Lessons for the Long Term
Facts and Highlights

Investigation into the Ministry of Long-Term Care's oversight of long-term care homes through inspection and enforcement during the COVID-19 pandemic

Ombudsman's investigation

- Number of recommendations: **76** (see full list after **para 571)**
  - All recommendations have been accepted
- Total cases (complaints and inquiries) received: **269 (para 54)**
  - Complaints and inquiries came from long-term care residents, their families, staff, family councils and other stakeholders.

Key figures (for dates, see **Chronology, Appendix A,** after **para 574)**

- Long-term care homes in Ontario: **600+**
- Number of resident beds: **80,000**
- Deaths in Ontario long-term care homes, March 2020-April 2022: **4,335** residents and **13** staff
- Number of weeks inspections ceased: **7** (March 13, 2020 to May 8-20; dates for resuming inspections varied by region – **para 144**)
- COVID-related long-term care deaths during this period: **720** (**para 142**)

Ombudsman's findings:

During the first wave of COVID-19, the Ministry of Long-Term Care:

- Had no plan for how inspections would work during a pandemic, and did not provide inspectors with the necessary training and equipment.
- Did no inspections of long-term care homes for seven weeks (in Hamilton, no inspectors were in the field for three months – **para 145**).
- Assigned inspectors to "support and monitor" long-term care homes during this period, causing confusion for callers and long-term care homes alike.
- Failed to assess COVID-related complaints as "high risk." Inspectors closed many serious-sounding files without taking any action.
- Rarely ordered homes to fix problems immediately, even where residents were at risk of serious harm.
- Sometimes took a narrow view of what inspectors could inspect, meaning it didn't act on issues that left residents in danger.

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- Often took low-level enforcement action against homes for issues that presented a serious risk of harm to residents, and often didn't follow up to ensure problems were fixed.
- Allowed inspectors to choose a lower-level enforcement action than recommended by the Ministry's decision-making grid, even for homes that had recurring issues.
- Stopped issuing inspection reports for more than two months, effectively pausing all enforcement action.

Ombudsman's key recommendations (see full list after **para 571**)

The Ministry of Long-Term Care should:

- Ensure it always has inspectors available to inspect on-site at long-term care homes.
- Clarify when its inspectors will generally inspect on-site versus off-site during any future pandemic or other type of emergency.
- Ensure it briefs its inspectors on emerging threats (like a new virus), and provides guidance to the inspectors on the risk the new threat poses to long-term care residents.
- Ensure it inspects any complaint that alleges a resident is at significant risk of harm, instead of conducting "inquiries."
- Take a broad approach to its mandate – meaning it can inspect anything that leaves long-term care residents unsafe.
- Issue immediate compliance orders for situations where residents are at an ongoing risk of serious harm.
- Ensure that any third-parties supporting or managing long-term care homes know they must report serious concerns to the Ministry immediately, by law.

The government should:

- Work with the Ministry to ensure there are sufficient inspectors and other necessary staff to fulfill the Inspection Branch's mandate.
- Revise the whistleblowing protections in the legislation to ensure complainants are protected when they raise concerns.

Selected stories

- **Examples of Ministry handling of complaints**
    - "Gemma" (Mon Sheong, Toronto) complained to the Ministry after her mother died of COVID in the home and her father contracted the virus there. She said there was a staff shortage and residents were not

being cleaned, fed or given medication. An inspector gave her general information and closed the file **(paras 250-251).**

- "Peter" (Altamont Care Community, Scarborough) complained three times about the lack of COVID infection control and his mother's worsening condition at the home – and again after she died. An inspection was not done for six months **(paras 252-264).**
- "Raheem" (Altamont Care Community, Scarborough) complained three times about the home's lack of COVID infection control putting both his parents at risk. His father died and his mother was hospitalized. The Ministry ultimately inspected the home but took more than two months to issue an inspection report **(paras 278-285).**
- "Soren" (Extendicare Guildwood, Scarborough) complained three times about a lack of COVID infection control and 20 deaths in 10 days at the home, where his father lived. An inspector called him more than two weeks after his first complaint, read him some "key messages," and closed the file **(paras 299-305)**

- **Examples of serious lack of enforcement/penalties at specific homes**
  - Altamont Care Community, Scarborough – **paras 424-429, and 482-493**
  - Midland Gardens, Scarborough – **paras 469-481**
  - Pinecrest Nusing Home, Bobcaygeon – **paras 494-500**