UNEQUAL OVERSIGHT?

A TALE OF TWO NURSING HOMES

SENIORS FOR SOCIAL ACTION (ONTARIO)

August 24, 2020

UNEQUAL OVERSIGHT?

A TALE OF TWO NURSING HOMES

Misrepresentation by Government: From a Comprehensive to a Complaints/Critical Incident Driven Inspection System

The Ministry of Health and Ministry of Long Term Care's website states that "The Long-Term Care Home Quality Inspection Program (LQIP) safeguards residents' well-being by continuously inspecting complaints and critical incidents, and by ensuring that all Homes are inspected at least once per year."(MOH, MOHLTC, January 15, 2019).

That is not true.

Inspectors do respond to critical incidents when facilities report them. However, as inspection reports show, facilities are cited by inspectors for <u>not</u> reporting to the Director even serious incidents that cause harm to residents (Eg. May 26, 2020 Critical Incident Inspection Report – Orchard Villa – Pg. 10 . http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25326&FacilityID=20100)

Under the Ford government, comprehensive, yearly Resident Quality Inspections (RQI's) have all but been eliminated with only 7 completed in 2019 (Pedersen et al, April 15, 2020).

The Ministries describe RQI's:

"With the implementation of the LTCHA, all LTC Homes are subject to a Resident Quality Inspection (RQI) by LTC Home inspectors. An RQI inspection is a comprehensive, systematic two-stage inspection. During a Comprehensive Inspection, if deficiencies with compliance orders are discovered, a follow-up inspection(s) will be conducted.

The following Inspection Protocols are used in all Home inspections:

- ***Infection prevention and control practices***
- ***Medication***
- ***Residents' Council Interviews***
- ***Family Council Interviews***

The Dining Inspection Protocol is also used in an Intensive Risk Focused RQI".

For all Homes, a standardized sample of residents is randomly selected in advance from a provincial database. The purpose of Stage 1 is to conduct preliminary reviews of the quality of

care and quality of life indicators (QCLIs) of these randomly sampled residents using a structured set of questions. This structured process ensures consistent results that are comparable across inspectors and Homes.

There are two approaches to conducting an RQI. One is an Intensive Risk Focused RQI and the other is a Risk Focused RQI. The main differences between the two types of RQIs are the number of residents randomly selected, the QCLI thresholds, the mandatory Inspection Protocols used and the number of triggered QCLIs.

In an Intensive Risk Focused RQI the random sample of residents is 40 while in a Risk Focused RQI the random sample of residents is 20. The type of RQI is based on the level of risk in the home. Every home must have an Intensive Risk Focused RQI at least once every three years.

The RQI questions cover a wide range of QCLIs. Inspectors collect resident specific information in Stage 1 from observations, interviews (with residents, family, staff), and health records. The frequency of positive and negative responses to such questions as "Do you feel staff treat you with respect and dignity?" is analyzed by comparing them to thresholds shown through research to be predictive of the presence of non-compliance. Through analysis, this enables Inspectors to assess whether deficiencies may be present that warrant inspection in Stage 2.

The extent of an in-depth Stage 2 inspection is based on results of Stage 1 interviews, observations and record reviews. If there are no potential deficiencies from Stage 1, there is no need for the Stage 2 process. Stage 2 is the inspection of the triggered QCLIs from Stage 1. This inspection is conducted by using the corresponding Inspection Protocol and by responding to the relevant questions within the Inspection Protocol(s).

These Inspection Protocols require LTC Home Inspectors to gather the information necessary to determine whether or not standards of care set out in the LTCHA , and its regulations, are in compliance.

Following are some examples of Inspection Protocols which may be triggered:

- *Continence care and bowel management*
- *Dignity, choice and privacy*
- *Falls prevention*
- *Minimizing restraint*
- *Nutrition and hydration*
- *Pain management*
- *Personal support services*
- *Recreational and social activities*
- *Responsive behaviours*
- *Safe and secure home*
- *Skin and wound*

Findings of non-compliance are documented within the inspection report. Inspectors have a duty under the LTCHA to identify in an Inspection Report all non-compliances found during the course of an inspection." (MOH, MOHLTC, January 15, 2019).

With yearly comprehensive inspections all but eliminated, none of the activities detailed here is actually happening anymore in most facilities, even during and after the enormous impact of the pandemic.

The only things that appear to trigger an inspection now is if someone files a complaint, or the home reports a critical incident to the Director, in which case an inspection will occur, narrowly focused on that complaint or critical incident.

Misrepresentation of Effectiveness

Both Ministries say that the role of the Inspection Branch is to protect the 78,500 residents of long term care facilities, to safeguard their rights, safety, security and quality of life. The Branch's role is to also ensure their compliance with the Long Term Care Home Act and Regulations.

In reality, it meets none of these objectives with facilities reporting the same or similar breaches of the Act and Regulations year after year and no effective actions such as license revocation taken by the Branch. An examination of inspection reports of almost any facility in Ontario, but especially Orchard Villa, will reveal repeated violations of the same sections of the Act and Regulations.

Very few admissions are stopped. No licenses have been revoked. There has been no non-renewal of licenses. And the Act does not give the Inspection Branch the authority to levy fines against facilities that are repeat offenders (Source: Legislative Research).

Are Inspections Really Unannounced?

The claim is that inspections are unannounced, except that facilities can expect inspectors if Critical Incident reports are filed. They could previously expect yearly Resident Quality inspections[1] at around the same time of year every year even though the Ministries claim that "the inspection schedule is randomized and prioritized based on risk." (MOH, MOHLTC, January 15, 2019).

[1] Health Minister Deb Matthews referred to these RQI inspections as "unannounced" in 2013. These are the unannounced inspections that have now all but been eliminated by the Ford government. https://toronto.ctvnews.ca/more/local-news/ontario-commits-to-more-unannounced-inspections-of-nursing-homes-1.1319194

There are also exceptions to inspections being unannounced as set out in Section 298 of Ontario Regulation 79/10 of the Long Term Care Homes Act

Is There Public Accountability?

The Ministries claim that all findings of non-compliance must be publicly posted in the facilities and provided to Residents' and Family Councils and also published on the Ministry's website. Yet Director's Referrals are not generally posted so that the public can determine the reason for the Director's Referral by an inspector.

EQUAL APPLICATION OF INSPECTION PROTOCOLS AND ACTIONS: A TALE OF TWO FACILITIES

The criteria for when Director's Referrals are issued and when they are not also appears not to be clear <u>in practice,</u> or evenly applied across the system, as this comparison of two facilities will outline.

The Act states:

299. (1) For the purposes of sections 152 to 156 of the Act, in determining what actions to take or orders to make where there has been a finding of non-compliance with a requirement under the Act, an inspector or Director shall take all of the following factors into account, and shall take only those factors into account:

1. The severity of the non-compliance and, in cases where there has been harm or the risk of harm to one or more residents arising from the non-compliance, the severity of the harm or risk of harm.

2. The scope of the non-compliance and, in cases where there has been harm or risk of harm arising from the non-compliance, the scope of the harm or risk of harm.

3. The licensee's history of compliance, in any home, with requirements under the Act and with requirements under the Nursing Homes Act, the Charitable Institutions Act or the Homes for the Aged and Rest Homes Act, the regulations under those Acts and any service agreement required by any of those Acts. O. Reg. 79/10, s. 299 (1).

(2) In determining whether to make an order under section 157 of the Act, the Director may take into account,

(a) the factors referred to in subsection (1), where applicable; and

(b) any other factors the Director considers relevant. O. Reg. 79/10, s. 299 (2).

(3) In this section, "scope" means pervasiveness throughout the home. O. Reg. 79/10, s. 299 (3).

So severity is assessed to the degree that it causes harm to a resident, the scope of the non-compliance is considered - presumably how prevalent the problem is, how often, in the past, the facility has been out of compliance, and any other factor the Director considers relevant – giving the Director wide discretionary authority.

ORCHARD VILLA (OV)

Orchard Villa, owned by Southbridge Homes, but managed by Extendicare Assist has had a long history of serious care, health and safety, and residents' rights issues. In some cases unwitnessed falls resulting in serious injury have occurred and there have sometimes been significant delays in providing assistance to injured residents who have fallen or transporting them to hospital. This has been a problem irrespective of the cause of the injury - medication errors, serious deterioration in someone's condition, and most recently during the pandemic severe dehydration and malnutrition during the pandemic. Families were reporting that Orchard Villa was discouraging them from having their families transported to hospital (Pedersen et al, June 17, 2020).

An examination of the last 5 years of Orchard Villa's inspection history tells the story:

(OV) History of Non-Compliance, Complaints, Critical Incidents

From July 2010 to approximately late June, 2015 when Southbridge took over ownership of Orchard Villa, there had been a total of:

- 12 Critical Incident Inspections – 2 with Orders
- 17 Complaint related Inspections – 2 with Orders
- 2 Resident Quality Inspections – 1 with Orders
- 2 Follow-up Inspections

From July, 2015 to July 2020 after Southbridge had taken over ownership of Orchard Villa, there were a total of:

- 9 Critical Incident Inspections – 4 with Orders
- 14 Complaint related inspections – 1 with Orders
- 4 Resident Quality inspections – all with Orders
- 9 Follow-up Inspections – 5 with Orders

So twice as many Orders issued by the Inspection Branch from July 2015 to July 2020 than the five years earlier. Some of the Inspections with Orders are worthy of note for their seriousness.

Shortly after Southbridge took over a July 30, 2015 report of an Inspection that had occurred on June 9 – 11th, 2015 stated:

"Resident #01 had an unwitnessed fall on a specific date and at a specific time; Resident #01 was found on the floor in a pool of blood, with blood noted to extremities, night gown and the bedside drapes. The CIR, resident incident report and progress notes all indicated resident sustained substantial injuries, as a result of the fall." The R.N. on duty did not assess the resident's injuries after the fall before bandages were applied. The R.P.N. had tried communicating with the R.N. supervisor that she had changed the resident's bandages twice since the original dressing was applied because they had been saturated with blood. The R.P.N. wanted the resident transferred to hospital because of significant blood loss, but the R.N. directed her to just keep monitoring the resident – a directive with which the R.P.N. disagreed. The matter was not brought to the Director of Care. No one notified the physician and it took 7 hours for the resident to finally be transferred to hospital.(Pgs. 4 & 5 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=14003&FacilityID=20100)

On the face of it this incident seems serious enough that not only should the Director have been notified immediately, but the resident should have been transferred to hospital immediately, a Director's Referral should have been made, and the police called – none of which occurred.

On September 28, 2015 another Critical Incident Inspection occurred, this one dealing with staff to resident abuse – "the day before the allegation was made, staff had reported a large injury was noted to a specified area on the resident of unknown cause. No internal incident report was completed and there was no indication of an investigation to determine the cause of that injury" (Pg. 7 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=13712&FacilityID=20100) 11 WN's, 2 CO's.

On April 19, 2016 a Resident Quality Inspection was completed. Compliance order issued for failure to report abuse – financial, incompetent care resulting in injury, injuries resulting in significant change to resident's health status, hospitalization for 12 days, resident left lying in pain, resident dying after receiving injuries during a transfer incident etc. In other words, extremely serious non-compliances apparently resulting in considerable harm and death. 19 WN's, 5 VPC's, 5 CO's http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=15133&FacilityID=20100

A couple of months later in June, 2016 4 more WN's and 2 CO's again because of failure to use fall prevention measures, medication errors etc. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=15657&FacilityID=20100

By September, 2016 inspectors were issuing 15 WN's, 7 VPC's, 3 CO's and finally 1 Director's Referral the contents of which were not posted publicly. Again, residents injured while staff

gave care, care plans not followed, resident left on toilet, not fed etc
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=16083&FacilityID=20100

By November the facility was till out of compliance.

In February 2017 with the facility still out of compliance, another Director's referral was issued. Medication errors still occurring.

In May, 2017, things appear to have gotten worse, with inspectors this time issuing 23 WN's, 7 VPC, 3 CO's during a Resident Quality Inspection. Staff to resident verbal and physical abuse, dietary issues, "Resident #010 reported the previous evening, two staff were rough when providing care and resulted in pain. The resident also indicated that PSW #139 and PSW #149 also made inappropriate comments towards the resident regarding personal care." (Pg. 12 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=17740&FacilityID=20100) unsanitary conditions, dietary issues, shortages of towels and other linens etc. this report went on for 102 pages.

By March 2018, inspectors issued 6 WN's, 3 VPC's and another CO during a Resident Quality Inspection. Medication errors, skin and wound care inadequate, failure to report a critical incident to the Director after another resident fell and sustained an injury.
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=19481&FacilityID=20100

By July 2019 the facility was still out of compliance – during a Critical Incident Inspection inspectors issued 3 WN's, 3VPC's, and 1 CO. Residents were still falling sustaining injuries, not transferred to hospital as appropriate, and their pain was not being adequately managed. Physician not informed again and safe transferring methods were still not being used.
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=22869&FacilityID=20100

By December 2019 the facility remained out of compliance. During a Critical Incident inspection 4 WN's, 2 VPC's and 1 CO were issued for failure to protect residents from abuse, fall resulting in injury, care plans not devised or followed, falls prevention not instituted.
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=24062&FacilityID=20100

In March and April the pandemic hit this facility and the infection and death toll rose sharply. The Durham Region Medical Office of Health ordered Lakeridge Health teams in and the Canadian Military also went in, later writing a devastating indictment of what they had found in this facility.

Nevertheless by May 26, 2020 when a Critical Incident Inspection that had been conducted in February and March was finally filed, there were 4 WN's and 3 VPC's for problems with wound care, failure to report an allegation of abuse and improper care were reported to the Director,

and failure to appropriately document a resident's response to medication. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25326&FacilityID=20100

By July, 2020 fall prevention and appropriate care planning and follow up were still not occurring based on May and June 2020 inspections. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25687&FacilityID=20100

By the end of July 2020, the last inspection report filed, inspectors had cited the facility for 13 WN's, 9 VPC's and 2 CO's for care not being adequately provided, lifts not being in proper working condition or cleaned, falls prevention and management was still not occurring, falls involving injury were still not being appropriately addressed – "The licensee has failed to ensure that when resident #010 had fallen, a post-fall assessment was conducted using a clinically appropriate instrument specifically designed for falls.A CIR was submitted to the Director, regarding a fall incident involving resident #010. The CIR indicated the resident was transferred to hospital and was diagnosed with an injury" Pg 13 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25688&FacilityID=20100 skin and wound care and pain management were still not adequate, there were dietary issues, medication errors and most incredibly, an Assistant Deputy Minister's memo requiring all long term care facilities to ensure that any new staff hired were appropriately trained, was not being followed. ***"1. The licensee failed to ensure that all staff have received training within one week of hire.On March 20, 2020, the Assistant Deputy Minister, Long-Term Care Operations Division of the Ministry of Long-Term Care, issued a memorandum to the sector specific to Amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007related to the COVID-19 Pandemic. The memorandum and directed the following specific to training: 3. Prioritize the timing of specific training requirements such as Abuse, Infection prevention and Control ensuring those requirements are completed as soon as possible. Training must be provided within one week of the staff member beginning to perform their responsibilities on the following specific topics:- The Residents¶————————————Bill of Rights.- The long-term care home¶s policy to promote zero tolerance of abuse and neglect of residents.- The duty under section 24 of the Long-Term Care Homes Act, 2007 to make mandatory reports.- Fire prevention and safety.- Emergency and evacuation procedures.- Infection prevention and control.All other required training must be provided within three months of the staff member beginning to perform their responsibilities.During separate interviews, PSW #159, #162, #116, RPN #110 and RPN #147 confirmed that they had no training provided at the LTCH on the above mentioned topics. PSW #116, RPN #110 and RPN #147 indicated they had training on donning and doffing of PPEs and hand hygiene."*** Pg. 21 http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25688&FacilityID=20100

The same report indicated **that staff were not following adequate infection control procedures almost 5 months after the start of the pandemic.**

Nevertheless, OV retains its license, never had its admissions stopped, has presumably had its license renewed, and was never subject to a Director's Referral during the Ford government's tenure, or a Director's Order in spite of inspectors citing serious non-compliances resulting in harm to residents over the past two years and before. The Inspection Branch, no doubt having seen repeated press reports on conditions in this facility and the military report, and continuing non-compliance with the Act and Regulations has not even ceased admissions there.

TSIIONKWANONHSOTE ADULT CARE HOME, OPERATED BY THE MOHAWK COUNCIL, AKWESASNE

The issues in this facility pale in comparison to the Orchard Villa inspection history.

In 2011 and 2012 a total of 4 WN's were issued in this facility for the two years involving written care plans not always adequately followed and staff not always collaborating, wound care not adequately done and the director not notified of a critical incident where a resident wandered away from the facility, and the Director was not informed of a bruise to a resident and their subsequent transfer to hospital and a lap belt was improperly used with staff not recognizing that a lap seat belt was a restraint. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=5871&FacilityID=20508

In 2013 a total of 2 written notices were issued by inspectors – one that an injury to a resident was not reported to the Director, and another where furnishings and equipment were not in a good state of repair. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=7551&FacilityID=20508

In 2014 a total of:

16 WN's 3 CO's – doors not locked, R.N. not always on duty, no written staffing plan resulting in short staffing and care plans not always followed, dietary and toileting issues, windows not all screened, doctor's order for bed rail not provided, residents not always safely positioned to eat, staff training to minimize restraints not done, PSW applying a topical cream without training, infection control manual not up to date, residents not always screened for TB, furnishings not always in a good state of repair, personal items not always labelled, some walls dirty, resident information package missing some items, hazardous substances not always kept secure http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=10379&FacilityID=20508

By November, 2015 Resident Quality Inspection, a total of:

22 WN's, 8 VPC's, 1 CO http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=14262&FacilityID=20508

Medication errors (ran out of pain medication for resident), doors not always locked, call bells not always easily accessed in residents' gathering areas, some dietary issues and unsafe positioning when feeding, staff not trained in zero tolerance of abuse and neglect, residents restrained, staff did not take part in infection control training, personal health information not kept confidential, abuse policy does not include duty to report, windows not always screened, wound care not always adequate, Resident's Council does not always receive a timely response and admin does not always consult with Council, not all staff have post-secondary education, satisfaction survey not done yearly,

In 2016 there was 1 Resident Quality Inspection and 2 Follow-Up inspection that resulted in a total of 21 Written Notices, 7 VPC's and 5 CO's involving medication errors and storage, the DON and Administrator not always working required hours, dietary issue.

In 2017 there was only 1 Resident Quality Inspection resulting in 13 WN's and 5 VPC's dealing with use of restraints, communications with the Resident's Council, quality improvement system not written down although DOC mentioned a satisfaction survey, a fall and skin committee and the purchase of new mechanical lifts , medication errors, safety risk – wheelchair in disrepair, safe transfer issues, dietary issues, monitoring of adverse drug reactions - http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=18799&FacilityID=20508

In 2018 things changed. There was one Critical Incident Inspection with Orders under the Liberals – (2WN's, 1VPC, 1 CO) dealing with failure to deal adequately with responsive behaviors, failure to report a fire, unexpected death, a missing resident, a communicable disease outbreak, contamination of drinking water.

After the election of the Ford government in 2018 there were 1 Complaints Inspection with Orders and 1 Resident Quality Inspection with Orders resulting in a combination of 29 WN's, 18 VPC's and 6 CO's – several dealt with failure to protect a resident from abuse, update the abuse policy, and police not called when a staff member was rough with a resident causing injury. Also included was the DON not working expected number of hours, concern about bed rail entrapment, staffing concerns, staff not being trained in zero tolerance of abuse, wound care and skin assessment, care plans providing clear direction to staff, bathing needs not met, dietary issues and weight monitoring, not promoting Resident's Council, inappropriate medication administration, infect wounds due to lack of infection control, power outages without required evacuation plan, failure to address urine odour.
http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=19607&FacilityID=20508

And http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=20508&FacilityID=20508

In 2019 there was 1 Resident Quality Inspection and 2 Follow-up Inspections. There were no Complaint or Critical Incident inspections. However in these 3 inspections, inspectors cited this facility for a combination of 30 WN's, 20 VPC's, 7 CO's and 3 Director's Referrals. The RQI report was 105 pages covering largely a repeat of the previous year – abuse/neglect and failure to report, bed rail issues, staffing problems, wound care and skin breakdown, plan of care not providing clear direction to staff etc. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=21330&FacilityID=20508 and http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=23357&FacilityID=20508 and http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=23358&FacilityID=20508

In 2020 there were again no Complaint Investigations, No Critical Incident Investigations, only a Follow-up Inspection and an Other Inspection with Orders with 10 WN's, 1 VPC and 5 CO's. http://publicreporting.ltchomes.net/en-ca/File.aspx?RecID=25474&FacilityID=20508

These were for dietary issues, wound care, and failure to conduct a satisfaction survey.

A Tale of Two Facilities

If Complaint and Critical Incidents are the intended trigger for inspections, then the inspection reports for this facility are puzzling.

TSIIONKWANONHSOTE ADULT CARE HOME

In 2011 there was 1 Critical Incident Inspection.

In 2012 there was 1 Complaints inspection

In 2013 there was 1 Complaints and 1 Critical Incident inspection

In 2014 there were 2 Complaints Inspections and 1 Resident Quality Inspection with Orders.

In 2015 there was 1 Complaints Inspection, 1 Resident Quality Inspection with Orders and 1 Follow-up Inspection

In 2016 there were zero Complaints or Critical Incident inspections, 1 Resident Quality Inspection and 2 Follow-Up Inspections both with Orders.

In 2017 there were again zero Complaints or Critical Incident inspections, and 1 Resident Quality Inspection.

In 2018 there were 1 Complaints Inspection, 1 Critical Incident Inspection and 1 Resident Quality Inspection – all with Orders.

In 2019 there were again zero Complaint or Critical Incident Inspections, 1 Resident Quality Inspection and 2 Follow-Up Inspections – all with Orders.

In 2020 there were again zero Complaint or Critical Incident inspections, 1 Follow-up Inspection and 1 Other Inspection with Orders.

TOTAL 21 Inspections of all kinds from 2011 to 2020. In 2019 there were 3 Director's Referrals issued.

ORCHARD VILLA

Since Southbridge's takeover of Orchard Villa there have been:

2016 – 4 Complaints Inspections; 2 Resident Quality Inspections with Orders; 2 Follow-up Inspections with Orders.

2017 – 2 Complaints Inspections – 1 with Orders; 2 Critical Incident Inspections; 5 Follow-Up Inspections – 2 with Orders; 1 Resident Quality Inspection with Orders.

2018 – 4 Complaints Inspections, 1 Resident Quality Inspection, 1 Follow-Up Inspection

2019 – 2 Complaints Inspections, 3 Critical Incident Inspections – 2 with Orders, 1 Follow-Up Inspection with Orders.

2020 – 2 Complaints Inspections, 2 Critical Incident Inspections.

Last RQI was in 2017.

TOTAL 34 inspections of all kinds from 2016 to 2020. 1 Director's Referral that resulted in a Director's Order issued under the previous Liberal government in 2017.

ANALYSIS:

ORCHARD VILLA is not one of the facilities listed as having had a Director's Referral since the Ford government came into office in spite of it having the highest death rate in the province during the pandemic, having had both a Lakeridge Health team and the Military ordered in.

TSIIONKWANONHSOTE ADULT CARE HOME has had 3 Director's Referrals with far fewer Critical Incident or Complaints investigations. The last 5 inspections in this facility were all government initiated. This facility did not have a high death rate during COVID nor were a hospital management team or the military sent in.

Akwesasne reserve is surrounded on all sides by COVID hot spots with Ontario and Quebece having had the highest number of cases throughout the pandemic – about 41,000+ cases in

Ontario and over 60,000 in Quebec accounting for 85% of all cases in Canada. In the U.S. New York was the epicentre of the pandemic and had the third highest number of confirmed cases at over 418,000 – 10% of the cases in America. This necessitated Akwesasne protecting itself by imposing its own quarantine requirements – an approach that worked with only about 12 cases occurring in the community (Gunnarsson, 2020). In early May, the Mohawk Council of Akwesasne's Department of Health which manages both Tsiionkwanonhso:te Long Term Care Facility and Iakhihsohtha Lodge said in a message to its community that COVID 19 protocols were in place in each facility, that it was requesting an additional 190 test kits from the Eastern Ontario Health Unit to ensure full implementation of the MOLTC directive and that all staff had personal protective equipment (masks, gowns, gloves) and isolation protocols in place if a resident tested positive (Mohawk Council of Akwesasne, May 7, 2020).

At about the same time families of residents in Orchard Villa were accusing the facility of what amounted to criminal neglect in a letter addressed to Durham Regional Police Chief, Paul Martin signed by 41 families.(Roca, May 19, 2020). A week later the devastating military report was released and conditions at Orchard Villa were detailed in it (TVO, May 26, 2020).

In sharp contrast to the Akwesasne facility where the Mohawk Council had reassured the community that all staff had adequate PPE, families were alleging in a 40 million dollar class action lawsuit against Orchard Villa that residents were being infected after being "attended to by staff who had improper or inadequate personal protective equipment, which had been contaminated by repeated usage" (Mandel, May 27, 2020).

Irrespective of all of this, under the Ford government, Orchard Villa was never subject to a Director's Referral much less a Director's Order, but the Tsiionkwnonhsote Adult Care Home in Akwesasne was subjected to 3 Director's Referrals.

No facility should have the substandard conditions detailed in hundreds of inspection reports. Inspectors have an important job to do in protecting residents from substandard care and conditions however it is also critical that inspectors do their jobs in a way that is seen to afford facilities equal treatment. For there not to have been significant consequences such as ceasing admissions, Director's referrals and orders, and license revocation in a facility with the kind of documented life-threatening conditions reported by the military and families of Orchard Villa residents is inconceivable.

It raises an important question – why were 3 Director's referrals levied against a facility in Mohawk territory but not levied against a corporate facility in Pickering Ontario with what would seem to be a much worse track record?

REFERENCES

Gunnarsson, M. (2020). What happens to a community divided by an international border when the border closes? McGill Blogs. https://blogs.mcgill.ca/humanrightsinterns/tag/akwesasne/

Mandel, M. May 27, 2020. MANDEL: Proposed $40 million class action lawsuit filed against Orchard Villa owners. https://torontosun.com/news/local-news/mandel-proposed-40-million-class-action-lawsuit-filed-against-orchard-villa-owners

Mohawk Council of Akwesasne. (May 7, 2020). MCA long term care facility testing protocols. http://www.akwesasne.ca/mca-long-term-care-facility-testing-protocols/

Pedersen, K, Mancini, M., Common, D. (April 15, 2020). Ontario scaled back comprehensive annual inspections of nursing homes to only a handful last year. https://www.cbc.ca/news/canada/seniors-homes-inspections-1.5532585

Pedersen, K., Mancini, M., Common, D. (June 17, 2020). Nursing home told families hospital wouldn't accept sick residents during pandemic. That wasn't true. https://www.cbc.ca/news/canada/toronto/orchard-villa-families-hospital-pandemic-1.5614511

Roca, R. (May 19, 2020). Coronavirus: Families allege neglect at Pickering Ontario care home where 70 died, call for police investigation. https://globalnews.ca/news/6960274/coronavirus-orchard-villa-families-letter/

TVO. (May 26, 2020). COVID-19: Read the Canadian Forces report on long term care. https://www.tvo.org/article/covid-19-read-the-canadian-forces-report-on-long-article-care