Long-Term Care COVID-19 Commission Meeting

Ministry of Long-Term Care
on Wednesday, February 3, 2021

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

Held via Zoom Videoconferencing, with all participants attending remotely, on the 3rd day of February, 2021, 10:00 a.m. to 12:30 p.m.

PRESENTERS:
Lynne Haves, Senior Manager, Ministry of Long-Term Care
Valerie Johnston, SAO Manager, Central East Service Area, Ministry of Long-Term Care
Andrew Wisdom, Manager - Compliance Inspection (Toronto), Ministry of Long-Term Care

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

PARTICIPANTS:
John Callaghan, Esq., Co-Lead Commission Counsel
Kavi Sivasothy, Esq., Counsel
Peter Gross, Esq., Counsel
Lynne Mahoney, Esq., Counsel
Joshua Shoemaker, Counsel
Alison Drummond, Assistant Deputy Minister
Derek Lett, Policy Director
Jessica Franklin, Policy Lead
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Nelly Farid, Esq., Counsel, Ministry of the Attorney General - Health and long-term care branch

Eveliene Symonds, Stenographer/Transcriptionist

-- Upon commencing at 10:00 a.m.

MR. CALLAGHAN: Okay. Good morning, commissioners. Today we have a three-person panel, and the panelists are Ms. Haves, Mr. Wisdom, and Ms. Johnston. And I would ask them to introduce themselves and provide their title and what they do.

And I suppose, Lynne, we should start with you, because I believe you're the most senior person.

MS. HAVES: Thank you. Good morning, everyone. My name is Lynne Haves. And my permanent position is senior manager with the Ministry of long-term care, the Inspections branch. And in the past two weeks, I am acting assistant director for the Inspections branch.

MR. CALLAGHAN: Now, Mr. Wisdom, perhaps you might introduce yourself?

MR. WISDOM: Sure, my name is Andrew Wisdom. I am the manager for the Toronto service area office. Over the past month, I've been acting as senior manager for the Toronto and Hamilton service area offices. And, yeah, that's my role.

But if I could also add, before we go further, I have a -- a quirky internet connection.

So every so often while we're on the call, it may degrade, so I may have to turn off my camera. But I will still be able to speak. So I just wanted to flag that up front.

MR. CALLAGHAN: Mr. Wisdom, we're going to review some of these homes between wave 1 and wave 2 that had issues, and you'll be speaking about St. George. Correct?

MR. WISDOM: Yes, that's correct.

MR. CALLAGHAN: Ms. Johnston?

MS. JOHNSTON: Good morning, yes. I'm Valerie Johnston. My permanent position is inspection manager for the central east office. I'm currently acting SAO manager for central east.

MR. CALLAGHAN: And you have experience with Orchard Villa, Sunnycrest, and Tender Care?

MS. JOHNSTON: That's right.

MR. CALLAGHAN: I don't know who to direct this to first to, but, Lynne, since you're the senior person, I'll direct it to you. What I'd like to do now is just go through some of the inspection policy documents so that the commissioners have an understanding of the role and what the responsibilities are.

So, Kavi, if you could put up

Document 1(b), the inspection policy?

And we've already heard, Lynne, about the move in 2018 to do more targeted inspections. So we won't belabour that. But as I understand it, is this the general inspection policy dated September 8th?

MS. HAVES: Yes, correct. It's been updated since the date that you have on there, but it is the inspection policy that we follow.

MR. CALLAGHAN: And, well, I'll tell you what. If I'm on an area that has been updated, perhaps you might tell me if you can recall. And not sure we know that there was an update in January dealing with the COVID part, but is this the general policy has been updated since September?

MS. HAVES: It has been updated. And when I'm looking at it, it's basically just to modernise the look of it. But our recent one, there's nothing substantial that changed in it.

MR. CALLAGHAN: Okay. And then if we can go to Objectives and Outcomes? And it says:

"In keeping with the framework of the LQIP, the following outcomes are expected to be achieved as

described in this policy.

A comprehensive applicable preparation plan developed prior to inspection, which directs the inspector to conduct a focussed inspection and then supports the inspector after the inspection is completed, determining actions to take or orders to make if non-compliance with the requirement."

I note the word "a focussed inspection." That comes up again. These are generally inspections that are addressing an incident, and the idea is the absence of circumstances -- we'll get to -- they're supposed to focus on the incident on which they're called to do an inspection. Is that correct?

MS. HAVES: That's correct. It could be a critical incident or a complaint that's based on risks that brings us to a certain home to address a certain situation.

MR. CALLAGHAN: But both are invoked by an event. Correct?

MS. HAVES: Correct. The critical

incident that's reported by the home or a complaint from another party.

MR. CALLAGHAN: And just on the procedure, long-term care home inspectors are required to conduct inspections for the purpose of ensuring compliance with the requirements under the Long-Term Care Home Act. So, essentially, they're applying the regulation that's there and the statutory requirements?

MS. HAVES: Correct.

MR. CALLAGHAN: And then it says for CIS. What is CIS?

MS. HAVES: Critical incident system. And so that --

MR. CALLAGHAN: And that -- go ahead, Lynne.

MS. HAVES: No, yes. What we call CIs that are reported by the home.

MR. CALLAGHAN: Right. We'll see that homes are to report when they're in outbreak. Correct?

MS. HAVES: Correct.

MR. CALLAGHAN: For ICS and low level 1 and 2 follow the requirement policy for CIS complainant and take level 3, 3+ or 4 for

inspection policy. And I'll take you there in a minute as to what the difference is. But there are two different routes that inspectors follow, then?

MS. HAVES: Correct. Yes.

MR. CALLAGHAN: And if we could just move, then, to page 729? And this, I'm addressing is Orders and Follow-Up.

Just a little further down, Kavi, please.

All right. So if an order is issued, there is time for a response, I take it, by which you do follow-up. So as it says:

> "Orders require follow-up in a timely manner within 30 business days after the compliant due date is past for high priority orders and within 60 business days for orders that are not high priority."

Do you see that?

MS. HAVES: Yes, I do.

MR. CALLAGHAN: All right. So when you have a complaint that's verified or an incident that's verified, you can categorise it such that they have either 30 days or 60 days? In other words, if it's a high priority, 30 days to respond,

and 60 days if it's not a high priority. Correct?

MS. HAVES: These are orders that we issued to a home with a compliance due date. So with that compliance due date, then that follow-up inspection that we do -- not the initial inspection but the follow-up inspection for the high priority orders -- and we identify what the high priority orders are -- it's 30 days before orders that are not high priority that we originally left with the -- pardon me -- with the home. Those are 60 days.

MR. CALLAGHAN: Right. And what is the distinction between high priority and not high priority?

MS. HAVES: So high priority order would be a compliance order that we left. So it could be an immediate order. It could be a reissued order, so when we've gone into a home multiple times and issued the same order. It could be an order that's accompanied by a director referral. Or it could be an order associated with a key risk indicator. And the list of key risk indicators -- we have, I believe, 13 of them.

And to give you an example of a key risk indicator, so this could be an order that

related to abuse, medication, skin and wound. These would be orders that we would consider high risk where we would go in to follow up within 30 days.

MR. CALLAGHAN: Okay. Let's go to the front then. I didn't read the policy as saying that there's a specific time after a critical incident was reported that you must go into the home. That's dependant on staffing?

MS. HAVES: So this area -- you're talking about two different things.

MR. CALLAGHAN: I understand.

MS. HAVES: So the original CI in complaints, yes, we have specific timeframes that we go into a home to conduct an inspection.

The area that you see in this inspection policy is where we did that initial inspection, and now we've -- we've issued an order. So there's a compliance order that was issued. We need to follow up on that compliance due date.

So the section that we're referring right here, these orders for follow-up, that's what that is.

MR. CALLAGHAN: So maybe I missed it, but perhaps sticking with the initial intake of the

critical incident or complaint, what's the timing by which an inspector is to go out? I had thought that was as available. Is it not? Or is it --

MS. HAVES: Yes. No. So what happens is when we get a critical incidental or complaint, it is triaged and then we assign it a risk level. So if it's a level 1 or a level 2, and then we have definitions on those levels. So a level 1 would be no harm or no risk. And that one there would be 90 days. We would consider that to be reasonable.

So -- and if it's a level 2, again, it's minimal harm or minimal risk, and that too is 90 days.

And then we move on to level 3. Level 3+, and a 4. So these too have assigned definitions.

So for level 3, it would be 60 days, we would consider reasonable.

3+ would be 30 days.

And level 4 is serious harm or immediate risk. We would go in right away.

MR. CALLAGHAN: Okay. So --

MS. HAVES: It's an immediate action.

MR. CALLAGHAN: So was there any direction given or to the inspectors or to the

triage people as to what level they should take an outbreak?

MS. HAVES: So the outbreaks as of January 18th, we are giving them a level 4.

MR. CALLAGHAN: Okay. That's January 18th, 2021. We'll come to that.

MS. HAVES: Yes.

MR. CALLAGHAN: But prior to that, was there any direction from management as to how it would address the notice of an outbreak?

MS. HAVES: So it changed between wave 1 and wave 2 on how we were directing our inspections. So it depended on a number of factors of when we would go into an outbreak home.

MR. CALLAGHAN: So what was it in wave 1, and how did it change in the middle towards wave 2? And when did that happen?

MS. HAVES: Okay. I'm going to try to capture all of the information that's happened in the past year.

So for wave 1, we initially did the support and monitoring calls. So we would not go out to inspect when a home was considered an outbreak. So we were doing them via telephone call.

There was a time in May, I -- in April and May, we were getting ready for IPAC. So there was the SWAT team that we implemented. So our inspectors were going out to outbreak homes with the additional partners. So that was around May that we were doing that.

And then we moved on to -- there was the CAF homes, the Canadian armed forces. Those were a priority for outbreaks also.

So there was no direction for initial outbreak on the levels that we were assigning them. But depending on the circumstances is when we would send out the inspectors to go visit the home.

MR. CALLAGHAN: So did it change after the May -- I think you said May 25th. Did it change after that, a further change before January of 2021?

MS. HAVES: So if we're talking about triaging of intakes --

MR. CALLAGHAN: Right.

MS. HAVES: -- for an outbreak intake, the levels didn't change until January 2021. January 18th.

MR. CALLAGHAN: So let me -- and I take it that just so I'm clear, if we go to page 10 of

this document, it says "conduct an offsite inspection." Is that intended to be a phone inspection?

MS. HAVES: Yes. An offsite inspection is when an inspector will reach out to the home. And if it's something that is at a level or a situation where we can request evidence from them or do our interviews via telephone, we consider that to be an offsite inspection.

MR. CALLAGHAN: Okay. And am I to read this that an offsite inspection would not be appropriate for level 4 or --

MS. HAVES: Correct. Yeah.

MR. CALLAGHAN: -- anything to do with -- okay.

If we could go then to Document 1(c)? This is Critical Incident Inspection Policy. And if we go to the definition, it says:

> "An occurrence is outlined in the Ontario regulation that relies on results from harm or risk of harm to the safety and security and/or health of the resident staff member and/or to the safety and security of the long-term care home. The

licensee of a long-term care home must complete and submit the CI -- critical incident -- report to the director within the specified timeframe using the critical incident system and after-hours emergency contact number as applicable."

And as we go down and look, you'll see that includes an outbreak of a reportable disease or communicable disease as defined on the HPPA. So a critical incident by definition would include an outbreak of COVID. Correct?

MS. HAVES: Correct.

MR. CALLAGHAN: And if we then go over to page 9 of 36 on Inspection Process, and it says:

"A CIS report --"

that's a critical incident -- is that submission?

"-- reports are received by the central intake assessment and triage team where they are assessed the triaged. A CIAATT triage inspector initiates an intake form in IQS to record the highest risk CIS item and

the assessed overall risk level.
The intakes are forwarded to the appropriate service area office at the end of each business day or immediately if the CIS report is an immediate jeopardy situation, risk level 4. This policy begins when the SAO manager/inspection manager assigns the CIS inspection to the inspector."
And then if you go to Inspection Notes:
"If at any time throughout the inspection the inspector identifies an immediate jeopardy situation, the inspector/primary inspector will follow the immediate jeopardy policy including notifying the licensee and the SAO manager."
So I take it that this is what you're saying, that if it's a risk level 4, you're required to attend on site, and it's defined as an immediate jeopardy. Correct?
MS. HAVES: Correct. It's an immediate risk.
MR. CALLAGHAN: All right. Okay. It

says immediate jeopardy, but, anyway.

The immediate risk or immediate jeopardy can also be brought into play during an inspection if an inspector sees something that reaches a level 4. Right?

MS. HAVES: Correct.

MR. CALLAGHAN: All right. So if we go into -- this provides for a whole chart of the inspection process. I won't take you through it all. But if you go to page 19 of 36? And there's a requirement that when the inspector receives the intake form and has an appreciation for the critical incidents, they prepare an inspection plan. Correct?

MS. HAVES: Correct.

MR. CALLAGHAN: Is that reviewed by anybody, or is that just by the inspector?

MS. HAVES: By the lead inspector. So there may be a team of inspectors, and then there's also a lead inspector.

MR. CALLAGHAN: So the lead inspector would approve the inspection plan. Is that it?

MS. HAVES: Correct. Yes.

MR. CALLAGHAN: So these are steps. So I didn't take you through them all, but one of the

steps is:

"Refer to the inspection plan to ensure all applicable information is gathered related to the CIS inspection prior to leaving the long-term care home site. Plan may be adjusted throughout the inspection as necessary.

Then it says, and it's pretty emphatic:

"Stay focussed. However, if additional potential non-compliance is identified which poses a risk to one or more residents, risk level 3 or greater, other related information will need to be gathered to ensure compliance. If a potential non-compliance is at risk level 4, refer to the immediate jeopardy policy."

So when you changed over the policy system in 2018 and we were dealing with critical incidents, the concept of stay focussed was a primary concern. Right? You want to -- unless it's a level 3 or 4.

MS. HAVES: So what we mean by this is

that when a complaint or a critical incident is received based on a certain topic -- for example if it's falls, we will open an inspection protocol for those falls. That's what they mean by staying focussed. So you're not looking at absolutely everything in the home. You're looking at what pertains to that complaint or that critical incident.

MR. CALLAGHAN: So I ask -- and we'll get to the levels in a minute, but I ask, because we've heard evidence from the hospitals that went into some of these homes and described them in deplorable condition, including cockroaches and mold. If that occurred, I'm assuming that wouldn't be a level 3 or 4. Like, if that were seen by your inspector, would you expect them to have addressed it?

MS. HAVES: So we have a definition for our inspectors. So if it's a level 4, they need to take a look at the situation. If it places the residents or the group of residents in an immediate jeopardy/risk, and if it has caused or likely to cause serious consequences, injury, harm, impairment, or could result in death. So we're very specific on our definition of what is serious

risk or harm and risk.

MR. CALLAGHAN: So mold in bathrooms, mold in kitchens, cockroaches on the floor, was that perceived to be immediate risk?

MS. HAVES: I don't know all the circumstances or what exactly was seen by the inspector. But depending on the severity of it and what impact it had structurally or to the residents that were there if the residents were on that floor, I would need more details to be able to answer if we could change that to a level 4 or not.

MR. CALLAGHAN: All right. Well, let's go take a look at the levels. So let's go at page 32. So here are the levels. Let's just go over them.

"Level 1, no harm or no risk. A situation that has caused no negative impact on the residents, it poses no risk of harm to the residents. An inquiry within 90 days is considered reasonable."

That's what you're saying?

MS. HAVES: Yes. Reviewing that, yes.

MR. CALLAGHAN: And the second is:

"Level 2, minimal harm or

minimal risk, a situation that results in minimal discomfort to the residents and/or minimal risk of harm. An inquiry within 90 days is considered reasonable."

That's the second thing you talked about. Correct?

MS. HAVES: Correct.

MR. CALLAGHAN: And then:

"Level 3, actual harm or actual risk, a situation that results in actual harm to residents, which will not resolve without further intervention or actual risk of harm or where there is a pattern of incidents contributing to the harm/risk. This may include a situation involving actual harm/risk where action was taken by the licensee or long-term care staff to minimise the risk or prevent the situation from recurring or escalating. An inspection within that 60 business days is considered reasonable."

And that's level 3. Right?

MS. HAVES: Correct.

MR. CALLAGHAN: So I'm a little confused about the wording. Like, we have minimal harm and minimal risk at level 2, and then we have actual harm. So that's actual harm having happened to the residents?

MS. HAVES: Based on that definition, yes.

MR. CALLAGHAN: And was there any guidance given to you as to when a home had an IPAC issue as to whether or not it was actual harm or minimal harm or risk of harm to the residents contracting COVID? Was there any guidance given to you on that prior to January of 2021?

MS. HAVES: Not that I can recall. So every situation would be different in every home on the circumstances, whose involved, what actions are taking place. And then depending on the severity of any IPAC breaches to -- of what level the inspector -- the inspector uses their judgment and expertise to determine if the levels should be changed.

But based on the information that we have at triaging, also, we would determine the

applicable level.

MR. CALLAGHAN: So we heard from Public Health Ontario that they provided no training to the inspectors. So since COVID came up, let's take from April, so after wave 1, was there further training to your inspectors on COVID?

MS. HAVES: We did provide in October of 2020 an IPAC guideline, infection and control guideline that has some resource documents and the directives. So we would have provided training to the inspectors as inspection became available. We would have reviewed the -- because we were looking at the PPE back in April, making sure that they had appropriate training there, and also the right resources available to them for IPAC.

MR. CALLAGHAN: So just unpack that a little bit. Was that self-study? In other words, I know Public Health Ontario produced -- the PDAC group produced information. Was it self study of reading? Is that what you're talking about?

MS. HAVES: There was some videos also. Sorry, there was some feedback there. There was some videos we offered to inspectors. There was some self-study also . And then we were just making sure that they were quite proficient and

they knew where to get all the information related to IPAC.

MR. CALLAGHAN: But Public Health Ontario or -- did you have an IPAC specialist you turned to? Or was this material that with you sent to you by the people in long-term care?

MS. HAVES: So I know that our education manager was communicating with Public Health Ontario to -- for the sharing of information for IPAC and arranging some training, some video training for our inspectors.

MR. CALLAGHAN: So let's continue on. Level 3+. This is significant actual harm or significant actual risk.

> "A situation that results in an outcome that had a serious negative impact on one or more resident's health, quality, or life and/or safety or that it is creating a serious risk of significant actual harm or significant actual risk related to one or more resident's health, quality of life, and/or safety.
>
> An inspection within 30 business

days is required. The situation does not require an immediate inspection as outlined in 25(2)."

So we're going to read level 4 in a second, but was level 3+ added for some reason? Because it seems to be significant actual risk. It seems to be contemplated but no immediate inspection, so can you tell us why that is?

MS. HAVES: So, obviously, it's higher than the -- could we just go up to the level 3, please? Could we just include level 3?

MR. CALLAGHAN: Did I miss level 3?

MS. HAVES: No, I'm just --

MR. CALLAGHAN: I thought I read it.

MS. HAVES: Yeah, you did. I'm just looking at the wording for level 3 and level 3+ to determine. So there's a little bit of different wording for 3 and 3+. And again it depends on the situation. Every situation is different based on the evidence that's provided.

So the 3+ does say that it has serious negative impact on one or more residents. So there's a little bit of -- so the 3 is actual harm to the resident, whereas a 3+, it includes one or more residents.

MR. CALLAGHAN: Right. So if a place had COVID and the residents were at risk of getting COVID and 30 percent of the residents were going to die, would that be in level 3 or level 3+? Do you know?

MS. HAVES: Well, we wouldn't -- we wouldn't know if they were going to die or not.

MR. CALLAGHAN: Okay.

MS. HAVES: Again, it depends on the situation and the circumstances and the evidence that's presented on where we would place it.

MR. CALLAGHAN: So just to be clear, so you were never educated by your training exercises that statistics showed, at least in wave 1, 30 percent of residents in long-term care were going to die if they contracted COVID in some way, something like 20 -- little bit more than 20 percent in wave 2? That -- that wasn't part of the training?

MS. HAVES: What I'm going to say is I don't -- I -- I personally don't know what the direction was for triaging the outbreaks for COVID, what specific direction was given for the levels. I can't answer that. I would have to look that up.

LEAD COMMISSIONER FRANK MARROCCO:

Commissioner Kitts has a question, John.

COMMISSIONER JACK KITTS: Just the difference I see between 3 and 3+ is harm or risk -- actual harm or actual risk versus significant actual harm versus significant actual risk. Is there a definition of what the difference between harm and significant harm or risk and significant risk is? Do they list what that might be?

MS. HAVES: I don't have that at this time. I would have to research to see if we have further definitions for that.

MR. CALLAGHAN: If we take you down below on that, they seem to direct us to what I believe to be the definition in the Long-Term Care Act. It says.

"An immediate inspection --"

You see that? There you go.

"-- as per Long-Term Care Act in section 25(2) is required for the following that resulted in serious harm or a significant risk of serious harm to the resident, improper or incompetent treatment or care of a resident, abuse of a

resident by anyone, or neglect of a resident by the licensee or staff or unlawful conduct."

Is that your understanding of what the Act provides, and this is their interpretation?

MS. HAVES: Yes.

MR. CALLAGHAN: So what they're saying is that an immediate inspection is not required, whether serious negative impact on one or more resident's health quality or life and safety. They don't interpret that to be an immediate -- requiring an immediate inspection as required by the Act. Is that right?

MS. HAVES: Correct. So if there was an actual -- for the immediate inspection, they're saying that there is actual harm/abuse to a resident or neglect by licensee or staff.

MR. CALLAGHAN: Okay. So if we go to level 4, it says:

"Serious harm or immediate risk, a situation that places a resident or a group of residents in immediate jeopardy (risk) as it has caused or is likely to cause serious consequences, injury, harm,

impairment and/or could result in death or did result in death to a resident receiving care in the long-term care home.

This also includes a situation that the licensee is not taking immediate action to appropriately rectify the issue or has failed to intervene to prevent the situation from unfolding.

This level includes situations that require an immediate visit to the long-term care home."

So in reading that -- and we know that COVID, we just mentioned, does result in death for 30 percent or 20 percent, depending on wave 1 or 2 -- would you need to know that they weren't following proper IPAC to do an inspection? Or was it sufficient to know that they've got an outbreak?

MS. HAVES: So as of January 18th, 2021, we've issued -- the COVID outbreaks, we've done that as a level 4 immediately. Prior to that, I'd have to double check to see how they were being -- the appropriate levels were being -- but for us to go into a home to conduct an inspection,

it would depend on the situation of the individual homes, the information that we were given and also our support and monitoring calls of every home. So we were supporting monitoring every home that was in outbreak, reaching out to them. And we would have received information about what the individual partners were also doing in those homes, and that would help us determine if an immediate inspection is required.

LEAD COMMISSIONER FRANK MARROCCO: Help me with that. In wave 1, if the home is in outbreak, when you -- the inspection was by phone, is there a -- so who would they phone?

MS. HAVES: So our inspectors. So in wave 1, as of March and April, we had a team of two inspectors calling. They were assigned specific homes. So they were calling the homes and would speak to the administrators or the clinical staff and would ask specific questions. That was in wave 1.

LEAD COMMISSIONER FRANK MARROCCO: And in terms of the follow-up, it's dependent entirely, then, on the answers to those questions, which are given by -- the answers are given either by the executive director or --

MS. HAVES: The administrator.

LEAD COMMISSIONER FRANK MARROCCO: -- the administrator?

MS. HAVES: Correct. So when we were calling it wave 1, initially, we were asking them the situation on PPE. We were asking them about the outbreak, their case numbers. We were asking them about staffing.

And then if the questions -- the answers led us to care of residents also -- because we were concerned. We knew that is a shortage of staffing would definitely impact care of the residents. So it would --

LEAD COMMISSIONER FRANK MARROCCO: And --

MS. HAVES: Sorry.

LEAD COMMISSIONER FRANK MARROCCO: No. I'm sorry. Please finish your answer.

MS. HAVES: So it would depend on the answers given to us on us assessing the risk and what the next steps are required.

LEAD COMMISSIONER FRANK MARROCCO: And did they routinely report to the inspectors that there was a shortage of staff or a lack of understanding on how to use -- how to put on and

take off personal protective equipment and that sort of thing?

MS. HAVES: So during wave 1, absolutely. For staffing, they were saying to us that they had staff that were scared, there was a shortage of staff. And for PPE, I personally didn't hear them say to us we don't know how to use PPE. They would just say to us that they were afraid that there would be a shortage of PPE at that time.

LEAD COMMISSIONER FRANK MARROCCO: So what happens then, when somebody says, "We've got a staff shortage. We don't know how to -- we're having difficulty with the PPE"? Assuming someone told you that, what happens then?

MS. HAVES: So it's different now in wave 2 than it was in wave 1. We have a very comprehensive process now when people -- when a home tells us that they're short of staff.

In wave 1, we were escalating those. We were establishing partnerships with the hospitals and with Ontario Health at that time, and it has grown. In wave 2, there are far more supports. But during wave 1, there were supports with the hospitals. The hospitals had more staff

to assist the homes. Wave 2 is a little bit different to that.

And in wave 1, some of these homes, we had reached out to Canadian Red Cross; however, they could only support a limited amount of homes. We would also -- Ontario Health to see if they would assist, and they were reaching out to different agencies to help these homes.

And now wave 2, there's additional resources in wave 2 to assist with staffing. But there still is staffing shortages for our homes.

LEAD COMMISSIONER FRANK MARROCCO: Yeah. And I don't mean to quarrel with any of that, but reaching out doesn't help you much if they can't help. Like --

MS. HAVES: Yes. Yes. At the time -- you're right. During wave 1 when we were calling, they're saying, "We're short of staff." We, the Ministry, didn't have the staff to send. So we would have to establish those partnerships, those relationships with the partners to see who can help this home to get some staff into this home?

LEAD COMMISSIONER FRANK MARROCCO: Do you think if there had been a pandemic plan in place that these partnerships would have already

been established?

MS. HAVES: I don't know. We didn't know at that time the -- how this pandemic was going to -- we knew that it was going to be difficult for our homes, but we didn't know the severity for some of our homes. We learned a lot through wave 1 and -- and wave 2.

But I can tell you that now with the best practices and what we've seen, definitely the partnerships have helped tremendously.

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Kitts?

COMMISSIONER JACK KITTS: Yeah. I come from the hospital sector, where a lot of the staff concerns go through the Ministry of Labour. So I'm just wondering in long-term care, is your role as inspectors of Ministry of Long-Term Care to actually do what Ministry of Labour does? Because I see a lot of your stuff is about residents. But do you look after the well-being of the staff, health and safety of the staff as well?

And then a third overlap is Public Health does restaurants, kitchens, eating areas to make sure that they're clean and up to standards. So I'm just wondering if the Ministry of Long-Term

Care wraps that all up into one home where they inspect resident safety and risk, staff safety and risk, and cleanliness and compliance with Public Health measures for eating areas and kitchens.

MS. HAVES: So our legislation -- you're right. Our legislation is very focussed on resident care. Do we inspect on staff issues? No. Often when we get complaints from staffs, we will reference them to Ministry of Labour, because they have that regulatory oversight over the staff themselves. Ours is -- our legislation, we basically inspect legislation, which is focussed on residents.

For cleanliness, it's anything that impacts the residents. There's specific sections of the legislation that talk about maintenance of the home and cleanliness, and we will take a look at that to see if it impacts resident care.

COMMISSIONER JACK KITTS: So Public Health does or doesn't inspect the kitchens and the dining areas in the home like they do with restaurants and other things in the community?

MS. HAVES: Yes, sorry. I missed that part of your question. Yes, Public Health is also involved in doing their inspections, and they're

very specific to those items that you described.

COMMISSIONER JACK KITTS: So you have three different types of inspections, and are they coordinated in any way? Do you speak to each other about -- because often the environment often affects both residents and staff.

MS. HAVES: I can say that prior to the pandemic, no, we didn't. We did work with Public Health. So we have what we call LCEIs. They're long-term care consultants and environmental inspectors. They work very closely with Public Health. They would reach out to Public Health if they have an inspection on a certain issue; for example, food, kitchen, cleanliness. So they did work on that.

So Ministry of Labour, prior to the pandemic, we didn't. I can say as of today, however, we have a partnership established with them, and we work together. So when we hear of complaints or situations, we will inform each other. But we do not take a look at their process, or they don't share with us their reports. They'll just let us know that they've been into a home, and they're inspecting a home given to some complaints that they received.

COMMISSIONER JACK KITTS: Yeah. I'm just wondering, I guess -- last question is if you compared, you could probably come to a common definition by Labour and Long-Term Care as to what serious risk or significant risk or what those -- serious harm, those things are. Because --

MS. HAVES: We have very defined -- we have very defined roles, yes.

COMMISSIONER JACK KITTS: Okay. Thank you.

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Coke?

COMMISSIONER ANGELA COKE: Sorry, I just wanted to clarify something. You mentioned that since January 18, 2021, you assign a level 4 to the outbreaks. Is that correct?

MS. HAVES: Correct. So as of January 18, 2021, we are inspecting on the COVID outbreak homes. There's a certain criteria for that, and we are doing an IPAC inspection. So we're using our IPAC protocols to -- and a check list to do an inspection on those homes.

COMMISSIONER ANGELA COKE: So prior to that time, you didn't have sort of any mapping of specific COVID scenarios in homes against the

levels to provide some guidance to the inspectors on how to triage?

MS. HAVES: It was based on risk. So it would depend on the complaint that was received, the critical incidents, what are the information that was provided in that critical incident or that complaint, the SAO would assign a risk to it.

Now, the SAO, keeping in mind, that we were having those support and monitoring calls regularly with the homes. They were also advised of additional background information to know what was happening in home. Was a hospital in the home? Did it have a Public Health Unit IPAC assessment? So all of those would be tactors on us determining what level to assign those outbreaks, those intakes for those outbreaks.

COMMISSIONER ANGELA COKE: Okay. I guess I'm trying to envisage in this whole COVID scenario would ever be less than a 4, but I understand what you're saying.

MS. HAVES: We were just looking at very -- there were so many different factors for every home. We're being -- we're trying to be -- all of the partners are being very proactive . And as we start seeing -- so through the support and

monitoring call, the home would have told us, "Public Health Unit has declared an outbreak. These are the numbers we have." And then we would ask the questions related to PPE, to staffing, HR, leadership. And all of that would determine that when we actually got the intake, we were being proactive, we would know what's happening in the home if we needed to go out to the home to do an inspection right away.

LEAD COMMISSIONER FRANK MARROCCO: But you weren't going out in wave 1 to do an inspection?

MS. HAVES: Not initially, no. So in March and April, as we're getting our inspectors ready for IPAC training and getting them the appropriate PPE, we were doing support and monitoring only over the telephone.

We were doing offsite -- sorry, we were going offsite inspections too for the critical incidents that were coming in as 3+s and 4s.

LEAD COMMISSIONER FRANK MARROCCO: So those are offsite inspections. But if nobody is going in, then whatever's being reported is being reported, but nobody's going in to do anything as a result of what they're hearing.

MS. HAVES: Correct.

LEAD COMMISSIONER FRANK MARROCCO: Is that right?

MS. HAVES: Correct.

LEAD COMMISSIONER FRANK MARROCCO: Okay. Thanks. And one last question, and I'll let you go back to continuing this presentation. But did the inspectors ever complain that these various levels are difficult to read and understand?

MS. HAVES: I'm -- I'm going to say that the levels can be changed. So when our CEAT department gives it a level, the SAO manager or the inspection manager could review that level, and they could change it. So there could be as a result of that them not quite understanding -- determining what level could be difficult.

LEAD COMMISSIONER FRANK MARROCCO: Yeah. And I wasn't so much speaking of that. It's just reading it, just being an ordinary person trained as an inspector and reading those different levels, I wondered if there were complaints that just the descriptions of the different levels were confounding.

MS. HAVES: Yeah. We do quite a comprehensive training on the levels and reviewing

the levels. And I note in the training, we will give examples to the inspectors to say, "What would you determine the levels?" So we recognise that it's difficult.

LEAD COMMISSIONER FRANK MARROCCO: Go ahead, Mr. Callaghan.

MR. CALLAGHAN: If we can go to 1(e)? I just want to talk a moment about follow-up inspections. And I won't take you through the whole document, but perhaps we might put the schematic up. It's at page 5. And I just want to make sure... So page 5 was a schematic, and this is all put in pros and verbalised in writing in the report. But there's an order issued, as I understand it, and if you go to the middle box, is the order in compliance? If it's no, you reissue the order, and then you conduct another follow-up inspection.

And if the order is -- is the order in compliance? If no, reissue the order, conduct another follow-up inspection. Is that the process? Or is there some immediate action that is taken? Am I reading this correctly, that the powers of the inspectors are just to issue an order, return with a follow-up inspection, and issue another order?

MS. HAVES: So we have a process that's not outlined here that we did pre-pandemic. So when an inspector goes in to issue the original order and then they go in to do the follow-up, and if they have to reissue an additional order, a second time order, it becomes a senior manager referral.

So at that time, the senior manager will meet with the home to say, "This is your second time order. What are you doing to rectify the issue?" And then the inspector will go back into the home. They'll do another follow-up. And if they have to reissue again, it becomes a director referral.

And then it goes to the director for them to determine what do we do next? Do you -- and she has -- the director has different avenues available to them to determine how to get the home back into compliance.

But to answer your question, yes, we continue to follow-up on that order, but there's an additional process that isn't outlined here.

MR. CALLAGHAN: Right. But it would take two follow-ups to engage that other process. And is it engaged every time after two orders, or

is it there a discretion to that as well?

MS. HAVES: There could be a discretion. So if it's a high-risk order, if it was falls or if it was abuse and we had to reissue again, we would definitely have that call with the senior manager.

If it's something that is not identified as high risk, we would normally have a call. But I can say that during the pandemic, we may not have had the calls with the lower risk ones.

MR. CALLAGHAN: So, yeah. So you prefaced your initial answer with pre-COVID. Is there a difference now post-COVID?

MS. HAVES: Well, it's just because of the resources and the amount of backlog and work that we have and the fast pace that's happening right now. If a second time order is issued -- and we review it as a team. So the SAO, service area office, will let the senior manager know this is second time order, this is the section of legislation.

The senior manager will make the determination if they feel it's a high-risk order, and then they'll meet with the home. If it's not a

high-risk order or if the inspector has said to them, "The home will be into compliance. They have a solid plan; they just needed more time," then we may not do that call with that senior manager.

MR. CALLAGHAN: So --

MS. HAVES: -- in the home.

MR. CALLAGHAN: So on the issue of backlog, I believe we heard this evidence, but was there more inspectors hired during this COVID period, and is there still backlog?

MS. HAVES: There was -- before the pandemic, there were vacancies, inspector vacancies. We received approval to -- just let me pull up the date here. We received approval to hire inspectors. That was in October of 2020. And then we have been in the process of hiring 27 inspectors.

MR. CALLAGHAN: So your complement was down 27 from January to October. Is that what I'm --

MS. HAVES: No. We received additional funding. So back in December of 2019, we had a number of inspectors. This was the funding that we had. We received additional funding to hire more inspectors.

MR. CALLAGHAN: Was that in -- you say December 2019. Was that independent of COVID because of the backlog? Because I'm assuming --

MS. HAVES: Yes. In December of 2019, we had a number of inspectors and a number of -- and a certain amount of funding. So -- and then with COVID, with the pandemic, we received additional funding, and we received approval to hire additional inspectors in October of 2020.

MR. CALLAGHAN: All right. So just to be clear, the 2019 approval was to address the existing backlog, and the October 2020 approval was to address the COVID issue. Correct?

MS. HAVES: Additional for COVID. Yes.

MR. CALLAGHAN: So if we --

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Coke?

COMMISSIONER ANGELA COKE: Sorry. So I'm just trying to understand. You didn't have your full complement staff before. So you had FTE -- maybe FTE count but not money. Is that what you mean?

MS. HAVES: Yes. We were -- we were -- in December of 2019, we were -- we had too many FTEs for the funding that we had, is my

understanding. So we were -- we had said that we weren't going to fill the vacancies that we had for the inspectors in December of 2019.

But we have submitted additional requests for funding to hire -- to fill the vacancies that we had and to hire new inspectors. And that's as of October 2020.

COMMISSIONER ANGELA COKE: Okay. So with you didn't get an complement of increased staff. You just got the funding to fill the FTEs that you couldn't afford?

MS. HAVES: In December? So in December of 2019, we had too many FTEs for the amount of funding that we had. So we were told in December of 2019 we can not hire any new inspectors.

And then -- but in October of 2020, we received approval for additional, including the vacancies that we had.

COMMISSIONER ANGELA COKE: Okay.

LEAD COMMISSIONER FRANK MARROCCO: So the number of inspectors that you could hire remained -- or the number of inspect -- the funding which prohibited you from filling all the FTEs remained in place until October of 2020, when you

were given additional funding that allowed you to fill the FTEs that you had, assuming you could find people, and provided additional FTEs? Or --

MS. HAVES: Correct.

LEAD COMMISSIONER FRANK MARROCCO: -- or permission to hire additional inspectors?

MS. HAVES: Correct. So we receive -- so in December 2019, we had vacant positions for inspectors. We -- but we didn't -- we had too many inspectors --

LEAD COMMISSIONER FRANK MARROCCO: I understand.

MS. HAVES: -- yeah, for the funding that we had. And then what we asked for was to fill the vacant positions that we had during the pandemic, and that was approved. And then we asked for additional funding for more inspectors, which we received approval.

LEAD COMMISSIONER FRANK MARROCCO: And the approval and the additional funding was in October of 2020?

MS. HAVES: Correct.

MR. CALLAGHAN: All right. Okay. So from December '19 to October 2020, you don't have additional -- you don't have the ability to fill

any of those FTEs or hire additional inspectors?

MS. HAVES: Correct.

LEAD COMMISSIONER FRANK MARROCCO: You have to make do with the complement of inspectors that you had in December 2019?

MS. HAVES: Correct. And we were -- keeping in mind also we were during a pandemic. There was a shortage of trainers also. And to on-board an inspector, it takes about eight to nine months to fully train an inspector.

LEAD COMMISSIONER FRANK MARROCCO: Okay. Commissioner Coke, you were trying to ask questions?

COMMISSIONER ANGELA COKE: No, sorry, I'm just wondering. At the end of the day now, what is total funded complement of inspectors that you have? You may not have completed the recruitment, but what is the total allowable number that you have funded?

MS. HAVES: So -- so the number that I am given is 174 total inspector positions, and we have 144 active inspectors.

COMMISSIONER ANGELA COKE: Okay. Thank you.

LEAD COMMISSIONER FRANK MARROCCO: So

do you have permission to fund 174 positions?

MS. HAVES: That I would need to verify. I'm not sure.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

MR. CALLAGHAN: Perhaps you can tell Eric, who can advise us.

If we could just go on to tab 1(g)? And this the policy to which you were referring when you were talking to Commissioner Coke about dated January 18th, 2021. And it says on its face page:

> "Within the long-term care quality inspection program, there is a standardised approach which all inspectors must follow when conducting a CIS outbreak inspection. This policy will be applied when an inspection manager/SAO manager assigns a CIS outbreak inspection to an inspector."

And if we go to the next page, it says it's objective is to have a consistent process across the province, and inspection resources are

focussed and prioritised based on risk.

And if we go into Important Considerations, it says:

"This is a brief high level focussed inspection. However, where observations, interviews, or record reviews lead the inspectors to believe there is actual potential risk or non-compliance in high-risk areas, the inspection should be expanded to include a further inspection of identified areas of concern in consultation with the SAO manager."

So this new process that you spoke about, what does it mean when it says it's a high level risk focussed inspection? Actually, sorry, I should add brief. Are these supposed to be quicker inspections, these ones we're about to talk about?

MS. HAVES: So these are IPAC-specific inspections, outbreak-specific that are assessed as a level 4.

MR. CALLAGHAN: What does it say?

"Brief high-level risk focussed inspections."

Are they supposed to be quick inspections? I'm having trouble with the word "brief."

MS. HAVES: So they're not going to be including other complaints or other critical incidents. They're just doing the inspection for IPAC. Unless during their observation they see something at a very -- at a high risk level, then they may open other inspection protocols.

MR. CALLAGHAN: Right. So as they say, if at any time throughout the CIS outbreak, inspectors identify immediate jeopardy situations, they are to follow the immediate jeopardy policy, which we sort of touched on before?

MS. HAVES: Right.

MR. CALLAGHAN: So basically what you're saying what this should be read to be said is this is an inspection to address the immediate issue of the outbreak, not -- you're not looking at other things. That's the critical incident that's of issue. Correct?

MS. HAVES: It's the outbreak inspection.

MR. CALLAGHAN: Right. Okay. If we could go to the next page?

LEAD COMMISSIONER FRANK MARROCCO: Just so I understand it, so the fact that there's a COVID outbreak in the home isn't really sufficient. There has to be an outbreak in the home, and it has to be identified as posing a risk?

MR. CALLAGHAN: So, Chair, if you wait one second, I'll show you what the language is.

If we can go to page 4 of 7, please? And it says:

"When a long-term care home declares a COVID-19 outbreak."

So just to repeat, as we looked at, they're required to identify whenever there's a COVID outbreak. Correct?

MS. HAVES: Correct.

MR. CALLAGHAN: In the homes. And we've been told a COVID outbreak in the current environment is one case. Is that what you understood it to be in terms of notification by the home?

MS. HAVES: Yes. The Public Health Unit determines it could be a suspected outbreak with one case.

MR. CALLAGHAN: Okay.

"A CIS intake is assigned to a

service area office. As the outbreak progresses, the CIS report may be amended by the long-term care home or partners in the community and may advise the SAO of the outbreak status.

When the SAO is notified of the initial outbreak or at any time the outbreak progresses, the following criteria will be considered when determining the risk level for assigning a CIS outbreak inspection:

There are four or more confirmed COVID positive residents and no partners have completed an IPAC assessment or inspection since the outbreak has been declared.

If these criteria are met, the CIS intake will be changed to a risk level 4 by the IM/SAO manager and assigned for immediate inspection."

So there are two criteria. There have to be four or more confirmed positive residents, and then no partner -- and I will have to ask about that in a second -- will have done an on-site IPAC

assessment or an inspection since the outbreak has been declared.

So dealing with the first one, do you have any reason -- do you know why they chose four or more confirmed COVID-19 positive residents? Were you involved in that decision?

MS. HAVES: No.

MR. CALLAGHAN: All right. So you don't have information as to why?

MS. HAVES: I don't have additional information, no.

MR. CALLAGHAN: And when it says, "No partners have completed an on-site IPAC assessment," what partners are we speaking of?

MS. HAVES: We could be speaking about Public Health Unit, Public Health Ontario, or we could be speaking about a local hospital going in to do an IPAC assessment.

MR. CALLAGHAN: So if there's a suspected outbreak, maybe one case, and a hospital goes in and does an IPAC assessment, then it would not rise to a risk level 4 if more cases turned up past 4?

MS. HAVES: Correct. We would not -- we could not assign an inspection for this.

MR. CALLAGHAN: Is there --

LEAD COMMISSIONER FRANK MARROCCO: Was there a sense when this number 4 was selected -- we've heard evidence that 30 percent of the people in long-term care homes who get COVID die. So if there's four before -- if that's one of the criteria, that's really another way of saying one person will -- has likely -- is likely going to die before that criteria is engaged.

MS. HAVES: I don't know why --

LEAD COMMISSIONER FRANK MARROCCO: Is there a sense of that when they were selecting the number four?

MS. HAVES: I don't know. All I can say is there was a working group that did an analysis, and they determined that they were going to use this criteria for us to go in to do an IPAC inspection. So I don't know what they used exactly, what they analysed, and what they considered to determine the four.

MR. CALLAGHAN: And do you know whether the working group would have included any IPAC doctors or the chief medical officer of health?

MS. HAVES: No. It was a Ministry of Long-Term Care working group.

MR. CALLAGHAN: So if we then -- then you have directions upon entering the long-term care home down below a little bit after Planning the Inspection. And so when we're talking immediate, I take it people go out that moment, because you say within the hour of the inspection, they're to get a certain amount of information regarding the areas in the home with outbreak, the list of residents, the IPAC policies and procedures and the testing and visiting policies. So when people go out immediately, is that -- just so I understand, so is somebody on call to go out to a home within the hour, for example?

MS. HAVES: This is referring to them entering the home.

MR. CALLAGHAN: I see.

MS. HAVES: Yeah, it's when they enter the home, they will go to -- directly to the administrator or executive director, and they'll be asking for this information within the first hour that they're there.

MR. CALLAGHAN: So how long between the designation by the IM/SAO manager and the inspection? It says immediate. Is that, like, within the half day? Is that with --

MS. HAVES: Yes. We will pull -- so we will look at available resources, inspector resources, and we will pull them and ask them to enter this home immediately to do the IPAC assessment -- or the inspection.

MR. CALLAGHAN: Now, in fairness --

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Kitts has a question.

MR. CALLAGHAN: Thank you. I can't see everybody.

LEAD COMMISSIONER FRANK MARROCCO: You may be on mute, Commissioner.

COMMISSIONER JACK KITTS: I'm sorry. I just want to go to the concerns that Commissioner Morocco raised about -- you know, and I'm not holding you to number four, because you said you weren't part of that decision. But, you know, we found in wave 1 that where IPAC preparedness was not in place had high levels of mortality rate and spread, and it's been almost a year that we've known that.

And so my question is what is the level of confidence in the long-term care system now that every long-term care home has learned from wave 1 and has -- should have or has declared that they

have a functional IPAC program in place now?

Because it seems odd to wait for an outbreak or four to go see if it's functional. We should know that it is, and if there's any outbreak, you know, go and help.

Am I clear in sort of -- what's the level of confidence that you're going to go a home now, and it's going to have an IPAC program that meets the inspection criteria?

MS. HAVES: I can't say for 100 percent that I'm very, very confident that all homes have a very good program, because we're still seeing issues, we're still seeing outbreaks, we're still assisting homes, we're still asking hospitals to assist homes. However, we've given them, the homes -- we've given them some tools. We asked them for action plans. We make sure we've offered the IPAC hubs. We've offered them funding. We've -- you know, it's very -- we've given them a lot of resources and tools to have and told them what is expected from them.

But am I 100 percent confident that they're applying it? Not by the numbers and the complex situations that we're seeing.

COMMISSIONER JACK KITTS: So if we

combine all of your resources with hospital resources and Public Health Unit resources and did a blitz on all the homes to see where their level of IPAC is, wouldn't that give you more confidence in having to respond to homes with four or more?

MS. HAVES: Yes.

LEAD COMMISSIONER FRANK MARROCCO: Is there --

MS. HAVES: But we -- sorry.

LEAD COMMISSIONER FRANK MARROCCO: No, you go ahead.

MS. HAVES: I was going to say we -- we do work with the other partners. We do work with the Public Health Unit. In some of our areas, our service area office managers have regular calls with the LHINs, they have regular calls with Ontario Health and all of the experts in Public Health and the medical practitioners to talk about the trends that they're seeing in homes what they've done in homes, what resources are available for IPAC. We have IPAC extenders and, like I said, funding that.

So we are -- is it happening in all areas? No. Some areas like Toronto does it very, very well. But we are sharing more and more

information on IPAC on how to assist and help these homes.

And I know that the leads -- our assistant deputy minister and also the lead for Ontario Health -- are meeting with the large chains to say, "Here are the resources that we're giving you. You need to be prepared. You need to be accountable. You need to use these best practices to control your outbreaks."

COMMISSIONER JACK KITTS: And I completely agree. And so accountability is everything. If they're not compliant at this stage in the pandemic, what is the consequence from an inspection that shows they're not compliant?

MS. HAVES: Well, we're working with the Public Health Unit. So on the homes that are not compliant, I've seen the Public Health Unit actually issue orders. And we work collectively together, and we are issuing orders.

And where we're seeing that the licensee is not accountable and not able to comply, we're asking either for a management company to go in to manage the home or a hospital to go in through a mandatory management order or a volunteer management contract to assist the home.

COMMISSIONER JACK KITTS: Thank you.

LEAD COMMISSIONER FRANK MARROCCO: Do you insist that where you're forced to take the kind of action you've just described, that the home has to pay for that?

MS. HAVES: Yes, they are. When a hospital goes in, the contracts that they sign with the hospitals, those are a mandatory management -- or management companies, sorry. They pay for that.

LEAD COMMISSIONER FRANK MARROCCO: Would there be any reason why, in conjunction with the Ministry of Labour, you couldn't inspect every one of the 626 homes to see if they're competent with, you know, infection control practices? And I say in conjunction with the Ministry of Labour, because if it's dangerous for the residents, it's probably dangerous for the staff. Then, like, just an audit of every single place. How do you put it on? How do you take it off? And have somebody watching who understands that, ask them some questions about their IPAC practices, and then pass or fail?

MS. HAVES: So we don't have the resources to do that. We don't have the capacity to do that. We are taking in complaints on abuse,

on neglect, on falls. We have a tremendous amount of workload that we are also inspecting on.

And in our role as inspections, we're very regulatory. We're not advisors. We do not educate. So when we go into homes, Public Health does -- what you're saying is something that the hospitals and Public Health Units have been doing. They have been assisting with the audits. They've been educating. They've been showing the home. They don't know what they don't know, and that's what's happening in a lot of these homes. There's so much --

LEAD COMMISSIONER FRANK MARROCCO: Yeah.

MS. HAVES: There's so much information given to them. But we just don't have the resources or the skillset or the training to specifically do a deep, deep education like Public Health Unit does.

LEAD COMMISSIONER FRANK MARROCCO: I appreciate what you're saying. You can't get to the baseline, because for resource reasons, you just simply can't establish the baseline. The difficulty with what happens after there's an outbreak is that then you're playing catch-up right

from the beginning with a very infectious disease. It seems to me every day makes a difference if that infection is spreading through the home.

MS. HAVES: Yes. Like, we're having calls with all partners. The partners are going in to do assessments. Some of the homes, we're seeing that the numbers are -- are still continuing to rise, and it's finding that smoking gun. Where is the issue? And using the best practices. And we're doing that altogether collectively.

LEAD COMMISSIONER FRANK MARROCCO: All right.

MR. CALLAGHAN: So just following --

LEAD COMMISSIONER FRANK MARROCCO: Commissioner Coke?

MR. CALLAGHAN: Sorry.

COMMISSIONER ANGELA COKE: It's a bit more general than the COVID issue, but I'm just trying to wonder if you have some sort of threshold or some characterisation of a home that has a pattern of non-compliance. Is there some way that you categorise the homes that have a pattern is what I'm describing it as of non-compliance? And is there a point at which there's some different type of intervention?

You described, you know, there's follow-up orders and there's some escalation in terms of what type of order. But at what point do you say, you know, "There's a pattern of non-compliance here, and some different level of measure needs to be taken"? I mean, you can't just keep going back and reordering and reordering if this is the nature of the way this home is performing.

MS. HAVES: It's a good question, and thank you for asking it. So, yes, what we do is -- pre-COVID again, is we have compliance histories. So we will deal with -- we will work with the licensee. We will look at the compliance history. If they're a chain, for example, that has multiple homes, we will see a trend. We will see a trend on staffing. We will see a trend on falls. And it could be that they don't have a very good falls program or they need additional training.

What we have done in the past -- and we are doing it through COVID also -- was some of our larger chains where we're seeing that pattern of their homes coming out in outbreak and that they don't have solid leaderships, we are escalating. We are meeting with them. And those meetings can

also include our Public Health partners and Ontario Health. We have a consolidated front to say, "We are seeing an issue. You need the submit a plan. And we are going to monitor that plan to make sure that you're sustaining whatever you're saying you're going to do."

COMMISSIONER ANGELA COKE: I guess what is the threshold at which point you say, "You know what? These people need to be out of the business"? What is that threshold?

MS. HAVES: I don't have a specific threshold for you. There is just the discussions that we're having and determining what the next steps are.

COMMISSIONER ANGELA COKE: Okay. Thank you.

MR. CALLAGHAN: If we could just go ahead a little bit on this document? And we have to move along for the timing reasons.

But I take it you designed for this new protocol for COVID outbreak a new checklist for IPAC issues. Right?

MS. HAVES: Correct.

MR. CALLAGHAN: All right. And that's at page 5 of 7.

MS. HAVES: Yes.

MR. CALLAGHAN: I don't think we need to -- okay. And it deals with things, everything from signage postages to cleaning and disinfections, et cetera. Could you tell me, then, this was January 21st -- or, pardon me, January 18th. Has this new policy been used yet? Have you had occasion to have an immediate inspection on the basis of this?

MS. HAVES: Yes. Yes. I don't have the exact -- sorry. I don't have the exact number for you of how many IPAC inspections we've done.

MR. CALLAGHAN: Okay. So I just want to touch base, then, quickly on what you said a moment ago, which is about the inspections that seem to have been done, you said, in May.

We have a slide deck, and I'm not expecting you to have seen it, but it just gives us a jumping off part. That's at -- unless you did see it -- number K, please. And while that gets pulled up, we're at page 4. And when it comes up, it will say:

"On May 27th, 2020, the Ministry deployed long-term care inspectors team to conduct

comprehensive detailed inspections of high risk red long-term care homes over a 21 day period. That will end June 17th."

Was that done by your office, by your inspectors?

MS. HAVES: By the individuals through the area office, yes.

MR. CALLAGHAN: Okay. These are only of 19 homes, was there? Or, pardon me, how many homes were there?

MS. HAVES: There was 19 red homes at the time. So the list was fluctuating. So information was being gathered by Ministry of Long-Term Care, Public Health, Ontario Health. We would determine what the red homes were, and we were inspecting on those homes.

MR. CALLAGHAN: And is there a score card as to how those homes fared after the inspections? Like, do you keep track as to whether or not the red homes that were inspected had an outbreak or didn't have an outbreak?

MS. HAVES: So they would have been -- they would have been in outbreak, because they are identified as a red home. They would have been in

risk either of IPAC, leadership, staffing issues, and that's why we were going out to do the inspections.

For a score card, I could say that, yes, you would have seen that, because the level -- the -- it would have been gone from a red to an orange to a yellow to a green saying that it's now fine. We also would have our heads ups -- our regular heads ups to show the progress and to show that the numbers were declining, what issues were addressed also.

MR. CALLAGHAN: So I guess what I'm asking -- and if you could just go down one more slide? And this is the slide at a period of time as you point out. Is there a score card, if I may, or some sort of calculus that we can look at and say a home's in red that you inspected and subsequently had no outbreak or had an outbreak. Do we know how successful your inspection process was during that?

MS. HAVES: Nothing specific. We would have to go case by case, home by home.

MR. CALLAGHAN: All right. And I take it we could probably map the red ones against homes that are known to have an outbreak and start there,

I suppose. Is that the way --

MS. HAVES: Yes.

MR. CALLAGHAN: -- to do it?

MS. HAVES: Yes. We would pull all of the information to see, in the inspection, what did we inspect? What did we issue? And were they in compliance the next time that we went to do an inspection? We'd have to pull all of that, the heads ups information.

Because I -- I'm just looking at some of these too. They would have had voluntary management contracts. The hospital would have been in. They would have had their score card, their database, their -- of showing what they've done and how they address compliance.

MR. CALLAGHAN: But what I'm understanding is that there's been no comprehensive review of the success of that program as of yet?

MS. HAVES: You're correct. Yes.

MR. CALLAGHAN: And we were going to pick a view of a couple of homes that we have heard about already, one of which was Sunnycrest.

And, again, our time is getting short, and we have a couple of homes to do. So I'll try to move through this gingerly.

But I think -- who is that? That is -- Ms. Johnston, is that your territory?

MS. JOHNSTON: Yes, it is.

MR. CALLAGHAN: So now I'm at tab 2(i), Kavi.

So we're aware, and I'm assuming you're aware, that there was a comprehensive inspection of that home in December of 2019.

MS. JOHNSTON: M-hm. Yes.

MR. CALLAGHAN: All right. You have to say yes or no.

LEAD COMMISSIONER FRANK MARROCCO: This is Sunnycrest, is it, Mr. Callaghan?

MR. CALLAGHAN: Yes. Yes. Yes, it is.

So if we go over, if we're looking at -- if we go over the page, you'll see this report is dated December 3rd and 4th. But this was done as a result of a critical incident.

And if we can go to through the next page, Kavi?

So, Ms. Johnston, I take it -- this says that the inspection was conducted on the following days, and it's September 24, 25, 26, 27, 30th, October 1, 2, 3, 4, 7, 8, 10, 11, 15, 16, 17, 18, 21, 22, 23, November 12, and 13, 2019. And

you'll see the basis of it at the bottom is included. There's a falls prevention, but infection prevention and control.

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: So just tell me, is that a -- that's a lot of days. Is that typical for an inspection to be in there that many days?

MS. JOHNSTON: Not necessarily. So I know -- I know for sure for this one, we had one of the inspectors -- there was illness amongst those days, so there were two inspectors that did conduct this inspection.

And it also is in dependant on the nature of what they are looking at and in terms of the findings.

MR. CALLAGHAN: All right. So let's just take look at -- I just wanted to touch on a few of these. If we could go to page 4 of 20? And under Findings, it says:

"The licensee has failed to ensure that there was a designated staff member to coordinate the infection prevention and control program. Critical incident report was submitted to the director for a

specific outbreak declared in the home on a specified day.

In an interview with inspector number 571, the director of care in place at the time of the outbreak, indicated that they were not the lead for infection prevention and control.

RN number 116 was uncertain as to whether the infection control lead was resource RN number 112 or number 156 or both when this specific outbreak was declared.

In separate interviews with inspector number 571, resource RN number 112 and 156 indicated they were not the infection prevention and control program lead at the time of the outbreak."

It goes on:

"The licensee has failed to ensure there was a designated staff member to coordinate the infection prevention and control program."

So the first issue, then, is that there

was some uncertainty or, indeed, no clarity whatsoever as to who was in charge as it related to IPAC. Right?

MS. JOHNSTON: That's correct.

MR. CALLAGHAN: And number two:

"The licensee failed to ensure that symptoms of infection gathered and recorded were analysed daily to detect the presence of infection for the purpose of reducing incidents of infections and outbreaks."

This is -- I've forgotten the name of it, but this is the list one is to keep to make sure we track who is infected or not. Correct?

MS. JOHNSTON: That's right.

MR. CALLAGHAN: Line listing, I think we call it.

MS. JOHNSTON: Yeah, surveillance line listing.

MR. CALLAGHAN: And I'm not going to -- we won't take a look at this whole thing, but there were specific orders then issued in respect of this home. And I think if we go to the back of that document at page 1 of 8, if I've got this correct. And this is the order, and it's dated December 3rd

and 4th. And if you go over the next page, it says -- and we won't go through the whole thing, but it says:

> "The licensees must be compliant with section 229(6) of the Ontario regulation. Specific, the licensee must:
>
> (A) ensure that all registered staff and managers are educated on Ontario regulations 79/10 section 229(6), and a licensee's process for ensuring symptoms of infections that are monitored and recorded are analysed daily to detect the presence of infection for the purpose of reducing incident of infection and outbreaks.
>
> (B), a documented record will be kept of the training."

And at the back of the document, if you go to page 4 of 8, please? Right there. Thank you. The licensee -- pardon me, the inspector's report:

> "The severity of this issue was

determined to be a level 3, because there was actual harm to the residents. Scope of the issue was a level 2, as it related to 7 of 15 residents reviewed and concluded both floors, where residents reside in the long-term care home. The home had no previous history."

They're given till January 31st, 2020. So that would be -- I'm not sure. That would be 60 days, I assume?

MS. JOHNSTON: It's issued December 19th, yeah, thereabouts.

MR. CALLAGHAN: I'm sorry. You broke up there.

MS. JOHNSTON: I -- yeah, from the report date, it was December -- December 9th, so it would be, yeah, close to 60 days.

MR. CALLAGHAN: Well, 60 days is 60 business days. Right? That's what the requirement is?

MS. JOHNSTON: Yes.

MR. CALLAGHAN: And there was another report on March 9th, 2020, because we couldn't find anything of any follow-up on March -- on January

31st. We did find a republic report of March 9th, 2020, and it would appear that there was a complaint regarding a fall and that the inspectors went in for that purpose. Is that correct?

MS. JOHNSTON: They -- they also went in to follow up on that. It's a (audio glitch).

MR. CALLAGHAN: I'm sorry. You broke up again. You'll have to speak clearer.

MS. JOHNSTON: You can see where they (audio glitch).

Sorry. It must be my connectivity.

Yes, if you scroll further down, you can see where they did follow up on the order at this time.

MR. CALLAGHAN: Okay. So I just want to be clear. Was there a scheduled revisit, or did they actually just go out because there was an incident, and then they followed up? Like, I'm just trying to understand this. Was this a scheduled visit, a follow-up, or was this a critical incident they were going out and they therefore followed up? The prior order.

MS. JOHNSTON: Well, it would have been both. So with -- so with any order, we schedule them.

My internet. I might have to stop my video because of the internet.

MR. CALLAGHAN: Okay. That's fine.

MS. JOHNSTON: So, anyway, it's both. So the inspection was scheduled for follow-up. And with any inspection, what the inspector will do at the time, if there's other intakes on file, they'll be inspected at the same time, which would have been the case in this particular situation.

MR. CALLAGHAN: Okay. Well, let's go, then, because in this follow-up order at --

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: -- page 5 of 6 -- your earlier pages deal with the fall, which we're not interested in, per se. But it says on page 5 of 6 -- it says:

> "On December 3rd, the compliance order from the inspection was made. They restate the order."

And then it says:

> "The licensee failed to comply with part A, whereby the licensee failed to ensure that all registered staff and managers were educated.
>
> A review of the read and sign

education materials provided to registered staff in response to CO were reviewed.

The educational materials failed to include reference to the education under regulation 79/10. Separate interviews with full time RN number 2, Number 103, and infection control lead 101 all confirmed an awareness of the requirements of the legislations."

At the end, they conclude:

"The licensee did not comply with the order made under this Act."

So they didn't rectify the order of December 2019 and 2020. So what happens to this now, now that we have a follow-up and they haven't complied?

MS. JOHNSTON: So in this particular case, so the inspector followed up on the -- following up on an order is twofold. So they would look -- when they go in to inspect, they look to see if the home is still in -- whether they're in compliance or non-compliance with section 229(6).

In this particular case, they were in

compliance with the legislation, the 229(6). However, a component of the order, the home was not in full compliance with. So in that particular case, the -- the inspector would leave section 101 of not complying fully with the order set out by the inspector.

MR. CALLAGHAN: Right. But I don't see any follow-up after this. Am I missing something? We've not found anything that shows that anybody did a visit after March 9th, escalated it to the director, or what have you. Am I correct on that?

MS. JOHNSTON: Yes, because this was -- this wasn't a reissued order. So the order was complied. They were issued a written notification under section 10(3). So we would not follow up on a written notification.

MR. CALLAGHAN: So it's March 31st, we're in the middle of a pandemic, and they don't have anybody who's educated in IPAC and there's no follow-up. That's what I'm to understand?

MS. JOHNSTON: No. So -- so they would have -- so the -- the home would have been in compliance with section 229 . So they would have had -- they would have had the -- the IPAC lead in play. But what they didn't -- what they failed to

do is finish with all the education for all the staff. So the educational materials failed to include the reference in education.

So the staff were educated, but -- they didn't they didn't support -- able to supply the read and signed component that the staff were actually educated. But through the inspector's inspections -- so they would interview staff, they would conduct observations, they would have determined at that point in time that the staff would have been educated.

MR. CALLAGHAN: Okay. I see. So I don't see them limiting the requirement to -- like, if we look up here, it says the licensee was ordered -- pardon me. I'm not being very clear. Was:

"Licensee was ordered."

And referring to 229(6), and they refer to:

"(A) ensure all registered staff and managers are educated and (B) document the record.

And it says:

"The licensee failed to comply with part (A) whereby the licensee

failed to ensure all registered staff and managers were educated."

I don't read this as meaning that they failed to have a document. Am I reading this wrong? Because it would appear to be saying that they came, and they didn't have the education. But what I hear you saying is they didn't have the document evidencing education.

MS. JOHNSTON: Right. I see. So I -- I -- so based on -- for -- further down in the finding, it says.

> "A review of the read and sign education materials provided to registered staff in response to the compliance order were reviewed. The educational materials failed to include reference in education under section 229(6)."

MR. CALLAGHAN: Okay. There's that too. And then it says that the RN 102, 103 and the infection control all confirmed an unawareness of the requirements of 229(6). I don't want to be unfair to the home here, but is it your understanding they failed in the education component, or is it just the recording of the

education?

MS. JOHNSTON: In the education component.

MR. CALLAGHAN: All right. Well, then let's just move ahead then. There was --

LEAD COMMISSIONER FRANK MARROCCO: I'm sorry, John. I'm sorry. I missed the answer.

MS. JOHNSTON: Oh, in the education (audio glitch).

LEAD COMMISSIONER FRANK MARROCCO: It's breaking up for me, which is why I've turned off --

MS. JOHNSTON: I'll turn off my --

LEAD COMMISSIONER FRANK MARROCCO: -- the video.

MS. JOHNSTON: -- video. That might help.

LEAD COMMISSIONER FRANK MARROCCO: And I just missed the answer to your question. I didn't hear it.

MS. JOHNSTON: Oh, the education component.

MR. CALLAGHAN: So they didn't follow through with educating their staff on the IPAC requirements. Correct?

MS. JOHNSTON: Right.

MR. CALLAGHAN: All right.

LEAD COMMISSIONER FRANK MARROCCO: John, there's a question from Commissioner Coke.

COMMISSIONER ANGELA COKE: Sorry, just a question about timing issues. So when they have a compliance date of January 31st, are they required to report to you that we're now in compliance? And if you're going back, why the gap for three months before going back? Or two months?

MS. JOHNSTON: So the homes -- so a compliant due date of January 31st, the homes wouldn't necessarily report to us that they're in compliance. So what happens is the -- a follow-up inspection is scheduled on our part. And we enter the home unannounced, so the home does not know that we are -- when we're arriving.

So we did go back in March. And, again, we -- we schedule, you know, based on our resources as well at the time.

COMMISSIONER ANGELA COKE: Okay. Thank you.

MR. CALLAGHAN: So I think --

MS. HAVES: If I could just add some --

MR. CALLAGHAN: Go ahead.

MS. HAVES: If I could just add some

context here too? We have a chart available for our inspectors to issue compliance due dates. And it depends on the orders and if it's a high priority compliance order or if it's one that's not a high priority. So if it's a high priority, it would be 90 business days that we would try to schedule a follow-up inspection. And if it's not a high priority -- excuse me, it's 120 days.

MR. CALLAGHAN: So this was a level 3/level 2. So was that a -- I think we established it was supposed to be a 60-day follow-up.

MS. HAVES: So the compliance -- when we're talking about compliance due date.

MR. CALLAGHAN: I see.

MS. HAVES: Yeah, not follow-up. But Commissioner Coke was asking why the delay? But this is just to provide some additional context that we have timeframes of when we should be scheduling a follow-up inspection or the compliance due dates, how long we give them.

MS. JOHNSTON: Right.

MR. CALLAGHAN: And just to repeat, you were no direction from management about changing those dates in respect of things like IPAC in the middle of a pandemic. Correct?

MS. HAVES: Are you talking about the compliance due dates or the follow-ups, inspections?

MR. CALLAGHAN: Either.

MS. HAVES: They are two separate --

MR. CALLAGHAN: Either.

MS. HAVES: Yeah, no, there was no specific direction.

MR. CALLAGHAN: So if we could go then to 1(b)? We had talked -- I think, Lynne, you mentioned that there was the self-assessment process or preparedness assessment, and this is the home's preparedness assessment. Can I ask whether, Valerie, you saw this?

MS. JOHNSTON: I -- I -- I only saw it recently. I did not see it at the time.

MR. CALLAGHAN: So these would not have been given back to the Inspection branch to look at?

MS. JOHNSTON: No. I did not receive this.

MR. CALLAGHAN: So if we go -- now, this self-assessment has very little comments. If we could just go to -- well, just take a look at one page for timing reasons.

For example, if we go to page 9, this is the -- you'll see this is IPAC, and there's five levels. They marked themselves as a level 3. And they refer to:

> "Dedicated in-house IPAC resource, trained IPAC leads/champions on site. All staff trained on IPAC with clear policies."

And I take it that they're indicating that they have that, and yet there's no reference here to the outstanding order. So I take it from your answers you wouldn't have been given an opportunity to assess the validity of this self-assessment against the outstanding order, because you never saw it. Is that right, Valerie?

MS. JOHNSTON: Well, I never saw this in conjunction with Ontario Health in the home. But I just want to add there was no outstanding order at this time. So the -- the order was complied in March of 2020, and my -- this IPAC preparedness assessment were completed latter part of August.

MR. CALLAGHAN: Sorry. I'm sorry. I thought we looked at it and said the education

component hadn't been done.

MS. JOHNSTON: But the home does not have an outstanding order. They were issued -- they were issued non-compliance under section 101.3 for not complying with the order.

MR. CALLAGHAN: So I'm a little confused. So they don't have sufficient IPAC training or IPAC leads in December. They go back in March, and there's no evidence of education, and, in fact, the person that's supposed to be the IPAC lead doesn't know about the section. And that from the inspection branch is a complied-with order?

MS. JOHNSTON: Because the inspector is looking for non-compliance under that particular section. So -- so -- and so when they originally left the order, it was in relation to not maintaining surveillance line listing sheets. So when the inspector goes back in to follow up, that's what they would look at.

So when an inspector leaves an order, they -- they order the home a possible solution in terms to rectify the problem. So it -- so at the time, the home had rectified the line listing. However, the one component of the order was not in

compliance. So by policy, by direction, we would leave a section 101.

MR. CALLAGHAN: All right. So, of course, you couldn't come back unless you came back in an outbreak to determine whether the line list and an outbreak was sufficient. Correct?

MS. JOHNSTON: Well, not necessarily. I mean, the inspector would have completed observations at that time, so they -- they still would have used the inspection -- infection prevention and control IP protocol. And by doing that, you know, there is -- there's a systemic way of conducting the inspection whereby they would be, you know, conducting observations, staff interviews, and record reviews. So...

MR. CALLAGHAN: Okay.

MS. JOHNSTON: At that time --

MR. CALLAGHAN: Well, I'm not sure I fully understand what you're saying, given the comments, but let's move on.

MS. JOHNSTON: It's Confusing.

LEAD COMMISSIONER FRANK MARROCCO: John, before you move on, this is in relation to Sunnycrest. Right?

MR. CALLAGHAN: Correct.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

MR. CALLAGHAN: Well, so --

LEAD COMMISSIONER FRANK MARROCCO: So do I have it right that Sunnycrest said that they had complied with the IPAC requirement as it's described in that spreadsheet?

MR. CALLAGHAN: They did. What the point is --

LEAD COMMISSIONER FRANK MARROCCO: That's what they said. When you said they did, that's what they said?

MR. CALLAGHAN: That's what they said. The March 9th order seems to indicate that the education component hadn't been completed, and, indeed, even the lead wasn't aware of the requirements --

LEAD COMMISSIONER FRANK MARROCCO: Right.

MR. CALLAGHAN: -- under that section. And so that's why -- and I think we're being told -- even though that's the conclusion, that doesn't mean that they're out of compliance. Which I'm not sure I understand, but that's what I think we're being told.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

MR. CALLAGHAN: All right. And then if I can take you then to document 2(c)? And this is a memo. But behind the memo -- and this memo goes to a number of people. I'm not suggesting it went to you, Valerie, or even you, Lynne, but it identifies Sunnycrest as a home of concern of the priority homes.

And then for Durham central east, you'll see that right there in the second column. And then if you go over the next page, you'll see this is the rolled up reports of the view of the various homes in the east region. And if you go over, you'll see they assess them, and they give various ratings as to which homes will require the most support. Did you ever get a copy of this document?

MS. JOHNSTON: I haven't, no.

MR. CALLAGHAN: So this was never provided to the inspectors?

Lynne, have you ever seen this document?

MS. HAVES: I haven't seen this document here, no.

MR. CALLAGHAN: So the general says:

"Based on the results of the preparedness exercise, identify the homes that you believe are at most risk from a preparedness perspective. They are not prepared for wave 2, have not made substantial improvements..."

And you'll see the home listed there under Durham central east. And then they go into very specific items. If you go to the next page?

"Based on the results of the preparedness exercise, identify the homes that you believe will require the most support in the area of HR."

And they don't actually list that home in there, Sunnycrest.

We go over another page, it says individual --

If you go up the next one, Kavi?

It says:

"Based on the results of the preparedness exercise, identify the homes that you believe will require the most support in the area of

safety and IPAC if wave 2 occurs."

And then they have:

"Please also comment on the specific IPAC deficiencies in these homes."

And then they refer to the Sunnycrest in the middle there. And there's commentary. I won't take you through all that. We go to the next, it says:

"Identify homes that are not active, do not participate in the Ontario Health regional planning tables, for example, homes that have refused/declined attendance, homes that you notice have not been on the call, participated in homes that do not include supportive partnerships in their preparedness."

And they list Sunnycrest. Now, just on that point, were you in constant -- were you in communication with Sunnycrest at your office, Valerie?

MS. JOHNSTON: Yes, for sure. For sure. Through wave 1 and 2.

MR. CALLAGHAN: That would not include your -- this August. This wouldn't include your -- in August, that comment wouldn't include you?

MS. JOHNSTON: Well, I'm not aware of this, but -- but in terms of -- as an SAO office, we were -- we would be in contact with Sunnycrest. We continued our support and monitoring throughout.

MR. CALLAGHAN: But this is done in August, so this is before any outbreak at Sunnycrest.

MS. JOHNSTON: Yeah, I don't know.

MR. CALLAGHAN: You don't know. But you don't recall them calling your -- you don't recall Ontario Health saying, "I'm doing this survey. I just want to get your views"? You don't recall that?

MS. JOHNSTON: No. No.

MR. CALLAGHAN: I'm just going to show you a --

LEAD COMMISSIONER FRANK MARROCCO: John, before you leave it, just so I understand what I'm looking at, this was done by -- this is a survey result that was obtained by Ontario Health?

MR. CALLAGHAN: Right.

LEAD COMMISSIONER FRANK MARROCCO:

Okay.

MR. CALLAGHAN: So as we understood it -- maybe Ontario Health should come and testify. But as we understand it, Ontario Health -- we've been told that this was part of the fall preparedness. They issued these self-assessments and then did these assessments of the homes. And we have now talked to Dr. Kyle and to Lakeridge, neither of them saw any of this material, and now we've been told that the inspectors never got it.

LEAD COMMISSIONER FRANK MARROCCO: All right.

MS. HAVES: Can I -- can I just add additional context here too?

MR. CALLAGHAN: Yeah, for sure.

MS. HAVES: So the preparedness assessments were done, you're correct, by the long-term care homes and Ontario Health. They were not forwarded -- the individual assessments were not forwarded to Ministry of Long-Term Care. However, in our support and monitoring calls or any calls that we would have with the home, we would ask them, "Could you please forward your preparedness assessment to make sure that preparedness assessment was matching what we were

being told?" But we -- we did not get them.

This is specific to the east. We did receive a general feedback from Ontario Health to say these are how many assessments -- preparedness assessments we received, and this is how many homes in the province fell under these categories.

MR. CALLAGHAN: But to be clear, nobody sent these to you with the idea that you'd go and check, because they're concerned of IPAC at Sunnycrest, for example?

MS. HAVES: Correct.

MR. CALLAGHAN: And there's a large chart for central east. It's maybe cumbersome.

I wonder, Kavi, if you can bring it up.

So we'll see how this works. But I'm not sure if you've seen this, but I just want to show at least the commissioners, and it's a chart of the various homes. And remarkably -- and I won't take you through it, but if you looked at it, you'll see homes, remarkably, rated themselves from 3 to 5. Weren't primarily 1s and 2s.

LEAD COMMISSIONER FRANK MARROCCO: John, the screen is blank. How did Sunny -- let's just cut to chase here. How did Sunnycrest rank themselves?

MR. CALLAGHAN: 3s across the board. And what's of interest, and I'll just take you quickly through it, their commentary in this chart -- and Ontario Health -- it seems to designate them as a concern, because this home has low engagement with the LHIN and a C class design. It should be closely monitored. In doesn't seem to be that they actually reflected anything about IPAC, and there's no reference to the orders to which we just referred.

LEAD COMMISSIONER FRANK MARROCCO: What does a 3 mean?

MR. CALLAGHAN: 3 means you're right in the middle of the pack.

LEAD COMMISSIONER FRANK MARROCCO: So their assessment of themselves is we're kind of average?

MR. CALLAGHAN: Yes.

LEAD COMMISSIONER FRANK MARROCCO: And Ontario Health's assessment of them is better keep an eye on them; they've got some problems?

MR. CALLAGHAN: Right. And we're going to talk about Tender Care, who rated themselves as 4s and 5s, and they don't show up on the list.

So then if we can then talk about the

outbreak then at Sunnycrest. And if we could go -- we'll go off a document that -- it's just easy. It's tab H.

LEAD COMMISSIONER FRANK MARROCCO: While they're finding the document, is there any reason why Ontario Health would not give the Ministry of Long-Term Care a heads up about these homes like Sunnycrest?

MS. HAVES: They did at a high level; they just didn't give at us individual assessments.

LEAD COMMISSIONER FRANK MARROCCO: You could see though -- I appreciate they may have given it at a high level. But they if they don't tell you which home, how do you know where to send an inspector, assuming you have an inspector to send?

MS. HAVES: But they did give us a list of those homes at a higher level, not the exact details of it. And at that time, I recall us looking to see on our daily support and monitoring, are we addressing these issues?

LEAD COMMISSIONER FRANK MARROCCO: But not in relation to Sunnycrest, surely?

MS. HAVES: Well, Val is saying no. At that time, she hadn't seen it.

LEAD COMMISSIONER FRANK MARROCCO: Because it would be extraordinary if you were saying that you assessed Sunnycrest as being kind of average, given what happened.

MS. HAVES: Well, they -- they assessed themselves with Ontario Health. We were not assessing them. But we were monitoring -- we were monitoring them, though. Yeah.

LEAD COMMISSIONER FRANK MARROCCO: See, that's what I'm having some trouble with. You're monitoring them. Ontario Health has this information, and Ontario Health is not satisfied. But you need to know that.

MS. HAVES: Yes.

LEAD COMMISSIONER FRANK MARROCCO: Yeah.

MR. CALLAGHAN: So this is a -- and we have this on many homes; I'm not sure we have them all. These are the outbreak, and it gives you a rundown of what's happening.

If we can go to the very back, please, Kavi? Bottom of the document.

Okay. So here it says that May 7th -- this is earlier, and I don't know, Valerie, if you're aware of this -- there was a positive COVID

test and that the outbreak was declared over from May 7th to May 20th. Were you aware of that?

MS. JOHNSTON: Yes.

MR. CALLAGHAN: Okay. So the information we have is that you get called on November -- not you personally, but it's called in on November 23rd, I believe --

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: -- that there's an incident. Okay? Are you familiar with the date?

MS. JOHNSTON: November 23rd, they were (audio glitch).

MR. CALLAGHAN: Right. They called in --

MS. JOHNSTON: Yes.

MR. CALLAGHAN: -- a critical incident because of the outbreak. Right?

MS. JOHNSTON: Correct.

MR. CALLAGHAN: All right. So November 24th, they have two staff tested positive, five residents confirmed positive.

And then we go -- and this records on a daily basis. And I take it is this your office communicating with them? Is that where this information is coming from?

MS. JOHNSTON: It is, yes.

MR. CALLAGHAN: So:

"November 26th, five residents remain positive with 14 additional residents symptomatic. 119 residents to be tested today.

November 27th, two new residents positive for a total of seven. 34 residents are symptomatic. 90 resident swabs are pending."

Then we go up to November 28th.

"One resident has now died. Six new residents positive for a total 13. Five new staff.

November 29th, one new resident death for a total of two deaths. 63 new residents for 76 residents confirmed positive. Three new staff for 11."

Now, you don't actually send an inspector out until November 29th. So can you explain why it takes from November 23rd to November 29th to send an inspector?

MS. JOHNSTON: So with this particular home, we -- so the inspector went in on -- on

Saturday, November 28th. The home went into outbreak, as you know, the 23rd to 24th. So at that time, we were having daily calls. The calls entailed, you know, members from the LHIN, the Public Health, Lakeridge Hospital. You know, there was all hands on deck in terms of how we're going to support this home. So, I mean, we were following this home really -- you know, ever so closely.

So by -- you know, by -- by Saturday, we had an inspector on site.

MR. CALLAGHAN: All right. And --

MS. JOHNSTON: And the hospital had already conducted IPAC assessments in this home. So there was already IPAC assessments, you know, being completed.

MR. CALLAGHAN: Had that happened yet? I got the impression that Lakeridge doesn't go in until the next -- till November 30th.

MS. JOHNSTON: Lakeridge had already been in the home.

MR. CALLAGHAN: They had. Okay. We would have heard that.

MS. JOHNSTON: As well as Public Health at that time.

MR. CALLAGHAN: All right. I'll defer to what we heard from them, so I'll defer to what they said.

But so if we can then turn over then to tab K, please? So the report as is dated November 20th. You're saying that Mr. Shi went in on the 28th?

MS. JOHNSTON: He did. He was there on Saturday, and we issued the report on the Sunday.

MR. CALLAGHAN: And if you go down, this is the order of inspection, and it says during the course --

We're at page 3 of 9, please, Kavi.

Okay. And I'm not going to read this whole thing, but it says -- I'll just quickly touch on some.

> "During the course of the inspection, the following was observed on November 28th.
>
> There was no designated screener wearing full personal protective equipment. At least eight resident rooms did not have PPE caddies. A PPE caddy was located outside room 2204 on the designated COVID

positive unit."

Anyway, I won't go through them all. But if we go to the end, just because of timing, he again, says severity.

So if you can go back up one, please? There we go.

"Severity. There was actual harm to residents. There was not enough staff in the home to provide timely medications and treatments, inconsistent IPAC practices during the course of COVID-19 outbreak, lack of education and information to the front-line staff related to IPAC practices and home's COVID-19 outbreak, lack of access to PPE supplies, and inconsistent precaution signage on resident rooms.

In addition, as of November 29th, there have been two resident deaths and two residents who have been hospitalised."

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: The scope:

"The scope of this non-compliance was wide-spread because of the concerns that were identified has the potential to affect a large number of long-term care residents. And as of November 29, there have been 67 residents who have tested positive."

And they require the order to be complied with by December 1st. Correct?

MS. JOHNSTON: That's right.

MR. CALLAGHAN: So now the peculiar thing about this is, as I understand, Lakeridge takes management of the home. So this order is basically Lakeridge's to fix?

MS. JOHNSTON: The -- yes. The -- the -- yes.

MR. CALLAGHAN: So when we go on December 14th.

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: And then it's fixed.

MS. JOHNSTON: The order was put back into compliance, yes.

MR. CALLAGHAN: Right. But to be fair, that was Lakeridge putting things back into

compliance as the managers of the home. Correct?

MS. JOHNSTON: Yeah, for sure. Yes.

MR. CALLAGHAN: Now, we were provided -- if we can go to Document 2(m)? We were provided that there was a review of this decision, and a decision was issued.

MS. JOHNSTON: Yes.

MR. CALLAGHAN: And I take it, just so we're clear, even through when the order was issued -- and perhaps this is an appeal by the owner of the home rather than Lakeridge. They had to comply with the order. Correct? Even though they could appeal it, but in the meantime, they had to comply. Is that the way the legislation is?

MS. JOHNSTON: It's exactly that.

MR. CALLAGHAN: Now, in this order -- we don't have the file, so I've got to be careful, because I haven't seen the file. But in this decision, the appeal is heard by Tammy -- I'm afraid I won't be able to pronounce her last name.

MS. HAVES: Syzmanowski.

MR. CALLAGHAN: Syzmanowski.

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: And she goes to the file on this appeal. She upholds the decision, as

I understand it, but she takes issue with some of the findings of the inspector. Is that how you understand it?

MS. JOHNSTON: Yes. Yes. She's -- yes. She -- she had issued, the order was rescinded, and a director's order was issued in place under the same legislation.

MR. CALLAGHAN: Right. To the same effect?

MS. JOHNSTON: To the same effect. M-hm.

MR. CALLAGHAN: I don't know how these appeals work, but I just have to ask you about one thing. It's page 12 of 17. And this might have some impact. We've heard from family members who are notably very concerned about their loved ones and what happened.

So I think that might be further down, Kavi.

First of all, the first one, the inspector notes:

> "On the grounds of the order that interviews were conducted with two PSWs and one RPN indicating that staffing was down to less than

50 percent of the home.

The inspector further states that the staff told the inspector that there was not enough time to stock the caddies with PPE that were by the resident's rooms. My review of the inspector's evidence, the home had significant staffing gaps and a lack of staff attending the home.

However, there was no evidence collected to support the statement that staffing was down specifically to less than 50 percent of the home.

Additionally, the RPN reported that they were unable to the find the staff to stock the PPE carts, since there was no staff available to do so.

However, there was no evidence collected to support the statement that staff indicated that there was not enough time to stock the caddies with PPE for the resident rooms. As such, I will be altering and substituting an inspector's order

with a director's order to remove/revise these statements on the grounds for the order."

I read that, because I'm curious as to what level of evidence is an inspector to get if not to hear from the staff at the home?

MS. JOHNSTON: Well, our policy protocol is we would -- we would need two -- two pieces of evidence.

So in this particular case, the inspector -- this is by staff interviews. There was no documented evidence to support, you know, the director further supporting this.

MR. CALLAGHAN: Well, I mean, I find it odd, because I would have thought two PSWs giving that evidence would constitute two separate pieces of evidence.

MS. JOHNSTON: Well, no, because that would be staff interview. So we would need documentation support or an observational support.

MR. CALLAGHAN: Okay. So the inspectors, if they had five PSWs tell them that's what they saw and the home didn't have a record of it, you couldn't rely on the five PSWs? Is that the current system?

MS. JOHNSTON: The five PSWs would be certainly evidence, for sure. But the inspector would have needed to, you know, investigate that a little further in terms of, you know, maybe care not provided or the staffing schedule. You just would have needed to have taken that a little further.

MR. CALLAGHAN: Okay. It's interesting --

MS. JOHNSTON: To support -- to support -- to support an order.

MR. CALLAGHAN: All right. That puts the inspectors up against the wall there.

But let me read the next line there.

"The inspector notes in the grounds for the order that on November 29, 2020, there was 76 residents and 11 staff who had tested positive for COVID-19.

The inspector further states there have been two resident deaths and two residents who have been hospitalised related to COVID-19.

After reviewing the evidence collected by the inspector, I'm

unable to verify or confirm either statement.

As a result, I'll be altering and substituting the inspector's record with the director's order to remove this statement from the grounds."

And I read this, because I found it particularly odd that when we go back to -- let me get my page number here -- document H. This decision is a recent date; this is the 19th day of January. And if we look at --

Can we go the front of this, Kavi?

LEAD COMMISSIONER FRANK MARROCCO: It's 2021.

MR. CALLAGHAN: Yes. Yes, Mr. Chair.

If we can go to the front of this document, please, Kavi?

This is the document I took you to. It's dated January 4th. See that? Is that January 4th, 2021? Do you see that? Valerie, do you see that? Can you see the date, please?

MS. JOHNSTON: Yeah, I see that.

MR. CALLAGHAN: All right. Now, the first name underneath that, it's to Tammy -- what's her last name? Syzmanowski?

MS. JOHNSTON: Syzmanowski.

MS. HAVES: Syzmanowski.

MR. CALLAGHAN: You see that? That's the same person. Right?

MS. JOHNSTON: Yeah.

MR. CALLAGHAN: All right. So we go to November 29, on this document that she received.

There you go.

MS. JOHNSTON: So can I explain? So the -- and I know Lynne, who certainly --

MR. CALLAGHAN: Sorry. Valerie, can you just let me show? I just want to illustrate. I think you know where I'm going, so I just want to show -- I just want the commissioners to follow me, and then you're free to speak.

MS. JOHNSTON: Oh, I see. Yes.

MR. CALLAGHAN: So this is November 29th, and that is one new resident death for a total of two deaths, which is consistent with what was in the report. 63 new residents confirmed for a total 76. That was also supposed to be expunged from the order. Three new staff positive for a total of 11 confirmed staff.

So she's expunging from the inspector's order information that she herself got. So I'm

sure there's some reason why that's being done. Perhaps you might explain that as to why -- and if you know. Maybe that it's up for the director to explain this. It's just I found it odd that she would expunge it.

MS. HAVES: Can I jump in, please? So being someone that conducts director reviews, I can't speak for Tammy. I can't speak of why she would not have verified through the heads up. But what I can say is director reviews are stand-alone. So we will review the order that is being appealed, and then we will make sure that the evidence that's collected in that inspection file supports the grounds and supports the order.

And perhaps she was looking for that specific evidence. And, again, I can't speak for Tammy; I don't know why. Perhaps there was nothing for her to substantiate the grounds. There was nothing in the inspection file that she was reviewing -- because, again, they're stand-alone files that we look at -- to say, yes, those were the numbers at the time.

MR. CALLAGHAN: And fair enough. And we don't have -- we have -- nobody's -- we haven't received the appeal files, so I can't tell you

what's there. Just an illustration. And I raise the illustration not because of the case but because of the commissioners are going to have to look at the broader context. And I can tell you there are some Sunnycrest families that would probably be very disappointed to have that expunged, given that was their loved ones. So there's a larger context. So I'm not suggesting from an evidentiary perspective. I'm just pointing out that inconsistently.

MS. HAVES: I can explain by doing these often that inspectors will sometimes put in the ground a certain statement. So I'm looking for the evidence to match that statement.

MR. CALLAGHAN: Yeah.

MS. HAVES: And often the evidence is not there, so we have to remove that statement, Because it's not there.

MR. CALLAGHAN: Right. And I understand that from an administrative law perspective, and I appreciate that.

So if we could go -- I just -- the last document on this one is 2.0, and this is what we understand is the Lakeridge Health management plan for Sunnycrest. And, Valerie, can you just tell

us -- we don't have time to go through this, but can you tell what you say the purpose is and why it is that it's Lakeridge and not Sunnycrest itself doing this?

MS. JOHNSTON: Okay. For sure. So Lakeridge Hospital entered into a voluntary management contract with Sunnycrest, and that was December 1st. And part of the agreement is the managing company has to supply or provide a management plan. So -- and that -- they have to submit that within five days.

So Lakeridge Hospital did provide this management plan December 4th within the five days outlining certain concerns that they found and how they're going to address them.

MR. CALLAGHAN: So I'll just give you one goal, page 2. So this is increased knowledge of IPAC best practices to improve compliance of same. And the performance measure that they're putting is 1 percent of staff and leaders will complete within 90 days.

I guess the question I have is how this is structured. Eventually, the home goes back to Sunnycrest. And if Lakeridge has put it back into a position, what is there to ensure that the

owner/operator actually can continue the good work of Lakeridge and not slip into what might have been the prior problem?

Because I haven't -- I have not -- by the way, I've not given you some of the evidence that we got from Lakeridge that state of how they found the place. We have that. But what's the mechanism to show that Sunnycrest can actually do that which Lakeridge is doing for them?

MS. JOHNSTON: For sure. So the voluntary management contract is for 90 days, which can certainly be extended if -- if they're not -- you know, if the homes aren't -- the transition between the home taking back management is -- is not sufficient.

So it's a process. So throughout this process, we have daily meetings with the home throughout the outbreak. The management plan is -- is discussed at that time. And then it rolls into transition planning meetings, which we will -- which we have just recently started.

So part of our transitional framework is that the home and the -- the hospital have to submit transitional plans, and they would be components of the management plans. So areas that

the hospital has identified that the home needs to rectify, you know, it's -- it's the hospital's recommendations, it's the plan, the outcome, there's a timeline in terms of when things are to be completed by.

So we continue at -- the Ministry, you know, are involved with some of these conversations. There also -- there's a transitional planning framework. So both the hospital and the home receive a transitional plan checklist, and both parties will be completing this checklist to ensure that key areas are met such as, you know, staffing, IPAC, leadership.

And it also has to be individualised. The -- the -- the planning, the transitional plan has to be individualised for the home to ensure that, you know, both parties agree.

And it's also reviewed by us, the Ministry, that the transition back to the licensee back to managing the home can go on.

MR. CALLAGHAN: Given the shortness of time, let me just deal with the other in a quicker fashion, if I might?

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: When we get to Tender

Care, I'm not sure you're aware of this, but there was -- you probably are, but there was an inspection report in 2019, which involved first an allegation that there was an IPAC issue, and then the inspector contacted the director, who said it was not necessary to follow up on that. Are you familiar with that?

MS. JOHNSTON: I'm familiar with this report. I'm not sure what you mean by not following up on it. There was no non-compliance.

MR. CALLAGHAN: If you go down to page 3 of 4.

MS. JOHNSTON: Okay.

MR. CALLAGHAN: I don't know. I won't -- I'll leave the names out of them. It says:

> "Skype message received indicated that because there was no negative consequences to the residents that they should not pursue the IPAC finding."

And this is in 2019. And then there is a -- there is an infection prevention and control checklist, I take it -- it's number L if you have it there -- that they have. But were you aware of

that?

MS. JOHNSTON: I was aware of the function from -- from what you've provided this morning for the IP. So the inspector reviewed the complaint regarding the -- the one resident with an infection.

MR. CALLAGHAN: Right. But if you go -- there's a whole list of questions here.

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: And most of them aren't answered.

It's 7 of 10, Kavi.

So I take it this is the old form.

"Do staff monitor symptoms of infections?"

Number 12.

And if you go down a little bit, please, Kavi?

You'll see that not answered right at the bottom. Over the next page:

"Do staff on every shift record symptoms of infection?"

So does this mean that we didn't follow-up on this instance and get those answers? Is that what that document would indicate?

MS. JOHNSTON: So the inspector -- so the -- there again, so this -- this inspector went in on a specific complaint related to a roommate having a medical condition, MRSA. So -- so the complaint was that they were roommates of such.

So the inspector would plan how they're going to inspect that inspection, and they would be focussed on those key areas. So depending on their findings, they don't necessarily have to answer all of these questions.

MR. CALLAGHAN: I see. So, effectively, it didn't rise to the level 4?

MS. JOHNSTON: That's right.

MR. CALLAGHAN: Or level 3+, I guess. Correct? That was the assessment?

MS. JOHNSTON: This was a level 3, but no. So the levels are -- are -- the levels are triaged at -- or created or triaged at the CEAT, at the CEAT level. So this came to the inspector as a level 3, and he's inspecting on -- upon it. He wouldn't necessarily change the level at the time. He would continue with the inspection and leave non-compliance if there's non-compliance.

MR. CALLAGHAN: Okay . So if we go to tab D? This is the outbreak in December. And I

take it you're notified in December?

MS. JOHNSTON: M-hm. Yes.

MR. CALLAGHAN: And so on this document --

If we can go down a little bit, Kavi, please?

It says:

"One staff who was tested on December 1st during our weekly staff surveillance results returned positive on December 4th."

That resulted in you guys being contacted for a CIS. Correct?

MS. JOHNSTON: That's correct.

MR. CALLAGHAN: All right. And that's -- but on this one, we don't see an inspection until later in December.

And if we go to tab G, we have a report date December 17th.

MS. JOHNSTON: M-hm. Yes. We went in December 16th.

MR. CALLAGHAN: Right. And the delay would be as a result of what?

MS. JOHNSTON: Sorry. You said?

MR. CALLAGHAN: What would the delay be

part of?

MS. JOHNSTON: I would -- so this was a level 3 inspection. We -- from onset of the outbreak, which was December 8th, we had daily meetings with the home, the hospital that was involved with this home. Everybody was involved with this home from the onset. So we continued to monitor the home daily, and an inspector went on -- on December 16th.

MR. CALLAGHAN: But was UHN in the home at that time? Or was it UHN, I believe?

MS. JOHNSTON: No, Scarborough Health Network was in initially, and the general came in later on.

MR. CALLAGHAN: Right.

MS. JOHNSTON: Public Health was involved.

MR. CALLAGHAN: So by December 16th -- if we go to tab F? And by this time -- well, let's look at December 17th, because it's easier to read. So it says by December 17th -- I'm afraid I can't put my eyes correctly on the other ones. It says:

"Two new resident deaths for a total of nine COVID related deaths."

So it's a day after you get in, the day

of the report.

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: It says:

"Total of 93 confirmed positive residents. With the nine deaths, that leaves 84 active."

And then they got two residents in palliative, again, it says. And then there are 11 new staff for 33 staff active cases. But so can you tell me exactly why you didn't go in until December 16th with that kind of issue?

MS. JOHNSTON: I can -- I can say that from the care partners, there were IPAC assessments already being complete by Scarborough Health Network. You know, this was a collaborative -- you know, collaborative daily meetings, support calls. You know, also resource-wise, you know, we went in as soon as we...

MR. CALLAGHAN: Okay. All right. Then the report itself, if we can go back to tab G? And I won't go through the details of it. And in this one, 5 of 9.

If we can go to 5 of 9? Okay. If we can go to the top there?

"As there was an outbreak at

the home, the observations demonstrated that there were inconsistent IPAC practices from the staff of the home and inconsistent supply of PPE outside of the residents home. As a result, the disease spread rapidly throughout the home, and there were a number of resident deaths and also a number of residents who have tested positive for the outbreak, resulting in actual risk to the residents.

The risk associated to staff not adhering to the home's IPAC programs would be possible transmission of infectious agents during the ongoing outbreak in the home.

Severity. There was actual risk of harm to the residents because the home was in outbreak, and there was a potential for possible transmissions of infectious agents due to staff not participating in the implementation of the IPAC program and an inconsistent supply

of PPE outside residents' rooms.

In addition, there were a number of resident deaths and a number of residents who tested positive."

And I believe, if I'm not mistaken, this home rated its IPAC at 5 in the inspection -- in the pre-inspection report.

LEAD COMMISSIONER FRANK MARROCCO: What does 5 mean?

MR. CALLAGHAN: 5 is the highest.

LEAD COMMISSIONER FRANK MARROCCO: Okay.

MR. CALLAGHAN: And just to make sure I'm correct, I don't want misstate this -- just one second.

If we go to tab B and down to page 9?

I apologise. Level 4. So it's level 4. And then they explain -- they give -- unlike some of the others, this home provided comments.

"An ADOC currently serves as IPAC lead, and there is an IPAC team in place. Education on the core competencies of IPAC are provided to all staff."

And it goes on to talk about 60 audits

a year -- or done monthly. 60 audits are done monthly.

"The average compliance rate of January to June is 91 percent."

And it talks about internal IPAC audits. And we heard some evidence about that from some of the other witnesses about how those worked.

But going back, then, to G. If we go -- now, this one, the order is to be complied with as of December 24th, 2020.

MS. JOHNSTON: M-hm.

MR. CALLAGHAN: And when we heard from North York General Hospital, I don't think they had heard from anybody about a follow-up. Has there been a follow-up done?

MS. JOHNSTON: There has, yes. The team went in January 7th for follow-up, and the report is pending.

MR. CALLAGHAN: So why would it take that long? Like, North York -- we heard some, shall we say, exasperation from North York General Hospital, who is in the home or was for a period. I think they're still there. And they can't quite understand why they haven't actually got the feedback from your department. So can you explain

why it is that they don't have it?

MS. JOHNSTON: Sure. So the team went in -- a team of two went in January 7th, and they exited the home January 20th. The team had a follow-up order. They had a number of complaints. They had nine compliant intakes as well as the follow-up and a critical incident inspection to complete at the same time. So the team has exited the home, and -- and they are working on the report.

MR. CALLAGHAN: Okay. Do they sit down and give a debrief?

MS. JOHNSTON: Yes, they would have.

MR. CALLAGHAN: So we're just waiting --

MS. HAVES: So prior -- prior the leaving the home, they would give their initial observations.

And then they leave the home, and then they prepare the report by examining all of the evidence collected. And then they do what you see at the bottom right here. They do the judgment matrix. They evaluate the severity, the scope, the compliance history to determine what level of non-compliance is going to be issued. So it's a

detailed process that the inspector will go through.

MR. CALLAGHAN: So then when can North York General Hospital or the home expect that response? When will that be out?

MS. JOHNSTON: It depends when the inspection report is finalised. So it will be in the next, probably, week or so.

MR. CALLAGHAN: But to be clear, there's been no policy direction to your office that --

MS. JOHNSTON: Yes.

MR. CALLAGHAN: -- inspections related to IPAC and COVID ought to be expedited?

MS. JOHNSTON: Inspection reports must be issued within 20 business days.

MR. CALLAGHAN: Okay. So this is longer than 20 business. This is the follow-up, is it? This is December 24th, and then there is -- I'm just trying to understand. Like, I think Lynne took us through the timelines at the beginning. I'm just asking, they seem to be abiding by whatever the timelines are. I'm not doubting that.

I'm asking whether or not there's been any direction from senior management on a policy

level that, given the outbreak, that when we're dealing with a COVID-related response, that perhaps these reports should be done quicker.

MS. HAVES: No, we have not given that direction.

MR. CALLAGHAN: So if we could then move on to the next home? We'll try to finish as quickly as we can here. This is St. George's.

And if we could pull up Document 5(f), please?

So this is in April of 2020. This is a critical incident report, and it refers to an outbreak.

And if you go to the second page?

And these are notations that start the beginning of May, I think, if I read it correctly at the bottom. May 1st, 2020, and they go to June 15th. And I won't belabour the reading of this. But I take it you never did an inspection, even though there were, I think, as many as 10 team members and 1 resident tested positive in this outbreak. So there was never an inspection? Or would this all have been over the phone, as we discussed earlier?

MR. WISDOM: There -- there was no home

inspections on site, but we were doing the monitoring calls with -- with the homes.

MR. CALLAGHAN: Right.

MR. WISDOM: And also there were staff that were positive, but there were no residents that were positive.

MR. CALLAGHAN: Well, this one says there was one resident.

"Outbreak continues, June 8th. 10 team members and one resident have tested positive."

MR. WISDOM: Okay.

MR. CALLAGHAN: And one resident was isolated, and that isolation was completed. Would it have made a difference if a resident was ill, or would it have still been same process?

MR. WISDOM: No, it would have been the same process.

MR. CALLAGHAN: So then if we can bring up document L?

MR. KAVI: Which one is that one?

MR. CALLAGHAN: Maybe I have the wrong one in hand. My apologies. There's an inspection report July 24th, 2020.

Now, I just bring this up -- and I

won't read any of this out, but, Mr. Wisdom, this is a report dealing with another critical incident. And that's as of July 27th, and it deals with a personal care plan. But I take it -- and I've read others -- your inspectors were called about this home on a number of occasions during this period for various incidents?

MR. WISDOM: What do you mean, called?

MR. CALLAGHAN: Well, here's one where you went in to the inspect -- the inspectors went into the home on July 24th, 2020.

MR. WISDOM: Okay.

MR. CALLAGHAN: And I'm putting to you that whatever was going on in that home was whatever was going on, but you were there focussed on the critical incident that brought you there?

MR. WISDOM: Yes, that's right.

MR. CALLAGHAN: All right. Because I've seen other communications where there were a number of various complaints. And I won't go into them. They're in the file that you have --

MR. WISDOM: Yes.

MR. CALLAGHAN: -- including people not wearing masks when they went to smoke and stuff, things like that. You would get complaints about

that and deal with them. Correct?

MR. WISDOM: Yes. Some of the -- the way that we dealt with that was over the -- the phone with the partners, and the partners and ourselves would be talking about the various IPAC strategies that the home should be implementing. And -- and so in those conversations, those would be brought to the attention of the home, and we would have the discussions around what's happening and what they should be doing. Public Health would be giving their recommendations about the IPAC assessments done at the home as well.

MR. CALLAGHAN: So on that front, would that include UHN?

MR. WISDOM: Yes, UHN was in -- in home as well.

MR. CALLAGHAN: But they were in the home as a result of a later outbreak. Correct?

MR. WISDOM: Yes, as a -- as a result of the outbreak, providing support to the home.

MR. CALLAGHAN: Well, I take it they provided other support, because Dr. Hota specifically told the commission that, "We had encountered throughout this outbreak and even prior to the outbreak some resistance from the local

leadership to implement some of recommendations that we've made." Did you have the same issue in respect of this home?

MR. WISDOM: No. We were not aware they were having issues with implementing recommendations.

So the standard protocol is if the LHIN or the hospital finds that the home is resisting any directions we provided or recommendations -- same for Public Health as well -- that they reach out to the SAO office and speak to the manager. And then the manager would reach out to the home and, if necessary, to the licensee, and they would have a joint conversation about the concern of them not responding to the direction from whatever -- whatever partner, whether it's Public Health or the hospital.

MR. CALLAGHAN: Okay. If we could go to the critical incident report? I have it marked as number 3, which is probably the wrong number, Kavi, of 21st of September 2020. There you go.

So there was another critical incident report. This is in September. And it shows that as many as six team members were positive as of October 13th . Did you do an inspection of the

home at that point?

MR. WISDOM: No. We -- we -- no.

MR. CALLAGHAN: Sorry. I can't hear you, Mr. Wisdom.

MR. WISDOM: I'm sorry. No, we did not go into the home.

MR. CALLAGHAN: And can you tell me why you didn't go to the home at that point?

MR. WISDOM: Certainly. The -- we did not enter the home again, because we had -- we were monitoring the home on a daily basis and speaking to the various partners. And based on what we were hearing, it sounds like the home had the situation under control with the support from partners. And we also had a resource issue as well.

MR. CALLAGHAN: All right. And before we get to the subsequent outbreak, I just want to take you to their preparedness assessment, which is at tab D. And I'm not going to take you through it, but they gave a very detailed one, including at the beginning the UHN hospital partnership and IPAC leadership and consultation. And I've read to you what the review of IPAC said about complying with what was suggested.

But I'm more interested in the form of

this. This form of -- maybe, Lynne, this is a question for you, but this form seems a little bit different than what we saw from others.

And if we can go to page 14? And maybe this is something you haven't -- this is something that -- and maybe this is a rolled-up form from Ontario Health. But under Moderate Risk, and they're talking about IPAC and PPE, particularly PPE. And it says Trigger. And this is for a moderate risk. Improve staff --

You may want to blow that up, Kavi, so people can read it.

"Improve staff understanding and comfort choosing correct PPE. Donning and doffing compliance techniques improving. Auditing results show 50 to 75 percent compliance. Universal masking compliance improving."

I'm kind of struggling with why that would be moderately acceptable, 50 to 75 percent donning and doffing, when we've been told repeatedly these are the things that spread COVID. And improving masking use, it's not a rocket science. But did you have any input as to how this

would be a moderate risk as opposed to a high risk?

MS. HAVES: No. This is an Ontario Health --

MR. CALLAGHAN: Okay.

MS. HAVES: -- trigger.

MR. CALLAGHAN: I just thought I'd ask. I mean, I suppose Ontario Health has an explanation for that.

But if we then go back to Mr. Wisdom? So we then have an outbreak, and this is at tab E. What we have is the heads up for St. George's. And now it may be that we couldn't find it, but was a critical incident report phoned in?

MR. WISDOM: Yes, there -- there would have been one for the November outbreak.

MR. CALLAGHAN: All right. And so that starts -- we have it sort of -- it was being declared on December 4th. Are we talking the same thing, or are we talking an earlier outbreak? They have a --

MR. WISDOM: Yes, there's a --

MR. CALLAGHAN: -- suspected outbreak in November, and if we go back --

MR. WISDOM: These there was a --

MR. CALLAGHAN: -- to November 4th, you

have a declared suspected outbreak. It's declared over the 23rd. So now it's the third outbreak. I take it you didn't go in after this outbreak either. Correct?

MR. WISDOM: Not this one. That's correct.

MR. CALLAGHAN: Then there's another outbreak in December, and it continues on through January. And I take it you didn't go in on that either?

MR. WISDOM: No, we did not.

MR. CALLAGHAN: And is that for the same reasons, staffing reasons?

MR. WISDOM: Yes. That's also -- that's part of it in addition to the fact that we have a good grasp as to what's happening in the home based on the interaction and conversations with the partners.

MR. CALLAGHAN: So that's a confusing answer, because we've just gone through Valerie, who -- they did send people into homes. And there was Lakeridge in one of those homes and there was North York General in another home, And yet they sent people in.

So you took the view that UHN could

handle this inside? Is that the idea? I'm just trying to figure out why this is different.

MR. WISDOM: No, so it's not fundamentally different, because we have the same process where the partners are on the ground. But I think probably the difference is just the resource availability between what Valerie is saying and what we have in Toronto.

MR. CALLAGHAN: So if you had -- so I take it your view is if you had more resources, you ideally would have sent them in. Correct?

MR. WISDOM: Yes. Yes.

MR. CALLAGHAN: Okay. Those will be my questions, I think, commissioners. I apologise. It's taken much longer than I...

LEAD COMMISSIONER FRANK MARROCCO: I don't think we have any further questions. So thank you very much for the presentation, and thank you for answering the questions. And I guess with that, we will conclude for today.

MR. CALLAGHAN: Thank you very much.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thank you. Bye. -- Upon concluding at 12:30 p.m.

REPORTER'S CERTIFICATE

I, Eveliene Symonds, BA, CSR(A), Certified Shorthand Reporter, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

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

I further certify that this questioning was conducted in accordance with the Protocol for Remote Questioning, Revised 05/05/2020.

Dated this 3rd day of February, 2021.

NEESONS COURT REPORTING INC.
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CERTIFIED REAL-TIME REPORTER

C L A R I F I C A T I O N S

Page 8, line 24: "ICS" not "CIS"

Page 8, line 25: "complaints" not "complainant"

Page 39, line 14: "factors" not "tactors"

Page 41, line 11: "CIATT" not "CEAT"

Page 87, line 21: "completed in latter" not "complied in"

WORD INDEX