Court File No.: CV-20-00640016-00CP

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

WILLIAM BROUGH by his estate representative DARREN BROUGH, MAURICE ALBERT ORCHARD by his estate representative CHRISTINA KINDER, GASTON SCHWALB by his estate representative KIM KOBLINSKY, RUBY ANNIE MCCARROL by her estate executor MICHAEL MCCARROLL, ANNETTE DERY by her estate executor ELIE DERY, WILLIAM VAN DYKE by his estate executor TERENCE VAN DYKE, BEATRICE GRACE GENDRON by her estate executrix JACQUELINE AMABLE, MARIE BEDARD by her estate executrix ANGIE THORN, DARREN BROUGH, CHRISTINA KINDER, KIM KOBLINSKY, MICHAEL MCCARROLL, ELIE DERY, TERENCE VAN DYKE, JACQUELINE AMABLE and ANGIE THORN,

Plaintiffs

-and-

RESPONSIVE GROUP INC., RESPONSIVE MANAGEMENT INC., RESPONSIVE MANAGEMENT SERVICES INC., RESPONSIVE HEALTH MANAGEMENT INC., RYKKA CARE CENTRES LP, RYKKA CARE CENTRES GP INC., RYKKA CARE CENTRES II GP INC., RESPONSIVE MANAGEMENT II INC., RESPONSIVE HEALTH MENTORS LTD., VERMONT SQUARE LTC LP by its general partner VERMONT SQUARE LTC INC., COOKSVILLE CARE CENTRES FACILITY INC., EATONVILLE CARE CENTRE FACILITY INC., ANSON PLACE CARE CENTRE FACILITY INC., 914 BATHURST GP INC., SHARON FARMS & ENTERPRISES LTD., HAWTHORNE CARE FACILITY INC, DTOC II LONG TERM CARE LP by its general partner DTOC II LONG TERM CARE MGP (a general partnership, by its partners DTOC LONG TERM CARE GP INC. and ARCH VENTURE HOLDINGS INC.), INA GRAFTON GAGE HOME OF TORONTO and 848357 ONTARIO INC.

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Defendants

Proceeding under the *Class Proceedings Act, 1992*

AMENDED CONSOLIDATED STATEMENT OF CLAIM

TO THE DEFENDANTS:

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the Plaintiffs. The claim made against you is set out in the following pages.

IF YOU WISH TO DEFEND THIS PROCEEDING, you or an Ontario lawyer acting for you must prepare a Statement of Defence in Form 18A prescribed by the Rules of Civil Procedure, serve it on the Plaintiff's lawyer or, where the Plaintiff does not have a lawyer, serve it on the Plaintiff, and file it, with proof of service, in this court office, WITHIN TWENTY DAYS after this Statement of Claim is served on you, if you are served in Ontario

If you are served in another province or territory of Canada or in the United States of America, the period for serving and filing your Statement of Defence is forty days. If you are served outside Canada and the United States of America, the period is sixty days.

Instead of serving and filing a Statement of Defence, you may serve and file a Notice of Intent to Defend in Form 18B prescribed by the Rules of Civil Procedure. This will entitle you to ten more days within which to serve and file your Statement of Defence.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

TAKE NOTICE: THIS ACTION WILL AUTOMATICALLY BE DISMISSED if it has not been set down for trial or terminated by any means within five years after the action was commenced unless otherwise ordered by the court.

Date _____ Issued by _____
Local Registrar

Address of Court Office:
Ontario Superior Court of Justice
393 University Avenue
Toronto, Ontario M5G 1E6

TO: RESPONSIVE GROUP INC.
3760 14th Avenue, Suite 402
Markham, ON L3R 3T7
Canada

AND TO: RESPONSIVE MANAGEMENT INC.
3760 14th Avenue, Suite 402
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AND TO: RESPONSIVE HEALTH MANAGEMENT INC.
429 Walmer Road
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AND TO: RESPONSIVE MANAGEMENT SERVICES INC.
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AND TO: RYKKA CARE CENTRE LP
3760 14th Avenue, Suite 402
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AND TO: RESPONSIVE HEALTH MENTORS LTD.
429 Walmer Road
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AND TO: VERMONT SQUARE LTC INC.
c/o All Seniors Care Living Centres
175 Bloor Street East, Suite 601
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AND TO: VERMONT SQUARE LC LP
c/o All Seniors Care Living Centres
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AND TO: COOKSVILLE CARE CENTRES FACILITY INC.
55 The Queensway West
Mississauga, ON L5B 1B5
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AND TO: EATONVILLE CARE CENTRE FACILITY INC.
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AND TO: ANSON PLACE CARE CENTRE FACILITY INC.
85 Main Street North
Hagersville, ON N0A 1H0
Canada

AND TO: 914 BATHURST GP INC.
914 Bathurst Street
Toronto, ON M5R 3G5
Canada

AND TO: SHARON FARMS & ENTERPRISES LTD.
108 Jensen Road
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Canada

AND TO: HAWTHORNE CARE FACILITY INC.
2045 Finch Avenue West
North York, ON M3N 1M9
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AND TO: RYKKA CARE CENTRES GP INC.
370-14th Avenue, Suite 402
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AND TO: RYKKA CARE CENTRES II GP
490 Hwy. #8
Stoney Creek, ON L8G 1G6
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AND TO: RESPONSIVE MANAGEMENT II INC.
429 Walmer Road
Toronto, ON M5P 2X9
Canada

AND TO: DTOC II LONG TERM CARE LP
TD Canada Trust Tower
161 Bay Street, Suite 2100
Toronto, ON M5J 2S1
Canada

AND TO: INA GRAFTON GAGE HOME
40 Bell Estate Road
Scarborough, ON M1L 0E2
Canada

AND TO: 848357 ONTARIO INC.
33 Christie Street
Toronto ON M6G 3B1
Canada

I. CLAIM

1. The Plaintiffs, on their own behalf, and on behalf of the members of the Classes of persons described at paragraph 2, claim:

i) an order certifying this action as a class proceeding and appointing the named Plaintiffs as Representative Plaintiffs;

ii) a declaration that the Defendants were grossly negligent or negligent in exposing the Plaintiffs, the Resident Class Members and the Visitor Class Members to an unreasonable risk of contracting COVID-19;

iii) a declaration that the Defendants breached their fiduciary duties to the Plaintiffs and the Resident Class Members;

iv) a declaration that the Defendants violated the Resident Class Members' and Visitor Class Members' rights under section 7 of the *Canadian Charter of Rights and Freedoms* by their adoption of delayed, arbitrary, *ad hoc*, and grossly inadequate measures in response to the COVID-19 pandemic;

v) a declaration that the Defendants violated the Resident Class Members' rights under the *Human Rights Code*;

vi) a declaration that the Defendants are in breach of the *Occupiers' Liability Act*;

vii) a declaration the Defendants are in breach of contract/warranty by failing to provide Resident Class Members with the promised level of service;

viii) a declaration that the Defendants have been unjustly enriched at the expense of the Class Members;

ix) general damages in the amount of $100,000,000.00, or such other amount as may be proven in this Honourable Court, on an aggregate basis;

x) special damages in an amount to be determined;

xi) aggravated, punitive and/or exemplary damages in the amount of $10,000,000.00;

xii) damages or such other remedy as this Honourable Court may consider just and appropriate pursuant to section 24 (1) of the *Canadian Charter of Rights and Freedoms*;

xiii) a reference or such other directions as may be necessary to determine issues not determined at the trial of the common issues;

xiv) prejudgment interest on the damages in accordance with the provisions of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, as amended;

xv) the costs of this action on a substantial indemnity basis;

xvi) the costs of notice and administering the plan of distribution of the recovery of this Action, plus applicable taxes; and

xvii) such further and other relief as this Honourable Court may deem just.

2. In this Claim, the following capitalized terms have the following meaning:

a) "**CAF**" means the Canadian Armed Forces;

b) "***Charter***" means the *Canadian Charter of Rights and Freedoms*;

c) "**Classes**" and "**Class Members**" mean, collectively, members of the Resident Class, the Visitor Class and the Family Class;

d) "**Defendants**" means Responsive Group Inc., Responsive Management Inc., Responsive Health Management Inc., Responsive Management Services Inc., Rykka Care Centre LP, Rykka Care Centres GP Inc., Rykka Care Centres II GP Inc., Rykka Care Centres GP, Responsive Management II Inc., Responsive Health Mentors Ltd., Vermont Square LTC LP, Cooksville Care Centres Facility Inc., Eatonville Care Cente Facility Inc., Anson Place Care Centre Facility Inc., 914 Bathurst GP Inc., Sharon Farms & Enterprises Ltd., Hawthorne Care Facility Inc., DTOC II Long Term Care LP by its general partner, DTOC II Long Term Care MGP (a general partnership, by its general partners, DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc.), Ina Grafton Gage Home of Toronto and 848357 Ontario Inc.

e) "**Family Class**" and "**Family Class Members**" mean all persons including, but not limited to, spouses, children, parents, and other relatives who, on account of a personal relationship to any one or more Resident Class Members and Visitor Class Members, have a derivative claim for damages under s. 61 of the *Family Law Act*, R.S.O. 1990, c. F.3;

f) "***Long-Term Care Homes Act, 2007***" means *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8;

g) ***"Human Rights Code"*** means *Human Rights Code*, RSO 1990, c H.19;

h) ***"Occupiers' Liability Act"*** means *Occupiers' Liability Act*, RSO 1990, c O.2;

i) ***"Emergency Management and Civil Protection Act"*** means *Emergency Management and Civil Protection Act*, RSO 1990, c E.9;

j) ***"Family Law Act"*** means *Family Law Act*, RSO 1990, c F.3;

k) "**LTC home**" means long-term care home;

l) **"Responsive Group"** means Responsive Group Inc.. and all of its subsidiaries and/or affiliates engaged in and/or licensed to be engaged in the management and operation of the Responsive Group LTC homes;

m) **"Responsive Group LTC homes"** means the long-term care homes owned, operated, managed, and/or licensed by Responsive Group which are the subject-matter of this claim, as listed in "Appendix A" hereto;

n) "**Minister**" means the Ontario Minister of Long-Term Care and/or, where applicable, the Minister of Health and Long-Term Care;

o) "**Ministry**" means the Ontario Ministry of Long-Term Care and/or, where applicable, the Ministry of Health and Long-Term Care;

p) **"Residents"**, "**Resident Class**" and "**Resident Class Members**" mean all persons who were residents in, or received care at, the Responsive Group LTC homes during the COVID-19 pandemic, or, where the person is deceased, the estate of that person;

q) "**Representative Plaintiffs**" means Maurice Albert Orchard, deceased, by his estate representative Christina Kinder; Christina Kinder; William Brough, deceased, by his estate Representative, Darren Brough; Darren Brough; Gaston Schwalb, deceased, be his estate representative, Kim Koblinsky; Kim Koblinsky; Duby McCarroll, deceased by her estate executor Michael McCarroll; Michael McCarroll; Annette Dery, deceased, by her estate executrix Elie Dery, Elie Dery, Beatrice Grace Gandron, deceased, by her estate executrix, Jacqueline Amable; Jacqueline Amable; William Van Dyke, deceased, by his estate executor Terence Van Dyke; Terence Van Dyke; Marie Bedard, deceased, by her estate executrix, Angie Thorn, Angie Thorn.

r) "**Visitors**", "**Visitor Class**" and "**Visitor Class Members**" mean all persons who were visitors or volunteers at the Responsive Group LTC homes during the COVID-19 pandemic, or where the person is deceased, the estate of that person.

II. NATURE OF THE CLAIM

3. This claim is for negligence, gross negligence, breaches of fiduciary duty, violations of section 7 of the *Charter*, breach of contract/warranty, breach of the *Occupiers' Liability Act*, and breach of the *Human Rights Code*. It arises from the failure of the Defendants to adopt and implement timely, reasonable and effective infection prevention and control ("IPAC") protocols, directives, action plans and measures to prevent the exposure of the elderly residing in the Responsive Group LTC homes to the risk of contracting the highly contagious SARS-CoV-2 virus and suffering from the COVID-19 illness and related complications including death.

4. At all material times, both prior to and after the declaration of a COVID-19 pandemic affecting Canada, and specifically Ontario, the Defendants had statutory, common law, equitable *Charter*-based, and contractual obligations to ensure that the care and treatment of the Resident Class Members in the Responsive Group LTC homes were carried out in accordance with a reasonable standard of care. The minimum standard of care should have respected the rights of Resident Class Members to life and security of the person, to be treated with dignity and to receive appropriate care and services from the Defendants.

5. The standard of care was informed by the clear warnings, findings and recommendations of the SARS Commission Report of January 2007, including the need to have plans in place to address any potential pandemic outbreak and to ensure that such plans were capable of being activated, as and when required, with the necessary expertise, staff, equipment and supplies, as well as adequate contingency plans related to both supplies and staffing requirements.

6. The standard of care, both prior to and after COVID-19 cases emerged in the Responsive Group LTC homes, was guided by the precautionary principle as initially set out in the 1997 report from the Krever Commission's inquiry into Canada's tainted blood supply. According to the precautionary principle, where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.

7. At all material times, the Defendants owed a duty to the Resident Class Members and to the Visitor Class Members to take reasonable care to prevent their exposure to the risk of infection with COVID-19, and to adopt timely, adequate, and effective IPAC practices and protocols. The Defendants knew, or ought to have known, that such measures were necessary to prevent COVID-19 outbreaks in LTC homes and to mitigate and manage infections among Residents and Visitors. The Defendants further knew that long-term systemic deficiencies in LTC homes in Ontario, including overcrowding, physical neglect of the facilities, staffing issues and non-compliance with the minimum standards of care established by the *Long-Term Care Homes Act, 2007* had made these facilities ripe for outbreaks, including respiratory outbreaks such as COVID-19.

8. The Defendants knew, or ought to have known, since as early as January 2020, that SARS-CoV-2 is a highly contagious, novel virus that targets the respiratory system. They further knew, or ought to have known, from the experience of other countries, including China, Italy, Spain and the United States, that the elderly are at a particularly high risk of experiencing complications, including death, once infected with the virus. The experience of these countries with early exposure to the COVID-19 pandemic illustrated the importance of effective IPAC protocols.

9. Specifically, the experience with COVID-19 in other countries provided the Defendants with early warnings regarding the risk of asymptomatic community transmission, particularly in congregate settings like LTC homes, which highlighted the critical importance of protecting LTC homes by implementing rigorous screening and protective measures, including the use of personal protective equipment ("PPE"), restricting visitors' access to LTC homes, active testing, isolating those residents infected with the virus from others, limiting co-mingling between residents of these facilities to the extent possible and restricting staff mobility between different LTC homes.

10. Despite this knowledge, and the early red flags regarding the harmful, if not fatal, nature of COVID-19, the Defendants failed to act promptly and reasonably, exposing thousands of the most vulnerable members of our society to the risk of infection, complications and death. The

Defendants were not prepared for a pandemic affecting the Responsive Group LTC homes in Ontario. Plans, precautionary measures, PPE supplies, and IPAC protocols were not in place either prior to the start of the pandemic or in the weeks leading up to the outbreaks in the Defendants' LTC facilities.

11. The Defendants breached their duty of care to the Class Members by failing to undertake timely and reasonable measures to secure the Responsive Group LTC homes from visitors and third parties and to prevent the exposure of the Class Members to the risk of COVID-19. Instead of adopting the rigorous measures required to minimize, if not eliminate, the exposure of the Residents and Visitors to the risk of contracting COVID-19, the Defendants delayed in implementing safety and infection control measures. Further, the Defendants failed to implement adequate corporate-wide IPAC policies and instead negligently and recklessly adopted *ad hoc* and inadequate protocols and plans, thus increasing the risk of outbreaks at the Responsive Group LTC homes. As particularized below, the Defendants markedly departed from, and failed to adhere to, the standard of care required of responsible operators and owners of LTC homes; failed to implement rigorous and active screening; failed to implement timely and reasonable protocols for visitors; and failed to adhere to reasonable IPAC standards in the Responsive Group LTC homes.

12. At all material times, the Defendants owed a fiduciary duty to the Resident Class Members to ensure that their IPAC protocols and measures were developed and implemented in the best interest of the Residents. The Residents were a group of highly vulnerable individuals. The Defendants were in a position of power vis-à-vis the Residents and, entrusted with their care, had an obligation to exercise their power and authority in the best interest of the Residents, not to subordinate their care and medical and health needs to other interests, and not to abuse the trust reposed in them by the Residents and their families. The Defendants' fiduciary duties were grounded in their undertaking to operate LTC homes and their statutory duties under the *Long-Term Care Homes Act, 2007* to provide Resident-focused care that ensured the health and integrity of the Resident Class Members.

13. The Defendants had broad discretion to exercise their statutory duty to provide the Residents with appropriate care, and had the power to unilaterally exercise their authority to develop and implement reasonable IPAC protocols in accordance with the Residents' statutory rights to appropriate care, respect and dignity. The Residents were dependent on the Defendants for all aspects of their care, health and well-being. They were at the mercy of the Defendants and vulnerable to their exercise of their authority which could, and did, affect the Residents' legal and substantial practical interests, including their health, their right to life and personal security, their right to receive care with dignity, and their right not to be unreasonably exposed to the risk of COVID-19 and foreseeable complications.

14. The Defendants breached their fiduciary duties by exercising their power, authority and discretion to the detriment of the Resident Class Members and by subordinating the Residents' interests to their own financial interests. The Defendants' delayed and inadequate practices and protocols in response to the COVID-19 pandemic were developed and implemented recklessly and carelessly, exposing the Residents to an avoidable risk of infection, which ultimately materialized, causing the Plaintiffs and the Class Members illness, pain, suffering, emotional distress and death.

15. The establishment, maintenance, regulation, enforcement and implementation of care and services to the elderly is within the jurisdiction of the province. Pursuant to sub-sections 92 (7)(8) and (13) of the *Constitution Act, 1867*, provinces have exclusive power with respect to: the establishment, maintenance, and management of hospitals; municipal institutions; and property and civil rights in the province, respectively. Ontario has delegated its authority with respect to the provision of care to the elderly to LTC homes in the province. As a result of this delegation of authority, the Defendants are responsible for providing care to the Resident Class Members. In operating and maintaining the Responsive Group LTC homes in the province and discharging their obligations pursuant to the *Long-Term Care Home Act, 2007*, the Defendants perform essential government functions, namely, providing basic care, necessities of life and services to the elderly, such that their decisions, actions and inactions are subject to *Charter* scrutiny.

16. By adopting delayed, *ad hoc*, and unreasonable measures and protocols in response to the COVID-19 pandemic, the Defendants breached the Resident Class Members' section 7 *Charter* rights to life and security of the person. These breaches of the Resident Class Members' section 7 *Charter* rights did not accord with the principles of fundamental justice and are not demonstrably justified in a free and democratic society.

17. The Resident Class Members have a right to equal treatment under the *Human Rights Code*, with respect to provision of services, goods and facilities and to occupancy of accommodation, without discrimination because of age and/or disability.

18. The Defendants failed to provide the requisite level of services, goods, facilities and accommodation to the Resident Class Members because of their age and/or cognitive and physical disability, thereby infringing their rights under Part 1 of the *Human Rights Code*. The Defendants and/or their servants, agents and/or employees did not treat Resident Class Members with respect and dignity, and provided them with grossly deficient services, contrary to the requirement to treat them in a manner that respects their right to equality.

19. In adopting grossly delayed and deficient IPAC measures and protocols, and failing to provide the Residents with appropriate care and services, the Defendants violated the Resident Class Members' right to be free from discrimination on the basis of age and/or disability in their occupancy of accommodation and their receipt of services.

20. The Defendants were, at all material times, occupiers of the Responsive Group LTC homes within the meaning of the *Occupiers' Liability Act* and owed a duty to the Residents and Visitors to keep them reasonably safe on the Responsive Group LTC homes' premises. The Defendants could reasonably foresee that persons entering or residing at the Responsive Group LTC homes, including the Resident Class Members and the Visitor Class Members, would be placed at risk of serious bodily and psychological harm, including serious illness and death, by their grossly delayed, arbitrary, and *ad hoc* response to the pandemic, and by their failure to adopt and implement reasonable and timely IPAC protocols and measures. The Defendants could

not, and did not restrict, their duties under the *Occupiers' Liability Act* to the Residents and Visitors of the Responsive Group LTC homes.

21. The Defendants represented and promised to the Resident Class Members and/or Family Class Members that they would provide competent care and treatment to the Residents and ensure their safety while under their care. The Defendants breached the terms of their contracts with the Residents and/or the Family Class Members by neglecting Residents and by failing to protect them from exposure to the deadly COVID-19 virus. These breaches of contract resulted from the Defendants' chronic understaffing at the Responsive Group LTC homes, and their failure to maintain and implement appropriate and effective IPAC protocols to protect both Residents and staff from infection. The Defendants' failures resulted in both staff and Resident infections which, along with attrition among staff who refused to work in the Responsive Group LTC homes due to their fear of becoming infected, resulted in woefully deficient care and services to the Residents in breach of the applicable contracts.

22. The Defendants' staffing practices, including, *inter alia*, the use of staff across multiple Responsive Group LTC homes and the use of agency staff who worked at multiple LTC homes, also contributed to the spread of COVID-19 within and between Responsive Group LTC homes, which resulted in the infection of Residents. These improper staffing practices also resulted in catastrophic understaffing in many Responsive Group LTC homes, which led to Residents being neglected both in terms of their healthcare requirements and basic necessities of life such as food, water and basic hygiene, all of which represent breaches of the fundamental terms of the contracts that the Defendants entered into with Residents and/or Family Class Members.

23. As of May 12, 2021, thousands of residents in LTC homes in Ontario have died as a result of COVID-19 outbreaks in the very facilities that were entrusted with their care and safety. A significant portion of these outbreaks and fatalities took place in the Responsive Group LTC homes owned, operated, and controlled by the Defendants herein. These outbreaks and the resulting deaths and illnesses were both foreseeable and preventable.

24. As a result of the Defendants' breaches of their duty of care, fiduciary duties, violations of the Resident Class Members' rights under section 7 of the *Charter* and the *Human Rights Code*, breach of contract/warranty and breach of the *Occupiers' Liability Act*, the proposed Representative Plaintiffs and the Class Members suffered significant harm including, but not limited to, illness, complications and death, psychological trauma, harm to their dignity, loss of care, guidance and companionship, and financial loss. As a result of these breaches, the Class Members seek compensatory, special, aggravated, punitive and/or exemplary damages, as well as remedies pursuant to s. 24(1) of the *Charter*.

III. THE PARTIES

The Plaintiffs

25. The Plaintiffs are described in the below paragraphs and include Class Members from the following Responsive Group LTC homes: Eatonville Care Centre ("Eatonville"), Hawthorne Place Care Centre ("Hawthorne Place"), Anson Place Care Centre ("Anson Place"), Cooksville Care Centre ("Cooksville") and Ina Grafton Gage Home ("Ina Grafton").

a) The Estate of Maurice Albert Orchard and Christina Kinder

26. The Plaintiff Christina Kinder ("Christina") is the daughter of the late Maurice Albert Orchard ("Maurice"). Maurice resided at Eatonville, at all material times until his death on April 2, 2020. Maurice tested positive for COVID-19 on April 1, 2020, the night before he died.

27. Christina resides in Toronto, Ontario and brings this action in her personal capacity and in her capacity as the representative of Maurice's estate.

28. Maurice began to suffer from symptoms of COVID-19, including fever and coughing, on March 16, 2020. While staff told Residents that there was a respiratory outbreak at Eatonville, they did not initially acknowledge the existence of a COVID-19 outbreak at the facility. At all material times, Eatonville failed to conduct COVID-19 tests or proper screening of its Residents, staff and visitors, or to ensure an adequate supply of PPE to its staff.

29. Maurice was not tested for COVID-19 until Christina demanded that he be tested. On April 1, 2020, Maurice became the first Eatonville Resident to test positive for, and die of, COVID-19. Nevertheless, Eatonville staff did not isolate Maurice from his roommate, nor did Eatonville test Maurice's roommate or other Residents for COVID-19 at that time. In fact, at all material times, symptomatic Residents at Eatonville shared rooms with asymptomatic Residents.

30. Eatonville staff found Maurice deceased in his room on April 2, 2020. Christina was obliged to self-quarantine as a result of having had contact with Maurice, and was unable to gather with her family and friends to mourn him. Christina has been traumatized by thoughts of Maurice fighting for breath alone in the last stages of his illness and suffers from nightmares related to the manner of his death.

b) The Estate of William Brough and Darren Brough

31. The Plaintiff Darren Brough ("Darren") is the son of the late William Brough ("William"). William resided at Eatonville from April, 2019 until his death on April 12, 2020 at age 88. Darren resides in Toronto, Ontario and brings this action in his personal capacity and in his capacity as the representative of William's estate.

32. Prior to the pandemic, Darren visited his father on a daily basis and would bring him home-made food for dinner. Darren was able to visit his father in person until March 16, 2020. During their last visit, William was in good spirits as he watched a movie with Darren and enjoyed a home-cooked meal. On March 16, 2020 Darren was able to go directly into his father's room without being screened upon entering the home nor being required to wear PPE. During the last visit, Darren noticed that staff were not wearing PPE and he did not notice any measures being put in place to prevent the spread of COVID-19. Darren received notice on March 17, 2020 that Eatonville was restricting visitor access to the home and he could no longer visit William in person.

33. On or about April 2, 2020 Darren learned from a personal contact that someone residing on the floor above William's room had tested positive for COVID-19. Darren and his family were very concerned and proceeded with making several calls to the home in order to receive an

update on the outbreak and William's condition. However, staff did not provide any information about William's condition other than reporting that he had not been eating well. Nor did Eatonville issue a notification to families that at least one Resident at the home had tested positive for COVID-19.

34. The family was left in the dark about William's condition until Darren's brother received a phone call on April 10, 2020 notifying him that William was ill and that family members would be permitted to visit him on compassionate grounds. On the following day, on April 11, 2020 Eatonville informed the family for the first time that there was an outbreak of COVID-19 at the home. However, the family was not informed as to whether William was exhibiting symptoms of COVID-19 or whether he had been tested for the virus.

35. Darren went to visit William on April 12, 2020. When he arrived at the home, he found William in very poor condition. He had lost half of his body weight and he looked very frail. William's room was uncleaned and in disarray. The bathroom was in a very unsanitary condition and Darren found urine on the floor. William passed away later that same day on April 12, 2020.

36. William's wife was later informed by a nurse that he was scheduled to be tested for COVID-19 on April 13, 2020, the day after his death, despite having been ill for days. The family is not aware that William was tested for COVID-19 at any time prior to his death. William's rapid deterioration came as a shock to Darren, who had, only weeks prior, been able to visit his father and see him in good health.

a) The Estate of William van Dyke and Terence van Dyke

37. The Plaintiff Terence van Dyke ("Terence") is a Resident of Mississauga, Ontario and is the son of the late William van Dyke ("William"), who was a Resident of Eatonville until his death on April 11, 2020. Terence is a Resident of Mississauga, Ontario and brings this action in his personal capacity and in his capacity as Executor of William's estate.

38. William became a Resident of Eatonville in and around January 2020. On March 11, 2020, Terence drove William from Eatonville to Etobicoke General Hospital for a hernia repair day surgery. Terence drove William back to Eatonville that same day.

39. On March 12, 2021, an Eatonville staff member telephoned Terence and advised him that William was being transferred back to Etobicoke General Hospital due to a high fever. Despite continuing to have a high fever, William was not isolated from other Eatonville Residents upon his return to the home on March 13, 2021.

40. By late March, despite William continuing to exhibit symptoms of COVID-19, he was permitted to eat with other Residents in the lunchroom.

41. On April 11, 2020, Terence received a voicemail from Eatonville asking that he call them back. When Terence was unable to connect with staff at Eatonville, he called one of the other missed call numbers on his phone. He was connected with a nurse at St. Joseph's Health Care Centre ("St. Joseph's") who advised him that William was being treated at St. Joseph's and a doctor would call to update him. Shortly thereafter, Terence received a call from a palliative care physician who told Terence that William was on oxygen support, had a high fever and pneumonia in his lungs. A second doctor later informed Terence that William was gravely ill, and had likely had been infected with COVID-19.

42. Shortly after this communication, Terence was called by this same doctor who informed him that William had passed away. William died alone, unable to speak with any friends or family members before his death.

b) The Estate of Gaston Schwalb and Kim Koblinsky

43. The Plaintiff Kim Koblinsky ("Kim") is the daughter of the late Gaston Schwalb ("Gaston"), who passed away on April 27, 2020 from COVID-19. Kim brings this action in her personal capacity and in her capacity as the representative of Gaston's estate. Gaston was a Resident of the Hawthorne Place in Toronto. He was a former restaurant owner in Toronto. He was diagnosed with dementia in or around 2014, which resulted in an increased need for care

and assistance with day-to-day tasks. Gaston was admitted to Hawthorne Place in March 2019 due to his ongoing need for long-term care.

44. In the weeks preceding Gaston's death, the facility did not provide Kim with any information regarding Gaston's health. On the morning of April 27, 2020, Kim received a call from Hawthorne Place advising that her father was not doing well, that his breathing was shallow and that he was put on oxygen. He died on the same day. The facility did not confirm at that time if Gaston had been tested for COVID-19.

45. After Gaston's death, in response to repeated inquiries from Kim, the facility finally confirmed that Gaston had been tested for COVID-19 on April 14, 2020. The facility advised Kim that it appeared that the test result was negative, but was unable to confirm this formally or to advise if any follow-up tests had been done. In fact, Gaston's COVID-19 test result was never registered.

c) The Estate of Annette Dery and Elie Dery

46. The Plaintiff Elie Dery ("Elie") is the daughter of the late Annette Dery ("Annette"), who passed away from COVID-19 related complications on April 25, 2020. Elie brings this action in her personal capacity and in her capacity as Executor of Annette's estate. Annette was a Resident of Hawthorne Place for approximately six years between April 2014 to April 2020.

47. In mid-March 2020, Hawthorne Place went into lockdown and Elie could no longer visit his mother. From then until April 2020, Annette's health deteriorated rapidly. Annette was tested for COVID-19 on April 15, 2020. Elie was never informed that his mother was being tested for COVID-19.

48. On a Skype call arranged for Elie and Annette just over a week later, on April 23, 2020, Elie observed a Hawthorne Place nurse who was not wearing PPE.

49. On April 25, 2020, Annette was found by Hawthorne Place Staff unresponsive in bed with no vital signs. She was declared deceased shortly thereafter. Hawthorne Place 's temporary

Director of Care later confirmed with Elie that Annette had passed away from COVID-19 related complications.

d) The Estate of Ruby McCarroll and Michael McCarroll

50. The Plaintiff Michael McCarroll ("Michael") is the son of the late Ruby McCarroll ("Ruby"), who passed away from COVID-19 related complications on March 30, 2020. Michael brings this action in his personal capacity and in his capacity as Executor of Ruby's estate. Ruby was a Resident of Anson Place Care Centre ("Anson Place") in Hagersville.

51. On March 23, 2020, Michael was informed by an Anson Place staff member that his mother was unwell and had been sent to the hospital. The hospital had a no visitor policy in place and Michael was not able to visit her on that day. On March 27, 2020, the hospital contacted Michael to let him know that Ruby was gravely ill and it might be Michael's last opportunity to see her. Michael was allowed to see his mother that day wearing full PPE. As he was leaving the hospital, Michael was informed by the nurse on-duty that his mother tested positive for COVID-19. The nurse further informed Michael that another Anson Place Resident had passed away from COVID-19 related complications. This was the first time Michael was informed of a COVID-19 outbreak at Anson Place, let alone that his mother had COVID-19, or had been tested for it.

52. Ruby passed away from COVID-19 related complications on March 30, 2020. She died alone without Michael or any family by her side. In the days following her death, certain of the Defendants deducted payment from Ruby's bank account purportedly on account of her April 2020 fees for living at Anson Place.

e) The Estate of Beatrice Grace Gendron and Jacqueline Amable

53. The Plaintiff Jacqueline Amable ("Jackie") is a resident of Waterdown, Ontario and is the daughter of the late Beatrice Grace Gendron ("Beatrice"), who passed away from COVID-19 related complications on May 3, 2020. Jackie brings this action in her personal capacity and in her capacity as Executor of Beatrice's estate.

54. Beatrice was a Resident of Cooksville in Mississauga from around October 2014 to May 2020. Beatrice was one of dozens of Residents at Cooksville who tested positive for COVID-19 in late April 2020.

55. Beatrice was bedridden due to her medical condition. Once the COVID-19 pandemic began escalating in Ontario, Jackie reached out to Cooksville staff to express her concerns about her mother being cared for by PSWs working in multiple long term care facilities. Jackie was assured that Beatrice would be safe as the Cooksville PSWs had been asked not to work in other homes.

56. A few weeks after this assurance, Jackie was informed that a PSW at Cooksville had been working in another home, but failed to inform Cooksville of this fact. This PSW tested positive for COVID-19.

57. On April 23, 2020, Jackie was informed by Cooksville that Beatrice had developed a cough and would be tested for COVID-19. Jackie was informed that Beatrice was negative for COVID-19 on April 25, 2020 and was relieved. However, the relief was short-lived as on April 27, 2020, Jackie was advised that Beatrice had tested positive for COVID-19.

58. Jackie was advised by Beatrice's treating physicians that there was no point transferring Beatrice to the Hospital for treatment.

59. On May 3, 2020, Beatrice died alone in her room at Cooksville.

f) The Estate of Marie Bedard and Angie Thorn

60. The Plaintiff Angie Thorn ("Angie") resides in Pickering, Ontario and is the daughter of the late Marie Bedard ("Marie"), who passed away from COVID-19 on May 3, 2020. Angie brings this action in her personal capacity and in her capacity as the executrix of Marie's estate.

61. Marie was a Resident of Ina Grafton from February 28, 2020 until her death on May 3, 2020. Marie was a particularly vulnerable individual. She was a diabetic and ambulated independently with a walker.

62. From March 11, 2020 to April 13, 2020, Marie, moved freely throughout Ina Grafton. After April 13, 2020, the dining rooms in Ina Grafton were closed, and the Residents received their meals in their rooms. By April 19, 2020, all social activities in the home were stopped, and Marie was confined to her room until her death on May 3, 2020. While confined in her room, Marie's meals and medication would always be brought late by staff who had improper or inadequate PPE. The lateness of her meals and medication affected Marie's diabetes management. At the same time, the lack of social interaction during this time had a negative impact on her mental health.

63. On April 23, 2020, Marie was tested for COVID-19, and was advised that she had tested negative. At this time, she was confined to her room with her roommate, Joyce. Marie's family was assured that while Marie was isolated in her room with a roommate, there was a protective divider between Marie and Joyce's bed. This was not the case, as only a curtain separate their beds.

64. Some time after April 23, 2020, Joyce contracted COVID-19. On May 1, 2020, Angie was advised by a PSW that the PSW could not longer bring the laptop to Marie for Skype calls, because Joyce had tested positive for COVID-19. The inability to communicate with each other via Skype during the last days of Marie's life made Marie and Angie's suffering worse.

65. On May 3, 2020, a day after her 90th birthday, Marie passed away due to COVID-19.

66. The proposed Representative Plaintiffs bring this action on their own behalf and on behalf of the Resident Class Members, Family Class Members and Visitor Class Members, as defined in sub-paragraphs 2(e), (p) and (r).

The Defendants

67. The Defendant, Responsive Group Inc., is a privately held owner-operator of LTC and retirement homes in Ontario. Responsive Group Inc., directly or through its subsidiaries, provides management, consulting, mentoring, restructuring and redevelopment services to 20 LTC homes in Ontario, <u>including the Responsive Group LTC homes set out in Appendix "**A**".</u>

68. The Defendant Responsive Health Management Inc. is a subsidiary of Responsive Group Inc. It manages LTC and retirement homes in Ontario and provides financial management and consulting services to the Responsive Group LTC homes. Responsive Health Management Inc. is the management firm for Vermont Square, Earls Court Village (until October 31, 2020), and The O'Neill Centre. As of April 1, 2020, Responsive Health Management Inc. is also the management firm for Champlain Long Term Care Residence.

69. The Defendant Responsive Management Inc. is a subsidiary of Responsive Group Inc. It is the operating partner of the defendant Rykka Care Centre LP which is the licensee for the following LTC homes: Anson Place, Banwell Gardens Care Centre, Berkshire Care Centre, Cooksville Care Centre, Dundurn Place Care Centre, Eatonville Care Centre, Hawthorne Place Care Centre and Orchard Terrace Care Centre.

70. The Defendant Responsive Management Services Inc. is a subsidiary of Responsive Group Inc. It is the management firm for Ina Grafton Gage Home. As of April 1, 2020, Responsive Management Services Inc. is also the management firm for Bon Air Long Term Care Residence, Lancaster Long Term Care Residence and Niagara Long Term Care Residence.

71. The Defendant Sharon Farms & Enterprises Ltd. is the owner and licensee of Earls Court Village.

72. The Defendant Hawthorne Care Facility Inc. is the owner of Hawthorne Place.

73. The Defendant Anson Place Care Centre Facility Inc. is the owner of Anson Place.

74. The Defendant Vermont Square LTC Inc. is the general partner of Vermont Square LTC LP which is the licensee for Vermont Square. The Defendant 914 Bathurst GP Inc. is the owner of Vermont Square.

75. The Defendants DTOC Long Term Care GP Inc. and Arch Venture Holdings Inc. are the general partners for DTOC II Long Term Care MGP, a general partnership. DTOC II Long Term Care MGP is the general partner of DTOC II Long Term Care LP. As of April 1, 2020,

DTOC II Long Term Care LP is the licensee for Bon Air Long Term Care Residence, Lancaster Long Term Care Residence and Niagara Long Term Care Residence.

76. The Defendant Ina Grafton Gage Home of Toronto is the licensee for Ina Grafton.

77. The Defendant, 848357 Ontario Inc. is the licensee for the O'Neill Centre.

78. The Defendant Rykka Care Centres GP Inc., is the licensee of Arbour Creek Long Term Care home.

79. The Defendant, Rykka Care Centres II GP Inc. is the licensee for Pine Villa Care Centre.

80. The Defendants and the Responsive Group LTC homes are governed by the *Long-Term Care Homes Act, 2007*, and Regulation 79/10. The Responsive Group LTC homes are regulated, inspected and licensed by the Ministry.

81. Each of the Responsive Group LTC homes was established with the approval of the Minister. The Minister granted a license to operate to each of the Responsive Group LTC facilities. The Minister approved the establishment of the Responsive Group LTC homes and has the power to request inspections of every facility. In operating and maintaining LTC homes and discharging their obligations pursuant to the *Long-Term Care Homes Act, 2007*, the Responsive Group LTC homes perform essential government functions, namely providing care, services and housing to vulnerably elderly residents, within the meaning of section 32(1) of the *Charter*.

82. Each of the Defendants were, at all material times, engaged in the provision of care and services to the Resident Class Members. At the time of the COVID-19 pandemic, the Defendants housed and were responsible for the care of a vulnerable population of Residents, all of whom were physically frail, had pre-existing medical conditions, and were completely reliant on the Defendants for the provision of care.

83. The Defendants were, at all material times, occupiers of the Responsive Group LTC homes, within the meaning of the *Occupiers' Liability Act*, and owed a duty to the Resident Class Members and the Visitor Class Members to keep them reasonably safe while at the Responsive Group LTC homes.

IV. MATERIAL FACTS

A. Facts relating to LTC homes in Ontario

a) Admission Requirements for LTC homes

84. Residents of the LTC homes in Ontario are among the most vulnerable members of society, and include those in significant need of substantial medical and personal care. Admission requirements to LTC homes are particularly onerous. Since 2010, only those residents with high or very high care needs are eligible for admission to LTC home in Ontario.

b) Statutory regime governing LTC homes in Ontario

85. Long-term care is part of the province's health care system and is publicly funded on a cost-shared basis with residents. Ontario partially funds LTC homes in Ontario, while residents pay a portion of their "room and board" to the LTC home.

86. LTC homes are the most highly regulated area of healthcare in Ontario. Each of the Responsive Group LTC homes is a "long-term care home" pursuant to the *Long-Term Care Homes Act, 2007*, and is, therefore, operated under and subject to the requirements of that Act.

87. The *Long-Term Care Homes Act, 2007* and its regulations establish a regulatory framework for resident-centered care, imposing clear standards for LTC homes and a rigorous inspection regime to enforce those standards. Among other things, this regulatory regime establishes minimum standards of care for residents in LTC homes, including with respect to residents' rights, care and services; reporting requirements; medication management; infection control; food safety and quality; and staffing. It also imposes comprehensive obligations on all licensees of LTC homes. This regulatory regime is designed to ensure that residents are safe and secure, and are treated with dignity and respect. The Defendants are all bound by these standards.

c) Ministry's oversight and control of Ontario's LTC homes

88. The Ministry is responsible for overseeing LTC homes and the provision of publicly funded home care services.

89. In 2015, the Ministry's Long-Term Care Division was established. This division includes both an Inspections Branch and a Licensing and Policy Branch. In 2019, the Ministry of Health and Long-Term Care was split into two ministries: the Ministry of Health and the Ministry of Long-Term Care.

90. The Long-Term Care Inspections Branch oversees the Long-Term Care Home Quality Inspection Program (LQIP) and is responsible for developing and implementing all operational policies relating to both inspections and inspectors. The Licensing and Policy Branch is responsible for the licensing of LTC homes, as well as the development and implementation of funding and financial policies.

91. The *Long-Term Care Homes Act, 2007* confers broad powers on the Ministry with respect to the establishment, licensing, operation, inspection, and funding of LTC homes in the province.

92. Pursuant to section 174.1 of the *Long-Term Care Homes Act, 2007*, the Minister may issue operational or policy directives with respect to any matter it deems relevant. In issuing such directives, the Minister may consider the proper management and operation of the LTC homes and the quality of care and treatment of residents in general. These directives, while mandatory, set only the minimum standards with which the LTC homes must comply.

d) Responsive Group's ownership and operation of LTC homes

93. The Defendant, Responsive Group Inc., its business units and its subsidiaries are engaged in the day-to-day operations of long-term care homes and retirement homes in Ontario. They also provide management, restructuring and consulting services.

94. As of 2021, Responsive Group Inc. has developed a network of 83 owned and operated LTC and retirement homes in Ontario and British Columbia.

95. Responsive Group and the Responsive Group LTC homes are subject to the requirements of the *Long-Term Care Homes Act, 2007*.

96. The COVID-19 outbreaks in the Responsive Group LTC homes were foreseeable given the Defendants' history of non-compliance and failure to implement reasonable IPAC measures. Both before and during the pandemic, many Responsive Group LTC homes were found non-compliant with the requirements of the *Long-Term Care Homes Act, 2007* and its regulations, including requirements pertaining to IPAC measures and policies.

B. Facts relating to COVID-19 Outbreaks in Ontario's LTC homes

a) The global COVID-19 outbreak and response by the World Health Organization ("WHO") and the health sector in Ontario

97. On or about January 4, 2020, the WHO reported on social media that there was a cluster of pneumonia cases of unknown origin in Wuhan, Hubei province, China, and on January 5, 2020, it published a Disease Outbreak news release for members of the scientific and public health community, as well as the global media. The news release contained a risk assessment, information about what China had told the WHO about the status of infected patients and the public health response, and advised Member States to take precautions to reduce the risk of acute respiratory infections.

98. Even before this news release, the IPAC Medical Director at Sinai Health in Toronto had alerted her hospital's leadership about the risk of a novel coronavirus arriving in Toronto from travellers returning from holidays.

99. By January 7, 2020, the Chinese authorities had conducted gene sequencing of the virus using an isolate from one positive patient sample, which excluded known respiratory pathogens and allowed for a preliminary determination that the virus was a novel coronavirus.

100. On January 10, 2020, the WHO issued a comprehensive package of technical guidance online which provided advice to all countries with respect to detecting, testing and managing potential cases, based on what was known about the virus at the time. This guidance was based

on prior experiences with Severe Acute Respiratory Syndrome ("SARS") and Middle East Respiratory Syndrome ("MERS"). The guidance provided recommendations regarding known modes of transmission of respiratory viruses, IPAC measures, as well as droplet and contact precautions for public health workers and airborne precautions for aerosol generating procedures conducted by health workers when caring for patients.

101. On January 12, 2020, Chinese officials publicly shared the genetic sequence of COVID-19. The following day, officials confirmed a case of COVID-19 in Thailand, which represented the first recorded case of the virus outside of China.

102. On January 14, 2020, the technical lead for the WHO advised in a press briefing that human-to-human transmission of the coronavirus would not be surprising given the global experience with SARS, MERS and other respiratory pathogens. On January 22, 2020, evidence of human-to-human transmission was confirmed following a brief field visit to Wuhan, China.

103. At or around this time, in anticipation of the risk of COVID-19 arriving in Toronto hospitals, Sinai Health and other hospitals in Toronto began planning their response on January 21, 2021, with Sinai Health running a tabletop exercise and struck a pandemic task force that same day.

104. On January 22, 2020, the WHO convened an Emergency Committee, and the Director-General issued a declaration that the novel coronavirus outbreak was a Public Health Emergency of International Concern.

105. COVID-19 was first detected in Canada in late January 2020. On January 25, 2020, Health Canada reported on the first Canadian case of COVID-19 in a Toronto man who had recently travelled to Wuhan, China.

106. On January 30, 2020, the WHO confirmed a total of 7,818 cases of COVID-19 worldwide. The majority of these were reported in China, with 82 cases reported in 18 other countries. The WHO gave the virus a risk assessment of "high" at the global level.

107. Also by the end of January 2020, evidence from China indicated that it took 2 to 14 days for symptoms to appear in infected individuals and that asymptomatic transmission of the virus was likely. Guidance from health authorities in Australia at this time also cited international evidence of asymptomatic transmission and recommended that a "highly precautious approach" be taken.

108. On March 11, 2020, the WHO declared a COVID-19 pandemic. This decision followed a WHO-China Joint mission, which included experts from Canada, and reflected the alarming levels of both the spread and the severity of the virus.

b) Widespread knowledge about the risk of transmission in congregate settings and the vulnerability of the elderly to COVID-19

109. By January 23, 2020, long before the formal declaration of an international pandemic, it was extensively reported worldwide and well-understood by the federal and provincial governments, healthcare providers and the Defendants that the elderly were particularly at risk of contracting COVID-19.

110. By early February 2020, there was also clear evidence of asymptomatic community spread and rapid infection in congregate settings; outbreaks were being reported on cruise ships like the *Diamond Princess*, as well as in other congregate settings such as churches and prisons in South Korea and between health care providers and patients in care settings in China. All of these examples demonstrated that the risk of rapid spread in the congregate setting of LTC homes would be high if appropriate precautions were not taken.

111. In addition, there was evidence that the virus posed a higher risk to the elderly and those who had pre-existing health issues and that the mortality rate was increasing markedly among these groups. On January 23, 2020, the New York Times reported that, at the time, the median age of the victims of COVID-19 was 75 years old. The New York Times reported that medical experts understood that the majority of fatalities were the elderly and/or those with chronic diseases that increase their susceptibility to infectious diseases. Maria Van Kerkhove, the Head of the Outbreak Investigation Task Force at the Institut Pasteur's Center for Global Health,

confirmed that advanced age is a known risk factor for both developing a severe form of the illness and death as a result of respiratory pathogens.

112. The serious vulnerability of the elderly to the harmful effects of COVID-19 was again confirmed by data from China. A February 8, 2020 WHO – China Joint Mission on Coronavirus Disease report found that the fatality rate among patients older than 80 was 21.9%, as compared to 1.4% among other patients. The WHO Recommendations on IPAC specifically included guidelines for elderly care, targeting prevention of the introduction and spread of COVID-19 in nursing homes. The WHO's technical recommendations emphasized the importance of isolating patients who have not been tested for COVID-19 in single rooms.

113. On February 18, 2020, BBC News, relying on a paper by the Chinese Journal of Epidemiology, reported that the COVID-19 fatality rate was higher for those over the age of 80. The study specifically found that the fatality rate was 15% for those over the age of 80.

114. Articles published in the Economist and the Washington Post on February 18 and 25, 2020, respectively, reported that COVID-19 was disproportionately affecting the elderly.

115. By February 2020, international experience with COVID-19 outbreaks in Washington State (United States), Italy, Japan, Spain and South Korea had confirmed that LTC homes could become deadly COVID-19 hotspots in the absence of strict precautions and prevention plans.

116. On February 28, 2020, a respiratory outbreak was reported among seniors in the Life Care Centre in Seattle, Washington State. By March 1, 2020 the first Life Care resident had died from the virus. On March 6, 2020, a United States Federal medical disaster team was dispatched to the Life Care Centre. Within 10 days, 70 of the 180 staff at Life Care Center were showing signs of COVID-19. By March 21, 2020, 129 individuals, including 81 residents, had tested positive, and 35 residents had died of COVID-19 and related complications.

117. On March 7, 2020, Canada's first LTC home outbreak was declared in British Columbia. The outbreak began with a staff member , who tested positive on March 5, 2020, six days after her last shift in the home on February 29, 2020. By March 7, 2020, when the outbreak

was declared, two residents had also tested positive, one of whom died on March 8, 2020. The outbreak spread rapidly to infect 36 residents (8 of whom died) and 18 health care workers within two weeks.

118. The experiences of these facilities in Washington State and British Columbia demonstrated the reality of community transmission, including the potential for rapid spread of COVID-19 in LTC homes. It also confirmed the high mortality among elderly residents of LTC and nursing homes that had already experienced COVID-19 outbreaks.

119. On March 19, 2020, the South China Morning Post reported new clusters of COVID-19 infections in South Korean nursing homes, mirroring outbreaks reported in Italy, British Columbia and the United States.

120. Data from Italy reflected a surge in deaths in LTC homes, where dozens of patients were dying each day. By March 11, 2020, LTC homes in that country had suffered 827 deaths and 12,462 confirmed cases. On March 24, 2020, Al Jazeera confirmed that 85.6% of those who died of COVID-19 in Italy were over the age of 70.

121. On April 1, 2020, the CNN reported that in Milan, Italy, one third of residents in an elder care home had died in less than one month during the pandemic.

122. On April 3, 2020, BBC News reported that, in Spain, 3,000 people died of COVID-19 in LTC homes during the month of March. It also reported that in Stockholm, 400 elderly residents were infected in LTC homes and 50 died. Similarly, in France, 1,416 elderly in LTC homes died.

c) Declaration of a State of Emergency and Outbreaks in Ontario LTC Facilities

123. On January 25, 2020, the first presumptive case of COVID-19 was reported in Ontario. By March 9, 2020, the number of confirmed cases in Ontario climbed to 29.

124. On March 9, 2020, Ontario's Assistant Deputy Minister for Long-Term Care issued a Memorandum to the LTC homes Sector, instructing LTC homes to screen visitors for symptoms

of the illness, ideally over the phone. The Directive was only extended to staff on March 11, 2020.

125. On or around March 11, 2020 the first death caused by COVID-19 was reported in Ontario and on March 13, 2020, the Province confirmed 20 new positive cases of COVID-19, bringing the total to 79. That same day, Ontario's Chief Medical Officer of Health ("CMOH"), Dr. David Williams, made a strong recommendation that LTC homes cease non-essential visits. Until then, LTC homes in Ontario, including the Responsive Group LTC homes, remained open to visitors.

126. Soon after, on March 16, 2020, the first outbreak in an Ontario LTC home was declared by Durham Public Health.

127. On March 17, 2020, Ontario Premier Doug Ford declared a state of emergency in Ontario. As of this time, there were 189 confirmed cases of COVID-19 across the province. Among other things, the government ordered the closure of select establishments and prohibited public gatherings of over 50 persons.

128. The following day, on March 18, 2020, an outbreak of COVID-19 infection was declared at an LTC home in Bobcaygeon, Ontario (Pinecrest Nursing Home). Approximately three weeks later, 28 of the home's 64 residents were dead as a result of COVID-19, and half of the staff were reportedly ill and exhibiting COVID-19 symptoms.

129. On March 19, 2020, a resident of Hillsdale Terraces LTC home in Oshawa, Ontario had symptoms of COVID-19. She tested positive for COVID-19 on March 23, 2020, and died of the virus on the same day.

130. On March 27, 2020, the Globe and Mail newspaper published an article reporting that there were cases of COVID-19 in at least 16 LTC homes in Ontario.

131. On April 2, 2020, CBC news revealed that approximately 40 people had died of COVID-19 at LTC homes in Ontario, and that there were outbreaks in at least 41 facilities in Ontario.

132. On April 3, 2020, Provincial Officials revealed modelling that forecast up to 15,000 deaths in the Province.

C. Facts relating to Government Guidelines, Emergency Orders and Directives for LTC homes

133. The Government of Ontario failed to issue timely, rigorous, and effective orders and directives to protect the Resident Class Members and Visitor Class Members from exposure to COVID-19. In failing to implement even the minimal orders and directives issued by the Government of Ontario, the Defendants acted recklessly and extremely carelessly, in a manner that was grossly negligent and that exposed vulnerable elderly Residents of the Responsive Group LTC homes to an increased risk of infection and complications.

134. On March 2, 2020, after cases of COVID-19 were confirmed in Ontario, the Minister of Health announced that Ontario was implementing an enhanced response structure to the COVID-19 outbreaks. The new response structure was comprised of a number of "tables" with specific mandates, including the "Command Table" in charge of strategic direction.

135. The Command Table is reported to be the government's main advisory body on COVID-19, and reports directly to the Minister. At the inception of the Command Table, the co-leaders of the Command Table were Matthew Anderson, president and CEO of Ontario Health, and Helen Angus, the Deputy Minister of Health. Other members of the Command Table included CMOH Williams, representatives from Public Health Ontario and the Ministry, and unidentified external experts.

136. The new response structure also included a "Scientific Table", led by Public Health Ontario, which was ostensibly responsible for the provision of evidence and scientific and technical advice to inform planning and response.

137. The new response structure further included a Collaboration Table, staffed with members from key health sector organizations, which was also responsible for providing advice to the Command Table. As the pandemic has progressed, there have been numerous reports indicating that the advice provided by these experts has not been followed.

138. The timeline below captures a selection of the guidelines, emergency orders and directives issued by the Government of Ontario pertaining to LTC homes.

a) Novel Coronavirus (2019-nCoV) Guidance for Primary Care Providers in a Community Setting

139. On January 28, 2020, the Ministry of Health and Long-Term Care issued its initial "Novel Coronavirus (2019-nCoV) Guidance for Primary Care Providers in a Community Setting" ("the January 28 Guidance"). The January 28 Guidance requested that retirement and long-term care facilities prepare for both active (asking questions) and passive screening (signage) of patients for COVID-19. The January 28 Guidance also requested that primary care providers follow the Routine Practices for managing acute respiratory infections.

b) Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care"

140. On January 31, 2020, the Government of Ontario released he Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care, a fact sheet that provided guidance on the prevention and screening of COVID-19, specifically in LTC homes. The guidance noted the heightened vulnerability of residents in LTC homes stating:

> The resident community in LTCHs [Long-Term Care Homes] is likely to be older, frailer, and have chronic conditions which weaken their immune systems. Residents may have chronic lung or neurological diseases which impair their ability to clear secretions from their lungs and airways. Residents are also at risk because respiratory pathogens may be more easily transmitted in an institutional environment. [emphasis added]

141. Further, the Government provided the following general advice to LTC homes to prevent an outbreak of COVID-19 in their facility:

- Have procedural masks, tissues and alcohol-based hand rub available to residents and staff;
- Review infection prevention and control and occupational health and safety policies and procedures;
- Post signage on building entrances informing persons to self-identify if they are experiencing fever and/or acute respiratory illness, and have a travel history to

Hubei province (including Wuhan), China in the last 14 days since onset of illness or contact with a person who has the above travel history and is ill; and

- Have ongoing surveillance programs in place throughput the year, including both passive and active surveillance to quickly detect respiratory infections.

c) "Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care"

142. On February 11, 2020, the Government of Ontario released "The Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care" providing updated guidance on the prevention and screening of COVID-19 in LTC homes.

d) Memoranda Regarding Visitor Policies

143. On March 11, 2020, the Government of Ontario and the Command Table instructed LTC homes to begin actively screening visitors, volunteers, staff and new residents for symptoms of COVID-19. No instructions with regard to testing visitors were provided by the Government of Ontario at this time.

144. On March 13, 2020, the Chief Medical Officer of Health *recommended* that LTC homes only allow essential visitors. Again, the recommendation provided instructions with regard to the screening of visitors, but was silent on testing requirements. The government did not require LTC homes to preclude visitors from the facilities housing vulnerable Resident Class Members, nor did the Defendants undertake such necessary steps.

e) Amendment to Regulation 79/10 under the *Long Term Care Homes Act, 2007* regarding staffing

145. On March 20, 2020, the Government of Ontario amended Regulation 79/10 under the *Long Term care Homes Act, 2007* to implement the following changes regarding staffing requirements at LTC homes:

- Amending the exemptions to the 24/7 registered nurse requirement;
- Temporarily providing for flexibility in the timing of police record checks;
- Prioritize the timing of specific training requirements such as Abuse and IPAC; and

- Staffing Requirement Exemptions for the number of hours the Director of Nursing and Personal Care must work in their positions to allow them to focus on frontline activities.

f) Directive #3 for Long Term Care Homes under the *Long-Term Care Homes Act, 2007*

146. On March 22, 2020, the CMOH issued a directive under the *Long-Term Care Homes Act, 2007* specifically addressing the province's LTC homes ("Directive #3") Directive #3 finally required LTC homes not to permit residents from leaving the home for short-stay absences to visit family and friends and to, wherever possible, limit the number of work locations at which employees were working.

g) Amendment to Regulation 79/10 under the *Long Term Care Homes Act, 2007* and Policy regarding short-term stays in LTC homes

147. On March 23, 2020, the Ministry issued a COVID-19 Emergency Policy ("Emergency Policy") which amended Regulation 79/10 under the *Long-Term Care Homes Act, 2007*. The amendment suspended the short-stay program in LTC homes until further notice. The Emergency Policy provided direction to LTC providers and Local Health Integration Networks (LHINs) on how to utilize short-stay beds to maximize capacity for applicants awaiting for admission to a long-stay bed in an LTC home.

h) "Streamlining Requirements for Long-Term Care Homes" Emergency Order

148. On or around March 27, 2020, an Emergency Order titled "Streamlining Requirements for Long-Term Care Homes" was passed under section 7.0.2(4) of the *Emergency Management and Civil Protection Act*. This Order authorized LTC homes to take any reasonable measure to respond to, prevent and alleviate COVID-19 outbreaks.

i) Directive under the *Long-Term Care Homes Act, 2007* regarding visitors

149. It was not until March 30, 2020, that the Chief Medical Officer of Health issued a Directive under the *Long-Term Care Homes Act, 2007* requiring long-term care homes to immediately implement active screening of all staff, essential visitors and anyone else entering the home for COVID-19. In addition, the Directive required that LTC homes conduct active

screening of all residents, at least twice a day, to identify if any resident had fever, cough or other symptoms of COVID-19. It further required that residents with symptoms be isolated and tested for COVID-19.

j) Updated Directive #3 for Long Term Care Homes under the *Long Term Care Homes Act, 2007*

150. On April 8, 2020, over two months after COVID-19 was first detected in Ontario and approximately one month after COVID-19 was declared a pandemic by the WHO, the Chief Medical Officer of Health issued an updated Directive #3 to LTC homes. At this time, the Province had reported 78 deaths in LTC homes, and outbreaks in at least 58 LTC homes. The Directives pertained to practices and procedures in LTC facilities and to the supply of PPE, including N95 respirator masks. For the first time, the updated Directive #3 required all LTC staff to wear surgical or procedure masks at all times for the duration of their shifts and increased the frequency of screening for COVD-19 symptoms to twice a day.

151. Updated Directive #3 recognized the serious nature of the potential complications that could be caused by COVID-19, including pneumonia and death. It finally provided for specific IPAC precautions and procedures understood, since 2003 at the latest, to be necessary for prevention of respiratory outbreaks. These IPAC measures included the active screening of all residents; the appropriate use of PPE; the use of masks by staff and essential visitors; limitations on staff working at multiple locations; staff and resident cohorting; management of COVID-19 cases in both residents and staff and outbreaks LTC homes; steps to be followed in response to outbreaks; testing; ensuring COVID-19 preparedness; communications, food and product deliveries.

152. Updated Directive #3 directed all LTC homes, regardless of the existence of an outbreak, to immediately require that all staff and essential visitors wear surgical/procedure masks at all times for source control for the duration of their shifts or visits in the LTC home.

153. Updated Directive #3 also required that LTC homes use staff and resident cohorting to prevent the spread of COVID-19. Updated Directive #3 directed LTC homes to adopt cohorting by, among other things, designating staff to work with either ill or healthy residents.

154. Cohorting involves grouping residents based on their risk of infection or whether they have tested positive for COVID-19 during an outbreak. Each cohort must be separated from other cohorts, and within cohorts, residents must remain as far apart from each other as possible. Staff should work with only a single cohort if possible. Within an outbreak area, staff should wear a mask, eye protection and gowns. Gloves should be worn when providing direct care to a resident.

155. Cohorting under updated Directive #3 also involved alternative accommodation in the home to maintain physical distancing of two metres, resident cohorting of the well and unwell, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate.

156. On April 11, 2020, data published by Public Health Ontario illustrated the devastating impact of COVID-19 on Ontario's LTC homes: the number of cases among residents and staff had surpassed 1,000 and the number of deaths had surpassed 100.

k) Directive #5 for Long Term Care Homes under the *Long-Term Care Homes Act, 2007*

157. On April 10, 2020, the Chief Medical Officer of Health issued Directive #5. Directive #5 applied to both hospitals and LTC homes and finally reflected the recognition that COVID-19 potentially presented an immediate risk to the health of the Resident Class Members.

158. Directive #5 included the following requirements:

a) public hospitals and LTC homes explore all available avenues to obtain and maintain a sufficient supply of PPE;

b) public hospitals and LTC homes, as well as health care workers and other employees, must engage on the conservation and stewardship of PPE;

c) hospitals and LTC homes must assess the available supply of PPE on an ongoing basis;

d) in the event that utilization rates indicate that a shortage of PPE will occur, the government and the public hospital or LTC home will develop contingency plans in consultation with the affected unions; and

e) at a minimum, for health care workers and other employees in a hospital or LTC home, contact and droplet precautions must be used for all interactions with suspected, presumed or confirmed COVID-19 patients or residents, including surgical/procedure masks.

159. It was not until April 13, 2020, that the Province began to provide same-day delivery of supplies and equipment to LTC homes.

l) "Work Deployment Measures Long-Term Care Homes" Emergency Order

160. On or around April 14, 2020, an Emergency Order titled "Work Deployment Measures Long-Term Care Homes" was passed under section 7.0.2(4) of the *Emergency Management and Civil Protection Act*. This Order authorized LTC homes to take with respect to work deployment and staffing, any reasonably necessary measure to respond to, prevent and alleviate the outbreak of COVID-19 for residents.

m) "Limiting Work to a Single Long-Term Care Home" Emergency Order

161. On or around April 16, 2020, an Emergency Order titled "Limiting Work to a Single Long-Term Care Home" was passed under section 7.0.2(4) of the *Emergency Management and Civil Protection Act.* This Order limited employees of long-term care homes from working at more than one long-term care home as of April 22, 2020. Operators of LTC homes in Ontario, including Responsive Group, would nonetheless have been aware of the importance of this issue long before April 16, 2020, given the knowledge of community spread going back to no later than the end of January 2020, as well as the implementation of a similar restriction on March 26, 2020 in British Columbia.

n) Ontario's Action Plan for LTC homes

162. On April 15, 2020, when COVID-19 was already running rampant in LTC homes, Premier Doug Ford announced Ontario's "action plan" for residents of LTC homes. The action plan promised wider testing in LTC homes and offered help from hospital teams specialized in preventing and controlling infections. The action plan finally placed a ban on employees working at more than one facility, which was to take effect in one week. On the same day, the Province

published official figures confirming that 162 residents of LTC homes had died and 933 residents and 530 staff at LTC homes were infected with COVID-19.

163. The "action plan" recognized that enhanced guidance was required to support LTC homes on the usage of PPE, including on what PPE to use in what circumstances. It also noted that training and education were required to support staff working in outbreak situations.

164. As of April 17, 2020, nearly 2,000 residents and staff of LTC homes had already been infected with COVID-19, and the provincial death toll had surpassed 200. The Province confirmed that the spread of COVID-19 was still accelerating in LTC homes.

o) Memorandum Regarding Testing

165. On or about April 21, 2020, the Province's Command Table issued a memorandum to Health System Organizations and Providers, to require enhanced testing guidelines for LTC homes, including immediate testing of all residents and staff in homes with outbreaks and surveillance testing in homes with no symptomatic residents.

p) Request for Reinforcement from Public Health Agency of Canada and the Canadian Armed Forces

166. On April 22, 2020, Premier Doug Ford made a formal request for reinforcement from the Public Health Agency of Canada and the CAF. A day later, the Federal Government approved his request and authorized the CAF to assist at five LTC homes, including Eatonville and Hawthorne Place. By this time, the death toll from COVID-19 at LTC homes had reached 295. Ultimately, the CAF attended at seven of the hardest-hit LTC homes in Ontario.

q) Emergency Order Regarding Management Agreements

167. On May 12, 2020, Ontario issued an emergency order which allowed the Ministry to temporarily replace management at some LTC homes struggling to contain the virus, including the Responsive Group LTC Homes Eatonville Care Centre and Hawthorne Place.

r) "New Admissions and Readmissions for Long-Term Care Homes" Directive

168. On or around June 10, 2020, Ontario's Chief Medical Officer of Health issued a Directive prohibiting incoming residents at LTC homes to be placed in a room with more than one other resident.

s) Directives Easing Visitor Restrictions

169. On June 18, 2020, Ontario's Chief Medical Officer of Health allowed family and friends to participate in outdoor visits with residents at LTC homes, in accordance with specific conditions. These visits were limited to one visitor per week.

170. On July 2020, Ontario's Chief Medical Officer of Health allowed family and friends to participate in indoor visits with residents at LTC homes, in accordance with specific conditions, even though the COVID-19 pandemic was ongoing and no vaccines were available to protect the residents from the risk of infection.

171. On or around August 28, 2020, the Ministry announced that in certain circumstances, residents were permitted to leave the LTC home for short-stays and temporary absences.

t) Directive Restricting Visitor Access

172. On or around September 29, 2020, the Province of Ontario announced that as of October 5, 2020 only staff and people deemed essential caregivers or essential visitors would be permitted at LTC homes in Ontario.

u) Directive from the Chief Medical Officer Regarding Various IPAC Measures

173. On or around October 8, 2020, the Chief Medical Officer of Health issued a directive for LTC in Ontario to implement the following procedures: provide all regulated health professionals and other health care workers with information on the safe utilization of all PPE; assess their available supply of PPE on an ongoing basis; the employer will be responsible for PPE supply levels; a point-of-care risk assessment must be performed by every regulated health professional before every patient or resident interaction; droplet and contact precautions must be used for all interactions with suspected, probable or confirmed COVID-19 patients or residents;

and staff at long-term care homes must wear surgical masks at all times for source control for the duration of full shifts, regardless of whether the home is in outbreak or not.

v) Update to Directive #3 to align with the *COVID-19 Response Framework: Keeping Ontario Safe and Open*

174. On or around December 7, 2020, the Chief Medical Officer of Health issued another directive which required active screening, including temperature and symptom checks of all staff, visitors and residents twice a day. It also required a proper protocol for the return to the home from the hospital or the community, including a 14-day isolation period and steps on how to react to a single case of COVID-19 in a resident, i.e. the resident must be in isolation under Droplet and Contact Precautions, in a single room.

D. Facts relating to the Class Members' Vulnerability and the Defendants' Inadequate and Unreasonable Response to the COVID-19 Pandemic

a) Vulnerable resident populations

175. As described above, the Ontario government tightened admissions criteria to LTC homes in 2010. Since then, only those residents with high or very high care needs are eligible for placement in LTC homes in Ontario. As a result, the average age of residents in LTC homes has risen to older than 85.

176. Residents of LTC homes are among the most vulnerable and frail members of the aging population, and include those in need of substantial medical and personal care. Many residents are physically impaired and unable to perform even basic tasks, such as getting out of bed, bathing, going to the washroom or feeding themselves. The vast majority of LTC home residents are cognitively impaired, with two-thirds of residents impacted by dementia.

b) The Defendants' collective failure in adopting and implementing IPAC protocols

177. Many of the Responsive Group LTC homes subject to this claim experienced outbreaks of COVID-19 among Residents during the pandemic. As of May 9, 2021, at least 207 Residents of Responsive Group LTC homes in Ontario had died as a result of COVID-19 related

illness and related complications. These deaths were caused by the Defendants' collective and systemic failure to adopt, implement and enforce timely, effective and reasonable IPAC protocols and practices at their respective facilities.

178. The particulars of the Defendants' grossly unreasonable practices are summarized below and apply to each of the Responsive Group LTC homes identified in this Claim.

i) Significant delay in implementing necessary IPAC protocols

179. The Defendants were significantly delayed in implementing necessary IPAC measures to prevent COVID-19 outbreaks, despite the fact that the appropriate IPAC protocols for preventing respiratory outbreaks were known to the Defendants long before the pandemic and were implemented by certain other LTC homes in Ontario which did avoid outbreaks of COVID-19 in their facilities.

180. In November 2012, the Provincial Infectious Diseases Advisory Committee released the "Routine Practices and Additional Precautions in All Health Care Settings" ("Routine Practices") as guidance to reduce the risk of transmission of microorganisms in all health care settings (including LTC homes). The Routine Practices include "Best Practices for Prevention of Transmission of Acute Respiratory Infections," which set the baseline standard for responding to acute respiratory infections in retirement and long-term care facilities. The relevant portion of the Routine Practices is set out below:

> Recommendations
>
> 13. Clients/patients/residents presenting for care in a health care setting who have symptoms of acute respiratory infection should be asked to perform hand hygiene and wear a mask, practice respiratory etiquette and either wait in a separate area or keep at least two metres away from other clients/patients/residents and HCWs.
>
> 14. Whenever possible, patients who have symptoms of an acute respiratory infection who are admitted to a hospital should be accommodated in a single room under Droplet and Contact Precautions.
>
> 15. Residents of long-term care homes with an acute respiratory infection who are not in single room accommodation should be managed in their bed space using Droplet and Contact Precautions with privacy curtains drawn.

181. On November 2018, the Ministry issued the "Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes" (the "Acute Respiratory Outbreak Guide"), which sets out various required components of an outbreak response, including:

> a) ongoing surveillance programs to determine the presence of infections, including a sufficiently sensitive surveillance program to identify sentinel events and trends;
>
> b) analysis of surveillance data by the IPAC Professional in order to trigger actions designed to reduce or eliminate disease transmission and influence policy and practice; and
>
> c) control measures to be implemented as soon as an outbreak is suspected, namely:
>
> i) staff notified quickly of the outbreak;
>
> ii) supplies made available as necessary (e.g., alcohol based hand rub, PPE, including gowns, face protection, gloves, surgical masks, etc.); and
>
> iii) symptomatic residents placed on droplet/contact precautions in addition to Routine Practices being employed as soon as possible after symptoms identified.

ii) Staffing shortages

182. Both before and throughout the pandemic, severe staffing shortages were experienced across all Responsive Group LTC homes. Much of the individual care at LTC homes is carried out by low-wage, part time shift workers, known as Personal Supports Workers ("PSWs"). Many of these workers were forced to work multiple jobs across multiple facilities to supplement their income, both before and during the pandemic, thus substantially increasing the risk of COVID-19 transmission, particularly asymptomatic transmission, among both staff and Residents at the Responsive Group LTC homes.

183. There was a high staff turnover rate in the Responsive Group LTC homes due to poor working conditions, low pay, precarious schedules and, as the pandemic progressed, fear among workers about contracting COVID-19 by working in the Responsive Group LTC homes. The Defendants' staffing capacity at the Responsive Group LTC homes had almost completely collapsed at the height of the first wave of the pandemic, as a result of staff being infected with

COVID-19 or refusing to work out of fear of becoming infected and risking their and their families' health. At a time when adequate staffing was critical, there were insufficient staff in place at the Responsive Group LTC homes to look after the Residents' basic needs.

184. During the pandemic, inadequate staffing at the Responsive Group LTC homes resulted in significant failures to adhere to appropriate IPAC standards. Among these failures were inadequate and/or absent on-site IPAC leadership, improper use and changing of PPE by staff members, inadequate cleaning practices, inadequate infection screening and an almost complete lack of appropriate cohorting of infected and non-infected Residents.

185. Further, the insufficient staffing resulted in many Residents being deprived of the services that the Responsive Group LTC homes were required to provide by both statute and contract. Tragically, this lack of staffing contributed to many Residents dying or becoming seriously ill not only from COVID-19, but also as a result of being deprived of necessary medical care and in many cases, the basic necessities of life, including food, water and basic hygiene.

iii) Outbreak Planning

186. The Defendants failed to implement any or any adequate pandemic response plan ("Plan") for the Residents, contrary to their common law, statutory and contractual obligations. This is despite the fact that they knew, or ought to have known, that such a Plan was required to safeguard the health, safety, well-being and dignity of the Residents.

187. When faced with a spread of COVID-19 in the Responsive Group LTC homes, the Defendants failed to conduct even the most basic acute respiratory infection surveillance or to take standard droplet/contact precautions, let alone ensure the adequacy of PPE supplies or their use. The Defendants also failed to communicate with the families of Residents living in the Responsive Group LTC homes or staff regarding "presumptive positive" cases of COVID-19 at the homes, in contravention of the Acute Respiratory Outbreak Guide.

iv) Failure to restrict visitor access

188. The Defendants continued to allow visitors into their facilities weeks after the highly contagious nature of COVID-19 was known.

189. The Defendants failed to undertake even the most basic, timely and reasonable measures to secure LTC homes and to restrict access from visitors and third parties and to prevent the exposure of Residents to the risk of contracting COVID-19. The Defendants delayed the implementation of IPAC measures, including active, rather than passive, testing and screening of all visitors.

v) PPE shortages

190. The Responsive Group LTC homes were highly unprepared for the pandemic, notwithstanding the recommendation that all health care facilities, including LTC homes, maintain their own four-week supply of PPE. Many workers at the Responsive Group LTC homes did not have access to PPE at the beginning of the pandemic and the Defendants failed to quickly and adequately address this shortcoming.

191. As a result, PPE was not routinely available to staff, and staff were frequently not given access to fitted N95 respirators, the most protective masks that block aerosolized virus particles and offer better protection than surgical masks. Some facilities kept masks, and in particular N95 respirators, under lock and key, and did not provide them to staff unless an outbreak occurred. PPE was only available to staff if there were outbreaks.

vi) Lack of IPAC and PPE training

192. Responsive Group's management and leadership failed to address and remedy the improper use of PPE and inadequate IPAC practices. In spite of the requirements imposed by sections 229 and 230 of O. Reg 79/10 relating to IPAC and emergency planning, many staff at the Responsive Group LTC homes never received proper training on IPAC, PPE use and safe hygiene practices. If a Responsive Group LTC home had IPAC protocols, these protocols were

incomplete, inadequate and were in any event not followed by staff due to a lack of proper training and/or due to significant staffing shortages.

193. A survey conducted by the Canadian Union of Public Employees found that 95% of the 2,000 PSWs employed by LTC homes surveyed had no access to training on how to deal with or interact with COVID-19 positive patients. Staff frequently failed to wear their PPE correctly or change their PPE as required. Due to the shortage of PPE, some staff were forced to re-use PPE which increased the risk of spreading the virus. Due to the lack of proper training, staff at the Responsive Group LTC homes used PPE inappropriately, for example, by layering a scarf underneath a mask, or using hand sanitizer to sanitize protective gloves. The Canadian Military Report on some of the Responsive Group LTC homes described that staff were afraid to use vital supplies and PPE because they were advised by management that the PPE was costly. It also reported that the Defendant LTC homes did not provide PPE training to new staff.

vii) Overcrowding

194. The Responsive Group LTC homes were overcrowded and did not have adequate space for Residents. Private rooms were scarce before and during the pandemic. As of April 1, 1998, the design standards for the construction and/or renovation of LTC homes in Ontario were updated in accordance with the *Long-Term Care Facility Design Manual* (the "*Manual*"). Pursuant to the *Manual*, bedrooms accommodating four residents were expressly not allowed and semi-private rooms had to have at least 130 square feet of floor space and were required to provide two separate bedrooms joined by a "barrier-free" washroom. Standard bedrooms were required to have at least 115 square feet of floor space and were shared by two residents with a separate "barrier-free washroom.

195. Contrary to these regulations, the Defendants failed to upgrade, modify, or renovate these Responsive Group homes when they knew or ought to have known that several Responsive Group LTC homes had C-level bed design, which did not meet the applicable design standards as set out in the Manual. During the pandemic, at least 13 of the Responsive Group LTC homes remained at outdated design standards which included many that allowed for rooms that accommodated four Residents, with only a curtain separating Residents. Residents in communal

rooms shared bathrooms. In addition, Residents still dined in communal dining rooms at many of the Responsive Group LTC homes. The Responsive Group homes with the outdated design include Anson Place, Banwell Gardens Care Centre ("Banwell Gardens"), Berkshire Care Centre ("Berkshire"), Bon Air Long Term Care Residence ("Bon Air"), Champlain Long Term Care Residence ("Champlain"), Cooksville, Dundurn Place Care Centre ("Dundurn"), Eatonville, Hawthorne Place, Lancaster Long Term Care Residence ("Lancaster"), Niagara Long Term Care Residence ("Niagara"), Pine Villa Care Centre ("Pine Villa") and Vermont Square.

196. Space constraints made cohorting of COVID-19 positive patients, isolation and social distancing difficult during the pandemic. COVID-19 positive Residents, or those showing symptoms consistent with COVID-19 frequently were kept in rooms with Residents who were COVID-19 positive or asymptomatic. Given that isolation was a reasonably foreseeable requirement for respiratory outbreaks of any significance, the Defendants had an obligation to have contingencies imbedded into their emergency response planning that would allow for the isolation and cohorting of Residents, including protocols for transferring Residents to alternative health care facilities when Responsive Group LTC homes reached capacity. No such contingencies were in place or implemented by the Responsive Group LTC homes during the pandemic.

viii) Failure to implement the inadequate and delayed Directives issued by the Ontario government

197. At the Responsive Group LTC homes, Residents were typically not isolated in a timely fashion, or at all, upon exhibiting symptoms of COVID-19. Residents with COVID-19 were frequently allowed to move from room to room, increasing the risk of an outbreak or the spread of the virus.

198. At the outset of the pandemic and for some time thereafter, the testing of Residents, staff and Visitors was infrequent, if not absent, at the Responsive Group LTC homes, resulting in a failure by the Defendants to control or slow the spread of the virus.

199. The Defendants did not communicate with the Residents, Visitors and staff about the risk of infection. At some of the LTC homes, such as Anson Place, COVID-19 outbreaks were only declared many days after the virus had entered the facilities.

200. On April 23, 2020, Morgan J. granted an injunction requested by the Ontario Nurses Association ("ONA") requiring three of the Responsive Group LTC homes to stop ongoing breaches of directives issued by the CMOH. Among other things, the ONA requested "appropriate access to the PPE that they need[ed] to protect themselves and the Residents of the facilities" and for the implementation of "required administrative controls for LTC facilities" including isolation and cohorting. Morgan J. granted the injunction on the ground that if it were not granted, it would lead to irreparable harm in the form of risk to patient and staff safety.

201. The Defendants did not respond to or implement even the grossly delayed and inadequate government directives, despite the gravity of the harm that could come to Residents if infected with COVID-19.

202. In addition, the Defendants' response to the COVID-19 pandemic reflected the following deficiencies which were shared among all Responsive Group LTC homes:

a) failure to properly and correctly identify COVID-19 positive patients, and to cohort or separate COVID-19 positive and negative Residents who shared the same room;

b) inadequate or no follow-up on Residents with documented respiratory symptoms in December 2019 and January and February 2020;

c) lack of adequate cleaning supplies;

d) lack of appropriate end of life and palliative care; and

e) lack of standardized and regular communication with families and Residents regarding Resident care and outbreak status.

E. Overview of Outbreaks at the Responsive Group LTC Homes

203. Responsive Group was, and remains, responsible for the adoption and implementation of reasonable and timely IPAC protocols and policies at the Responsive Group LTC homes.

Responsive Group failed systemically at adopting and implementing timely and appropriate corporate-wide IPAC protocols and practices for the Responsive Group LTC homes. It further failed to ensure that its licensees were adopting and implementing timely and reasonable IPAC protocols and practices to prevent foreseeable but avoidable COVID-19 outbreaks at the Responsive Group LTC homes.

204. The Responsive Group LTC homes listed below suffered from significant understaffing, lacked adequate PPE, and had failed to implement appropriate IPAC protocols and practices, all of which resulted in devastating outbreaks. At all times during the outbreaks at these facilities, Residents were not receiving basic care and attention to their health and hygiene and had poor nutritional status due to underfeeding.

205. The specific facts relating to the outbreaks and fatalities at Responsive Group's worst-hit LTC homes are set out below. The number of Resident deaths is based primarily on information published by the Government of Ontario, current as of May 10, 2021.

206. In addition to those Residents who became infected with COVID-19 and suffered the pain and suffering associated with complications from that disease, all Residents in the Responsive Group LTC homes suffered from the Defendants' systemic gross negligence. Among the harms suffered by infected and non-infected Residents alike were the lack of basic necessities of life, resulting in dehydration, malnutrition, and untreated medical conditions which, in some cases, resulted in death, as well as confinement syndrome caused by neglect. All Residents suffered a variety of indignities demonstrating the Defendants' abject failure in meeting the standard of care required of LTC operators in Ontario.

a) Anson Place

207. Anson Place is an LTC home located in Hagersville, Ontario. It is owned by Anson Place Care Centre Facility Inc. and licensed by Rykka Care Centres LP. The home has capacity for 61 beds.

208. A COVID-19 outbreak was first declared at Anson Place on March 27, 2020.

209. On March 29, 2020, a COVID-19 outbreak was declared on the second floor of the LTC facility. Despite the outbreak, the Defendants did not put into effect its Pandemic Plan.

210. Ward rooms were shared by four Residents, and the beds, which were not the required 2 metres apart, were separated merely by a curtain. Residents diagnosed with COVID-19 were not moved from these shared rooms, and remained in close proximity to, and were treated by the same nursing staff, as those Residents who were not infected. This increased the risk of the virus spreading throughout the home.

211. During the outbreak, Residents from the first and second floors had been permitted to continue intermingling freely in the building's common lobby, thus increasing the risk of infection and foreseeable complications and death.

212. Further, during the outbreak, staff moved freely between the two floors of Anson Place, which contains both a retirement residence and an LTC facility. Staff had contact with both the retirement Residents and the far more vulnerable LTC Residents, causing the virus to spread throughout the facility. Staff of both the retirement residence and the LTC facility share a common elevator, kitchen and rest areas, which put Residents of both facilities at a greater risk of contracting the virus.

213. Staff at Anson Place had minimal access to N95 respirators. Up until April 6, 2020, nurses were advised that N95s were unnecessary and would only be provided when a nurse was swabbing a patient for COVID-19.

214. On April 6, 2020, nearly 40% of the Residents of Anson Place had tested positive for COVID-19, along with 22 staff. Five Residents had died as a result of COVID-19 exposure. Two weeks later, the death toll rose to 24.

215. On April 9, 2020, the Haldimand-Norfolk Medial Officer of Health was advised that Anson Place was not cohorting Residents and staff. Yet, Anson Place did not add more PPE, including N95 masks, and did not separate Residents into segregated

wards such that COVID-19 positive patients would not be in the same room as those who had not yet been infected.

216. As of April 14, 2020, 49 of the 58 Residents of Anson Place had tested positive for the virus, and all of the other Residents were presumed positive.

217. On April 18, 2020, the Ontario Nurses' Association applied for an injunction requiring three Responsive Group LTC homes, including, Anson Place, to refrain from ongoing breaches of directives issued by the CMOH. The following deficiencies were reported with respect to Anson Place:

a) Although a COVID-19 outbreak was only formally declared at Anson Place on March 27, 2020, infections "certainly started before that date." Until April 6, 2020 – 20 days after the declaration of a provincial public emergency - nurses were advised that N95s were "unnecessary and would only be provided when nurse was swabbing a patient for COVID- 19." Nurses were reportedly asked by Anson Place leadership to wear lesser protective surgical masks instead of N95 masks when those nurses had assessed the Resident under their care to be "actively contagious" and pose a "serious risk," in direct contravention of Directive #5. Even as late as the second week of April 2020, N95 masks remained under "lock and key" in the Executive Director's office and "rationed" out.

b) There was a complete lack of isolation or cohorting at Anson Place despite known cases of COVID-19. Indeed, even after the declaration of an outbreak at Anson Place on March 27, 2020, management did not put into effect its existing Pandemic Plan such that Residents and staff were not separated, or cohorted, into contagious and non-contagious groupings. Ward rooms were shared by four Residents, and the beds, which are not the required 2 metres apart, were separated merely by a curtain. Residents diagnosed with COVID-19 were not moved from these shared rooms, remaining in close proximity both to nursing staff and fellow Residents (who may not be infected). Staff at Anson Place's retirement and LTC residences moved between the two floors and shared a common elevator after the declaration of an outbreak, thereby having contact with both the somewhat less vulnerable retirement Residents and the far more susceptible long-term care Residents. Residents from both the floors continued to intermingle freely in the building's common lobby without any supervision or regard to infection

218. Further, prior to the start of the pandemic, Anson Place had a self-professed "staffing crisis". The spread of the COVID-19 infection among staff members made the staffing crisis

worse. And yet, as the staffing crisis worsened throughout the pandemic, the Defendants took no steps to ameliorate the situation. For example, Anson Place received an offer from the province of Ontario to supply a "SWAT team" of hospital workers to help manage its COVID-19 outbreak. The Defendants initially refused the Province's offer, saying that they were currently able to meet the care needs of Residents.

219. Anson Place remained in an outbreak for almost three months. Since the start of the pandemic, Anson Place reported no active cases in Residents for the first time on June 22, 2020.

220. As of May 9, 2021, 23 Residents, representing 38% of the total number of Residents at the home, had died of COVID-19.

b) Cooksville

221. Cooksville is an LTC home located in Mississauga, Ontario. It is owned by Cooksville Care Centres Facility Inc. and licensed by Rykka Care Centres LP. The home has capacity for 192 beds.

222. A COVID-19 outbreak among Residents was declared at Cooksville on April 14, 2020. The virus spread quickly as a result of the Defendants' failure to implement any measures to contain the outbreak. By May 8, 2020, the home reported 40 active cases among Residents. Cooksville remained in an active outbreak for a period of over three months while the Defendants lost control of the situation. The outbreak finally ended on June 29, 2020.

223. As of May 9, 2021, a total of 21 Cooksville Residents, had died of COVID-19 as a result of the facility's failure to implement reasonable IPAC protocols in a timely manner.

c) Dundurn Place Care Centre

224. Dundurn is an LTC home located in Hamilton, Ontario. It is owned by Responsive Group and licensed by Rykka Care Centre LP. It has capacity for 201 beds.

225. As of May 9, 2021, two COVID-19 outbreaks among Residents have occurred at Dundurn. The first outbreak started in or about April 2020. On May 6, 2020, 6 active cases among Residents were reported at Dundurn. The first outbreak lasted until May 19, 2020.

226. Despite clear warnings and the experience with the first outbreaks, the Defendants were unable to take the necessary measures to prevent further outbreaks at Dundurn. A second COVID-19 outbreak among Residents was reported at Dundurn from October 15, 2020 to November 4, 2020. Several Residents tested positive for the virus during the second outbreak.

227. As of May 9, 2021, several Dundurn Residents have died after contracting COVID-19 at the home. In the meantime, as a result of the Defendants' gross negligence, the Residents of Dundurn have suffered from a diminished level of care and neglect due to significant understaffing, staff outbreaks and lack of a cohesive and effective plan to prevent and manage outbreaks at the home. At all material times, the Residents of Dundurn have been malnourished, have lived in unhygienic conditions, have been exposed to a significant risk of, and have suffered, serious illness, including COVD-19, without receiving adequate medical care.

d) Eatonville Care Centre

228. Eatonville Care Centre ("Eatonville") is an LTC home located in Etobicoke, Ontario. It is owned by Eatonville Care Centre Facility Inc. and licensed by Rykka Care Centres LP. It has capacity for 247 beds.

229. On March 16, 2020, Eatonville had an outbreak of illnesses in three units, with symptoms resembling COVID-19. Residents in a fourth Eatonville unit also showed COVID-19 symptoms. These Residents were permitted to move freely around the entire facility.

230. Only staff attending to Residents diagnosed with COVID-19 were given N95 respirators. Eatonville provided the nurses with ordinary surgical masks rather than with N95 respirators.

231. Furthermore, despite knowledge of an outbreak at the home, Residents exhibiting symptoms of COVID-19 were not tested for several days, reportedly due to the lack of testing swabs.

232. On April 2, 2020, the ONA filed a grievance under its collective agreement with Eatonville, alleging that the LTC home had failed to adequately ensure the safety of its nursing staff and to provide adequate PPE. The grievance also alleged that Eatonville had failed to take reasonable precautions under the circumstances of the COVID-19 pandemic, and ONA sought access to N95 respirators for its members.

233. On April 18, 2020, the ONA applied for an injunction requiring Eatonville to refrain from breaches the CMOH's directives. Nurses working at Eatonville expressed concern that Residents exhibiting symptoms of COVID-19 were permitted to roam freely about the residence. Morgan J. granted the injunction on April 23, 2020 on the grounds that irreparable harm to Residents and staff would occur.

234. On April 14, 2020, Eatonville had 25 deaths and 49 confirmed cases of COVID-19. The Coroner's Office would no longer enter the building to access dead bodies. Staff members were required to bring dead bodies outside to officials from the Coroner's Office and were instructed to avoid media and families when doing so.

235. By April 24, 2020, the number of active cases had risen to 143 and 37 Residents had died. This means that at least 72% of the home's Residents had been infected with COVID-19.

236. On April 28, 2020, the CAF Joint Task Force (Central) dispatched one of its Augmented Civilian Care teams ("CAF ACC") to Eatonville in order provide support and bring the situation under control. The home was one of seven LTC homes in Ontario to receive assistance from the CAF.

237. In a letter dated May 14, 2020, CAF ACC identified a number of medical professional and technical issues at Eatonville related to IPAC, standard of practice/quality concerns,

ambiguity on local practices, supplies, communication, staffing and inappropriate behaviour. The CAF ACC observed the following at Eatonville:

(i) COVID-19 positive Residents “allowed to wander” putting “anyone in the facility” at risk “of being exposed and passing it throughout the home;

(ii) “facility staff often wear PPE outside of rooms and at the nurses station";

(iii) Use of supplies “even after sterility has been obviously compromised”;

(iv) a “culture of fear to use supplies” due to cost;

(v) “policies and facility-specific procedures” not communicated to staff

(vi) Despite the ONA injunction, “ministry requirement [still] cited as reason they still have negative Residents rooming with positive Residents”;

(vii) key supplies such as wipes for PSWs being put under “lock and key;” and

(viii) poor palliative care standards (inadequate dosing intervals for some medication) and poor wound care

238. The first outbreak at Eatonville lasted until June 11, 2020.

239. A second outbreak among Residents was reported at Eatonville on May 4, 2021 and it is still active as of May 9, 2021. Several more Residents have tested positive for COVID-19.

240. As of May 9, 2021, a total of 42 Eatonville Residents had died from COVID-19. Resident

e) Hawthorne Place

241. Hawthorne Place is an LTC home located in North York, Ontario. It is owned by Hawthorne Care Facility Inc. and licensed by Rykka Care Centres LP. It has capacity for 269 beds.

242. As of April 12, 2020, there were 6 diagnosed cases of COVID-19 among the 215 Residents of Hawthorne Place, and one Resident had died from COVID-19. Hawthorne Place was unable to contain and mitigate the outbreak. As a result of its untimely, inadequate and *ad hoc* practices, the virus spread rapidly among the Residents.

243. On March 30, 2020 and April 8, 2020, the ONA filed grievances under its collective agreement with Hawthorne Place alleging that Hawthorne Place had failed to provide access to necessary PPE, to isolate new admissions or readmissions and to cohort Residents as well as staff, thus exposing both staff and Residents to the risk of infection with COVID-19.

244. The ONA filed for an injunction on April 18, 2020 requiring that Hawthorne Place refrain from ongoing breaches of directives issued by the Chief Medical Officer of Health. Nurses working at Hawthorne Place expressed concern that nursing staff were routinely denied requests for PPE from the end of February 2020. The Executive Director, Gale Coburn, made it clear that staff were not even to wear their own surgical mask that they brought from home, for fear of frightening the Residents. Despite a request for an N95 respirator made by a nurse on April 3, 2020, after the declaration of an active outbreak of COVID-19 at the facility, staff were given no N95s at all. N95 masks were rolled out sporadically during the weeks of April 6 and April 13 with most nurses being given a single mask per shift. Further, problems with isolation and cohosting were pervasive within Hawthorne Place. Indeed, Residents exhibiting COVID-19 symptoms were re-admitted and not isolated despite awaiting COVID-19 test results. At the same time, staff who had been exposed to these patients were instructed to report for work as usual rather than to self-isolate.

245. <u>The Defendants lost control of the outbreak and the home reported 47 active cases among Residents by April 28, 2020. By May 20, 2020, the number of active cases among Residents had risen to 96 and 39 Residents had died.</u>

246. The CAF ACC was also dispatched to Hawthorne Place, beginning on April 28, 2020. The May 14, 2020 CAF Letter identified a number of egregious observations at Hawthorne Place:

a) poor training and adherence to Routine Practice and Best Practices;

b) fans blowing in hallways spreading droplets;

c) near 100% contamination rate for equipment, patients and overall facility to including:

i. nurses/PSWs observed “not changing PPE for several hours”

ii. equipment “seldom/ever observed to be disinfected”

d) gross fecal contamination in patient rooms and delayed changing of soiled Residents;

e) patients observed frying for help with staff not responding for 30 minutes to 2 hours; and

f) safety concerns regarding nurse to patient ratios.

247. As of May 9, 2021, 51 Residents at Hawthorne Place had died after contracting COVID-19. This represents approximately 20% of the home’s Resident population.

f) Vermont Square

248. Vermont Square is an LTC home located in Toronto, Ontario. It is owned by 914 Bathurst GP Inc., licensed by Vermont Square LTC Inc. as General Partner of Vermont Square LTC LP, and managed by Responsive Health Management Inc. Vermont Square has capacity for 130 beds.

249. As of May 9. 2021, three COVID-19 outbreaks among Residents have been reported at Vermont Square. The first outbreak was reported on May 2, 2020 and lasted until June 5, 2020. Several Residents were infected with COVID-19.

250. Despite the experience with the first outbreak, the Defendants failed to take action to prevent a second and potentially more serious outbreak. The second outbreak at Vermont Square was reported on September 30, 3030. By October 17, the home reported 55 active cases of COVID-19 among Residents. It further reported that 6 Residents had died of COVID-19. Almost

half of the Resident population had been infected. University Health Network and Mount Sinai Hospital provided assistance to bring the outbreak under control. The second outbreak ended on November 13, 2020, about a month and a half after it started.

251. A third outbreak was reported at Vermont Square from January 7, 2021 to January 18, 2021 with several more Residents testing positive for the virus.

252. As of May 9, 2021, 12 Vermont Square Residents had died as a result of contracting COVID-19.

g) Earls Court Village

253. Earls Court Village ("Earls Court") is an LTC home located in London, Ontario. It is owned and managed by Sharon Farms & Enterprises Ltd., and was licensed by Responsive Health Management Inc. until October 31, 2020. The home has capacity for 128 beds.

254. A COVID-19 outbreak was reported at Earls Court on or about April 2020. On April 29, 2020, 9 active cases among Residents were reported at Earls Court. The outbreak lasted until May 19, 2020. As of May 9, 2021 at least one Earls Court Resident had died after contracting COVID-19.

h) Ina Grafton

255. Ina Grafton is an LTC home located in Scarborough, Ontario. It is owned and licensed by Ina Grafton Gage Home of Toronto and managed by Responsive Management Services Inc. The home has capacity for 128 beds

256. A COVID-19 outbreak was reported at Ina Grafton in or about April 2020. At all material times, the facility had an inadequate response to the pandemic and failed to protect its employees and Residents from COVID-19. Employees were pressured to come to work even when they were showing symptoms of COVID-19. The facility also failed to isolate COVID-19 positive Residents from those who were not infected, thus exposing healthy Residents to the risk of infection. As a result ,COVID-19 spread rapidly among the Residents. On May 15, 2020, Ina

Grafton reported 53 active cases. By this date, 27 Residents had died. Therefore, at least 63% of the Residents had been infected by that date. The first outbreak ended on June 19, 2020,

257. After the devastating first outbreak, the Defendants did not take action to prevent the virus from re-entering the home. Two subsequent outbreaks among Residents have been reported at Ina Grafton as of May 9, 2021. A COVID-19 outbreak was reported among Ina Grafton Residents from November 3, 2020 to December 15, 2020 and from February 4, 2021 to February 8, 2021. Several more Residents tested positive for COVID-19 as a result.

258. As of May 9, 2021, 31 Residents, representing 24% of the total number of Residents at the home, have died of COVID-19.

i) Bon Air Long Term Care Residence

259. Bon Air is an LTC home located in Cannington, Ontario. Bon Air was previously licensed by Chartwell Master Care LP. As of April 1, 2020, it is licensed by DTOC II Long Term Care LP and managed by Responsive Management Services Inc. It has capacity for 55 beds.

260. Since the start of the pandemic, the Residents of Bon Air have suffered from a diminished level of care and neglect due to significant understaffing, staff outbreaks and lack of a cohesive and effective plan to prevent and manage outbreaks at the home. At all material times, the Residents have been malnourished, have lived in unhygienic conditions, have been exposed to a significant risk of, and have suffered, serious illness, including COVD-19, without receiving adequate medical care.

j) Champlain Long Term Care Residence

261. Champlain is an LTC home located in L'Orignal, Ontario. As of April 1, 2020, it is licensed by DTOC II Long Term Care LP and managed by Responsive Health Management Inc. Prior to that date, Champlain was owned by Chartwell and licensed by Chartwell Master Care LP. It has capacity for 60 beds.

262. Since the start of the pandemic, the Residents of Champlain have suffered from a diminished level of care and neglect due to significant understaffing, staff outbreaks and lack of a cohesive and effective plan to prevent and manage outbreaks at the home. At all material times, the Residents have been malnourished, have lived in unhygienic conditions, have been exposed to a significant risk of, and have suffered, serious illness, including COVD-19, without receiving adequate medical care.

k) Lancaster Long Term Care Residence

263. Lancaster is an LTC home located in Lancaster, Ontario.. As of April 1, 2020, it is licensed by DTOC II Long Term Care LP and managed by Responsive Management Services Inc. Prior to that date, Lancaster was owned by Chartwell and licensed by Chartwell Master Care LP. The home has capacity for 60 beds.

264. A COVID-19 outbreak among Residents was reported at Lancaster on December 30, 2020. The virus spread quickly among the Residents and by January 13, 2021, Lancaster reported 37 active cases among Residents. The outbreak lasted until February 4, 2021.

265. As of May 9, 2021, 14 Lancaster Residents, representing approximately 23% of the home's Resident population, have died after contracting COVID-19.

l) Niagara Long Term Care Residence

266. Niagara Long Term Care Residence ("Niagara") is an LTC home located in Niagara-on-the-Lake, Ontario. As of April 1, 2020, it is licensed by DTOC II Long Term Care LP and managed by Responsive Management Services Inc. Prior to that date, Niagara was owned by Chartwell and licensed by Chartwell Master Care LP. The home has capacity for 124 beds.

267. A COVID-19 outbreak among Residents was reported at Niagara on January 6, 2021. The Defendants failed to contain the spread of the virus, and by January 19, 2021, Niagara reported 71 active cases among Residents and 5 deaths. More than 60% of Niagara's Residents had been infected within the first two weeks of the outbreak being reported.

268. As of May 9, 2021, 13 Niagara Residents had died of COVID-19.

m) Arbour Creek Long Term Care

269. Arbour Creek Long Term Care ("Arbour Creek") is an LTC home located in Hamilton, Ontario. It is owned by Responsive Group and licensed by Rykka Care Centres GP Inc. It has capacity for 129 beds.

270. Since the start of the pandemic, the Residents of Arbour Creek have suffered from a diminished level of care and neglect due to significant understaffing, staff outbreaks and lack of a cohesive and effective plan to prevent and manage outbreaks at the home. At all material times, the Residents have been malnourished, have lived in unhygienic conditions, have been exposed to a significant risk of, and have suffered, serious illness, including COVD-19, without receiving adequate medical care.

n) Banwell Gardens Care Centre

271. Banwell Gardens is an LTC home located in Tecumseh, Ontario. It is owned by Responsive Group and licensed by Rykka Care Centres LP. The home has capacity for 142 beds.

272. A COVID-19 outbreak was reported among Residents at Banwell Gardens on December 16, 2020.The Defendants lost control of the outbreak and the virus spread rapidly among the Residents of the home. On January 8, 2021, Banwell Gardens reported 86 active cases among Residents and 8 Resident deaths to date. The outbreak lasted for about one month and a half, ending on February 4, 2021.

273. As of May 9, 2021, 23 Banwell Gardens Residents, had died from COVID-19.

o) Berkshire Care Centre

274. Berkshire is an LTC home located in Windsor, Ontario. It is owned by Responsive Group Inc. and licensed by Rykka Care Centres LP. The home has capacity for 231 beds.

275. A COVID-19 outbreak among Residents was reported at Berkshire on December 12, 2020. By December 22, 2020, the home reported 42 active cases among Residents. The outbreak ended on February 9, 2021, almost two months after it began.

276. As of May 9, 2021, 16 Berkshire Residents, had died as a result of contracting COVID-19.

p) Orchard Terrace Care Centre

277. Orchard Terrace is an LTC home located in Stoney Creek, Ontario. It is owned by Responsive Group and licensed by Rykka Care Centres LP. The home has capacity for 45 beds.

278. Since the start of the pandemic, the Residents of Orchard Terrace have suffered from a diminished level of care and neglect due to significant understaffing, staff outbreaks and lack of a cohesive and effective plan to prevent and manage outbreaks at the home. At all material times, the Residents have been malnourished, have lived in unhygienic conditions, have been exposed to a significant risk of, and have suffered, serious illness, including COVD-19, without receiving adequate medical care.

q) Pine Villa Care Centre

279. Pine Villa is an LTC home located in Stoney Creek, Ontario. It is owned by Responsive Group and licensed by Rykka Care Centres II GP Inc. The home has capacity for 41 beds.

280. Since the start of the pandemic, the Residents of Pine Villa have suffered from a diminished level of care and neglect due to significant understaffing, staff outbreaks and lack of a cohesive and effective plan to prevent and manage outbreaks at the home. At all material times, the Residents have been malnourished, have lived in unhygienic conditions, have been exposed to a significant risk of, and have suffered, serious illness, including COVD-19, without receiving adequate medical care.

r) The O'Neill Centre

281. The O'Neill Centre is an LTC home located in Toronto, Ontario. It is owned and licensed by 848357 Ontario Inc. Responsive Health Management Inc. is the management firm for the home. The O'Neill Centre has capacity for 162 beds.

282. As of May 9, 2020 three COVID-19 outbreaks have occurred at the home. The first outbreak started in or around April 2020 and lasted until May 22, 2020. Several Residents were infected as a result.

283. A second outbreak at O'Neill began on February 10, 2020. On that same date, the home reported its first Resident death from COVID-19. The second outbreak lasted until March 17, 2021.

284. Despite these prior experiences with outbreaks, a third COVID-19 outbreak among Residents was reported on April 21, 2021. As of May 9, 2021, the outbreak among Residents was still active with the O'Neill Centre reporting 20 active cases among Residents. Several Residents have died to date.

V. CAUSES OF ACTION

A. Negligence and Gross Negligence

285. The Defendants had a duty of care to the Residents to ensure that each of the Responsive Group LTC homes was a safe and secure environment, to protect their health and safety and to prevent their exposure to the risk of contracting COVID-19. Specifically, Responsive Group Inc. had a duty to ensure that its licensees had in place at each Responsive Group LTC home, prior to the outbreak of COVID-19, an IPAC program and an emergency plan that were fully operational, managed by personnel with appropriate training and expertise, that were drilled regularly and that were capable of being scaled up and implemented sitewide as and when required.

286. Responsive Group Inc. also had a duty to adopt, implement and ensure compliance by its licensees with timely and effective IPAC protocols and measures to reduce, if not eliminate, the risk of COVID-19 outbreaks. Responsive Group's duty of care to the Resident Class Members and Visitor Class Members is non-delegable in that it could not delegate legal responsibility for harm arising from its licensee's failure to adopt, implement and comply with reasonable IPAC protocols, to its licensees.

287. The Defendants owed a duty of care to the Plaintiffs and other Class Members who, at all material times, depended on the Defendants for their health and safety, basic physical needs, food and hygiene, and medical care and treatment.

288. As elderly individuals, often with pre-existing medical illnesses, the residents of LTC homes are particularly vulnerable to the Defendants' decisions and practices, relied on the Defendants for all aspects of their health, safety and treatment and expected that the Defendants would adopt practices and policies to minimize, if not eliminate, the risk of COVID-19 infection at their facilities.

289. The Defendants owed a duty of care to the Plaintiffs and other Class Members to take reasonable steps to protect their health and wellbeing. This duty was enhanced prior to and during the period of the pandemic, where the Defendants knew, or ought to have known, that COVID-19 is highly contagious and that the elderly are at a significant risk of experiencing serious side effects and complications, including death, once infected with the virus.

290. The Defendants also had a duty of care to prevent the exposure of the Resident and Visitor Class Members to the risk of becoming infected with COVID-19 while they were resident in and/or visiting the homes owned and/or operated by the Defendants.

291. Once a positive COVID-19 test was confirmed at each of the Responsive Group LTC homes, the Defendants had a further duty of care to the Plaintiffs and other Class

Members to take reasonable steps to prevent and/or control the spread of infection at each of those homes.

292. In developing, implementing and enforcing IPAC protocols and practices at their respective facilities, the Defendants had a duty to act reasonably, to:

a) implement timely and appropriate pandemic plans, including education and training on IPAC, and to ensure that every Responsive Group LTC home had an appropriately trained IPAC program coordinator;

b) undertake timely and frequent testing of Residents, staff and visitors for COVID-19;

c) take proactive steps to lock down the Responsive Group LTC homes and to preclude access to the homes by visitors;

d) isolate Residents who tested positive for COVID-19 or exhibited COVID-19 symptoms and, if necessary, ensure the safe transfer of Residents to offsite care providers to ensure that isolation measures were effectively implemented;

e) prevent staff and visitors who had not been tested for COVID-19 from entering or remaining in the Responsive Group LTC homes and to screen visitors and staff;

f) educate Residents and staff as to the measures that should be taken to prevent infection;

g) ensure that sufficient staffing resources were available, including a full complement of full-time workers, either a physician or a registered nurse for after-hours and on-call coverage at each Responsive Group LTC home, in order to properly protect Residents from infection;

h) stop the practice of employing part-time workers from working at the Responsive Group LTC homes and, in all events, cease the practice of permitting any employee from working at more than one home so as to prevent and control the spread of infection;

i) warn Residents, staff, and visitors of the risk of infection by COVID-19;

j) ensure that adequate supplies of PPE were available and were properly used by Residents, staff and visitors;

k) develop and implement appropriate cleaning and sterilization protocols, and update and augment same as necessary in order to prevent, control and respond to the spread of infection; and

l) ensure that staff at all Responsive Group LTC homes had the requisite training in IPAC, including hand hygiene, infection transmission, cleaning and disinfection practices, and use of PPE, cleaning and sanitizing equipment.

293. As described herein, it was reasonably foreseeable to the Defendants that the Plaintiffs and the Resident Class Members would suffer harm if the Defendants did not take the foregoing measures and precautions.

294. The Defendants were responsible for providing the Resident Class Members with care and services. As a result, they were in a relationship of proximity with the Plaintiffs and the Class Members, and had a duty to protect the Resident Class Members and to prevent their exposure to COVID-19. They were also responsible for providing a safe environment generally for the Visitor Class Members and not to expose them to health risks and safety hazards, including the risk of contracting COVID-19.

295. The Resident Class Members, the Visitor Class Members and the Family Class Members expected that the Defendants would take all reasonable steps to avoid exposing the Resident Class Members to an increased risk of infection. The Defendants further had the ability through their actions and omissions to prevent harm to the Plaintiffs and other Class Members.

296. The Defendants were grossly negligent in that they breached their duty of care to the Plaintiffs and to the other Class Members in a manner that reflects a marked departure from the standards of care applicable in the circumstances. Given the grave and foreseeable threat that COVID-19 posed to the elderly, the Defendants were required to implement a timely and reasonable measures to protect the Plaintiffs and other Class Members.

297. Further, the measures adopted by the Defendants in response to the COVID-19 pandemic did not comply with, and fell markedly below, the reasonable standard of care

of owners, operators and licensees of LTC homes in Ontario and did not meet the delayed and inadequate standards established by the Ontario government.

298. The Defendants breached the standard of care by:

a) failing to develop and implement an appropriate pandemic plan, or in the alternative, adopting an inadequate, unreasonable and arbitrary pandemic plan that exposed the Residents to an increased risk of harm;

b) exposing the Resident Class Members and the Visitor Class Members, to the risk of COVID-19 infection, including illness and other complications, by downplaying the severity of outbreaks at the Responsive Group LTC homes and by continuing to allow Visitor Class Members to attend at the Responsive Group LTC homes to assist COVID-19 positive patients;

c) failing to implement a proper hand hygiene program at the Responsive Group LTC homes, or at all, contrary to the *Long-Term Care Homes Act, 2007* and its Regulation;

d) failing to test Residents and staff for COVID-19 in a timely fashion or at all;

e) failing to screen staff and visitors for COVID-19 in a timely fashion or at all when they knew or ought to have known of the risk of Visitors and staff spreading COVID-19 to Residents at the Responsive Group LTC homes including the Resident Class;

f) allowing Residents who exhibited symptoms or tested positive for COVID-19 to share rooms and communal spaces with non-infected person, thus exposing non-infected Residents to COVID-19;

g) allowing staff and Visitors who exhibited COVID-19 symptoms to enter or remain in Responsive Group LTC homes when they knew, or ought to have known, those visitors and staff could infect the Residents of the Responsive LTC homes with COVID-19;

h) failing to communicate with Residents, staff and Visitors as to what steps that they should take in order to avoid infection and to warn them of the risk of infection by COVID-19;

i) failing to ensure that adequate supplies of PPE were readily available and that Residents, staff and Visitors had access to same;

j) failing to ensure that Residents, Visitors, and staff wore appropriate PPE whenever necessary when they knew or ought to have known that proper PPE

was necessary to prevent the spread of COVID-19 at the Responsive Group LTC homes, contrary to public health orders, guidance and directives;

k) requiring or allowing staff to re-use PPE and to wear the same PPE when interacting with, and moving between, COVID-19 positive and COVID-19 negative Residents;

l) failing to develop and implement appropriate cleaning and sterilization protocols, and to revise same as necessary in order to prevent, control and respond to the spread of infection;

m) failing to accept provincial offers to supplement LTC home staffing with hospital and other employees provided by the province;

n) failing to ensure that adequate staffing resources were available in order to properly care for, supervise and treat Residents;

o) allowing part-time workers to work in multiple homes, thereby increasing the risk of infection between homes;

p) allowing Visitors, including those who were elderly or who had pre-existing vulnerabilities to attend at the Responsive Group LTC homes, to assist staff with the day-to-day operation of the homes, including assisting and caring for Residents who had tested positive for COVID-19 or who had otherwise been exposed to other patients who had contracted COVID-19;

q) failing to comply with public health guidance, Directives, orders and other requirements issued by the provincial and federal government regarding IPAC and outbreak planning;

r) failing to ensure that all their staff participated in the implementation of the IPAC program at the Responsive Group LTC homes, including the Responsive Group LTC homes' policies and guidelines, contrary to the *Long-Term Care Homes Act* and its Regulation;

s) failing to properly train, supervise and instruct their staff in IPAC when they knew or ought to have known that the Responsive Group LTC homes had a history of failing to properly train and retrain its staff in IPAC, including a history of violations under the *Long-Term Care Homes Act*, *2007* and its Regulation;

t) failing to hire sufficient, qualified and accredited agents, servants and/or employees, and to properly train and supervise staff, to ensure the proper supervision of the Residents of the Responsive Group LTC homes and to prevent and/or control situations of danger, including the outbreak of COVID-19 at the Responsive Group LTC homes;

u) failing to enforce a code of conduct at the Responsive Group LTC homes, and to ensure that their agents, servants and/or employees acted in full compliance with the said code of conduct in the interactions and care of Residents, including during the pandemic;

v) neglecting Resident Class Members, including the Representative Plaintiffs;

w) failing to ensure the Responsive Group LTC homes were a safe environment contrary to the *Long-Term Care Homes Act, 2007* and its Regulation;

x) failing to operate the Responsive Group LTC homes in such a manner that respected the Residents' right to receive care and services with dignity and in security, safety and comfort, contrary to the Residents' Bill of Rights in the *Long-Term Care Homes Act, 2007*, its Regulation and the Ministry;

y) failing to put into place an adequate visitor policy, or have a visitor policy at all, within a reasonable timeframe;

z) failing to adhere to public health orders, guidance and directives regarding visitors at the Responsive Group LTC homes, to the detriment of the Resident Class;

aa) failing to implement adequate physical distancing and isolation measures within a reasonable timeframe, or at all, despite public health orders, guidance and directives;

bb) failing to properly identify, isolate and treat Residents infected with COVID-19 at the Responsive Group LTC homes within a reasonable time, to the detriment of the Resident Class;

cc) failing to adequately communicate with Resident Class Members and the Family Class Members about their condition when they had tested positive for COVID-19 or displayed symptoms of COVID-19;

dd) failing to adequately communicate with the families of Resident Class Members regarding presumptive positive cases of COVID-19 at the Responsive Group LTC homes;

ee) failing to ensure the care plan was updated to accurately reflect changes in Residents' needs;

ff) failing to perform regular assessments to ensure that any changes in Resident Class Members' conditions, were observed, recorded, reported to other staff/supervisors and/or the physician in charge of their care;

gg) failing to ensure that Resident Class Members, received the care required, and the care as set out in their care plans;

hh) failing to promulgate suitable policies for the prevention of injuries at the Responsive Group LTC homes;

ii) failing to take reasonable care to ensure the safety of the Resident Class Members under their custody and supervision, and to properly monitor and supervise them;

jj) failing to ensure a skin and wound care program was properly developed and/or implemented in the Responsive Group LTC homes and to ensure that Residents, including Resident Class Members exhibiting altered skin integrity were properly assessed, or at all, and/or received immediate treatment and appropriate interventions, contrary to the *Long-Term Care Homes Act, 2007* and its Regulation;

kk) failing to ensure that the Responsive Group LTC homes had adequate supplies for the proper treatment and care of the Resident Class Members;

ll) failing to ensure that Residents at the Responsive Group LTC homes, were properly bathed, or at all, in accordance with the *Long-Term Care Homes Act*, 2007 and its Regulation;

mm) failing to ensure that Resident Class Members, received three meals per day and were adequately fed and/or hydrated, contrary to the *Long-Term Care Homes Act, 2007* and its Regulation;

nn) failing to ensure that medications and/or other treatment was properly administered, or at all, to Resident;

oo) failing to ensure a falls management and prevention program was properly developed and/or implemented in the Responsive Group LTC homes;

pp) failing to ensure a continence care and bowel management program was properly developed and/or implemented in the Responsive Group LTC homes;

qq) putting corporate profits ahead of the care of their Residents by, among other things, failing to have adequate levels of staffing and PPE, knowing that doing so would expose the Resident and Visitor Class Members to the risk of infection and complications, including death;

rr) in the treatment, care and supervision of the Residents, falling far below the reasonable standard of care required in the circumstances, including during the pandemic;

ss) failing to ensure that the Responsive Group LTC homes' buildings met the required design standards for long-term care homes contrary to the *Long-Term Care Home Design Manual*, *2015*, and in the alternative, take into account the serious structural deficiencies of the Responsive Group LTC homes in adopting and implementing timely and reasonable IPAC policies consistent with the preventive principle;

tt) failing to make timely safety upgrades to the Responsive Group LTC homes' buildings, which failure contributed to the spread of COVID-19 at the Responsive Group LTC homes, and in the alternative, failing to take into account the serious structural deficiencies of the Responsive Group LTC homes in adopting and implementing timely and reasonable IPAC policies consistent with the precautionary principle;

uu) failing to upgrade and/or modify and/or renovate the building design of the Responsive Group LTC homes when they knew or ought to have known that these Responsive Group LTC homes had a C-level bed design, which did not meet the current design standards as set out in the *Manual* effective April 1, 1998, and when they knew or ought to have known that they were required to upgrade the structural safety design of the Responsive Group LTC homes, including eliminating shared bedrooms of more than two Residents, in accordance with the Manual effective April 1, 1998;

vv) failing to rectify the various deficiencies and infractions in the Responsive Group LTC homes that had been identified by the Ministry, and delaying and postponing the redevelopment and/or renovation of their homes with C-level bed design in the interest of saving costs and maximizing profits, where such delay would predicably cause or exacerbate the risk of mass spread of infectious diseases such as COVID-19 at the Responsive Group LTC homes; and

ww) such further and other allegations of negligence as shall become known to these Plaintiffs.

299. To the extent that the Defendants complied only with the directives issued by the Ministry, such compliance was not sufficient to discharge the Defendants' duty of care given their knowledge regarding the highly contagious nature of COVID-19 and the increased risk of serious complications and death in the elderly.

300. As a direct result of the Defendants' gross negligence, the Plaintiffs and other Class Members have suffered harm for which the Defendants are liable. In the alternative, the Defendants' gross negligence and negligence increased and/or made a material

contribution to the risk of injury to the Plaintiffs and other Class Members, with the result that the Plaintiffs and other Class Members have suffered injury for which the Defendants are liable.

B. Breaches of Fiduciary Duties

301. The Defendants were in a fiduciary relationship with the Resident Class Members, and, at all material times, had a duty to act in the best interests of the Resident Class Members in adopting and implementing IPAC protocols and practices in response to the COVID-19 pandemic.

302. The relationship between the Defendants and the Residents was one of power and authority on the one hand, and vulnerability and complete dependence on the other hand. The Defendant LTC homes had exclusive control over the care of the Resident Class Members during the COVID-19 pandemic, in that they controlled the screening, testing, cohorting and other protocols adopted at each of their respective facilities.

303. The Defendants exercised broad direction and authority in developing, implementing and enforcing IPAC protocols at their respective facilities. They further had the resources, knowledge and authority to make decisions with respect to the timing and nature of their IPAC practices and protocols, and unilaterally exercised their authority in a manner that directly impacted the legal and practical interests of the Residents, including their lives, safety, health and dignity.

304. The Resident Class Members were vulnerable, fragile and completely dependent on the Defendants for their safety and care. They were vulnerable by virtue of the Defendants' exclusive control over their care during the COVID-19 pandemic. Following the lockdown of the Responsive Group LTC homes, the Resident Class Members became even more dependent on the Defendants, as their family members, friends and outside caregivers were no longer able to enter the Responsive Group LTC homes and keep a watchful eye to ensure they were receiving adequate care, treatment

and protection from the Defendants. They were also vulnerable by virtue of their age, pre-existing illnesses and their isolation from family members and friends.

305. The Defendants' fiduciary obligations were also grounded in their statutory obligations to act in the best interests of the Resident Class Members in providing them with care and in preventing abuse and neglect. The *Long-Term Care Homes Act, 2007*, underscored the Resident Class Members' rights to be treated with the utmost care and dignity and imposed on licensees and operators of LTC homes a corresponding duty to provide the Resident Class Members with care and services in a manner that protects their integrity. By virtue of operating LTC homes, the Defendants undertook to abide by their statutory obligations to act in the best interests of the Resident Class Members in providing them with care, accommodations, and medical attention.

306. At all material times, the Defendants licensees had a duty to ensure that the rights of the Residents were fully respected and promoted in accordance with the Residents' Bill of Rights, including the right to live in a safe and clean environment, the right to be protected from abuse, the right not to be neglected by the licensees or their staff, and the right to be properly sheltered, fed and cared for in accordance with section 3 of the *Long-Term Care Homes Act, 2007*.

307. At all material times, the Defendant licensees had a statutory obligation to ensure that the homes that they operated were a safe and secure environment for the Resident Class Members and that the Residents had ongoing access to nursing and personal support services, as mandated by sections 5 and 6 of *Long-Term Care Homes Act, 2007*.

308. In addition, the Defendant licensees had an obligation to prevent the abuse and neglect of Residents in their facilities, and had a duty to ensure that the Resident Class Members were not neglected by the licensee or staff in accordance with sections 19 and 20 of the *Long-Term Care Homes Act, 2007*.

309. The Defendants breached their fiduciary duties to the Resident Class Members by adopting delayed, *ad hoc* and deficient practices in response to the pandemic that exposed the Residents to an increased risk of infection and complications.

310. The Defendants further subordinated the Resident Class Members' health and lives to other interests, including financial considerations and limiting the costs associated with providing adequate and effective PPEs and staffing.

C. Breach of Warranty/Contract

311. The Defendants warranted to the Resident Class Members and to the Family Class Members who were parties to contracts with the Defendants or who contributed financially to funding services at the Responsive Group LTC homes, that they would and could provide and arrange for competent, careful and skillful care and treatment and that they would and could provide safe facilities, resources and equipment necessary in the care, housing and treatment of the Resident Class Members.

312. The Defendants entered into a contract with the Representative Plaintiffs and the Resident and/or Family Class Members that they would and could provide and arrange for competent, careful and skillful care and treatment, safe facilities, and that they would and could provide facilities, resources and equipment for the Resident Class Members' care and treatment, in exchange for payments by the Plaintiffs and Class Members.

313. The Defendants breached the contract and/or warranty with the Residents and/or Family Class Members by failing to discharge their contractual obligations as described herein.

D. Violations of Resident Class Members' rights under section 7 of the *Charter*

314. As described above, the authority to establish, maintain, operate, regulate and inspect LTC homes in the province falls within the exclusive jurisdiction of Ontario pursuant to sub-sections 92 (7)(8) and (13) of *the Constitution Act, 1867*. Ontario has delegated its authority with

respect to the provision of care to the elderly to LTC homes in the province. As a result, the Defendants are responsible for providing care to the Resident Class Members.

315. The conduct of the Defendants as described herein is subject to *Charter* scrutiny.

316. In operating and maintaining LTC homes for the elderly in the province and discharging their obligations pursuant to the *Long-Term Care Homes Act, 2007*, the Defendants homes perform essential government functions within the meaning of section 32(1) of the *Charter*. In particular, the Defendants' facilities carried out specific care programs pursuant to the *Long-Term Care Homes Act, 2007*, and were the vehicles chosen by the legislature for the delivery of comprehensive care, services, and housing for elderly in high need of those programs.

317. The Defendants' conduct, as described herein, put the lives of the Resident Class Members at risk and directly and indirectly increased their risk of death, thereby violating their section 7 *Charter* right to life.

318. The Defendants' conduct, as described herein, further violated the Resident Class Members' section 7 *Charter* right to the security of the person by impairing their physical health and causing severe psychological harm. The Defendants' *ad hoc* and unreasonable protocols and practices, including their failure to adhere to reasonable standards for containing and controlling contagious outbreaks, had a severe and profound effect on the psychological integrity of the Resident Class Members.

319. The deprivation of the Resident Class Members' section 7 *Charter* right to life and security of the person was arbitrary, in that there is no rational connection between the reckless, neglectful measures adopted by the Defendants and the purpose of the action or inaction, which was and ought to have been the protection of the Resident Class Members' health and lives. The practices adopted at the facilities owned and controlled by the Defendant facilities fell woefully short of the reasonable standard of care. The breach of section 7 of the Resident Class Members' rights under the *Charter* are

inconsistent with the principles of fundamental justice and unjustifiable in a free and democratic society.

E. Breach of the *Human Rights Code*

320. The Resident Class Members had a right to equal treatment under the *Human Rights Code*, with respect to provision of services, goods and facilities and to occupancy of accommodation, without discrimination because of age and/or disability.

321. The Defendants failed to provide the requisite level of services, goods, facilities and accommodation to the Resident Class Members because of their age and/or disability, thereby infringing their rights under Part 1 of the *Human Rights Code*.

322. Elderly and disabled persons have the right to the same level and quality of services as everyone else. By failing to ensure there were adequate resources, protocols and staffing, especially adequately trained staff, at the Responsive Group LTC homes, the Defendants failed to treat the Resident Class Members equally. The Defendants provided a sub-standard level of care and services to the Resident Class Members because they were elderly persons.

323. Furthermore, those Resident Class Members with physical and/or cognitive disabilities were not provided with an equal level of services at the Responsive Group LTC homes because of their disability. For example, physically and cognitively disabled Resident Class Members were not transferred, bathed or changed for weeks because of their disability and they were neglected by the Defendants and/or their servants, agents and/or employees. The Defendants and/or their servants, agents and/or employees did not treat Resident Class Members with respect and dignity.

324. The Defendants and/or their servants, agents and/or employees violated the Resident Class Members' right to be free from discrimination on the basis of age and/or disability in their occupancy of accommodation and their receipt of services.

F. Breach of *Occupiers' Liability Act*

325. The Defendants were, at all material times, occupiers of the Responsive Group LTC homes within the meaning of the *Occupiers' Liability Act* and owed a duty to the Residents and Visitors to keep them reasonably safe on the premises. The Defendants could reasonably foresee that persons entering or residing at the Responsive Group LTC Homes, including the Resident Class Members and the Visitor Class Members, would be placed at risk of serious bodily and psychological harm, including serious illness and death, by their grossly delayed, arbitrary, and ad hoc response to the pandemic, and by their failure to adopt and implement reasonable and timely IPAC protocols and measures. The Defendants could not, and did not restrict, their duties under the *Occupiers' Liability Act* to the Residents and Visitors of the Responsive Group LTC homes.

326. The Defendants breached their duty of care to the Residents and Visitors as described herein and as described above at paragraph 300.

G. Unjust Enrichment

327. The Defendants were unjustly enriched at the expense of the Class Members. Specifically:

a) the Defendants obtained an enrichment through revenues and profit that were generated during the Defendants' grossly negligent ownership, operation and/or management of the Responsive Group LTC homes during the COVID-19 pandemic;

b) the Plaintiffs and other members of the Classes have suffered corresponding and devastating deprivation and losses, as set out in detail above; and

c) there is no juristic or other reason for the benefit obtained by the Defendants and the corresponding detriment experienced by the Plaintiffs and other members of the Classes.

VI. DAMAGES

a) General and Pecuniary Damages

328. As a result of the Defendants' gross negligence, and breaches of fiduciary duty, contract/warranty, the *Human Rights Code* and the *Occupiers' Liability Act*, the Plaintiffs, the Class Members, the Resident Class Members and the Family Class Members have suffered psychological and physical pain and suffering, deterioration in mental and physical health, injury to dignity, feelings and self-respect, serious and life-threatening illness, significant complications and in many instances, death.

329. But for the Defendants' gross negligence, negligence, recklessness, and breaches of fiduciary duties, contract/warranty, the *Human Rights Code* and the *Occupiers' Liability Act*, the Responsive Group LTC homes owned and operated by the Defendants would not have experienced outbreaks of COVID-19 and/or would have been able to properly contain outbreaks and the Resident Class Members and Visitor Class Members would not have been exposed neglect, to the risk of infection and serious and complications, including death.

330. The harm suffered by the Class Members was the proximate and foreseeable result of the Defendants' failure to adopt and implement reasonable and appropriate protocols and measures to protect the Resident Class Members and Visitor Class Members from the risk of COVID-19 infection. This harm was caused directly by the Defendants' breaches of their duty of care, fiduciary duties and contractual obligations to the Resident Class Members.

331. The Plaintiffs and other members of the Classes have suffered special damages, losses and expenses, including but not limited to: costs associated with hospitalizations and treatment; attendant care costs; housekeeping and home maintenance costs; out of pocket expenses; and funeral expenses. The Class Members have suffered severe psychological damage, including mental anguish, emotional distress and personality changes. In many cases, interpersonal relationships have suffered. These psychological injuries are ongoing.

332. The Plaintiffs and Class Members further state that they are entitled to a full return of all monies paid to the Defendants during the pandemic as a result of the breach of contract/warranty.

333. The general damages set out above are claimed on an aggregate basis if and where deemed appropriate by this Honourable Court.

b) *Charter* damages

334. The Plaintiffs claim damages pursuant to s. 24(1) of the *Charter* for the infringement of their rights to life and security of the person and the resulting injuries and harm suffered by each Class Member.

335. As a result of these *Charter* violations described above, the Defendants are liable for *Charter* damages, which would be appropriate and just as:

a) the Resident Class Members' *Charter* rights have been breached in a manner that shows clear disregard for their *Charter* rights;

b) such an award of damages would vindicate the Resident Class Member's rights and deter similar future breaches; and

c) there are no countervailing factors that defeat the functional considerations supporting such an award and such an award would not be inappropriate or unjust.

336. *Charter* damages are particularly appropriate and just in the circumstances having regard to the function of vindication, deterrence, and compensation. The Defendants acted recklessly and extremely carelessly in adopting dilatory, inadequate and unreasonable protocols and responses to the COVID-19 pandemic, such that a highly vulnerable group were placed at risk of serious harm and injury, including death.

c) *Family Law Act* Claims

337. The Plaintiffs claim pursuant to the *Family Law Act*, to recover their losses resulting from injuries sustained by the Resident Class Members and Visitor Class Members, including, but not limited to:

a) actual expenses reasonably incurred for the benefit of any Resident Class Member and Visitor Class Member;

b) a reasonable allowance for travel expenses incurred while visiting a Resident Class Member and Visitor Class Member during treatment or recovery;

c) loss of income or the value of services provided for a Resident Class Member and Visitor Class Member, where services, including nursing and housekeeping, have been provided;

d) compensation for loss of support, guidance, care and companionship that they might reasonably have expected to receive from the Resident Class Members and Visitor Class Members; and

e) compensation for mental anguish and a significant decrease in their enjoyment of life as they were deprived of the ability to properly say goodbye to deceased Resident Class Members prior to their death.

d) OHIP's Subrogated Claim

338. Some of the expenses related to the medical treatment and medical monitoring that the Class Members have undergone, and will continue to undergo, have been borne by the provincial health insurer, the Ontario Health Insurance Plan ("OHIP"). As a result of the Defendants' negligence, gross negligence, breach of fiduciary duty, breach of contract/warranty, breach of the *Human Rights Code and* breach of *Occupiers' Liability Act*, OHIP has suffered and will continue to suffer damages, which are claimed in this action pursuant to the *Health Insurance Act*, R.S.O. 1990, c. H.6.

e) Aggravated, Exemplary and/or Punitive Damages

339. The Defendants' conduct was high-handed and callous, demonstrating a wanton and reckless disregard for the safety of the Plaintiffs and other Class Members. Residents were living

in deplorable conditions during the pandemic. Basic Resident care and hygiene was lacking or not being performed at all. Staff and Residents were not provided with adequate PPE, and where it was provided, N95 respirators were not always properly fitted or changed between interactions with different Residents or moving between different rooms. Staff and Residents with COVID-19 symptoms were not always isolated. These practices exposed Residents to an unreasonable and increased risk of harm. The Defendants' conduct represented an abject failure to comply with their duties to care for some of the most vulnerable people in our society.

340. As a result of the Defendants' reprehensible and unconscionable conduct, many Residents and Visitors were exposed to, and became infected with, COVID-19. Residents have suffered significant harm from the devastating complications of the virus. Some Residents and Visitors have died alone and in anguish, without family members present in their last moments. The trauma suffered by the Resident Class Members was exacerbated by the fact that some infected Residents had the foreknowledge that in the last stages of their illness, they would not have the comfort of being surrounded by their loved ones.

341. The Defendants were aware that the Resident Class Members were vulnerable individuals and especially vulnerable to serious and/or fatal complications arising from contracting COVID-19. Furthermore, the Defendants were aware that the Resident Class Members were dependent on the Defendants for proper care, treatment and protection, especially from contracting COVID-19 during the pandemic when they were not able to have direct contact with outsiders.

342. The Defendants knew or ought to have known that the Resident Class Members were reliant on the professionalism, compassion, skills, expertise and knowledge of the Defendants to provide a safe environment and to deliver necessary medical and health care and to assess the Resident Class Members' physical and mental needs and to deliver appropriate services and/or treatments to meet those needs, including proper assessment, treatment and referral.

343. The Defendants had a history of failing to implement properly, or at all, an adequate IPAC program at the Responsive Group LTC homes. Despite being found non-compliant with the requirements of the *Long-Term Care Homes Act, 2007* and its Regulations prior to the pandemic and receiving instructions, directions and compliance orders from the Ministry, the Defendants failed to correct their behaviour.

344. The Defendants did not implement a proper IPAC program at the Responsive Group LTC homes during the pandemic when they knew or ought to have known that such measures were necessary to prevent and/or reduce the spread of COVID-19 infections at the Responsive Group LTC homes. Furthermore, despite their knowledge that the staff at the Responsive Group LTC homes had a history of failing to participate in the implementation of the IPAC program at the Responsive Group LTC homes, the Defendants failed to ensure, properly or at all, that staff implemented the IPAC program during the pandemic, thereby directly causing and exacerbating the COVID-19 outbreak at the Responsive Group LTC homes and the resultant injuries, illness and death suffered by the Class Members.

345. The Plaintiffs further claim that the Defendants systematically failed to upgrade and/or modify and/or renovate the Responsive Group LTC homes with a C-level bed design, when they knew or ought to have known that these Responsive Group LTC homes did not meet the current safety and design standards as set out in the Manual. The Defendants' failure to upgrade and/or modify and/or renovate these Responsive Group LTC homes was motivated by the incentive to maximize their profits even to the detriment of the Resident Class Members.

346. The Plaintiffs further claim that the Defendants failed to adequately fund and/or properly allocate funds to the Responsive Group LTC homes in order to maximize their profits when they knew or ought to have known that more funding was necessary to provide a safe environment and to deliver necessary medical and health care and to assess the Resident Class Members' physical and mental needs and to deliver appropriate

services and/or treatments to meet those needs, including proper assessment, treatment and referral.

347. The Family Class Members have suffered, and continue to suffer, from mental distress, anxiety, grief and fear as the result of the Defendants' conduct. They have specifically suffered as a result of the loss of their loved ones, the manner of their death, their concern that they themselves may have been infected, and their inability to visit their loved ones to say goodbye or physically gather and mourn their loved ones to the extent that they have been obliged to quarantine because they themselves may have been exposed to infection.

348. The conduct of the Defendants as pleaded above is such as to warrant an award of aggravated, punitive and/or exemplary damages.

349. The punitive, aggravated and/or exemplary damages set out above are claimed on an aggregate basis if and where deemed appropriate by this Honourable Court.

f) Disgorgement

350. In the alternative, the Plaintiffs and the Class claim disgorgement of the benefits received by the Defendants.

351. The Defendants committed multiple blatant breaches of duties of care owed to Residents, Visitors and Family Class Members, along with breaches of statutes, contracts and warranties as to services to be rendered as well as Residents' right to life and security of the person pursuant to the *Charter*, while continuing to reap financial gains at the Class Members' expense as described above. These wrongs conferred benefits on the Defendants, in the form of additional revenues, that they would not have acquired but for their wrongdoing.

352. The misconduct was motivated by the Defendants' desire to maximize the amount of profits they could reap from Class Members, who were vulnerable to the conduct of the Defendants.

353. There is no legitimate justification for allowing the Defendants to retain the profits derived from their wrongdoing. An award of compensatory damages against the Defendants would be an inadequate remedy and would fail to deter the type of misconduct exhibited by the Defendants.

354. It is appropriate that disgorgement of profits be assessed on an aggregate basis for the Class.

VII. LEGISLATION

355. The Plaintiffs plead and rely upon the following statutes and the amendments made thereto and the regulations promulgated thereunder:

a) *Constitution Act, 1867*;

b) *Canadian Charter of Rights and Freedoms*;

c) *Class Proceedings Act, 1992*, S.O. 1992, c. 6;

d) *Community Care Access Corporations Act, 2001*, S.O. 2001, c. 33;

e) *Emergency Management and Civil Protection Act*, R.S.O. 1990, c. E.9;

f) *Family Law Act*, R.S.O. 1990 c. F.3;

g) *Health Facilities Special Orders Act*, R.S.O. 1990, c. H.5;

h) *Health Insurance Act*, R.S.O. 1990, c.H.6.;

i) *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7;

j) *Homes for Special Care Act*, R.S.O. 1990, c. H.12;

k) *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, c. H.13;

l) *Human Rights Code, RSO 1990, c H.1;*

m) *9 Laboratory and Specimen Collection Centre Licensing Act*, R.S.O.1990 c. L.1;

n) *Long-Term Care Homes Act, 2007*, and the Regulations thereunder;

o) *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26;

p) *Negligence Act*, R.S.O. 1990, c. N.1;

q) *Nursing Homes Act*, R.S.O. 1990, c. N.7;

r) *Occupational Health & Safety Act*, R.S.O. 1990, c. O.1;

s) *Occupiers' Liability Act*, R.S.O. 1990, c. O.2; and,

t) *Trustee Act*, R.S.O., c. T.23.

VIII. PLACE OF TRIAL

356. The Plaintiffs propose that this action be tried in Toronto.

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APPENDIX "A"

Homes owned/operated by Responsive Group Inc. and its subsidiaries ("Responsive Group LTC homes")

	LTC Home	Licensee	Management Firm (if applicable)	Address
1.	Anson Place Care Centre	Rykka Care Centres LP		85 Main Street North Hagersville, Ontario N0A1H0
2.	Arbour Creek Long Term Care Centre	Rykka Care Centres Gp Inc.		2717 King Street East Hamilton, Ontario L8G1J3
3.	Banwell Gardens Care Centre	Rykka Care Centres LP		3000 Banwell Road Tecumseh, Ontario N8N2M4
4.	Berkshire Care Centre	Rykka Care Centres LP		350 Dougall Avenue Windsor, Ontario N9A4P4
5.	Bon Air Long Term Care Residence	DTOC II Long Term Care LP (as of April 1, 2020)	Responsive Management Services Inc.	131 Laidlaw Street South Cannington, Ontario L0E1E0
6.	Champlain Long Term Care Residence	DTOC II Long Term Care LP (As of April 1, 2020)	Responsive Health Management Inc.	428 Front Road West L'Orignal, Ontario, K0B1K0
7.	Cooksville Care Centre	Rykka Care Centres LP		55 The Queensway West Mississauga, Ontario L5B1B5
8.	Dundurn Place Care Centre	Rykka Care Centres LP		39 Mary Street Hamilton, Ontario L8R3L8

9.	Earls Court Village	Sharon Farms & Enterprises Limited	Responsive Health Management Inc.	1390 Highbury Avenue North London, Ontario N5Y0B6
10.	Eatonville Care Centre	Rykka Care Centres LP		420 The East Mall Etobicoke, Ontario M9B3Z9
11.	Hawthorne Place Care Centre	Rykka Care Centres LP		2045 Finch Avenue West North York, Ontario M3N1M9
12.	Ina Grafton Gage Home of Toronto	Ina Grafton Gage Home of Toronto	Responsive Management Services Inc.	40 Bell Estate Road Scarborough, Ontario M1L0E2
13.	Lancaster Long Term Care Residence	DTOC II Long Term Care LP (as of April 1, 2020)	Responsive Management Services Inc.	105 Military Road North P.O. Box 429 Lancaster, Ontario K0C1N0
14.	Niagara Long Term Care Residence	DTOC II Long Term Care LP (as of April 1, 2020)	Responsive Management Services Inc.	120 Wellington Street P.O. Box 985 Niagara-On-The-Lake, Ontario L0S1J0
15.	Orchard Terrace Care Centre	Rykka Care Centres LP		199 Glover Road Stoney Creek, Ontario L8E5J2
16.	Pine Villa Care Centre	Rykka Care Centres II GP Inc		490 Highway #8 Stoney Creek, Ontario L8G1G6
17.	The O' Neill Centre	848357 Ontario Inc.	Responsive Health Management Inc.	33 Christie Street Toronto, Ontario M6G3B1

18.	Vermont Square	Vermont Square LTC Limited Partnership	Responsive Health Management	914 Bathurst Street Toronto, Ontario M5R3G5

Court File Number: CV-20-00640016-00CP

WILLIAM BROUGH by his estate representative DARREN BROUGH et al. PlaintiffsPlaintiffs	-and-	RESPONSIVE GROUP Inc, et al. DefendantsDefendants

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PROCEEDING COMMENCED IN
TORONTO

AMENDED CONSOLIDATED STATEMENT OF CLAIM

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