-term-care sector and the rest of Ontario's health-care system. For example, the Royal Society of Canada Working Group's June 2020 Policy

Briefing Report on COVID-19 and the future of long-term care in Canada noted the importance of integrating the various parts of the health-care system, noting that what happens in one of these settings, such as an outbreak of communicable disease, can and does affect all other sectors. The report *A Perfect Storm*—issued in December 2020 by an expert advisory panel led by Dr. Bob Bell (the Deputy Minister of Health and Long-Term Care from June 2014 to June 2018) based on the experiences at Revera homes—commented that COVID-19 exposed the broken links between the long-term-care sector and the health system as a whole. Revera is a Canadian for-profit operator of long-term-care and retirement homes; it operates 53 long-term-care homes in Ontario. The panel stated in the report that home operators must rely on input and co-operation from across the health system to function well.

Benefits Evident Where Homes Had Partnerships with Hospitals and Public Health Units

Representatives from some stakeholder groups, such as the Canadian Patient Safety Institute, informed us that some homes that were informally associated with hospitals were able to access support from local public health units and were able to implement better IPAC measures. This is illustrated by the example highlighted in **Section 4.1.3** about the August 2019 planning exercise for severe influenza with long-term-care homes in Kingston.

In addition, a June 2020 report by the City of Toronto's Senior Services and Long-Term Care Division on the COVID-19 response of 10 long-term-care homes that are owned and operated by the City of Toronto (i.e., municipal homes) noted that the homes' relationship with the Toronto Public Health Unit allowed them to put in place outbreak protocols and preventative measures, such as active screening for COVID-19, before they were provincially mandated to do so. The City of Toronto homes made masks mandatory more than a week earlier, and restricted non-essential visitors two weeks earlier, than the provincial mandate ordering these measures. Prior to the pandemic, the City of Toronto conducted regular IPAC reviews of the 10 long-term-care homes it owned. In addition, during the pandemic, each home created an interprofessional team to support outbreak planning, and designated a manager to work with the Toronto Public Health Unit, Ontario Health, and the Ministry regarding outbreak statistics, laboratory testing, contact tracing, mortality, staffing and PPE inventory.

We analyzed the number of COVID-19 cases in all long-term-care homes in Toronto, which includes the 10 homes owned by the City of Toronto, 39 for-profit homes, and 36 non-profit homes. We found that the peak COVID-19 infection rate in the 10 municipal homes averaged at 9% of the homes' total bed capacity, compared with 13% for the 36 non-profit homes and 15% for the 39 for-profit homes. The peak COVID-19 mortality rate was also lower in the 10 municipal homes, averaging at 3%, compared with 6% for non-profit homes and 7% for for-profit homes. We also note that other factors likely contributed to this more positive result for the municipal homes.

As of July 8, 2020, only 347 or 55% of Ontario's 626 long-term-care homes had informal partnerships (i.e., no formal agreement or memorandum of understanding) with a local hospital. Such partnerships allow homes to access not only IPAC expertise but also staffing resources, which would have been valuable to the many homes without them in the initial wave of the pandemic. None of the homes had formal partnerships with hospitals prior to the pandemic to assist them in an emergency.

For example, we noted that the partnerships that Altamont Care Community (effective June 8, 2020) and Extendicare Guildwood (effective June 11, 2020) had with the Scarborough Health Network involved the hospitals providing mentorship support for IPAC and clinical care, and improved consultation access to specialists, including those working in palliative care, geriatric

psychiatry and internal medicine. In particular, hospital staff went into Extendicare Guildwood at the height of this home's outbreak, when almost half of its staff were not reporting in to work and the home had trouble recruiting temporary staff. At the start of its formal partnership contract on June 11, Extendicare Guildwood had the eighth-highest number of resident deaths due to COVID-19 in the province at 47. The hospitals subsequently helped Extendicare Guildwood develop a management plan, implement a resident quality improvement program, perform a situational analysis, develop recommendations, identify key performance indicators and create a transition plan to assist in the next wave of COVID-19. During the term of the initial formal partnership contract (June 11 to September 10) and up to December 31, 2020, one more resident died due to COVID-19.

Emergency Planning at Long-Term-Care Homes Did Not Include Pandemic or Significant Infectious Disease Planning

Under Regulation 79/10, long-term-care homes are required to have in place a written plan for responding to infectious disease outbreaks within the facility. However, we noted that the list of emergencies in Regulation 79/10 of the *Long-Term Care Homes Act, 2007* for which homes must develop a response plan does not include a pandemic. The Act and its regulation require all long-term-care homes to have emergency plans outlining how they will respond to emergencies such as fires, community disasters, bomb threats, chemical spills, and the loss of one or more essential services. The Ontario Health Plan for an Influenza Pandemic requires long-term-care homes to report to the Ministry of Health respiratory infection outbreaks and laboratory-confirmed cases of influenza. There are no other requirements for long-term-care homes under Ontario's Heath Plan for an Influenza Pandemic. As per our 2020 special report on Emergency Management in Ontario—Pandemic Response, the Emergency Management Office's 2019 Provincial Emergency Response Plan requires the Ministry of Long-Term Care to develop a plan to respond to emergencies related to human health and diseases. At the time of the pandemic, no separate plan for the long-term-care sector was in place.

Emergency plans must include procedures for evacuating and relocating residents if necessary, setting aside necessary supplies and equipment, and identifying relevant community agencies, partner facilities and resources that will be involved in responding to the emergency. During the initial wave of the COVID-19 pandemic, it was clear that many homes had not identified or established relationships with community agencies and partners that could have readily assisted in the event of a severe outbreak. An emergency plan that, for example, outlines procedures and sites to relocate residents with COVID-19, prescribes the necessary amount of PPE, and identifies partner agencies such as hospitals and public health units, would provide long-term-care home staff with a clearer and systematic way to deal with outbreaks.

We obtained documentation from eight out of 10 long-term-care homes we contacted and found that they had written plans for responding to infectious disease outbreaks (other than pandemics), as required under Regulation 79/10. These plans covered topics such as maintaining an adequate amount of PPE and collaborating with health system partners like public health units. However, these plans were not integrated as part of the homes' emergency planning because it is not required under legislation. Including pandemics as emergencies and integrating outbreak plans with emergency plans would provide a clearer and more systematic way of responding to events like the COVID-19 pandemic.

RECOMMENDATION 6

So that long-term-care homes are better prepared to manage the impact of future infectious disease outbreaks including pandemics, we recommend that the Ministry of Long-Term Care work with the Ministry of Health, Ontario

Health, and the Local Health Integration Networks to:

- develop a pandemic plan for the entire long-term-care sector that clearly outlines roles and responsibilities, specific actions to be taken, and the timing of such actions in the event of a pandemic;
- require all long-term-care homes to develop and regularly review and update a pandemic plan as part of its emergency planning;
- establish formal partnership agreements between long-term-care homes, local hospitals and public health units, with clear roles and provisions for sharing expertise and resources in specifically identified situations such as outbreaks of infectious disease and pandemics; and
- update Regulation 79/10 to include pandemics in the list of emergencies for which long-term-care homes must develop a response plan.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry accepts the recommendation and will work with partners to improve sector preparedness for managing during a pandemic.

In March 2021, the Ministry established the Response and Recovery Advisory Committee to provide expert advice and input for the development of an action-oriented recovery framework for the long-term-care (LTC) sector. The recovery framework will reflect LTC homes as being part of the broader health-care system, with connections to Ontario Health Teams, and will include specific actions to strengthen emergency preparedness. The work will also be informed by any relevant recommendations from the LTC COVID-19 Commission.

Recovery planning will explore opportunities to:

- formalize partnerships between LTC homes and hospitals or other organizations;
- standardize expectations for homes' contingency plans; and
- explicitly include pandemic planning in the statutory framework governing LTC.

4.2.2 IPAC Expertise Resides with Public Health Units, but Inspections for IPAC Practices at Homes Done by Ministry

Our review found that Ontario's current health-care system makes the Ministry primarily responsible for inspecting that homes are properly carrying out infection prevention and control (IPAC) practices, even though public health units are the experts on IPAC.

Ministry Has Oversight and Mandate to Inspect IPAC Programs But Does Not Have the Expertise to Do It Effectively

The *Long-Term Care Homes Act, 2007* (Act), which governs the operations of long-term-care homes, dictates that homes must have an IPAC program (see **Appendix 1**). The Ministry is then responsible for inspecting homes' compliance with the requirements of the Act and its regulations.

We found that there are only three staff in the Ministry's Inspection Branch who have IPAC expertise (discussed later in this section). Of the 140 inspectors who were active as of September 30, 2020, 74% were nurses, 21% were dietitians, and the remainder were mainly physiotherapists. Depending on their profession and the specialties pursued during their education, these inspectors received varying amounts of IPAC training, from basic to more extensive.

The Ministry inspectors we interviewed told us they did not have sufficient knowledge of and training in IPAC to know what to look for beyond the limited requirements in the Act. Specifically, Regulation 79/10 of the Act requires that long-term-care homes have a written plan for detecting, managing and controlling infectious disease outbreaks, a hand hygiene program, and an immunization and screening program for various infectious diseases. The regulation also requires

that each home have an interdisciplinary team to implement its IPAC program.

The Ministry inspectors we interviewed also told us that the Act and supporting regulation were not specific enough to allow inspectors to ensure that homes had good IPAC programs in place. They also said that the current inspection protocols needed to be improved to give inspectors a better understanding of what to look for when observing practices that should be included in a home's IPAC program. Inspectors are to go through a number of checklists to assess homes' compliance with the Act's requirements. However, the Ministry has not provided inspectors guidance on what constitutes "a good job" or a best practice for some items on the checklist, such as:

- observe staff's handling of supplies and isolation precautions;
- observe how staff use IPAC practices while caring for and assisting residents;
- review whether the home's IPAC program includes measures to prevent the transmission of infections; and
- determine whether the designated IPAC lead has appropriate education and experience in infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

We found that there are three specialized inspectors within the Ministry's Long-Term Care Inspection Branch who have backgrounds in public health and IPAC. Prior to 2010, this role provided IPAC expertise during annual inspections of homes. However, over time, the role was reduced and changed from field inspection to mostly developing policy and providing education. In November 2019, the Ministry implemented a process that allowed inspectors to request the help of one of these specialized inspectors on a variety of environmental areas, including IPAC. Our review of Ministry logs found that between November 2019 and November 2020, there had only been 10 requests for help on IPAC-related issues.

Public Health Units Have the IPAC Expertise but Not the Specific Inspection/Oversight Mandate for Long-Term-Care Homes

As discussed in **Section 2.2.5**, the *Health Promotion and Protection Act* (HPPA) requires public health units to conduct inspections within their jurisdiction for the purpose of "preventing, eliminating, and decreasing the effects of health hazards." The HPPA specifically requires local medical officers of health to inspect food premises and premises used or intended to be used as a boarding or lodging house.

The Ministry of Health's Infection Prevention and Control Protocol (IPAC Protocol), which outlines inspection requirements for public health units, requires every public health unit to inspect all licensed child care and personal service settings at least once every 12 months. However, we noted that the IPAC Protocol does not require public health units to conduct regular inspections of long-term-care homes for adherence to IPAC practices.

Currently, public health units inspect long-term-care homes on their own initiative and when they receive an IPAC-related complaint about a home. The Ministry of Health's Institutional/Facility Outbreak Management Protocol (see **Appendix 5**), developed under the authority of the HPPA (the Act from which public health units derive their authority), does require public health units to assist homes in preparing and reviewing their outbreak response plans every two years. However, this requirement is not specifically mentioned in the HPPA, and therefore, it may not be as clear a requirement as it may need to be.

We surveyed the five public health units in the province with the largest population coverage—Peel, Toronto, York, Durham and Ottawa—to understand the nature and extent of their involvement in monitoring IPAC practices in long-term-care homes prior to the COVID-19 pandemic. The five public health units reported varying levels of involvement:

Figure 20: Areas Inspected by Two of the Five Public Health Units That Conducted Proactive Inspections of Long-Term-Care Homes Prior to COVID-19 Pandemic

Prepared by the Office of the Auditor General of Ontario based on data from the York and Ottawa Public Health Units

Areas inspected	Ottawa	York
Existence of outbreak surveillance and management program	✓	
Accuracy of line list data (detailed information about outbreak incidents)		
Availability of personal protective equipment	✓	✓
Safe sample collection		
Presence of vaccination/immunization policy	✓	
Existence of cleaning and disinfection protocols	✓	✓
Existence of hand hygiene protocols	✓	✓
Existence of visitor policy	✓	✓
Existence of waste disposal protocols		✓
Availability of signage for residents, staff and visitors	✓	✓
Existence of food safety protocols		✓

- Only two public health units—York and Ottawa—stated that they had conducted proactive IPAC inspections in long-term-care homes prior to the pandemic. Our review of the forms used to conduct proactive inspections in the two public health units noted differences in methodology and topics covered (see **Figure 20**). For example, Ottawa's form assesses whether the home has an outbreak surveillance and management program in place, while York's does not. On the other hand, York's form assesses whether the home has waste disposal protocols in place, while Ottawa's does not.
- Three public health units—Peel, York and Ottawa—stated that they had limited co-ordination with Ministry of Long-Term Care home inspectors. Examples of limited co-ordination include informing the Ministry of instances of non-compliance found during public health inspections or referring a home for Ministry inspection. The other two public health units—Toronto and Durham—told us they had not co-ordinated work with Ministry of Long-Term Care home inspectors prior to COVID-19.
- All five public health units reported conducting educational outreach activities in long-term-care homes prior to the COVID-19 pandemic. For example, the Toronto Public Health Unit holds annual "Long-term Care Home Education Day" during which it provides information and resources regarding best practices and considerations in maintaining a healthy environment, including infection control. The Ottawa and Peel Public Health Units hold annual Outbreak 101 or IPAC education days to provide information about managing outbreaks and provide IPAC training. The Durham Public Health Unit provides IPAC education sessions, such as reviewing how to complete outbreak reports, cohorting, and laboratory sample testing, when requested by homes.

RECOMMENDATION 7

To improve oversight of infection prevention and control (IPAC) programs and practices at long-term-care homes, we recommend that the Ministry of Long-Term Care work with the Ministry of Health to review and revise the Ministry of Long-Term-Care's inspection program and the Ministry of Health's Inspection

Prevention and Control Protocol so that, as suggested in **Recommendation 5**:

- public health units are required to co-ordinate and participate with long-term-care homes within their jurisdictions in IPAC annual exercises;
- public health units are required to conduct regular IPAC assessments of all long-term-care homes within their jurisdictions, and provide such assessments to the Ministry of Long-Term Care; and
- Ministry of Long-Term Care inspectors use the IPAC assessments conducted by public health units to inform their inspections.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry will engage with Ontario Health, the new IPAC hubs and Public Health Ontario to ensure clear roles and responsibilities with respect to IPAC, including IPAC review and assessment processes. This will include confirming the role the hubs will have to support homes to further develop IPAC capacity and respond to assessment findings.

RECOMMENDATION 8

To improve oversight of infection prevention and control (IPAC) programs and practices at long-term-care homes, we recommend that the Ministry of Health update the *Health Promotion and Protection Act* to require local public health units to assist long-term-care homes in preparing and reviewing their outbreak response plans, which is currently in the Ministry of Health's Institutional/Facility Outbreak Management Protocol.

MINISTRY OF HEALTH RESPONSE

The Ministry is supportive of strengthening partnerships between public health units and long-term-care homes in preparing and reviewing outbreak response plans.

The Ministry, with the Ministry of Long-Term Care and public health partners, will implement lessons learned from the pandemic to make the health system stronger. As part of the health system and the long-term care recovery process, the ministries will develop proposals for government consideration regarding structural and operational requirements to enhance IPAC practices in the long-term-care sector, including potential legislative proposals related to the *Health Protection and Promotion Act*, its regulations, and the Ontario Public Health Standards, as well as the Ministry of Long-Term Care's legislative and regulatory mechanisms.

In March 2021, the Ministry of Long-Term Care established the Response and Recovery Advisory Committee to provide expert advice and input for developing an action-oriented recovery framework for the LTC sector. This committee will advise on opportunities to support improved IPAC.

4.2.3 Health Sector Reorganization Raised Concerns Regarding Timely Provincial Response to Outbreaks in Long-Term-Care Homes

Some of the reports we reviewed and stakeholders we interviewed raised concerns that the reorganization of the health sector still in process at the time of our review work (described in **Section 2.2.5**) may have slowed the province's response to COVID-19 in long-term-care homes. Stability in leadership and governance structures facilitate appropriate measures to be taken when a crisis occurs.

The Ministry of Long-Term Care was separated from the Ministry of Health in June 2019, less than a year before the initial wave of the pandemic. A new Deputy Minister of Long-Term Care was appointed by the Secretary of Cabinet on March 9, 2020, replacing the previous Deputy

Minister. In addition, in July 2020, the position of Assistant Deputy Minister (ADM) responsible for overseeing long-term-care home operations was filled by a new individual. The ADM who previously oversaw the inspection process and long-term-care home operations was re-assigned to be the ADM responsible for long-term-care capital projects.

While these individuals need to possess the administrative competencies to hold deputy and assistant deputy minister positions, having experience in the long-term-care sector would have given them on-the-ground understanding of the long-standing critical issues and challenges they would have to address during the pandemic.

Another consequence of the Ministry of Long-Term Care separating from the Ministry of Health was that the Long-Term Care Table (now called the Retirement Home/Long-Term-Care Operations COVID Action Table) was established on March 14, 2020—two weeks after the Health Command Table was established on February 28, 2020.

RECOMMENDATION 9

To better inform the Ministry of Long-Term Care's decision-making, we recommend that the Secretary of Cabinet include in the hiring criteria for this ministry that future Assistant Deputy Ministers and Deputy Ministers have knowledge and experience in the long-term-care sector.

SECRETARY OF CABINET RESPONSE

Hiring decisions for senior executives in the Ontario Public Service (OPS) necessarily take into consideration a wide variety of leadership qualities and competencies. Sectoral knowledge and experience are an important part of the selection criteria for senior executives, along with other important qualities, such as innovative, responsible and collaborative leadership behaviours that are essential for building a skilled, diverse and effective public service.

Sector-specific knowledge and experience will continue to be part of the criteria used to assess candidates for senior executive roles, but selection decisions will always be made in consideration of all the leadership competencies of a candidate. In this regard, we note that senior executives are appointed as an enterprise resource who can be strategically deployed, and are able to rely on their ministry teams for in-depth knowledge from subject-matter experts.

AUDITOR GENERAL RESPONSE

The long-term-care sector would benefit from the Ministry having senior leadership with operational experience in long-term care.

4.3 COVID-19 Pandemic Response Actions Had Unintended Consequences on Long-Term-Care Residents and Staff

Beginning in February 2020, the province implemented a number of measures to deal with the impact of COVID-19 and minimize its spread (see **Appendix 7**). These measures had unintended consequences on long-term-care home residents and staff by contributing to crowding and staffing shortages. Subsequent steps taken were insufficient to lessen the resulting negative impact of the initial measures.

4.3.1 Lack of Space Prevented Homes from Isolating Residents with COVID-19 Effectively

The Ontario Long Term Care Association informed us that when COVID-19 arrived in Ontario, homes were already at capacity, and did not have the space or bed capacity to effectively and safely isolate residents who eventually contracted or

were exhibiting symptoms of COVID-19. This was because long-term-care homes were designed to operate at full occupancy. Based on the Ministry of Long-Term Care's most recent (March 2020) occupancy information, homes were, on average, operating at 98% bed capacity. The Ministry of Long-Term Care did not initially provide specific guidance or assistance to help homes in isolating COVID-19-positive residents to prevent the spread of COVID-19 in homes. As of December 31, 2020, the occupancy rate at long-term-care homes was 90%.

On March 30, 2020, the Ontario Chief Medical Officer of Health (CMOH) updated Directive #3 to require homes to cohort residents and staff to prevent the spread of COVID-19. On May 23, 2020, the CMOH added a requirement for homes to have a plan for resident cohorting in the event of a COVID-19 outbreak (see **Appendix 7**). Cohorting options for residents included, for example, moving residents to alternative accommodation to maintain physical distancing of two metres at all times; grouping residents by COVID-19 status; and using other rooms to accommodate residents, including respite and palliative care beds and rooms. With respect to staff cohorting, options included designating staff to work in specific areas in the home and designating staff to work only with specific cohorts of residents based on their COVID-19 status in the event of a suspected or confirmed outbreak.

On April 1, 2020, the Ministry issued a guidance document, which contained limited direction on cohorting; for example, suggesting that additional rooms such as those for recreation be used to isolate residents. On April 15, 2020, the Ministry provided more detailed guidance in line with Directive #3 indicating that, in long-term-care homes where it was not possible to maintain physical distancing, all staff and residents were to be managed as if they were potentially infected with COVID-19. Both versions of the guidance document did not address off-site alternatives to help homes implement the cohorting directive, even when a home's lack of space made cohorting impossible.

According to the stakeholders we met with, homes could not effectively implement the CMOH directive because of lack of space. Maintaining physical distancing was even more challenging at facilities where residents, for example, eat in communal areas. Stakeholders cited the following examples of challenges and improper cohorting practices:

- assuming when a resident in a unit or bedroom tested positive for COVID-19 that other residents in the same unit or bedroom were also likely infected, and therefore allowing them to interact; and
- difficulties ensuring that residents were properly self-isolating and not wandering from their rooms.

Similar examples were cited by stakeholder testimonies at the Long-Term Care COVID-19 Commission (discussed in **Section 2.3.4**). For example:

- Dr. Gary Garber, former Medical Director of Infection Prevention and Control at Public Health Ontario, testified about a call he had with one of the long-term-care homes that was experiencing an outbreak. When asked whether the home was able to cohort and separate COVID-19-positive residents from the rest of the residents, the home stated it was not able to do so. He said the home ended up having a 90% COVID-19 infection rate.
- The Ontario Health Coalition described a case in a long-term-care home in Ottawa where one resident in a two-bed room had tested positive for COVID-19. The other resident was not moved to another room and contracted COVID-19.
- The Ontario Nurses' Association gave an example of another home in Ottawa that continued receiving new residents even after one resident developed COVID-19 symptoms.

In the Ontario Nurses' Association's September 2020 survey of its members, 20% of respondents reported that residents who showed symptoms of COVID-19 were not isolated, and an

additional 7% reported that there were delays in isolating those residents. Forty-four percent of respondents said that staff assignments were not based on residents' COVID-19 status—that is, a staff member who worked with COVID-19-positive residents also had to work with residents who did not have COVID-19. This is not unexpected given the staffing complements at long-term-care homes.

In our 2007 report, Outbreak Preparedness and Management, we raised the importance of identifying suitable quarantine sites for infected individuals not requiring hospital care in order to ease the burden on hospitals during an infectious-disease outbreak. We similarly recommended in our 2009 report Infection Prevention and Control at Long-Term-Care Homes that the then Ministry of Health and Long-Term Care develop guidance to help long-term-care homes isolate and group together residents who have or are at high risk of having an infectious disease, given the limited availability of private rooms. The Ministry responded that it planned to renovate 35,000 beds in older homes over the next decade, making them parts of larger rooms with a maximum of two beds each (versus four-bed wards in older homes), and that this "will assist homes in keeping residents with infectious diseases adequately separated." Between 2009 and 2019, only 3,766 beds were renovated. More than 10 years later, little progress had been made and the issue remains, now with significantly greater risks and consequences for the safety of residents.

4.3.2 Transfer of Patients Designated as Alternate Level of Care from Hospitals to Long-Term-Care Homes Contributed to Crowding in Homes; Alternative Accommodations Not Used

We found that transfers of patients designated as alternate level of care (ALC) from hospitals to long-term-care homes further contributed to crowding in homes that were already dealing with COVID-19 challenges (see **Section 4.1.1**). Patients designated as ALC are those who no longer require the intensity of care provided in a hospital setting but who are still occupying a hospital bed because they have no other place to go while they wait to be discharged to their home, a rehabilitation facility or a long-term-care home.

At the onset of the pandemic, decision-makers were concerned about the risk that hospitals could be overrun by an overwhelming influx of patients. While this did not transpire, the following steps were taken in case it would, with the following results:

- On March 16, 2020, the provincial Health Command Table (renamed to Health Co-ordination Table) informed health system organizations that it had been decided to quickly maximize the number of available acute-care beds, reduce the number of patients designated as ALC in hospitals and maximize placements in long-term-care homes.
- In the month of March 2020, 761 transfers of patients designated as ALC were made from hospitals to long-term-care homes, 50% more than the average of 508 patients transferred per month throughout 2019. (This was based on our analysis of transfers from hospitals to long-term-care homes from January 2019 to August 2020.) On March 30, 2020, after the transfers, the average acute-care occupancy rate in hospitals was at 70.9% (an 80% acute care occupancy rate is considered high). A September 2020 report by the Ontario Hospital Association noted that, prior to the COVID-19 pandemic, the acute care occupancy rate at many hospitals regularly exceeded 100%.
- In the month of April 2020, 691 transfers were made, 36% more than the 2019 monthly average. As of April 13, 2020, the hospital acute-care occupancy rate was at 64%.

Given that homes were, on average, at 98% capacity prior to the pandemic according to Ministry of Long-Term Care's occupancy data, these transfers of patients designated as ALC added pressure to some homes already struggling to contain the spread of COVID-19. By the time the Ministry of

Health, Ministry of Long-Term Care and Ontario Health ordered hospitals on April 15, 2020 to suspend transfers of patients designated as ALC to long-term-care homes, Public Health Ontario had reported that more than 933 residents and 530 staff had contracted COVID-19 in 104 different outbreaks. However, the Ministry of Health's expectation was that none of the patients designated as ALC were transferred to homes where there were active outbreaks of COVID-19—admission to homes experiencing an outbreak was prohibited under Directive #3.

On June 10, 2020, the province began allowing transfers of patients designated as ALC to homes again. This nearly two-month suspension of ALC transfers to long-term-care homes resulted in higher ALC transfers from hospitals to long-term care homes in July and August 2020. Total ALC transfers were 998 in July and 829 in August, which were 96% and 63% higher, respectively, than the 2019 monthly average. The number of new COVID-19 cases in long-term-care homes was down to an average of two residents and one staff per day in July, and an average of one resident and one staff per day in August 2020. In September, the number of new confirmed COVID-19 cases in long-term-care homes increased to an average of eight residents and four staff per day. In October, the numbers rose further to an average of 27 residents and 11 staff per day. As of December, this upward trend remained, with the number of new cases averaging 81 residents and 38 staff per day.

Our research found that other jurisdictions have identified alternative placements for patients designated as ALC. For example, in April 2020 in Saskatchewan, some rural hospitals were specifically dedicated to house patients designated as ALC. In Quebec, about 200 "transition" beds were created for seniors in the previously closed l'Hôtel-Dieu de Montréal hospital between April and August 2020. There were 100 beds to treat patients who tested positive for COVID-19, but were in stable condition. These patients no longer required urgent medical care, but still needed some form of care before returning to their long-term-care home. Another 100 beds were created for non-COVID-19-positive patients who could not return to their long-term-care homes.

In May 2020, the International Long-Term Care Policy Network—a network of researchers, policy-makers and other stakeholders that aims to promote the global exchange of evidence and knowledge on long-term-care—published a report on international policy and practices to prevent COVID-19 in care homes. According to the report, many countries had taken measures to limit direct hospital discharges to care homes during the pandemic, sometimes using "step-down" quarantine centres prior to admitting patients into a home. For example, people discharged from hospitals in the German state of Lower Saxony were sent to rehabilitation hospitals to quarantine and receive short-term care, prior to being placed in a long-term-care home.

In Ontario, we found one example of an alternative placement for patients designated as ALC: St. Joseph's Continuing Care Centre in Sudbury transferred them to the Clarion Hotel beginning in April 2020.

RECOMMENDATION 10

To minimize the spread of infectious diseases when long-term-care homes are at capacity, we recommend that the Ministry of Long-Term Care, in developing its future pandemic plan (in **Recommendation 6**):

- develop a strategy that would be followed for capacity and placement considerations in both long-term-care homes and hospitals regarding patients designated as alternate level of care;
- work with the Solicitor General to identify and establish agreements for alternative housing sites to facilitate proper cohorting; and
- develop emergency staffing plans to ensure that residents, whether in long-term-care

homes or in alternative housing sites, receive proper care.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry will work with partners to implement ways to minimize or protect residents from the spread of infectious diseases within long-term-care (LTC) homes as part of future pandemic planning.

In March 2021, the Ministry established the Response and Recovery Advisory Committee to provide expert advice and input for the development of an action-oriented recovery framework for the long-term-care sector. Taking into account the recommendations in this report, as well as any relevant recommendations arising from the Long-Term Care COVID-19 Commission, recovery planning will include:

- capacity necessary to support isolation needs within homes consistent with strong infection prevention and control practices;
- ways to improve the process of matching people, including alternative level of care patients, to available beds; and
- the inclusion of emergency staffing and decanting strategies in homes' contingency plans.

4.3.3 Restricting Family Caregivers from Visiting Homes Eliminated Valuable Source of Care Providers, Contributing to Decline in Residents' Mental, Physical Health

On March 30, 2020, the Chief Medical Officer of Health issued a directive that limited visitors to long-term-care homes to only essential visitors. They were defined as those performing essential support services, such as food delivery, inspection, maintenance and health-care services; or those visiting a very ill or palliative resident. The measure was intended to control COVID-19 outbreaks by limiting the number of people going into homes. The negative impact of the directive was that residents' family members could not visit their loved ones for the months the directive was in effect (it was lifted on June 10, 2020).

This lack of contact took an emotional toll on residents and their families, in many cases resulting in a deterioration in residents' physical condition. Dr. Samir Sinha, Director of Geriatrics at Sinai Health System and the University Health Network in Toronto, stated in testimony at the Long-Term Care COVID-19 Commission that visitor restrictions had not always balanced the risks of COVID-19 infection with the risks of social isolation. A range of stakeholders testifying at the Commission described examples of the impact of social isolation on residents:

- Dr. Sinha testified about increased rates of malnutrition, increased rates of functional decline, increased rates of behavioural issues and increased administering of anti-psychotics to the residents because of the lack of family caregiving.
- Dr. Andrea Iaboni—Geriatric Psychiatrist and Clinical Researcher at the Toronto Rehabilitation Institute—testified that isolating residents put them at risk of harm. For example, residents developed psychological symptoms, would no longer speak, would not get out of bed, or would have no motivation to continue life after being isolated.
- The Ontario Nurses' Association testified that residents become depressed and those with dementia often deteriorate as a result of social isolation.
- Revera representatives testified that residents had functional and cognitive decline because of the isolation and lack of contact with their families.

A November 2020 study by Cold Spring Harbor Laboratory (a research and educational institution) of all Ontario long-term-care home residents, found that compared with January and February 2020, there was a 1.6% increase in the proportion of residents who were prescribed antipsychotics as well as a 1.6% increase in the

proportion of residents who were prescribed antidepressants from March to September 2020. Findings from a survey by the Office of the Seniors Advocate in British Columbia released in November 2020 found that between March and September 2020, there was a 7% increase in the administration of antipsychotic drugs and a 3% increase in the administration of antidepressant drugs for residents who struggled to cope without adequate contact with their family caregivers. In addition, the UK Alzheimer's Society published survey results in June 2020 in which 79% of 128 care homes reported that lack of social contact was attributed as a cause of deterioration in the health and well-being of residents with dementia.

Given that family caregivers, private caregivers paid by residents' families and volunteers often help provide care to residents that includes feeding, grooming and bathing them, and helping them to exercise, the restriction also placed additional strain on some homes' already-stretched resources.

A 2015 study by Statistics Canada found that over 20% of family caregivers assisting their loved one in a care facility gave over 10 hours of care a week, with even more hours provided when a resident was older and had more severe health conditions such as dementia. More recently, a July 2020 report by the Canadian Patient Safety Institute and the Canadian Foundation for Healthcare Improvement noted that family members reported spending 20 hours a week in the past helping care for their loved ones in long-term-care homes. The report further states that such support is essential, particularly for residents with later-stage dementia or those who do not speak the same language as their paid care providers. We describe examples of the impact of staffing shortages in **Section 4.1.2**.

4.3.4 Inadequate Provisions Made for Severe Understaffing when Employees Restricted from Working in Multiple Homes

On April 14, 2020, the province issued a temporary order restricting long-term-care staff from working in more than one home—referred to here as the single-site order. Similar to the provisions related to essential visitors in Directive #3 (discussed in **Section 4.3.3**), the order was intended to control the spread of COVID-19 by limiting the number of people going into homes.

Although intentions were good, stakeholders expressed concerns that the province's single-site order further worsened the staffing shortage in the sector when home operators experienced difficulties hiring temporary staff to fill the vacant positions. According to the Ministry's July 2020 staffing study, some of the reasons for the difficulties in new hirings included potential staff's fear and anxiety about contracting COVID-19 at the long-term-care home; people's concerns about accessing adequate personal protective equipment; and certain employment agencies' unwillingness to staff certain homes. The direct impact of this restriction is unknown by the Ministry.

Another consequence of the single-site order was the potential of lost wages for staff who had to give up employment at other homes in order to comply with the order. According to the Ministry's July 2020 staffing study, almost one-third of registered nurses and registered practical nurses, and an unknown proportion of personal support workers working in long-term-care homes held two or more jobs in order to supplement their income. The actual impact of the single-site order varied depending on the staff person's individual situation. For example, while some workers may have lost wages due to reduced hours, some may have received increased hours at their chosen site, which would have lessened the impact of the order.

The province announced in late April that front-line workers would receive a temporary pandemic

payment of a $4-an-hour pay bump for 16 weeks, from April 24 to August 13, 2020, along with a monthly lump sum payment of $250 for those working more than 100 hours in that month. The Ministry indicated at the time that issuing these financial supports on a timely basis was critical, especially for workers who relied on multiple jobs and were likely experiencing financial hardships after giving up employment at other homes.

By June 30, 2020, however, $105.7 million, or 30%, of the $346.6 million that was approved had still not been paid to the homes. Further, the Ministry did not have information on the proportion of eligible workers who had not yet received their pandemic pay and the Ministry did not track when monies were paid to eligible workers. The Ministry distributed the pandemic pay to the home operators, who were then responsible for paying their staff. **Chapter 4** of our *Special Report on COVID-19 Preparedness and Management, Management of COVID-19 Health-Related Expenditures*, found that when the Ministry advanced funds to long-term-care homes, it did not determine how much pandemic pay was earned by eligible front-line workers during the period. The amounts advanced were estimates based on historical data maintained by the Ministry. After funds were transferred, the home operators provided summaries of the pandemic pay earned by long-term-care workers.

While Ontario's single-site order was issued on April 14, it did not require long-term-care homes to comply with the order until April 22, 2020. British Columbia's Provincial Health Officer issued an order requiring long-term-care home staff to work at a single facility on March 26, 2020, almost one month before Ontario. In addition, British Columbia took more timely action to support home staff whose wages were reduced due to the order. On April 10, British Columbia issued a ministerial order requiring government, bargaining associations, unions and employers to work together to protect the wages of long-term-care home staff during the term of the single-site order.

RECOMMENDATION 11

So that measures taken to control the spread of COVID-19 and future infectious disease outbreaks in long-term-care homes do not result in significant staffing shortages nor contribute to the deterioration of residents' mental and physical conditions, should the homes be impacted by future serious infectious disease outbreaks, we recommend that the Ministry of Long-Term Care, in developing its pandemic plan (under **Recommendation 6**):

- identify and implement ways that residents' family caregivers and caregivers paid by residents' family members can continue to provide care to their loved ones while ensuring the health and safety of the home's residents;
- based on lessons learned from the implementation of the single-site order in Ontario and other provinces, assess what approach can most effectively keep residents and staff safe while still allowing staff to work the hours they did prior to the single-site directive;
- develop backup staffing strategies that may be needed if staffing issues result from future outbreak and emergency situations; and
- assess whether monies provided to long-term-care homes for staffing remedies was used for the purposes intended.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry will work with partners to implement strategies to ensure engagement of families and other caregivers, as well as sufficient staffing to provide effective care for residents, as part of future pandemic planning.

In March 2021, the Ministry established the Response and Recovery Advisory Committee to provide expert advice and input for developing

an action-oriented recovery framework for the LTC sector. Recovery planning will include:

- the criteria by which to assess whether to change the staffing restrictions that were implemented, including restricting staff to a single home; and
- visitor and caregiver policies.

Long-term-care homes are required to report on the use of funding in their annual report. In addition, long-term-care homes are required to provide quarterly reports of incremental spending on prevention and containment measures including staffing. These reports are being used to inform targeted audits of the use of funding and funding not used for eligible purposes will be recovered. The Ministry will also consider additional measures as appropriate to increase accountability for the use of funding.

4.4 Delays, Unclear Communications and Lack of Enforcement by Long-Term Care Ministry Hampered Effectiveness of Measures to Contain COVID-19

4.4.1 Measures to Contain COVID-19 Initially Left Up to Home Operators to Implement

We discuss in *Outbreak Planning and Decision-Making* (**Chapter 2** of our *Special Report on* COVID-19 *Preparedness and Management*) the province's delay in following the precautionary principle during the first wave of the pandemic. The precautionary principle dictates that, where there is reasonable evidence of an impending threat to public harm, reasonable efforts to reduce risk should be taken without waiting for scientific certainty. The delay in requiring long-term-care homes to implement containment measures is an example of the precautionary principle not being followed in as timely a manner as needed.

Our review found that initial direction from the province was framed as guidance, suggestions or recommendations; therefore, it was ultimately up to home operators to decide what actions to take to protect their elderly, frail and ailing residents, even though the province was aware in March 2020 that 98% of COVID-19 deaths in Italy had been elderly people with serious preconditions. In addition, two doctors who were on the front lines during the 2003 severe acute respiratory syndrome (SARS) outbreak highlighted the vulnerability of the long-term-care sector in advice to the province published in media outlets as early as March 14, 2020. They warned that mortality would be very high if long-term-care residents became infected, and that the likelihood of COVID-19 spreading to both residents and staff was high. They added that homes would need support to determine how best to prevent infection and treat their residents.

The province issued its first mandatory instruction on March 22, when the Chief Medical Officer of Health (CMOH) issued a directive to long-term-care homes to not permit residents to leave the home for short-stay absences and limit, *where possible* [emphasis added], the number of homes that employees were working at. In its testimony to the Long-Term Care COVID-19 Commission, the Ontario Nurses' Association stated that, "putting aside the question of why [it was not] even mandatory by March 22, the problem is using words like 'where possible' creates so much wiggle room for employers not to comply."

In light of how quickly COVID-19 spread in long-term-care homes, every day that implementing mandatory requirements was delayed made a difference in the effort to control its spread. For example, our report on Outbreak Planning and Decision-Making (see **Chapter 2** of our *Special Report on COVID-19 Preparedness and Management*) noted that an Associate Medical Officer of Health at one of the public health units in Ontario emailed the CMOH on March 18, 2020 and stated that requiring long-term-care home workers to wear masks at all times while in the facility was an

Figure 21: Timing of Mandatory Measures in Select Canadian Jurisdictions, March 2020—June 2020[1]

Prepared by the Office of the Auditor General of Ontario

Measure	ON	BC	AB	SK	MB	QC
Restrict visitors to homes to essential visitors only	**Mar 30**	Mar 17[2]	Mar 20	Mar 17	Mar 17[3]	Mar 14
Require all staff to wear masks within homes	**Apr 8**	Mar 25	Apr 15	Apr 28	Apr 13	May 25
Restrict staff to working in one home only	**Apr 22**	Mar 26[2]	Apr 23	Apr 28	May 1	n/a[4]

1. Timing dates are for when enforcement of the measure became effective. Some measures became effective on a later date than when the measure was announced.
2. Based on letter from British Columbia's Provincial Health Officer to all long-term-care homes in the province restricting visitors to essential visitors only and an order issued under the British Columbia *Public Health Act* by the Provincial Health Officer restricting staff to work in one home only.
3. Manitoba public health officials recommended immediate suspension of visitors to long-term-care homes.
4. As of June 30, 2020, Quebec public health officials had not issued orders to restrict staff movement between homes.

urgent priority. By the time the CMOH issued the directive to homes to require all staff and essential visitors to wear masks on April 8, three weeks later, Public Health Ontario had reported 498 resident and 347 staff cases of COVID-19, and 86 resident deaths, in long-term-care homes.

Our review of the response in other select Canadian jurisdictions found differences in the timing of when certain measures became mandatory (**Figure 21**). Although not the slowest province to mandate measures to control the spread of COVID-19 in long-term-care homes, Ontario was generally behind, or slower than, British Columbia. A September 2020 *Canadian Medical Association Journal* article (discussed in **Section 4.2.1**) comparing Ontario and British Columbia's response to COVID-19 in long-term-care homes noted that during the first wave of the pandemic, British Columbia's response in that period was faster and more decisive, co-ordinated and consistent in how it was communicated overall.

4.4.2 Confusing Communications Led to Different Interpretations of Requirements by Home Operators

We heard from the stakeholder groups we met with that Directive #3, which contained most of the mandatory instructions for long-term-care homes (see **Appendix 13**), contained unclear language and guidance despite the frequent updates. This resulted in homes interpreting the instructions inconsistently. For example:

- Directive #3's restriction on admissions to homes during the pandemic did not initially differentiate new admissions from re-admissions. Therefore, in some cases, residents who left the home for an essential medical treatment were initially not able to return to it.
- Home operators, long-term-care home workers and other stakeholders interpreted the visitor restrictions (discussed in **Section 4.3.3**) differently. At the extreme, contract staff—temporary staff who are hired through employment agencies to fill vacancies—were allowed to work in multiple homes. In comparison, British Columbia's order regarding long-term-care facility staff movement limitation applied to contracted staff as well.

Homes also struggled with mixed and confused messages coming from local public health units, regarding cohorting, admitting residents into hospitals and the use of personal protective equipment (PPE). In its testimony to the Long-Term Care COVID-19 Commission, AdvantAge Ontario, which represents not-for-profit providers of long-term care, service and housing for seniors, pointed out an inconsistency between provincial requirements. Specifically, "the visitor policy put out by the Ministry of Long-Term Care says that all essential caregivers and visitors in long-term care must attest to having a COVID test that is negative. But,

Directive #3, which is put out by the Chief Medical Officer of Health, only requires screening. Both the Ministry of Long-Term Care and the Directive say that theirs should take precedence."

The Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement's July 2020 report on the impact of the COVID-19 pandemic in the long-term-care sector included interview results where many home operators said that communications in the early days of the pandemic were often confusing and unclear, and conflicted with each other. For example, home operators reported a lack of direction with respect to the single-site directive, use of PPE, dedicated entry points into the homes and cohorting residents.

RECOMMENDATION 12

So that long-term-care home operators can effectively implement the measures to control the spread of COVID-19 and other potential future infectious diseases in a timely manner, we recommend that the Health Co-ordination Table, the Chief Medical Officer of Health and the Ministry of Long-Term Care:

- in an expedient manner, clarify to whom the requirements and restrictions apply, and the precautions that must be taken by home operators where requirements allow for exceptions; and
- follow the precautionary principle when determining whether to make infectious disease containment measures voluntary versus mandatory.

MINISTRY OF HEALTH AND MINISTRY OF LONG-TERM CARE RESPONSE

The ministries will expediently clarify requirements and restrictions to support long-term-care home operators to effectively prevent and control the spread of COVID-19. Taking a precautionary approach has been a key consideration in the province's decision-making during this pandemic and will continue to inform responses in long-term care, including containment measures.

4.4.3 Lack of Monitoring by Ministry, Public Health Inspectors to Enforce COVID-19 Measures

Given that unclear and mixed messages can result in homes not properly following measures and ultimately experiencing a greater number of infections and deaths, we asked the Ministry what actions it took to ensure that homes understood and consistently complied with the various directives and orders made by the province from the onset of the pandemic. We were especially concerned about whether steps had been taken to ensure homes understood and stayed current with the various IPAC-related measures mandated in the many updates and iterations of Directive #3. The Ministry of Long-term Care responded that, because Directive #3 was issued under the *Health Protection and Promotion Act*, the province's 34 local public health units were responsible for interpreting and ensuring compliance with it.

We asked select public health units—Peel, Toronto, York, Durham and Ottawa—about what they interpreted their responsibility is for enforcing Directive #3 (see **Appendix 12**). The five public health units are the largest in the province, responsible for the health of a combined 6.8 million Ontarians. The Toronto Public Health Unit told us that it does not perform routine inspections of long-term-care homes for the purposes of monitoring compliance with Directive #3. Its understanding is that "the directive (or [its] mandate generally) does not require such inspections." Ten of the 15 long-term-care homes with the highest number of resident deaths were in Toronto.

The other four public health units (Peel, York, Durham and Ottawa), however, did consider themselves responsible for enforcement, and reported taking actions to do so, such as unannounced visits to homes, providing homes with further training

on IPAC, and undertaking ongoing communication with homes through memos.

Any confusion around the roles and responsibilities for enforcing Directive #3 had the potential to create a gap in promoting and enforcing IPAC principles in homes. Public health units consistently told us that more clarity was needed because they found that the oversight of long-term-care homes was unclear and fragmented.

Examples of poor IPAC practices (described in **Section 4.1.3**) and improper cohorting practices (described in **Section 4.3.1**) highlight the importance of monitoring and enforcing the requirements in Directive #3. In the September 2020 Ontario Nurses' Association survey of its members, only 27% of respondents reported that their employers—the home operators—put policies and procedures in place to implement government directives and orders relating to the COVID-19 pandemic. More significantly, of the approximately 60 nurses redeployed to long-term-care homes, 22% of respondents reported witnessing failures to comply with these government directives and orders.

The results of the Ministry of Long-Term Care's inspection of Sunnycrest Nursing Home in Whitby on November 28, 2020 (discussed in **Section 4.1.2**) illustrates the significant adverse consequences of failure to comply with government directives and orders. The Ministry inspection was triggered by a critical incident report, specifically that the home had experienced a COVID-19 outbreak. The inspector concluded that the home operator had failed to ensure that the home was a safe and secure environment for its residents based on the following observations:

- there was no designated screener wearing full PPE at the front of the building to screen people entering the building;
- when a staff member asked the home administrator to wheel a resident into their room in the outbreak unit, the administrator did not perform hand hygiene or wear PPE; and
- a PSW went in and out of a resident's room and into the hallway of an outbreak unit without taking off their used PPE and putting on new PPE.

At the time of the inspection on November 28, seven residents and three staff had COVID-19. By December 4, 105 residents and 52 staff had tested positive for COVID-19. Between November 28 and December 31, 2020, 34 Sunnycrest residents died from COVID-19, which is equivalent to one-quarter of Sunnycrest's 136 bed capacity.

RECOMMENDATION 13

To confirm that long-term-care homes are sufficiently implementing mandated measures to control the spread of COVID-19 in long-term-care homes, we recommend that the Ministry of Long-Term Care work with public health units to clarify roles and responsibilities and work in formal partnerships to conduct inspections of long-term-care homes for compliance with Directive #3, which is issued under the *Health Protection and Promotion Act*.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry accepts the recommendation. The Ministry will work with the Ministry of Health, Public Health units as well as the Ministry of Labour, Training and Skills Development to address intersecting legislative requirements and to clarify roles and responsibilities in relation to IPAC inspections and compliance with Directive #3.

4.5 Ministry's Oversight of Homes Before and During COVID-19 Pandemic Ineffective in Addressing Repeat Non-Compliance

The Ministry's oversight of the operation of homes is primarily to be achieved using inspections and

enforcement to address non-compliance, particularly repeated non-compliance with legislation, regulations and policies and procedures. Inspections are intended to enable the Ministry to proactively identify risks and problems, and recommend measures to reduce and resolve them. However, our review found that recent changes to the Ministry's inspection program, as well as the manner in which the Ministry used its inspection function during the COVID-19 pandemic, prevented the Ministry from reducing risks and resolving issues before they resulted in negative outcomes for residents. We also found the Ministry's handling of repeated non-compliance by home operators to be weak.

4.5.1 Proactive Comprehensive Inspections Discontinued in Fall 2018 to Address Growing Backlog of Complaints and Critical Incident Reports

Our review found that, in fall 2018, the Ministry significantly changed its overall inspection approach by discontinuing comprehensive or resident quality inspections (described in **Section 2.2.4**). This occurred despite the fact that inspectors had identified over 18,200 instances of non-compliance through those inspections between January 2015 and June 2019 (see **Figure 22a**, **22b** and **Figure 23**). With comprehensive inspections off the table, the bulk of inspections were focused only on responding to complaints and critical incident reports.

We reviewed documentation provided to us by the Ministry regarding its decision to discontinue comprehensive inspections and found that the decision was made by Ministry management in order to address the growing backlog of complaints and critical incident reports that required inspection or inquiry by the same staff that would have been involved in the comprehensive inspections. The Ministry did not have the level of staff needed in order to continue to conduct comprehensive inspections while simultaneously addressing the backlog.

In September 2018, there was a backlog of about 7,800 complaints and critical incidents that required follow-up or inspection. This backlog was almost 5,000 more than the backlog at the time of our 2015 audit, Long-Term Care Home Quality Inspection Program. By halting comprehensive inspections, the Ministry was able to substantially reduce the backlog. In December 2019, the backlog had decreased to 1,280.

Proactive comprehensive inspections can yield more meaningful information and result in more profound improvements to a home's systemic operations than complaint and critical incident inspections. The latter are reactive and occur only after a potentially harmful incident has occurred involving a resident, whereas the former can help identify risks and problems before they result in more serious outcomes for residents. However, complaints and incident reports require timely follow-up to protect residents from immediate concerns that cannot always wait for a comprehen-

Figure 22a: Types of Enforcement Actions Resulting from Comprehensive Inspections
Source of data: Ministry of Long-Term Care

Enforcement Action	Description	Follow-Up Requirement
Written notification	Specifies the details of each instance of non-compliance.	A follow-up inspection is not required.
Voluntary plan of correction	Requests that the home prepare a written plan of correction for achieving compliance, but there is no requirement for the home to submit the plan to the Ministry.	
Compliance order	Requires the home to take action, stop doing an action or prepare a plan in order to achieve compliance by a deadline.	A follow-up inspection is required once the deadline has passed.
Director referral	The matter has been referred to the Ministry's Program Director, who may issue an order.	Not applicable.

Figure 22b: Enforcement Actions Resulting from Different Types of Inspections, January 1, 2015–August 31, 2020

Source of data: Ministry of Long-Term Care

Type of Inspection	# of Written Notifications Issued	# of Voluntary Plans of Correction Requested	# of Compliance Orders Issued	# of Director Referrals
Complaint	6,821	3,066	948	41
Comprehensive	18,213	9,547	2,049	99
Critical Incident	6,848	2,569	1,043	31
Follow-up	1,504	471	823	162
Other	199	80	57	3
Total	**33,585**	**15,733**	**4,920**	**336**

Figure 23: Enforcement Actions Resulting from Comprehensive Inspections, January 1, 2015–June 30, 2019

Source of data: Ministry of Long-Term Care

Year[1]	# of Written Notifications Issued[2]	# of Voluntary Plans of Correction Requested	# of Compliance Orders Issued	# of Director Referrals
2015	6,346	3,066	647	12
2016	4,743	2,569	542	26
2017	4,110	2,260	453	25
2018	2,955	1,626	394	35
2019	59	26	13	1
Total	**18,213**	**9,547**	**2,049**	**99**

1. The year in which an inspection was started. Some inspections were not completed until the following year.
2. A written notification is issued for all instances of non-compliance. As indicated by the numbers, many written notifications do not go beyond specifying the non-compliance to include a further enforcement action. Roughly half include requests for voluntary plans of correction, while substantially fewer include requiring the stronger enforcement actions following from compliance orders and potentially following from director referrals.

sive inspection. The Ministry told us during our 2015 audit of its inspection program that one of the desired outcomes of annual comprehensive inspections of long-term-care homes was a reduction in complaints and critical incidents. However, as noted above, complaints and critical incidents continued to increase.

In their initial design, comprehensive inspections looked at residents' level of satisfaction and the homes' overall compliance with requirements in the Act across 31 different areas or protocols, including IPAC (see **Appendix 4**). In contrast, complaint and critical incident inspections focus only on the subject of the complaint or the circumstances of the critical incident. As a result, the likelihood of broad, profound, systemic problems being identified and addressed in the narrow context of these inspections can be less than in a comprehensive inspection. For example, as shown in **Figure 19**, although non-compliance with IPAC requirements was the fourth-most-cited type of non-compliance in comprehensive inspections between January 2015 and December 2019 (seven comprehensive inspections were completed in 2019), it was not a top-10 issue identified in complaint or critical incident inspections.

Non-compliances related to residents' plans of care were identified as the number one issue through comprehensive inspections. However, we noted that the Ministry does not have a specific inspection protocol focused on reviewing a sample of plans of care to confirm that the resident is receiving care in accordance with his or her plan of care.

Discontinuing comprehensive inspections also meant that the extent of the Ministry's oversight of IPAC in homes decreased significantly. Specifically, unless the Ministry received a complaint about them or a critical incident report relating to an infection outbreak, inspectors were no longer required to proactively inspect homes' IPAC practices and programs and assess whether homes were evaluating their IPAC programs annually, as required by the Act.

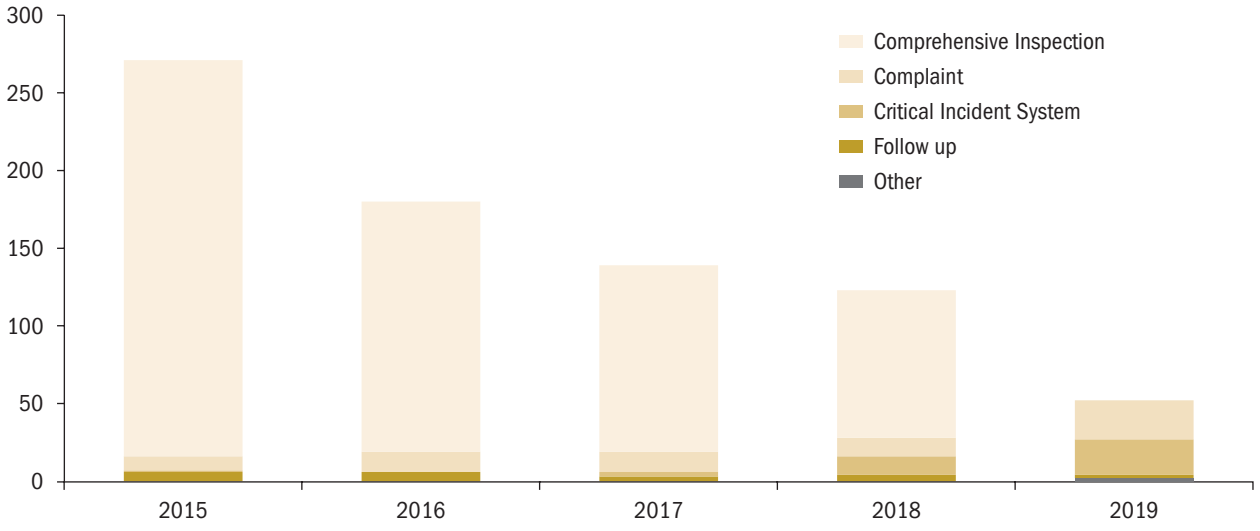
From 2015 to 2017, comprehensive inspections resulted in inspectors identifying, on average, 179 instances of IPAC non-compliance each year. Even in 2018, the last year of comprehensive inspections, when the Ministry conducted 40% fewer of them compared with the preceding three-year average (370 versus 624), inspectors still identified 95 instances of IPAC non-compliance. In contrast, in 2019, the Ministry identified only 52 instances of IPAC non-compliance from conducting primarily complaint and critical incident system inspections—less than one-third of what it was identifying when it was conducting comprehensive inspections at every home each year (**Figure 24**).

The Ministry informed us that it discontinued comprehensive inspections because it did not see the desired reduction in the number of complaints and critical incident reports it received. We found, however, that the Ministry discontinued comprehensive inspections without a thorough review to determine whether the comprehensive inspection process could be improved to achieve the objective of fewer complaints and critical incidents. Such a review could have, for example:

- analyzed the instances of non-compliance identified through comprehensive inspections and compared them to the types of complaints and critical incidents reported; and
- elicited feedback from inspectors, who have on-the-ground knowledge of the homes, on how the first stage of the comprehensive inspection process (see **Appendix 4**) could be improved to identify key risk areas to investigate further in the second stage. The first stage includes five mandatory protocols, and the second stage

Figure 24: Instances of Infection Prevention and Control Non-Compliance Identified by Inspection Type, 2015–2019*

Source of data: Ministry of Long-Term Care



* Based on the number of written notifications issued under section 86 of the *Long-Term Care Homes Act, 2007* and section 229 of Ontario Regulation 79/10. A non-compliance identified through a comprehensive inspection may be related to a critical incident or complaint that was investigated during the comprehensive inspection.

includes protocols that are triggered based on results of the first stage.

During our 2018 audit of Health Quality Ontario (HQO, now part of Ontario Health), we noted that every year, HQO identified priority performance indicators—for example, percentage of residents who had a fall in the last 30 days and percentage of residents who were given antipsychotic medication without a psychosis diagnosis—that long-term-care homes could include in their annual quality improvement plans. The intent of providing this information was to highlight areas for improvement both at the home-level and at the physician-level (through individualized reports). However, we noted in that audit that the use of these indicators by long-term-care homes, and physicians who worked in them, were optional. In 2017/18, only 57% of long-term-care homes included all of HQO's performance indicators in their quality improvement plans. As of March 2019, only 55% of physicians working in long-term-care homes had signed up to receive an individualized report.

We recommended that the then Ministry of Health and Long-Term Care, in conjunction with HQO, should look at requiring physicians to receive individualized reports and use such information to improve quality of care. We also recommended that health-care organizations that were performing below the provincial average of a performance indicator identified by Health Quality Ontario be required to include the indicator in their quality improvement plan. This information would also benefit the Ministry's inspection process.

4.5.2 Discontinuation of Comprehensive Inspections Contrary to Previous Recommendation by Our Office

The Ministry's decision to discontinue comprehensive inspections is contrary to **Recommendation 3** of our 2015 report on the *Long-Term-Care Home Quality Inspection Program*. We recommended that the Ministry prioritize comprehensive inspections of higher-risk homes over lower-risk homes, based on factors such as complaints, critical incidents and compliance history. We also recommended that the Ministry determine the frequency at which it would conduct comprehensive inspections in the future. Prioritizing inspection resources was important because our review found that complaints and critical incidents requiring inspections had increased and were not being addressed in a timely manner. The Ministry did not have sufficient resources to conduct annual comprehensive inspections of all long-term-care homes and address all complaints and critical incidents within the required time frames. The Ministry's policy is to conduct inspections of homes with complaints and critical incidents in accordance with their risk level: high-risk cases should be inspected immediately and medium-risk cases within 30 days.

In August 2016, the Ministry began conducting what it called risk-focused comprehensive inspections. Compared to full comprehensive inspections, risk-focused ones were shorter in duration, required fewer inspectors, and looked at fewer areas of the home's operation (**Figure 25**). At the time, the Ministry's goal was to still conduct full comprehensive inspections of medium- to high-risk homes at least once every three years and up to two risk-focused inspections every three years for low-risk homes. Based on this information, we assessed the status of our 2015 recommendations to be fully implemented at the time of our 2017 follow-up. These shorter, risk-focused inspections comprised 68% of the over 1,300 comprehensive inspections conducted between August 2016 and fall 2018.

According to the Ministry, the approach it adopted in fall 2018 (**Figure 25**) prioritized the highest-risk issues as identified exclusively through complaints and critical incident reports. Solely relying on complaints and critical incident reports to base inspections on cannot be considered an effective risk-based approach.

We agree that complaints and critical incidents are factors that could indicate a risk of non-compliance. However, certain types of non-compliance, such as those related to IPAC, are not evident when

Figure 25: Differences Between Inspection Approaches, 2011—2020

Prepared by the Office of the Auditor General of Ontario

	Full Comprehensive Inspections	Risk-Focused Comprehensive inspections	Complaint and Critical Incident Inspections
Started	2011	2016	2011
Ended	2018	2018	Ongoing and expanded in 2018
Proactive or Reactive	Proactive	Proactive	Reactive
Trigger for inspection	Scheduled based on several factors, including risk level of the home, inspector experience and availability, and geographic considerations. Regional office managers review this information quarterly and assign/reassign comprehensive inspections based on the above factors.	Scheduled for homes that were deemed substantially compliant in their most recent risk and performance assessment, and based on several factors, including number of findings of non-compliance; incidence of worsening pain of residents; and information from banks, suppliers, or other creditors that raises concerns about the home's operations.	Complaints or critical Incidents.
Overview	Objective is to assess residents' satisfaction and homes' compliance with the *Long-Term Care Homes Act, 2007*. A random sample of 40 residents is taken for whom the Quality of Care and Quality of Life indicators mentioned in **Appendix 4** are compared. Usually involves three to four inspectors examining a home over the course of an eight-day period. This inspection must be conducted at least once every three years for each home.	A random sample of 20 residents is taken for whom the Quality of Care and Quality of Life indicators mentioned in **Appendix 4** are compared. Usually involves two inspectors examining a home over the course of a three-to-five-day period. This inspection is conducted a maximum of twice in three calendar years for any given home with the third year being a comprehensive inspection.	See **Figure 13**, footnotes 2 and 4.
Areas inspected	Required components include: dining observation, a family council interview, infection prevention and control, medication, and a residents' council interview. Information from resident surveys may prompt inspections to include other protocols included in **Appendix 4**.	Required components include: a family council interview, infection prevention and control, medication, and a residents' council interview. Information from resident surveys may prompt inspections to include other protocols included in **Appendix 4**.	The subject of the complaint and/or areas mentioned in the critical incident report.

an inspector is focused solely on a complaint or critical incident.

As well, our review of information about acute respiratory infections reported by homes identified that the majority of outbreaks have not historically been investigated by the Ministry. From 2016 to 2019, there were an average of 1,150 acute respiratory infection outbreaks per year at homes across the province. The Ministry responded to only 10% of these outbreaks: 271 or 6% were deemed to require an inspection, while 161 or 4%, required an inspector to follow up by phoning the home. The remaining 90% of reported outbreaks were deemed to require no further action because they did not meet the definition of a "trend" under the Ministry's triaging policy. Under the Ministry's triaging policy, an inspection is deemed necessary where a "trend" has been identified. A trend is identified when there is a pattern or repetition of the same type of incident/issue that has occurred three times in a six- month period, for example, if a home reports three outbreaks within six months. So, under this triaging policy, a home that reports an outbreak in January and February and then again in November will not be inspected.

During this same period, 264 or 42% of homes averaged two or more outbreaks of acute respiratory infection per year. Also, during this same period, there were 32 outbreaks that were deemed to require no further action despite the fact that the outbreaks involved multiple resident deaths or one resident death plus over 10 suspected or confirmed cases. For example, one outbreak (in Extendicare Falconbridge in Sudbury) resulted in the deaths of seven residents, and another outbreak (in Cassellholme in North Bay) that lasted for 48 days included 41 suspected or confirmed cases of acute respiratory infections.

Infection outbreaks vary in severity depending on the type of infection, how contagious the disease is, the duration of the outbreak, and how many residents contract the infection. We noted that the current form used by homes to report outbreaks to the Ministry lacks a separate area to report outbreak statistics—such as confirmed cases, hospitalizations, and deaths—at the end of the outbreak. As a result, homes may not be consistently reporting this information to the Ministry. In addition, the form does not allow homes to report the number of affected residents separately from affected staff. This information would provide an additional basis for determining whether an inspection is warranted than simply checking whether three outbreaks have occurred in a six-month period.

RECOMMENDATION 14

So that risks, systemic issues and instances of non-compliance at long-term-care homes are identified and addressed before they result in even more significant negative outcomes for residents, we recommend that the Ministry of Long-Term Care (Ministry):

- determine the level of inspection staff needed to conduct proactive comprehensive inspections while also effectively addressing complaints and incident reports in the required timelines in accordance with legislation and Ministry policies;
- conduct annual comprehensive inspections of all homes including specific issues of care that are the subject of ongoing complaints, incidents and previous issues of non-compliance with legislation and regulations;
- develop an inspection protocol focused on directly inspecting residents' plans of care; and
- review and improve its triaging policy so that outbreaks reported by long-term-care homes are properly investigated.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry agrees with the goal of identifying and addressing issues of non-compliance before they result in more significant outcome for residents. To support this, the Ministry is:

- developing a Quality Framework that will articulate a common understanding of quality of care and quality of life, as well as performance measures to assess progress and support continuous improvement;
- evaluating the inspection program, including the triaging of complaints and critical incident reports, with the goal to develop an improved, standardized inspection process that aligns with addressing risk in reactive and proactive inspections. This evaluation will include what factors require annual inspections or reviews; and
- evaluating the appropriate use of and balance between supportive and compliance-focused mechanisms and tools to both provide quality assurance and support quality improvement.

The Ministry will evaluate the elements of this recommendation and any relevant recommendations from the Long-Term Care COVID-19 Commission in this work, including:

- evaluating the staffing needs to appropriately support compliance, enforcement and continuous quality improvement on an ongoing basis (the hiring of qualified staff for 32 new inspector positions is in progress with a projected target for completion by the end of April 2021); and
- evaluating the other recommendations in this report regarding issues that should be the subject of regular and ongoing inspection.

4.5.3 Non-compliance Still an Issue; Ministry Still Chooses Not to Implement Fines or Penalties

Our follow-up work in 2020 found that homes have continued to be non-compliant with legislative requirements since our 2015 audit of the Ministry's inspection program. From January 1, 2015 to August 31, 2020, Ministry inspectors issued 4,920 compliance orders to 565 homes to take immediate action, immediately cease inappropriate actions or prepare a plan to comply with the Act and Regulation 79/10 by a specified deadline.

In the five full calendar years from 2015 to 2019, Ministry inspectors issued an average of 931 compliance orders per year. In comparison, Ministry inspectors issued an average of 783 compliance orders per year from 2012 to 2014. We found that, despite the increase in compliance orders since 2016, the Ministry still had not implemented the recommendations from our 2015 report aimed at addressing the issue of repeated non-compliance by long-term-care home operators.

Those recommendations were (1) that the Ministry strengthen its enforcement processes to promptly address repeated non-compliance, including determining when to escalate to stronger levels of enforcement actions and (2) that the Ministry evaluate the use of other enforcement measures, such as issuing fines or penalties to homes. In 2018, the province passed amendments to the *Long-Term Care Homes Act, 2007* and Regulation 79/10 to allow fines and penalties. However, at the time of our 2020 continuous follow-up, the amendments had not yet been proclaimed.

The Ministry told us during our 2020 continuous follow-up work that it had decided to not implement any fines or penalties; instead, it will be taking a "supportive" rather than a punitive approach to overseeing homes. We have significant concerns about this decision:

- The Ministry could not explain what its supportive approach entailed or how it intends to implement it.
- In our view, the sustained levels of and trends in non-compliance suggest that there are underlying issues that need to be addressed. While some issues may be better addressed using a supportive approach that, for example, determines what additional funding, staffing, training and guidance the Ministry could provide to long-term-care homes, other issues

may require the firmer hand of enforcement to ensure that homes are places where residents live with dignity and in security, safety and comfort, and where residents' needs are met, as envisioned in the Act. For example, our 2015 audit of the Long-Term-Care Home Quality Inspection Program highlighted instances of sexual harassment and verbal and physical abuse of residents not being resolved for four to eight months after the Ministry issued the initial compliance order, with the Ministry having to subsequently issue another compliance order.

- Given the significant issues in the long-term-care sector (as described in previous sections) and the issues we previously raised in our 2015 audit about the Ministry's weak enforcement approach, we question the Ministry's decision to not fully implement, nor utilize, its existing and potentially new enforcement powers. The current Act's enforcement powers include issuing a Director's order, which can withhold a home's funding or request it be returned; having another party take over a home's management; and revoking a home's licence. Between 2011 and 2014, only six homes' repeated non-compliance, taking place over a year or more, were brought to the Program Director's attention, and issues continued to be identified in some of the homes' 2015 comprehensive inspections. Since 2010, the Ministry has revoked only two homes' licences and took action to recover monies from one of those homes because it failed to address serious fire and safety concerns. In its testimony at the Long-Term Care COVID-19 Commission, the Advocacy Centre For The Elderly highlighted the Ministry's "overuse" of written notices and voluntary plans of correction, as well as the Ministry's lack of follow up to ensure that a home has complied with the plan.

We also recommended in our 2015 audit that the Ministry help homes comply with the Act by providing additional information and support on how to rectify issues, and by sharing best practices with homes. Based on the significant number of compliance orders issued since 2015, this recommendation continues to be relevant. During our continuous follow-up work, the Ministry told us that it was planning to address repeated non-compliance through strategies for the sharing of best practices among homes. By the end of our work for this review, no such strategies had been developed.

RECOMMENDATION 15

So that long-term-care home operators who repeatedly do not comply with legislative requirements to provide residents with a home where they may live with dignity and in security, safety and comfort, and have their needs met are appropriately held accountable, we recommend that the Ministry of Long-Term Care (Ministry):

- analyze the nature and extent of the instances of non-compliance it has identified, including determining the root cause of the instances;
- determine, based on the results of this analysis, when a supportive approach can be taken, including the reasons why it would be better than taking firm enforcement action;
- develop a strategy for providing the necessary supports where a supportive approach is necessary and appropriate;
- monitor the extent to which better outcomes result from a supportive approach (in other words, establish using clear evidence whether or not a supportive approach demonstrably improves residents' quality of life and decreases the incidence of conditions and events that diminish quality of life);
- take stronger enforcement actions where monitoring shows that a supportive approach has not led to better outcomes;
- revisit proclaiming the 2018 amendments to the *Long-Term Care Homes Act, 2007*

that would allow the Ministry to issue penalties; and
- establish the criteria and circumstances when home operators must pay penalties with the proclamation of the outstanding 2018 legislative amendments.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry agrees with the goal of improving accountability in instances of repeated non-compliance. To support this the Ministry is:

- developing a Quality Framework that will articulate a common understanding of quality of care and quality of life, as well as performance measures to assess progress and support continuous improvement;
- evaluating the inspection program, including the triaging of complaints and critical incident reports, with the goal to develop an improved, standardized inspection process that aligns with addressing risk in reactive and proactive inspections. This evaluation will include what factors require annual inspections or reviews; and
- evaluating the appropriate use of and balance between supportive and compliance-focused mechanisms and tools to both provide quality assurance and support quality improvement.

The Ministry will evaluate the elements of this recommendation and any relevant recommendations from the Long-Term Care COVID-19 Commission in this work in order to enhance the accountability of long-term-care home operators' compliance with the legislation and regulations.

While this work is under way, the Ministry will use all available tools to increase compliance with the *Long-Term Care Homes Act, 2007* including, but not limited to, Director Orders, Directors Referrals, Mandatory Management Orders and Cease of Admissions.

4.5.4 No On-Site Home Inspections Conducted for Two Months During COVID-19 Pandemic

We found that for almost two months, from March 14 to May 8, 2020, Ministry inspectors did not conduct on-site inspections of long-term-care homes. Instead, beginning on March 21, the Ministry redeployed its inspectors to conduct "monitoring calls" to homes, during which inspectors asked about the status of outbreaks, staffing levels and personal protective equipment (PPE); and the types of support that homes needed, if any. Inspectors were also assigned to answer calls from residents' families that came through the Family Support Line. Residents' families can call the Family Support Line if they have questions or concerns about the care that their family members (who are residents of long-term-care homes) are receiving.

We noted the following issues with the way the Ministry used inspectors during this period:

- Homes were not clearly told that the inspectors' role in asking questions during the calls was not to perform an enforcement function but, on a temporary basis, to offer support by gathering information about challenges faced by the homes (for example, PPE and staffing shortages) and relaying such information to Ministry senior management. Representatives from the Ontario Long Term Care Association told us that some of its members were initially wary of the inspectors in this new temporary role, and so did not want to openly communicate issues to inspectors for fear of being found not in compliance with the Act.
- Prior to the pandemic, inspectors' responsibilities did not include making routine phone calls to homes and answering questions from residents' families. In addition, because inspectors were not physically at the homes, they had to first call the homes to gather information about a

particular resident before they could give families any information.

The inspectors we interviewed told us that not being able to conduct on-site inspections during the first months of the pandemic made it very difficult to address complaints received from residents and family members. Inspectors were instructed to call long-term-care homes only to determine whether there was non-compliance, and they could not adequately verify whether homes had addressed the issues that were a part of the complaints. They also could not verify whether the information being provided to them by the homes regarding any issues, including whether they were addressed, was complete and accurate.

According to the Ministry, sending inspectors without appropriate preparation into homes that had COVID-19 outbreaks would have put inspectors, residents and staff at risk. This concern was raised by the Ontario Public Service Employees Union in April 2020. We noted that inspectors were not fully trained and equipped with PPE to safely conduct inspections until May 1, 2020. Specifically:

- The Ministry sent IPAC training materials to inspectors on April 21, 2020.
- Inspectors received PPE, such as masks, gowns, face shields, gloves, sanitizers and wipes, the week of April 27, 2020.
- On May 1, 2020, the Ministry sent a checklist for inspectors to sign to confirm they had completed the online IPAC training that was provided by Public Health Ontario.

The first on-site inspection began on May 8, 2020—51 days after the first case of COVID-19 involving a long-term-care home resident was recorded on March 18, 2020. We reviewed the reports for all 30 inspections conducted from May 8 to May 31, 2020 and noted that half were still conducted remotely from inspectors' homes and not on site. In one-third of cases, inspectors performed a portion of their inspections on site and others remotely or off site. In summer 2020, the Ministry updated its inspection policy and guideline that outlined the inspection approach, including when inspections could be conducted off-site, during the COVID-19 pandemic. The policy leaves the decision of when an inspection can be conducted off site up to the inspectors and their managers and does not outline criteria to be considered.

RECOMMENDATION 16

So that the Ministry of Long-Term Care (Ministry) can better utilize its inspection function in cases of infectious disease outbreaks and other types of emergencies, we recommend that the Ministry:

- immediately establish the criteria for when inspectors will be required to do their work on site during an emergency such as a pandemic and what type of work they will be required to do;
- immediately prioritize and conduct required on-site inspections of long-term-care homes, such as those related to infection prevention and control and repeated non-compliance, based on assessed risks; and
- in cases of infectious disease outbreaks, have available a reliable supply of personal protective equipment and provide it to inspectors, along with the safety training required for them to conduct effective on-site home inspections.

MINISTRY OF LONG-TERM CARE RESPONSE

The Ministry accepts this recommendation. Inspectors are now required to primarily do inspections on-site, including during emergencies with inspector safety measures in place. The reasons for doing inspections off-site or partially off-site are very specific to each individual situation and require consultation between the inspector and manager.

The Ministry currently uses a risk-based approach for all intakes to prioritize the timing

of inspections and inquiries. The risk assessment is completed as the intakes are triaged and are also reviewed and reprioritized as needed at the Service Area Office level by the inspection managers.

Inspectors are currently supplied with appropriate personal protective equipment and this supply will continue to be made available as needed. Inspectors have now been provided safety training developed by both Public Health Ontario and the Long-Term Care Consultant/ Environmental Inspectors. This mandatory training requirement will continue as part of on-boarding of all new inspectors and re-training as needed for current inspectors.

Appendix 1: Select Key Provisions in Legislation and Regulations Relating to Long-Term-Care Homes and COVID-19

Prepared by the Office of the Auditor General of Ontario

Legislative Requirement	Report Sections
Long-Term Care Homes Act, 2007 (LTCHA)	
Section 1. Home: the fundamental principle "... a long-term-care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."	All
Section 5. Home to be safe, secure environment "Every licensee of a long-term-care home shall ensure that the home is a safe and secure environment for its residents."	All
Section 8(3). 24-hour nursing care "Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations (see O. Reg. 79/10 below)."	2.1.3
O Reg. 79/10. Exemptions to 24-hour nursing care 3. For all homes, in the case of a pandemic that prevents a registered nurse from getting to the home, and where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, i. a registered nurse who works at the home pursuant to a contract or agreement with the licensee or who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used, ii. a registered practical nurse who is an employee of the licensee or who works at the home pursuant to a contract or agreement with the licensee or who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse is available for consultation, or iii. a member of a regulated health profession who is a staff member of the home and who has a set of skills that, in the reasonable opinion of the licensee, would allow them to provide care to a resident, may be used if the Director of Nursing and Personal Care or a registered nurse is available for consultation. O. Reg. 79/10, s. 45 (1); O. Reg. 72/20, s. 1.	2.1.3
Section 24(1), 25. Reporting certain matters to Director Anyone who has reasonable grounds to suspect any of the following has occurred or may occur must immediately report their suspicion, and information upon which it is based, to the Ministry: • improper or incompetent treatment or care, or abuse or neglect, of a resident that resulted in harm or a risk of harm to the resident; • unlawful conduct that resulted in harm or a risk of harm to a resident; and • misuse or misappropriation of a resident's money or funding provided to a licensee under the LTCHA, the *Local Health System Integration Act, 2006* or the *Connecting Care Act, 2019*. Upon receipt of the above information, an inspector must conduct an inspection or make inquiries to ensure compliance with the requirements under the LTCHA. The inspector must immediately visit the home concerned if the information indicates that anything described in the first two bullets resulted in serious harm or a significant risk of serious harm to a resident.	4.5

Legislative Requirement	Report Sections
Section 86(1). Infection prevention and control program Each long-term-care home must have an infection prevention and control program that includes the following (as prescribed in Regulation 79/10 under the LTCHA): • daily monitoring, recording and analysis of symptoms to detect the presence of infection and measures to prevent transmission of infection; • an outbreak management system, including a written plan, for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the *Health Protection and Promotion Act*, communication plans, and protocols for receiving and responding to health alerts; • a hand hygiene program; and • an immunization and screening program for various infectious diseases for residents and staff. Each home must have an interdisciplinary team to implement the program and a designated staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including: infectious diseases, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management. The interdisciplinary team must have quarterly meetings to which the local medical officer of health is invited. The program must be evaluated and updated every year, the results of which must be documented. The licensee must ensure that all staff participate in the implementation of the program.	4.1.3, 4.2.2
Section 87(1). Emergency plans "Every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including, a) measures for dealing with emergencies; and b) procedures for evacuating and relocating the residents, and evacuating staff and others in case of an emergency."	4.2.1
Sections 142 to 144, 146(1), 147(1), 149(1), (3). Inspections An inspector may conduct inspections for the purpose of ensuring compliance with requirements under the LTCHA. In conducting an inspection, the inspector may inspect the home or a place operated in connection with the home and providing services to it, review records, question individuals, conduct tests, and call upon experts for assistance. Every long-term-care home must be inspected at least once a year without notice. After completing an inspection, an inspector must prepare an inspection report and give a copy of the report to the licensee and to the Residents' Council and the Family Council, if any. The inspector must document all identified non-compliances with the LTCHA in the inspection report.	4.5
Section 152(1). Actions by inspector if non-compliance found If an inspector finds that a licensee has not complied with a requirement under the LTCHA, the inspector must issue at least one of the following as the inspector considers appropriate: • a written notification of the non-compliance to the licensee; • a written request to the licensee to prepare a written plan to achieve compliance to be implemented voluntarily; • a compliance order requiring the licensee to either do, or refrain from doing, anything, or submit and implement a plan, to achieve compliance with the LTCHA's requirement; • a work and activity order for the licensee to allow, and pay for, employees, agents or contractors acting under the authority of the Ministry, to perform any work or activity at the home that is necessary to achieve compliance with a requirement under the LTCHA; and • a written notification to the licensee and referral to the Director for further action by the Director. *On December 12, 2017, the LTCHA was amended to give inspectors authority to issue a notice of administrative penalty. This amendment is not yet in force.*	4.5.3
Section 155(1). Order that funding be returned or withheld The Director may order that a specified amount of funding provided or to be provided to the licensee be returned by or withheld from the licensee. This includes funding provided under the LTCHA, the *Local Health Integration Act, 2006* or the *Connecting Care Act, 2019*.	4.5.3

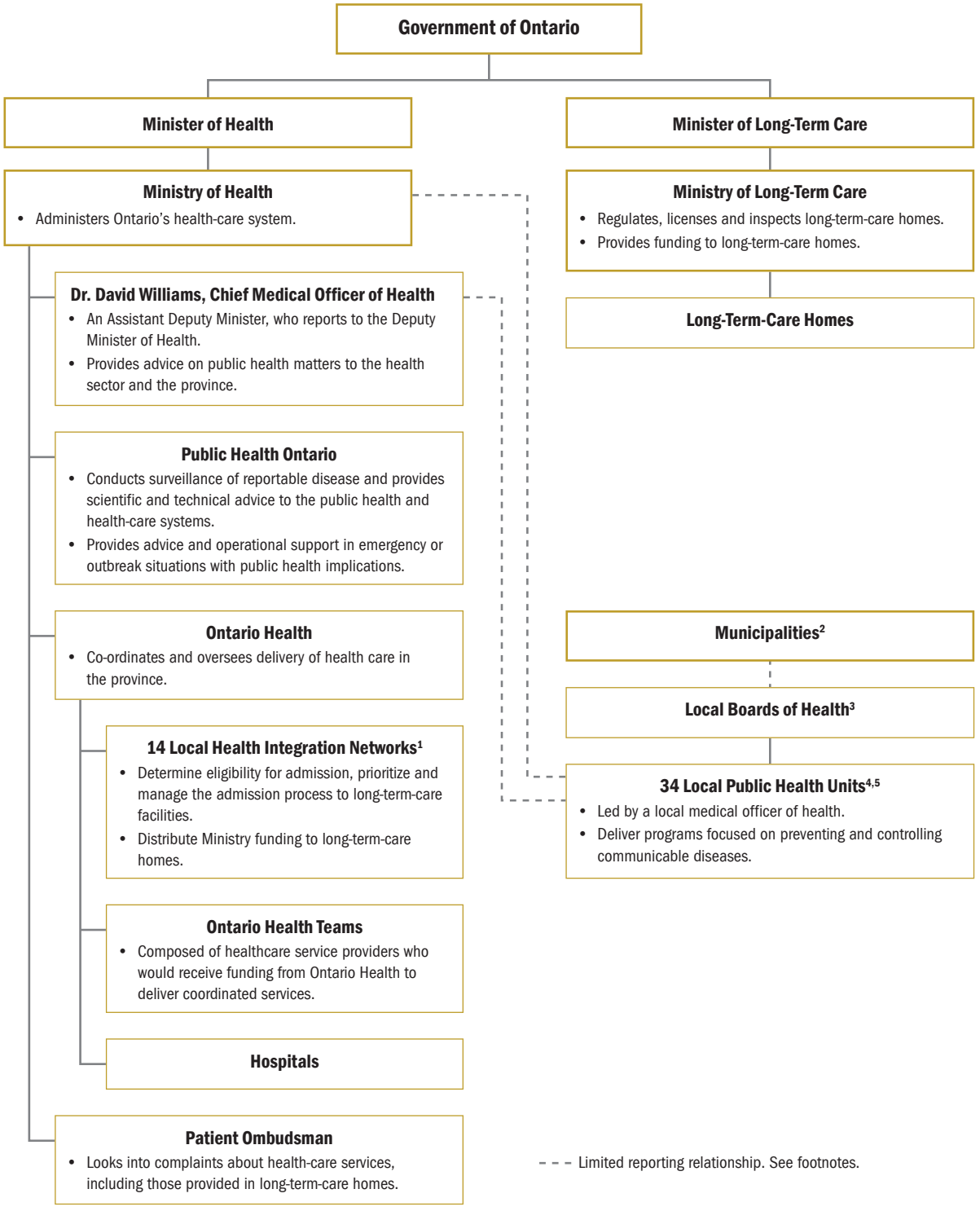
Legislative Requirement	Report Sections
Section 156(1). Mandatory management orders The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the home if the licensee has not complied with a requirement under the LTCHA and there are reasonable grounds to believe that the licensee cannot or will not properly manage the home, or cannot do so without assistance.	4.5.3
Section 157(1), (2). Revocation of licence The Director may make an order revoking a licence if, for example, the licensee has not complied with a requirement under the LTCHA, the home is being operated in a manner that is harmful to the health, safety or welfare or its residents, or the licensee, officers or directors of the home are not competent to operate the home in a responsible manner. If the Director has made an order revoking a licence, the Director may also make an order providing for the home to be operated by an interim manager until the revocation of the licence becomes effective and the residents of the home are relocated.	4.5.3
Ontario Regulation 79/10 under the LTCHA	
Section 107. Reports re critical incidents Every licensee of a long-term-care home must immediately inform the Director, in as much detail as is possible in the circumstances, of: emergencies such as fires, unexpected or sudden death, residents missing for three hours or more, residents returning to the home with an injury or adverse change in condition, outbreak of a disease of public health significance or communicable disease, and contamination of drinking water supply.	4.4
Health Protection and Promotion Act	
Section 10(1). Duty to inspect Every medical officer of health shall inspect or cause the inspection of the health unit served by him or her for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit.	2.2.5
Section 13(1).Order by Medical Officer of Health or public health inspector re health hazard A medical officer of health or a public health inspector, by a written order, may require a person to take or refrain from taking specific actions in respect of a health hazard in order to decrease the effect of or eliminate the health hazard.	2.2.5, 4.4
Section 29.2(1), (2). Orders to deal with communicable disease outbreaks A medical officer of health may make an order requiring a public hospital or an institution (long-term care home) to take any actions specified in the order for the purposes of monitoring, investigating and responding to an outbreak of communicable disease at the hospital or institution. A medical officer of health may make an order if he or she is of the opinion, upon reasonable and probable grounds, that an outbreak of a communicable disease exists or may exist at the public hospital or institution, and that the communicable disease presents a risk to the health of persons in the public hospital or institution, and that the measures specified in the order are necessary in order to decrease or eliminate the risks to health associated with the outbreak.	2.2.5, 4.4
Section 62(1), 67(1). Medical Officer of Health Every board of health must appoint a full-time medical officer of health and may appoint one or more associate medical officers of health. The medical officer of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other act within the health unit served by the board.	2.2.5
Section 77.1(1). Chief Medical Officer of Health may act where risk to health If the Chief Medical Officer of Health is of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, he or she may investigate the situation and take such action as he or she considers appropriate to prevent, eliminate or decrease the risk.	2.2.5

Legislative Requirement	Report Sections
Section 77.7(1) to (5). Directives to health-care providers Where the Chief Medical Officer of Health is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health-care provider or health-care entity regarding precautions and procedures to be followed to protect the health of persons anywhere in Ontario. Long-term-care homes are considered health-care providers or health-care entities. In issuing a directive, the Chief Medical Officer of Health must consider the precautionary principle where, (a) in the opinion of the Chief Medical Officer of Health there exists or may exist an outbreak of an infectious or communicable disease; and (b) the proposed directive relates to worker health and safety in the use of any protective clothing, equipment or device. A health-care provider or health-care entity that is served with a directive shall comply with it. However, the directive may not be used to compel regulated health professionals to provide services without their consent. Regulated health professionals are health practitioners whose profession is regulated under the *Regulated Health Professions Act, 1991* or the *Drugless Practitioners Act*. In the event of a conflict between this section and the *Occupational Health and Safety Act* or a regulation made under it, the *Occupational Health and Safety Act* or the regulation made under it prevails.	2.2.5, 4.4
Section 80(2). Inspections An inspector shall make inspections of health units to ascertain the extent of compliance with this Act and the regulations and the carrying out of the purpose of this Act.	2.2.5
Emergency Management and Civil Protection Act	
Section 7.0.1, 7.0.7. Declaration of emergency The Lieutenant Governor in Council (LGIC) or the Premier, if in the Premier's opinion the urgency of the situation requires that an order be made immediately, may declare that an emergency exists throughout Ontario or in any part of Ontario if the following criteria are satisfied: • There is an emergency that requires immediate action to prevent, reduce or mitigate a danger of major proportions that could result in serious harm to persons or substantial damage to property. • The resources normally available to a ministry of the government of Ontario or an agency, board or commission or other branch of the government, including existing legislation: cannot be relied upon without the risk of serious delay, or may be insufficiently effective to address the emergency. Unless terminated sooner or extended by the LGIC, emergency declarations are terminated 14 days after they are made. The LGIC may extend an emergency before it is terminated for one further period of no more than 14 days. The Assembly, on the recommendation of the Premier, may by resolution extend the period of an emergency for additional periods of no more than 28 days.	2.2.1
Section 7.0.2, 7.0.8. Emergency orders During a declared emergency, the LGIC may make orders that the LGIC believes are necessary and essential in the circumstances to prevent, reduce or mitigate serious harm to persons or substantial damage to property, if in the opinion of the LGIC it is reasonable to believe that the order will alleviate the harm or damage and is a reasonable alternative to other measures that might be taken to address the emergency. Such orders include, for example: regulating travel; establishing facilities for the care, welfare, safety and shelter of individuals; closing any public or private establishments or institutions; and requiring any person to collect, use or disclose information that may be necessary to prevent, respond to or alleviate the effects of the emergency. Unless revoked sooner or extended, emergency orders are revoked 14 days after they are made. The LGIC or a Minister to whom the power has been delegated may extend the effective period of an emergency order for periods of no more than 14 days.	2.2.1
Reopening Ontario (A Flexible Response to COVID-19) Act, 2020	
Section 2(1). Emergency orders Orders made under the *Emergency Management and Civil Protection Act* that have not been revoked as of the day this subsection comes into force are continued as valid and effective orders under this Act and cease to be orders under the *Emergency Management and Civil Protection Act*.	2.2.1

Legislative Requirement	Report Sections
Section 3(1). Time limit on application of orders An order continued under section 2 ceases to apply 30 days after it is continued under section 2, subject to extension under subsection.	2.2.1
Section 3(2). Extension of orders The Lieutenant Governor in Council may by order, before it ceases to apply, extend the effective period of an order for periods of no more than 30 days.	2.2.1
Section 4(1). Power to amend orders The Lieutenant Governor in Council may, by order, (a) subject to subsections (2) and (5), amend a continued section 7.0.2 order in a way that would have been authorized under section 7.0.2 of the *Emergency Management and Civil Protection Act* if the COVID-19 declared emergency were still in effect and references in that section to the emergency were references to the COVID-19 pandemic and its effects; (b) amend an order continued under section 2 to address transitional matters relating to the termination of the COVID-19 declared emergency, the enactment of this Act or the continuation of orders under section 2.	2.2.1
Section 5. Power to revoke orders The Lieutenant Governor in Council may by order revoke an order continued under section 2.	2.2.1
Section 10(1). Offences Every person who fails to comply with a continued section 7.0.2 order or who interferes with or obstructs any person in the exercise of a power or the performance of a duty conferred by such an order is guilty of an offence and is liable on conviction, (a) in the case of an individual, subject to clause (b), to a fine of not more than $100,000 and for a term of imprisonment of not more than one year; (b) in the case of an individual who is a director or officer of a corporation, to a fine of not more than $500,000 and for a term of imprisonment of not more than one year; and (c) in the case of a corporation, to a fine of not more than $10,000,000.	2.2.1
Section 17. Termination of COVID-19 declared emergency Unless it has been terminated before this section comes into force, the COVID-19 declared emergency is terminated and Ontario Regulation 50/20 (Declaration of Emergency) is revoked.	2.2.1

Appendix 2: Overview of Ontario's Health-Care System Related to the Long-Term-Care Sector

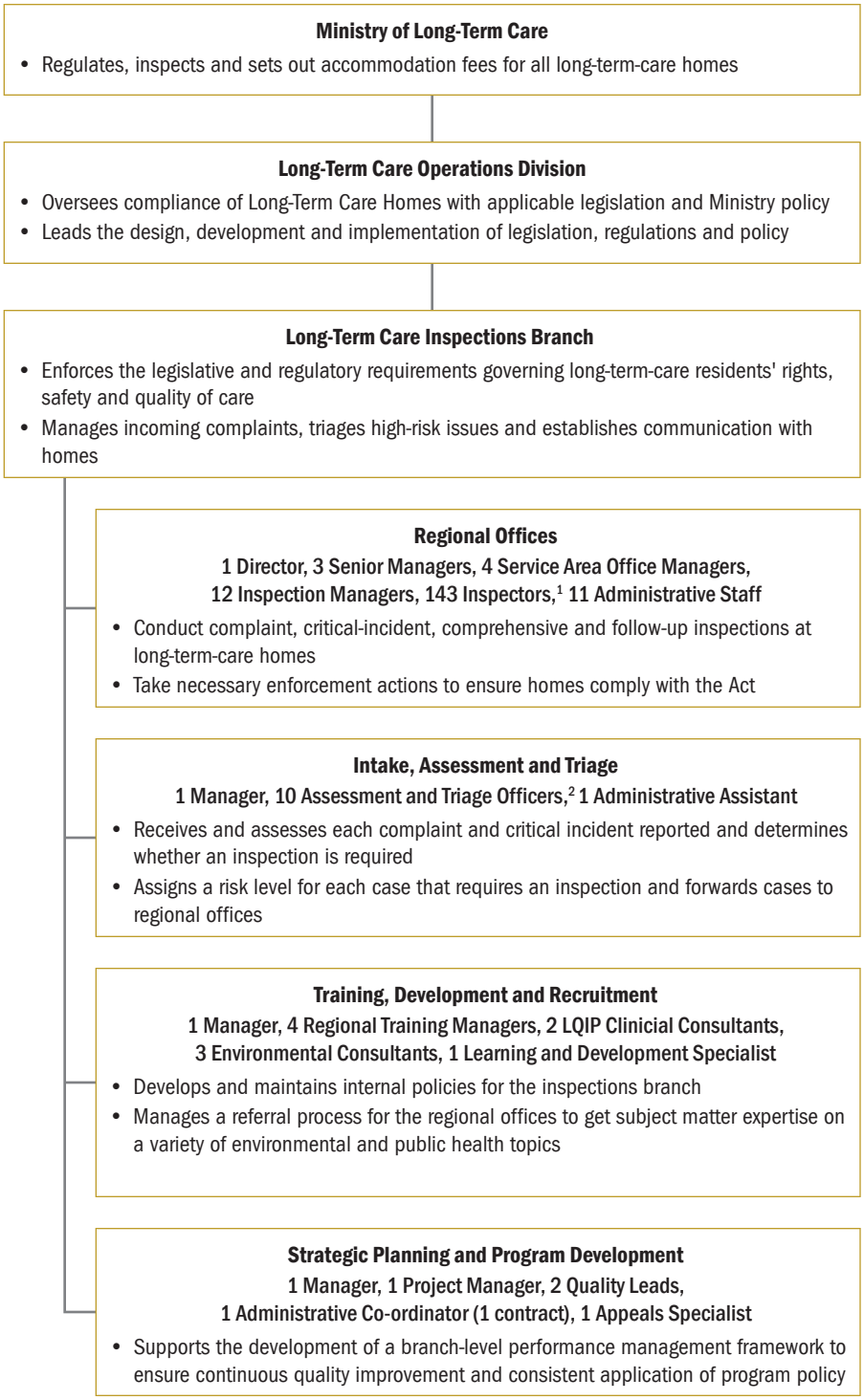
Prepared by the Office of the Auditor General of Ontario



1. As a part of the ongoing health-sector reorganization, the administrative functions of the 14 LHINs were transferred to Ontario Health on April 1, 2021. Effective April 1, 2021, the remaining operational functions of the LHINs became known as Home and Community Care Support Services. The responsibilities of current LHINs with respect to long-term-care homes will be moved to the Ministry of Long-Term Care.
2. Includes single-tier municipalities (e.g., City of Toronto) and upper-tier municipalities (e.g., Region of Peel, Halton Region).
3. Local boards of health operate under different governance models, some within the municipal structure, while others are separate.
4. Local public health units receive funding from the Ministry of Health and reports to the Ministry only regarding funded programs.
5. The Chief Medical Officer of Health has the authority to direct local jurisdictions in Ontario to implement public health actions in response to a public health risk or emergency.

Appendix 3: Ministry of Long-Term Care: Long-Term Care Inspections Branch, December 2020

Prepared by the Office of the Auditor General of Ontario



1. Approximately 20 inspectors are not currently active due to secondment, long-term disability, or another absence.
2. Nine Assessment and Triage Officers are located in Hamilton; one is located in Sudbury.

Appendix 4: Thirty-One Ministry of Long-Term Care Inspection Protocols Used in Comprehensive and Other Inspections

Source of data: Ministry of Long-Term Care

Note: Inspectors may review residents' Plans of Care if concerns are identified in any of the protocols that impact resident care.

Mandatory Inspection Protocols[1]

The following five protocols must be examined in stage one or two in every comprehensive inspection:

1. Dining observation[2]
2. Family council interview
3. Infection prevention and control
4. Medication
5. Residents' council interview

Other Inspection Protocols[1]

Inspectors examine one or more of the following protocols in stage two of a comprehensive inspection if it is called for (i.e., triggered by records review, their observations and/or interviews):

Home-Related (Triggered)

6. Housekeeping[3]
7. Laundry
8. Maintenance
9. Critical incident response
10. Food quality
11. Reporting and complaints
12. Safe and secure home
13. Snack
14. Staffing (whether sufficient)
15. Trust accounts[4]

Resident-Related (Triggered)

16. Continence care and bowel management[3]
17. Dignity, choice and privacy[3]
18. Falls prevention[3]
19. Hospitalization and change in condition
20. Minimizing of retraining[3]
21. Nutrition and hydration[3]
22. Pain[3]
23. Personal support services
24. Prevention of abuse, neglect and retaliation[3]
25. Recreation and social activities
26. Responsive behaviours
27. Skin and wound care[3]

Inspector-Initiated

28. Admission and discharge
29. Quality improvement
30. Resident charges[5]
31. Training and orientation

1. These inspection protocols can be used during any type of inspection. For complaint and critical incident inspections, inspectors use the inspection protocol(s) that best match the nature of the complaint or critical incident. The categorization of inspection protocols as mandatory, triggered, and inspector-initiated is only relevant for comprehensive inspections.
2. This protocol was not a mandatory inspection protocol for the risk-focused comprehensive inspection (see **Figure 25**).
3. This protocol was included in the risk-focused comprehensive inspection (see **Figure 25**).
4. Trust accounts are bank accounts into which the home operator is to deposit all money entrusted to its care on behalf of a resident.
5. Resident charges are charges to residents for goods and services they receive in the homes that are not covered by government funding, such as haircuts, cable TV and phone lines.

Appendix 5: Key Requirements Under the Institutional/Facility Outbreak Management Protocol, 2018

Source of data: Ministry of Health

Area	Protocols
General	• Develop and maintain policies and procedures to respond to infectious disease outbreaks in institutional settings. • Assist institutions during outbreak management preparation by establishing ways to collect data and providing education on preventing and management an outbreak. • Communicate disease policies and procedures. • Assist in the review and revision of infection prevention and control policies and procedures and provide health recommendations for outbreak prevention, detection and management. • Assist institutions in establishing and reviewing written outbreak response plans at a minimum of every two years.
Detection, Investigation, and Identification	• Inform institutions that they should notify the medical officer of health of all infectious diseases. • Work with institutions in developing surveillance system that can accurately assess a probable or confirmed outbreak. • Assist institutions in developing communication to receive notification and outbreak information. • Provide to institutions current epidemiological information on local occurrences of infectious diseases.
Notification: Reporting from Source to Boards of Health	• Have an on-call system for receiving and responding to notifications of infectious disease outbreaks. • Help in infectious disease outbreak assessments within 24 hours of receiving notification of an outbreak. • Obtain the epidemiological information necessary to assess, evaluate, and control the outbreak. • Assist in ensuring the collection of any environmental, clinical or other samples to assess, evaluate, confirm and control an outbreak.
Management	• Assist institutions in the management of infectious disease outbreaks however, it is ultimately the responsibility of the institution to manage the outbreak • Assist in confirming the existence of an outbreak and with declaring an outbreak • Perform the following actions when assisting in the management of outbreaks: a) Review and/or establish a case definition in collaboration with the institution; b) Determine the population at risk; c) Assist in active case finding; d) Assess the status of the outbreak daily, or as previously arranged; and e) Review and discuss line listings provided by the institution, including populations at risk and number of cases. • Recommend and assist with the implementation of appropriate infection prevention and control practices. • Participate in outbreak management team meetings. • Assist institutions with developing and implementing a risk communications plan. • Declare whether an outbreak is over, in consultation with the institution. • Review the response to outbreaks with institutions after they have been declared over. • Evaluate the management and impact of outbreaks and assist in identifying strategies for improvement in their management. • Inspect institutions for infection outbreaks, infection prevention and control practices, and food preparation and handling within the institution. • Respond to food safety and environmental issues in outbreak settings.

Area	Protocols
Data Collection, Reporting, and Information Transfer: Boards of Health to Ministry of Health, Ministry of Long-Term Care and Other Stakeholders	• Report outbreak data on diseases of public health significance to the Ministry and to Public Health Ontario within one business day of receiving notification of an outbreak or of assessing that an outbreak is occurring but has not been reported by the institution. • Update the outbreak file and enter data as required. • Communicate as soon as possible with the ministry and PHO about any unusual outbreaks or outcomes and/or the possibility of multi-jurisdiction. • Enter final summary outbreak data no later than 15 business days after the outbreak is declared over. • Assist the institution to summarize the outbreak and highlight areas for improved responses.

Appendix 6: Key Government Entities Involved in Ontario's COVID-19 Response

Prepared by the Office of the Auditor General of Ontario

Organization	Activities to be Performed and Other Information
Federal	
Public Health Agency of Canada	• Distribute to the provinces information received from the World Health Organization. • Collect COVID-19 information from provinces, such as case and death information, for consolidation and provision to the World Health Organization.
Canada Border Services Agency	• Facilitate flow of international travellers into Canada, including complying with travel restrictions imposed by the federal government on who may enter the country. • Collect information on international travellers to share with the Public Health Agency of Canada for ensuring compliance and enforcement of 14-day quarantine or isolation requirement established by the government of Canada as per the *Minimizing the Risk of Exposure to COVID-19 in Canada Order (Mandatory Isolation) No. 4*.
Canadian Armed Forces	• Deploy, through Operation LASER, medical and support personnel to seven long-term-care homes in Ontario from April to July 2020 to help prepare and serve meals, feed residents, assist residents with personal hygiene, accompany residents on walks, prepare and distribute medical products, and share observations with health-care staff. The Canadian Armed Forces released an interim report on May 24, 2020, followed by a final report on July 29, 2020.
Provincial (Health)	
Ministry of Health	• Lead Ontario's health-care response to COVID-19. • Deputy Minister of Health co-chairs the Health Command Table.
Ministry of Long-Term Care	• Support the Ministry of Health's response by participating in the Health Command Table and the sub-tables related to long-term-care and retirement homes. • Develop and implement policy for long-term-care homes.

Chief Medical Officer of Health	• Deliver a report annually on the state of public health in Ontario to the Speaker of the Legislative Assembly.
	• Issue a directive:
	  ◦ to any health-care provider or health-care entity identifying precautions and procedures to be followed when they are of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario; and
	  ◦ to any or all boards of health or local medical officers of health requiring the adoption or implementation of policies or measures when there exists or is an immediate risk of a provincial, national or international public health event, a pandemic or an emergency with health impacts anywhere in Ontario and the policies or measures are necessary to support a co-ordinated response to the situation.
	• Take on the role of an Assistant Deputy Minister, reporting to the Deputy Minister, Ministry of Health, with responsibility over the Ministry of Health's Public Health group.

Ontario Health	• Lead five regional steering committees.
Public Health Ontario	• Monitor infectious disease outbreaks and provides scientific advice to the health-care system and government of Ontario. • Operate 11 public health laboratories, which perform testing of infectious diseases (including seven laboratories that perform COVID-19 testing).
Health-care Providers	• Hospitals and primary care providers assist with assessing and treating individuals with COVID-19. • 13 hospital and three community laboratories perform COVID-19 testing. • 149 assessment centres (primarily operated by hospitals) collect specimens from individuals seeking a COVID-19 laboratory test.

Organization	Activities to be Performed and Other Information
Provincial (Non-Health)	
Solicitor General	• Administer the *Emergency Management and Civil Protection Act*, which was used on March 17, 2020 to require a number of public and private businesses to remain closed.
Emergency Management Ontario	• Report to the Solicitor General with responsibility for overseeing and co-ordinating the province's emergency management program and the emergency management programs of ministries and municipalities.
Municipal	
Public Health Units	• Administer health promotion and disease prevention programs as well as communicable disease control, including performing case management and contact tracing activities in relation to COVID-19.

Appendix 7: Chronology of Select Key Events Relating to COVID-19 in Ontario Long-Term-Care Homes, January 27, 2020–December 31, 2020

Prepared by the Office of the Auditor General of Ontario

Date	Event
January 27—Canada reports its first confirmed case of COVID-19 in Toronto, Ontario.	
Feb 3	Province releases guidance on COVID-19 prevention and screening in long-term-care homes.
Feb 11	Province releases updated guidance on COVID-19 prevention and screening in long-term care.
Feb 28	Ontario's Ministry of Health (Ministry) establishes a Health Command Table as a source of advice to the Minister of Health, Cabinet and the Premier.*
Mar 9	Ministry issues a memo to all long-term-care operators with guidance to actively screen all visitors, residents, re-admissions and returning residents to long-term-care homes.
Mar 9	Canada's first COVID-19 death occurred in a long-term care home in British Columbia.
March 11—World Health Organization declares COVID-19 to be a pandemic.	
Mar 11	Ministry amends March 9 memo to also include staff and volunteers.
Mar 13	Ontario's Chief Medical Officer of Health recommends that long-term-care homes allow only essential visitors, such as those visiting the very ill or making end-of-life visits.
Mar 14	The Ministry of Long-Term Care halts all on-site including complaint and critical incident inspections of long-term-care homes.
March 17—Ontario government declares a state of emergency.	
Mar 17	Province announces up to $304 million in funding to help respond to COVID-19, $50 million of which is allocated to long-term-care homes to support 24/7 screening, additional staffing and critical supplies.
Mar 17	The first resident cases of COVID-19 are confirmed in the long-term-care sector, in Toronto, Oshawa and Vaughan.
Mar 20	The first staff cases of COVID-19 are confirmed among long-term-care staff, in Scarborough, Oshawa and Bobcaygeon.
Mar 20	Province amends regulations under the *Long-Term Care Homes Act, 2007* (O. Reg. 72/20) to allow homes to quickly bring in more and new staff to prevent potential staffing shortages, and to allow staff to spend more time on direct care to residents.
Mar 22	Ontario's Chief Medical Officer of Health issues a directive (called Directive #3) to long-term-care homes to immediately implement the following: • to not permit residents to leave the home for short-stay absences to visit family and friends; and • to, wherever possible, limit the number of work locations that employees are working at.
Mar 23	Province issues a temporary order (O. Reg. 77/20) for long-term-care homes to support increased staffing flexibility, enabling homes to be able to respond to, prevent and alleviate an outbreak of COVID-19. Province also suspends short stays in long-term-care homes and provides guidance to homes on how to use short-stay beds to maximize capacity for applicants waiting for admission to a long-stay bed in a long-term-care home.
Mar 24	Province amends regulations to allow for streamlined long-term-care admissions, discharge and re-admissions processes.
Mar 25	Province launches Ontario's Action Plan: Responding to COVID-19, a $17-billion emergency relief package, which includes $3.3 billion in additional resources for the health-care system, and specifically $243 million for long-term care.
Mar 27	Province issues a second temporary order (O. Reg. 95/20) for long-term-care homes to provide further flexibility for long-term-care homes and allow homes to redirect their staffing and financial resources to essential tasks during the COVID-19 crisis.
Mar 30	The Chief Medical Officer of Health updates Directive #3 limiting visitors to long-term-care homes to only essential visitors—those performing essential support services, such as food delivery, inspection, maintenance, or health-care services; or those visiting a very ill or palliative resident.
Mar 30	Also, in Directive #3, the Chief Medical Officer of Health directs that, wherever possible, employers should work with employees to limit the number of work locations that employees are working at.

Date	Event
Apr 7	The Ministry launches the Ontario Matching Portal to triage and match potential employees and volunteers who wish to help with the COVID-10 pandemic.
Apr 8	The Chief Medical Officer of Health updates Directive #3 to: • implement masking for staff and essential visitors; • save and securely store used personal protective equipment; • provide direction for staff and resident cohorting; • recommend employers to work with staff in limiting the amount of locations staff are working at; • test for COVID-19; and • follow a protocol for outbreak management. The updated Directive #3 also directs long-term-care homes to immediately begin more aggressive screening—upgraded to twice daily—of staff, essential visitors and residents.
Apr 11	First meeting of the Provincial Central Co-ordination Table, which was formed for decision-making purposes on the advice of a contracted consulting firm.
Apr 13	The province begins to provide same-day deliveries of supplies and equipment to hospitals, long-term-care and retirement homes, and other facilities to support essential workers in all settings and expedites delivery of supplies to those most in need.
Apr 14	Province issues a third temporary order (O. Reg. 146/20) to restrict employees of long-term-care homes from working in more than one location. This order comes into effect on April 22, 2020.
Apr 15	The province orders hospitals to suspend transfers of alternate-level-of-care patients from hospitals to long-term-care homes.
Apr 16	Province issues a temporary order (O. Reg. 156/20) that allows Local Health Integration Networks (LHINs) to work with their home care service providers to redeploy workers to long-term-care homes. Province issues a temporary order (O. Reg. 157/20) that allows municipalities to have flexibility to reassign staff to where there is local need, including long-term care.
Apr 22	Province requests the Canadian Armed Forces to help five long-term-care homes with COVID-19 outbreaks.
Apr 24	Province amends O. Reg. 74/20 to authorize hospitals to redeploy staff to long-term-care settings to provide assistance.
Apr 28	Canadian Armed Forces staff are deployed to five long-term-care homes.
May 8	The Ministry of Long-Term Care allows inspectors to resume on-site inspections. However, inspectors are not required to go on-site to conduct inspections.
May 12	Province amends O. Reg. 210/20 to give the Ministry the ability to appoint a person to assume the management of a long-term-care home should at least one resident or employee test positive for COVID-19.
May 23	The Ontario Chief Medical Officer of Health (CMOH) updates Directive #3 to include a requirement for homes to have a plan for resident cohorting in the event of a COVID-19 outbreak.
May 24	The Canadian Armed Forces releases an interim report on its observations at the five long-term-care homes at which they were deployed on April 28.
May 25	The Ministry of Long-Term Care issues mandatory management orders appointing local hospitals to temporarily manage two long-term-care homes. Southlake Regional Health Centre temporarily manages River Glen Haven Nursing Home in Sutton, and Humber River Hospital temporarily manages Downsview Long Term Care in North York.
May 27	The Ministry announces it is appointing temporary management at five more long-term-care homes—in Brampton, Etobicoke, North York, Pickering and Scarborough. At four of those homes, the Canadian Armed Forces reported examples of homes not adhering to or not having required policies, inadequately trained staff and shortages of medical supplies, deficiencies in facilities, and concerns about standards of care.
Jun 2	Ontario's Patient Ombudsman launches an investigation into the complaints of long-term-care homes during the COVID-19 pandemic.
Jun 2	The Ministry of Long-Term Care issues a mandatory management order appointing a hospital to temporarily manage a long-term-care home in Kitchener.

Date	Event
Jun 10	Province begins allowing new admissions from community or hospital (including patients designated alternate level of care) to long-term-care homes.
Jun 12	The Ministry appoints a hospital to temporarily manage a long-term-care home in Scarborough.
Jun 17	The Ministry appoints a hospital to temporarily manage a long-term-care home in Vaughan.
Jun 16	The Ministry appoints a hospital to temporarily manage a long-term-care home in North York.
Jul 29	Province, under the authority of the *Health Protection and Promotion Act*, launches an independent commission to investigate the spread of COVID-19 within long-term-care homes.
Aug 14	The Canadian Armed Forces releases its final report on the Long-Term Care Mission, which states most concerns found in long-term-care homes are addressed. However, the report also states outstanding concerns exist, largely related to training of new staff and supervision to ensure consistent infection prevention and control measures are in place and followed.
Aug 28	Province announces that long-term-care residents can once again leave their residences for short-stay and temporary absences.
Sep 2	Province updates its long-term-care home visitor policy to help operators implement consistent visiting practices across the province. This policy includes guidance on safely allowing essential caregivers into homes.
Sep 25	Two new voluntary management agreements are established between The Ottawa Hospital and two long-term-care homes: Extendicare West End Villa and Extendicare Laurier Manor.
Oct 5	Province updates its visitor policy to address areas where there is a higher community spread of COVID-19, effective October 7, 2020.
Oct 7	The Ministry of Long-Term Care facilitates a voluntary management agreement between Unity Health Toronto and Norwood Nursing Home in Toronto.
Oct 13	The Ministry of Long-Term Care issues a Mandatory Management Order appointing Royal Victoria Regional Health Centre to temporarily manage Simcoe Manor Home for the Aged, on behalf of the Corporation of the County of Simcoe in Beeton.
Oct 23	Canadian Red Cross teams provide short-term support to the Prescott and Russell Residence long-term-care home in Hawkesbury.
Oct 28	The Ministry of Long-Term Care issues a Mandatory Management Order requiring the Millennium Trail Manor long-term-care home in Niagara Falls to retain the Niagara Health System to temporarily manage the home.
Nov 6	Province announces a new framework to categorize public health regions into five different levels: Green-Prevent, Yellow-Protect, Orange-Restrict, Red-Control and Lockdown.
Nov 9	Province launches The Ontario Workforce Reserve for Senior Support program, which focuses on recruiting, training and deploying individuals as Resident Support Aides (RSAs) to work at homes during the COVID-19 pandemic. The RSAs will assist residents with daily living activities, including assistance during meal times and nutrition breaks, the co-ordination of visits, and support with technology or recreational activities.
Nov 12	Province announces an additional $761 million investment to build and renovate 74 long-term-care homes across the province. This investment supports the commitment made by the government to create 30,000 beds over 10 years.
Nov 20	Province commits to 29 projects that would create 1,968 new spaces and 1,015 upgraded spaces in long-term care. Twenty-three projects involve constructing new buildings.
Nov 25	The Ministry of Long-Term Care issues a Mandatory Management Order naming Joseph Brant Hospital to temporarily manage Tyndall Nursing Home in Mississauga.
Nov 28	The Ministry of Long-Term Care approves new voluntary management agreements for two long-term-care homes. The agreements are between Scarborough Health Network and Rockcliffe Care Community in Scarborough; and Mackenzie Health and Langstaff Square Care Community in Richmond Hill.
Dec 3	The Ministry of Long-Term Care approves a voluntary management agreement between Southlake Regional Health Centre and King City Lodge Nursing Home, a long-term-care home in King City. The Ministry of Long-Term Care also approves a voluntary management agreement between Lakeridge Health to support Sunnycrest Nursing Home in Whitby.

Date	Event
Dec 14	The Ministry of Long-Term Care issues a Mandatory Management Order between Revera Long Term Care Inc. and UniversalCare Canada Inc. to temporarily manage Westside, a long-term-care home in Etobicoke.
Dec 15	The Ministry of Long-Term Care approves a Voluntary Management Agreement between Scarborough Health Network and Craiglee Nursing Home, a long-term-care home in Scarborough.
Dec 16	The Ministry of Long-Term Care approves a Voluntary Management Contract between Hamilton Health Sciences and Grace Villa Nursing Home, a long-term-care home in Hamilton.
Dec 18	The Ministry of Long-Term Care approves a Voluntary Management Contract between Cambridge Memorial Hospital and Cambridge Country Manor, a long-term-care home licensed under Caressant-Care Nursing and Retirement Homes Limited.
Dec 21	The Ministry of Long-Term Care approves a Voluntary Management Contract between Markham Stouffville Hospital and Faith Manor Nursing Home, a Brampton long-term-care home licensed under Holland Christian Homes Inc.
Dec 23	Canadian Red Cross teams begin providing short-term support to an additional 20 long-term-care and retirement homes in Ontario.
Dec 29	The Ministry of Long-Term Care approves a Voluntary Management Contract between North York General Hospital and Tendercare Living Centre, a Scarborough-based long-term-care home licensed under Tendercare Nursing Homes Limited. The Ministry of Long-Term Care also approves a Voluntary Management Contract between St. Joseph's Healthcare Hamilton and Shalom Village Nursing Home in Hamilton.
Dec 30	Province releases the Ethical Framework for COVID-19 vaccine distribution, which was developed in partnership with the COVID-19 Vaccine Distribution Task Force to guide further vaccine prioritization and distribution across the province.
Dec 31	The Ministry of Long-Term Care approves a Voluntary Management Contract between Niagara Health System and Oakwood Park Lodge, a Niagara Falls-based long-term-care home licensed under Maryban Holdings Ltd.

* See the Office of the Auditor General's *2020 Special Report COVID-19 Preparedness and Management*, **Chapter 2**: *Outbreak Planning and Decision-Making*, **Appendix 9** for a listing of sub-tables formed under the Health Command Table.

Appendix 8: Observations from the Canadian Armed Forces and Patient Ombudsman

Prepared by the Office of the Auditor General of Ontario based on data from reports by the Canadian Armed Forces[1] and Patient Ombudsman[2]

Observations	Canadian Armed Forces							Patient Ombudsman[2]
	Altamont Care Community	Downsview Long-Term-Care Centre[3]	Eatonville Care Center	Hawthorne Woods Care Community	Holland Christian Homes	Orchard Villa	Woodbridge Vista Care	
Poor infection control practices such as allowing COVID-19 positive residents to wander, putting staff, other residents and visitors at risk of exposure. (**Section 4.1.3**)	✓[4,5]		✓[4,5]	✓[4]	✓[4,5]	✓[4,5]		✓
Quality of care concerns such as forceful feeding, causing audible choking/aspiration, observed by staff. (**Section 4.1.2**)	✓[5]		✓[4,5]	✓[4,5]	✓[4,5]	✓[4,5]	✓[5]	✓
Discontinuance of Resident Quality Inspections that would have ensured an infection prevention and control (IPAC) protocol review and assessment. (**Sections 4.5.1 and 4.5.2**)								
Shortage of proper supplies and personal protective equipment, such as expired medication. (**Section 4.1.3**)	✓[4]		✓[4]	✓[4]		✓[4]		✓
Ambiguity with local practices such as cohorting residents. Ministry requirements were cited as a reason why COVID-19-negative residents were rooming with infected residents. (**Section 4.4.2**)	✓[4]		✓[4]	✓[4]		✓[4]		
Poor communication such as lack of handover during shift change, leading to instances of residents not receiving proper care. (**Section 4.1.2**)			✓[4]	✓[4]		✓[4]		
Staffing shortages such as facilities being severely understaffed during the day. (**Section 4.1.2**)	✓[4]		✓[4,5]	✓[4,5]		✓[4]		✓
Family caregivers being denied access to their loved ones in long-term-care homes and patients dying alone without their families. (**Section 4.3.3**)								✓
Long-term-care homes having significant COVID-19 outbreaks in April when patients were transferred from hospitals to create capacity. (**Section 4.3.2**)								

Observations	Canadian Armed Forces							Patient Ombudsman[2]
	Altamont Care Community	Downsview Long-Term-Care Centre[3]	Eatonville Care Center	Hawthorne Woods Care Community	Holland Christian Homes	Orchard Villa	Woodbridge Vista Care	
At the outset of the pandemic in March, large-scale testing for COVID-19 was impossible. (**Chapter 3, Laboratory Testing, Case Management and Contact Tracing**)								✓
Long-term-care homes cannot effectively cohort and isolate because of physical infrastructure limitations. (**Sections 4.1.1 and 4.3.1**)								
Local public health units should be sent into homes to conduct timely, focused inspections to ensure homes are properly implementing proactive IPAC measures and are responding effectively to their assessment results. (**Section 4.2.**2)								

1. The Canadian Armed Forces released an interim report on its observations at five of the seven homes on May 24, 2020, followed by a final report on all seven homes on July 29, 2020.
2. The Patient Ombudsman released her interim report with preliminary recommendations in October 2020. The Ombudsman report also included findings on inadequate access to home and community care services, delays in non-emergency procedures, and whistle-blower protection, which were not in the scope and objective of this report (see **Section 3.0 Objective and Scope**).
3. None of the issues listed were found in the Downsview home.
4. Observation included in the Canadian Armed Forces' interim report (Eatonville Care Centre, Hawthorne Place Care Centre, Holland Christian, Orchard Villa and Altamont).
5. Observation included in the Canadian Armed Forces' final report (which covered the homes included in the interim report along with Downsview Long Term Care and Woodbridge Vista Care Community).

Appendix 9: Criteria

Prepared by the Office of the Auditor General of Ontario

1. Roles, responsibilities and accountability requirements, including with respect to infectious disease outbreak and pandemic management and response, were clearly defined to achieve legislative objectives.
2. Partnerships between the Ministry of Long-Term Care, long-term-care homes and other health-care-sector partners, such as local hospitals and public health units, were in place to facilitate provision of staff and expertise with respect to infection prevention and control and outbreak management.
3. Relevant and timely information about long-term-care home facilities, residents and staffing were regularly collected, analyzed and used to inform the Ministry of Long-Term Care's ongoing oversight activities as well as decisions made during the pandemic.
4. Long-term-care home inspectors are sufficiently trained to assess long-term-care homes' compliance with legislative and regulatory requirements. Inspection staffing levels are sufficient to conduct inspections related to complaints and critical incidents within the required time frames as well as proactive comprehensive inspections.
5. Public health measures and restrictions that were intended to contain the spread of COVID-19 in long-term-care homes were clearly communicated in a timely manner. The consequences of such restrictions were examined to minimize adverse effects on the level and quality of care received by long-term-care home residents.

Appendix 10: Stakeholder Associations Our Office Met with for This Special Report

Prepared by the Office of the Auditor General of Ontario

Stakeholder Name	Description
AdvantAge Ontario	The provincial association representing not-for-profit providers of long-term care, and services and housing for seniors. Members include municipal, charitable and non-profit long-term-care homes, seniors' housing projects, and community service agencies. Member organizations serve over 36,000 long-term-care residents per year in Ontario.
Advocacy Centre for the Elderly	A specialty community legal clinic established to provide a range of legal services to low-income seniors in Ontario. Legal services include advice and representation to individual and group clients, public legal education, law reform and community development activities.
Canadian Patient Safety Institute	Regarded as the authority on patient safety in Canada, the Institute works with partners to implement and evaluate measurable and sustainable safety improvement projects aligned with pan-Canadian priorities.
CorHealth Ontario	Formed in 2017 after the merger of the Cardiac Care Network of Ontario and the Ontario Stroke Network, CorHealth Ontario provides advice to the Ministry of Health, Local Health Integration Networks, hospitals and care providers to improve the quality, efficiency, accessibility and equity of cardiac, stroke and vascular services for patients across Ontario.
Ontario Long-Term Care Association	The largest association of long-term-care providers in Canada, representing nearly 70% of Ontario's long-term-care homes. Focusing on advocacy, the Association works to influence legislative, policy and regulatory change, support sector expansion and redevelopment, and provide educational opportunities to ensure residents' needs are being met.
Ontario Nurses' Association	The union representing 68,000 registered nurses and health-care professionals. The Association works with members to ensure their front-line nurses working in hospitals, public health, community health centres, home care, family health teams, long-term care and private clinics can provide quality care to patients.
Ontario Hospital Association (OHA)	An association representing hospitals across Ontario. Hospital members would like OHA to be a leader in shaping new funding methodologies and in providing thought leadership on key ideas that can help build a better health system and ensure that Ontario hospitals have a strong voice in reshaping the system in the coming years.
Ontario Personal Support Workers Association	An association striving to improve the professional status of personal support workers in Ontario through advocacy for excellence and consistency in training, services, working conditions and value to personal support workers.
Ontario Public Sector Employees' Union (OPSEU)	A union representing about 170,000 public-sector employees in the province of Ontario. OPSEU has about 3,500 members working in long-term-care and retirement homes, and related facilities.
Ontario Society of Occupational Therapists	The voluntary provincial professional association representing the interests of the over 4,500 members, who are occupational therapists and students of occupational therapy.
Registered Nurses' Association of Ontario	The professional association representing registered nurses, nurse practitioners and nursing students in Ontario.

Appendix 11: Sources of Long-Term-Care Data

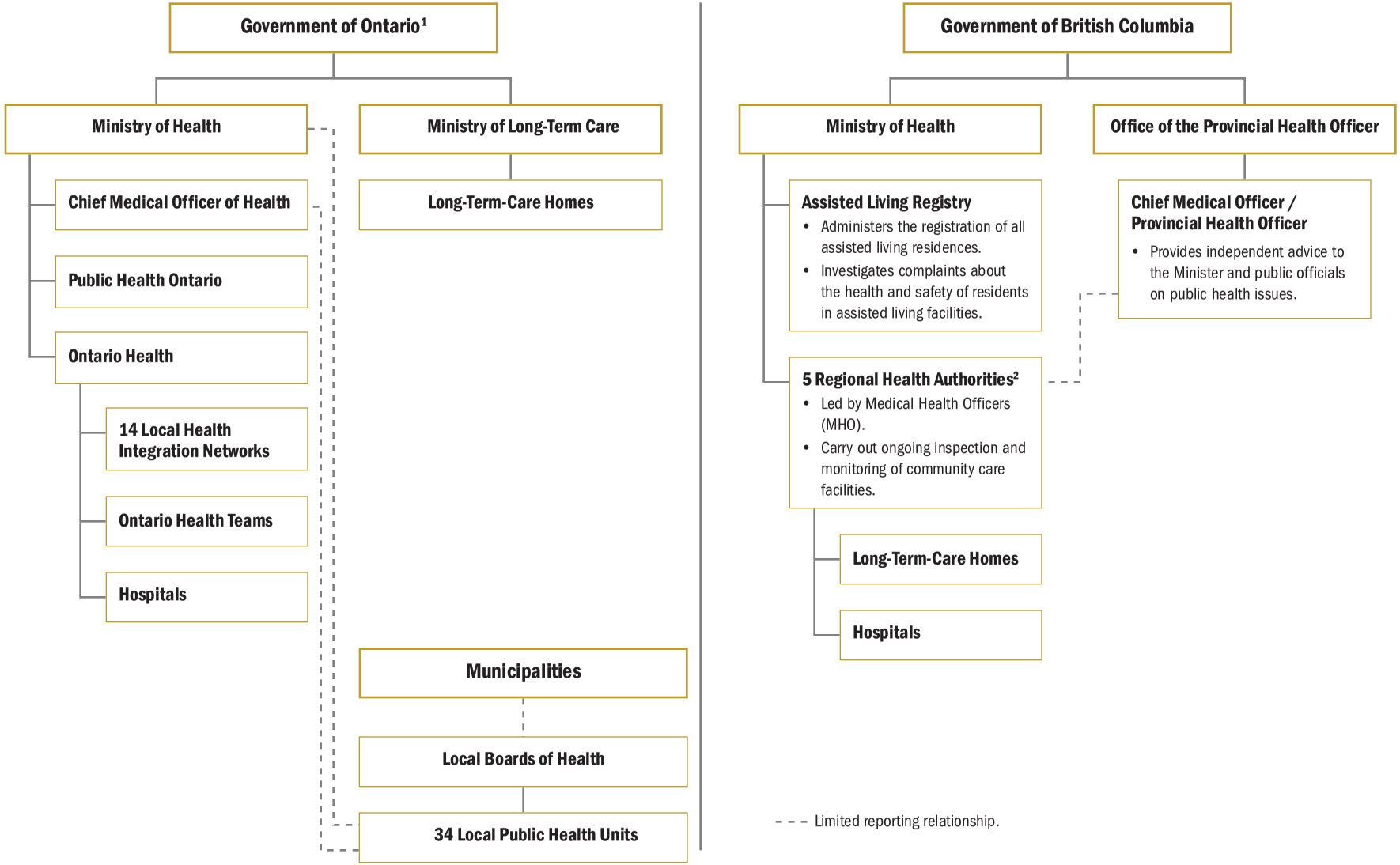
Source of data: Ministry of Long-Term Care

Data Source	Who Enters the Data	Who Collects the Data	Description of the Data
Integrated Public Health Information System/Case Contact Management System (iPHIS/CCM)	Local public health units	Public Health Ontario	• Primary data source for Ontario's public health information. • Contains personal information on positive COVID-19 cases (e.g., age, sex and risk factors). • Captures data on COVID-19 outbreaks at the facility level.
Ministry of Long-Term Care Inspectors Dataset	Ministry inspectors; long-term-care home staff	Ministry of Long-Term Care	• Inspectors call long-term-care homes daily and log their COVID-19 cases and deaths information into the dataset. • Long-term-care home staff enter facility-level information. • The updated number of cases, deaths and outbreaks are rolled up into the LTC Daily Summary Report.
Ontario Laboratories Information System (OLIS)	Testing facility staff	Ontario Health	• Ontario's primary lab test data repository, including data for all tests covered by OHIP. • Contains comprehensive test history for patients and can be used to monitor progress of treatments, support chronic disease management and monitor COVID-19 case growth.
Continuing Care Reporting System (CCRS)	Nursing staff in long-term-care homes	Canadian Institute for Health Information (CIHI)	• Contains demographic, clinical, functional and utilization data about long-term-care homes and their residents. • Allows for detailed analysis of long-term-care residents based on clinical characteristics. • Information is updated quarterly.
Office of the Chief Coroner of Ontario	Long-term-care home staff	Office of the Chief Coroner of Ontario	• Captures personal records of COVID-19 deaths within hours of the death being confirmed at the home.* • Data is reported within a day and contains details on the clinician-informed cause of death. • Does not track long-term-care staff deaths and residents who died in a hospital.

* Long-term-care homes were mandated to submit the COVID-19 status of resident deaths from April 14 to June 23, 2020.

Appendix 12: Comparison of Ontario[1] and British Columbia's Health-Care System Organization

Prepared by the Office of the Auditor General of Ontario



1. See **Appendix 2** for a description of the different entities in Ontario's health-care system.
2. Medical Health Officers (MHO) are employed by regional health authorities, and have reporting relationships to the Chief Medical Officer/Provincial Health Officer.

Appendix 13: Summary of Key Changes in Requirements under COVID-19 Directive #3 for Long-Term-Care Homes, March 30—December 7, 2020[1]

Source of data: Ministry of Health and Ministry of Long-Term Care

Date Issued	Requirement
Absences (Short-term, Temporary and Medical)	
Mar 30	"Long-term-care homes must not permit residents to leave the home for short-stay absences to visit family and friends. Instead, residents who wish to go outside of the home must be told to remain on the home's property and maintain safe physical distancing."
Jun 10	"Temporary short-stays in hospitals can be considered for residents in the event of an outbreak where residents cannot be placed in other areas of the home that are not part of the declared outbreak area, or there are other exceptional circumstances (e.g., resident safety, advice from local public health unit)."
Aug 28	"Residents may leave the home's property for a short-stay absence for health-care, social or other reasons. A short-stay absence does not include an overnight stay, with the exception of single-night emergency room visits. Upon return to the home, residents must be actively screened but are not required to be tested or self-isolate." "Residents may leave the home's property for a temporary absence (one or more nights) for personal reasons. Upon return to the home the resident will be required to self-isolate for 14 days."
Oct 14	"The resident or substitute decision-maker must make an absence request to the home. Homes must review and approve all non-medical absence requests based on a case-by-case risk assessment considering, but not limited to: the home's ability to support self-isolation for 14 days upon the resident's return, local disease transmission and activity, and risk associated with the planned activities that will be undertaken by the resident while out of the home." "If the home denies an absence request, the home must communicate this to the resident/substitute decision-maker in writing, including the rationale for this decision. Residents whose request for an absence is denied but wish to go outside must be told to remain on the home's property and maintain a physical distance of at least two metres from any other resident or staff on the property."
Admissions, Re-admissions and Transfers	
Mar 30	"Long-term-care homes must screen new admissions and re-admissions for symptoms and potential exposure to COVID-19. All new residents must be placed in self-isolation for 14 days on arrival at the long-term-care home."
Apr 8	"If test results are negative, they must remain in isolation for 14 days from arrival. If test results are positive, homes must report a confirmed case and follow case management protocol, which includes treating residents with compatible illnesses as probable for having COVID-19 pending test results, and cohorting confirmed cases. Patients transferred from hospital to a long-term-care home must be tested prior to the transfer."
Apr 15	"Hospitals are being asked to temporarily stop transfers to long-term-care and retirement homes. However, in the unlikely event that a transfer is still required, patients transferred from a hospital to a long-term-care home or retirement home must be tested and confirmed negative prior to transfer." All patients should self-isolate for 14 days following transfer."
Jun 10	New admissions and readmissions to a long-term-care home or retirement home can occur if a home has sufficient staffing and can ensure COVID-19 preparedness measures such as self-isolation, and the resident is placed in a room with no more than one other resident.
Aug 28	"In the case that there is any difference of view between a hospital and long-term-care home about the suitability of the return of the resident to the long-term-care home," parties should "contact the local placement coordinator/office." If the issue cannot be resolved, it will be "escalated to the Ministry."
Dec 7	"Individuals who may have challenges with isolation due to a medical condition (e.g., dementia) should not be denied admission or transfer on this basis alone."
Communications	
Mar 30	"Long-term-care homes must keep staff, residents and families informed about COVID-19, including frequent and ongoing communication during outbreaks."

Date	Event
COVID-19 Preparedness	
Mar 30	Long-term-care homes, in consultation with their Joint Health and Safety Committees or Health and Safety Representatives, if any, must ensure measures are taken to prepare the home for a COVID-19 outbreak, including: • ensuring outbreak swab kits are available; • ensuring sufficient personal protective equipment (PPE) is available, and staff are trained on the use of PPE; • reviewing advanced directives for all residents, reviewing communications protocols and reviewing staffing schedules; • reviewing internal activities to ensure social distancing; • reviewing environmental cleaning protocols; and • developing polices to manage staff who may have been exposed to COVID-19.
Sep 9	Long-term-care homes must discuss with each resident and their substitute decision-maker an advanced care plan for the resident, and document the plan. Homes must communicate with local acute care hospitals regarding outbreaks, including number of residents in the facility, and number who may potentially be transferred to hospital if ill based on the expressed wishes of the residents. Homes must develop policies to manage staff who may have been exposed to COVID-19 and must permit an organization completing an IPAC assessment to share the report with any or all of the following: public health units, local public hospitals, LHINs, and the Ministry of Long-Term Care in the case of long-term-care homes.
Limiting Work Locations	
Mar 30	Wherever possible, employers should work with employees to limit the number of work locations that employees are working at.
Apr 15	Long-term-care home employers are reminded that they must also comply with Ontario Regulation 146/20 under the *Emergency Management and Civil Protection Act*.
Management of a Single Case in a Resident	
Mar 30	The resident must be in isolation under appropriate droplet and contact precautions, which include staff wearing a mask and eye protection or face shield within two metres of the resident, wearing a long-sleeved gown for direct care when skin or clothing may become contaminated, wearing gloves for direct care, and being in a single room if possible.
Management of a Single Case in Staff	
Mar 30	Long-term-care homes must immediately implement outbreak control measures for a suspected outbreak. Even if the staff exposure was to a specific area of the long-term-care home, consideration must be given to applying outbreak control measures to the entire home.
Managing Visitors	
Mar 30	Long-term-care homes must be closed to visitors, except for essential visitors. Essential visitors include a person performing essential support services (e.g., food delivery, maintenance and other health care) or a person visiting a very ill or palliative resident. If an essential visitor is admitted to the home, the visitor must: • be screened on entry for symptoms of COVID-19, including temperature checks, and not be admitted if they show any symptoms of COVID-19; • visit only the one resident they are intending to visit and no other resident; and • wear a mask while visiting a resident who does not have COVID-19. For any essential visitor in contact with a resident who has COVID-19, appropriate PPE should be worn in accordance with Directive #1.[2]
May 21	For any essential visitor in contact with a resident who is suspected or confirmed to have COVID-19, appropriate PPE should be worn in accordance with Directive #5[3] and Directive #1.

Date	Event
Jun 10	At minimum, visitor policies must: • Be informed by the ongoing COVID-19 situation in the community and the home and be flexible to be reassessed as circumstances change. • Be based on principles such as safety, emotional well-being and flexibility, and address concepts such as compassion, equity, non-maleficence, proportionality (i.e., be appropriate to the level of risk), transparency and reciprocity (i.e., provide resources to those who are disadvantaged by the policy). • Include education about physical distancing, respiratory etiquette, hand hygiene, infection prevention and control practices (IPAC) and proper use of PPE. • Include allowances and limitations regarding indoor and outdoor visiting options. • Include criteria for defining the number and types of visitors allowed per resident when the home is not in an outbreak, in accordance with Ministry of Long-Term Care and Ministry for Seniors and Accessibility policies. When the home is in an outbreak, only essential visitors are permitted in the home. • Include visitors confirming they have not been experiencing any of the typical and atypical symptoms of COVID-19. • Comply with the home's IPAC protocols. • Clearly state that if the home is not able to provide surgical/procedure masks, no family visitors should be permitted inside the home. Essential visitors who are provided with appropriate PPE from their employer may enter the home. • Include a process for communicating with residents and families about policies and procedures, including the gradual resumption of family visits. • State that non-compliance with the home's policies could result in a discontinuation of visits for the non-compliant visitor. • Include a process for gradual resumption of family visitors that specify essential visitors.
Personal Protective Equipment (PPE)	
Mar 30	Long-term-care homes must follow COVID-19 Directive #1[2] for Health Care Providers and Health Care Entities.
May 21	Long-term-care homes must follow COVID-19 Directive #5[3] for Hospitals within the meaning of the *Public Hospitals Act* and *Long-Term Care Homes Act, 2007*.
Required Steps in an Outbreak	
Mar 30	When a local public health unit declares an outbreak in a long-term-care home: • New resident admissions are not allowed. • No readmission of residents until the outbreak is over. • If residents are taken by family out of the home, they may not be readmitted until the outbreak is over. • For residents who leave the home for an outpatient visit, the home must provide a mask, and the resident, if they can tolerate it, must wear a mask while out and be screened upon their return. • All non-essential activities must be discontinued.
Screening of Residents	
Mar 30	All residents must be actively screened and assessed at least twice a day—at the beginning and end of the day—including temperature checks, to identify if any resident has fever, cough or other symptoms of COVID-19. Residents with symptoms, including mild respiratory symptoms, must be isolated and tested for COVID-19.
Jun 10	The home must provide a mask to residents who leave the home for an outpatient visit. The resident must wear a mask while out, if they can tolerate it, and be screened upon their return, but does not need to self-isolate.
Screening of Staff and Visitors	
Mar 30	Active screening must include symptom screening and temperature checks twice a day (at the beginning and end of the day or shift). Anyone showing symptoms of COVID-19 should not be allowed to enter the home and should go home immediately to self-isolate. Staff responsible for occupational health at the home must follow up on all staff who have been advised to self-isolate based on exposure risk.
May 21	Should anyone show symptoms, staff members should contact their immediate supervisor/manager or occupational health and safety representative in the home.

Date	Event
Staff and Resident Cohorting	
Mar 30	Resident cohorting may include maintaining physical distancing of two metres, cohorting of the well and unwell, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate. Staff cohorting may include designating staff to work with either ill residents or well residents.
Triggering an Outbreak Assessment	
Apr 8	Once at least one resident or staff has presented with new symptoms compatible with COVID-19, the long-term-care home should immediately trigger an outbreak assessment. If the long-term-care home receives negative test results for the initial person who was tested, the long-term-care home can immediately end the suspect outbreak assessment-related steps. If the long-term-care home receives a single, laboratory-confirmed case of COVID-19 in a resident or staff member, an outbreak must be declared. Residents, staff and visitors who were in close contact with the infected resident, or those within that resident's unit/hub of care, should be identified. Further testing on those identified should be assessed, in collaboration with the local public health unit, using a risk-based approach based on exposures.
Universal Masking	
Apr 8	Long-term-care homes should immediately require all staff and essential visitors to wear surgical/procedure masks at all times for the duration of full shifts or visits in the home, regardless of whether or not the home is in outbreak or not. During breaks, staff may remove their mask but must remain two metres away from other staff to prevent staff-to-staff transmission of COVID-19.
Dec 7	When staff are not in contact with residents or in resident areas during their breaks, staff may remove their surgical/procedure mask but must remain two metres away from other staff to prevent staff-to-staff transmission of COVID-19. Long-term-care homes are required to have policies regarding masking for residents. It is strongly recommended that residents wear masks in common indoor areas in the home as tolerated. Homes are also required to follow any additional directions provided by provincial, local public health unit or municipal bylaws.

1. Directive #3 has been revised at least 10 times since March 22, 2020, (see **Appendix 7** for details) when it was first issued. As of December 31, 2020, the last revision was on December 7, 2020.
2. Directive #1, regarding personal protective equipment (PPE), was first issued on March 12, 2020 and directed the use of droplet and contact precautions for the routine care of patients or residents with suspected or confirmed COVID-19.
3. Directive #5 was first issued on March 31, 2020 to public hospitals, and lists the required precautions and procedures for disbursements and storage of PPE.

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