Office of the Auditor General of Ontario

Value-for-Money Audit

Retirement Homes Regulatory Authority

December 2020

Ministry for Seniors and Accessibility

Retirement Homes Regulatory Authority

1.0 Summary

Retirement homes have historically provided seniors with a residence within communities in Ontario where they live independently. Because seniors reside in retirement homes as tenants, they have the same rights and obligations as other tenants in Ontario under the *Residential Tenancies Act, 2006*. Seniors are provided with the option for health-care services through either these homes or by outside service providers, including those that are publicly funded by the Ministry of Health.

The Retirement Homes Regulatory Authority (Authority) was established in 2011 and oversees retirement homes under the *Retirement Homes Act, 2010* (Act). The Act contains a fundamental principle that states, "a retirement home is to be operated so that it is a place where residents live with dignity, respect, privacy and autonomy, in security, safety and comfort and can make informed choices about their care options." Through the Act, the Authority has been delegated to promote and enforce consumer protection and safety.

Our audit found that a shift is occurring whereby thousands of beds in retirement homes are being occupied by individuals who have more intense health-care needs than the more active and independent seniors that many retirement homes were designed for. According to Ontario Health, as of March 31, 2020, of the approximately 38,000 people waiting to be placed in long-term-care homes, 26%, or about 10,000, were waiting in licensed retirement homes. As of March 31, 2020, there were 770 licensed retirement homes in Ontario with the potential capacity to provide care and accommodation for about 80,000 Ontarians. The 10,000 individuals were housed across all retirement homes, including those that are co-located with long-term-care homes. According to the Authority, 101 or 13% of the licensed retirement homes share a location with long-term-care homes.

According to Ontario Health, in 2019/20 just over 4,000 people who lived in retirement homes were previously hospital patients who were designated as alternate level of care (ALC). Patients designated as ALC are discharged from a hospital because they no longer require acute care but can be in a condition where it may be suitable for them to be in a long-term-care home or other more appropriate alternative settings.

We were concerned to find that a gap in regulatory oversight exists that when beds in retirement homes are governed or funded by other ministries—such as patients designated as ALC who are part of the Ministry of Health's short-term transitional-care program—the patients occupying those beds are not subject to oversight by the Authority or by the ministries (such as the Ministry of Health) that fund these beds. This means that the potentially medically vulnerable individuals in this gap

are not afforded the safety, care and protection they should receive by the Ministry of Long-Term Care had they been placed in long-term-care homes.

The Authority is a self-funded, not-for-profit administrative authority and is overseen by the Ministry for Seniors and Accessibility (Ministry). The Ministry is responsible for developing and maintaining policy, legislation and regulations, and for providing oversight of the Authority to confirm that it is carrying out its objects set out in the Act.

The Authority provides policy advice, grants licences, oversees compliance and enforcement, conducts inspections, responds to public complaints, educates retirement homes, consumers and the public about the Act, and maintains a public registry of licensed retirement homes. It is headed by a Registrar and Chief Executive Officer and is governed by a nine-member Board. In 2019/20, the Authority recorded about $8.0 million in revenue and $8.7 million in expenses. In each of the four years prior, the Authority recorded a surplus. As of July 2020, about 50 people worked for the Authority, which is based in Toronto.

The impact of COVID-19 on retirement homes has been significant, even though they have experienced fewer reported cases and deaths than long-term-care homes. According to COVID-19 outbreak data collected by the Authority, 185 COVID-19 outbreaks were detected at 171 licensed retirement homes, affecting 989 residents and 491 staff as of August 31, 2020. A total of 209 residents from 48 retirement homes died. Such incidents of infection and death in retirement homes highlight the residents' susceptibility to harm.

Some of our significant audit findings include:

- **The care and accommodation of thousands of former hospital patients in retirement homes are not subject to Authority oversight, nor Ministry of Health inspections**. In 2019/20, 4,201 patients designated as alternate level of care (ALC) were discharged from hospitals to retirement homes. Some of these patients stay in retirement home beds under a program subsidized by the Ministry of Health. Neither the Ministry of Health nor the Local Health Integration Networks perform inspections or systematically handle complaints for these subsidized beds to ensure patient security and safety. While the Authority will respond to issues raised related to the conduct of a licensee irrespective of whether the home includes any patients designated as ALC, and informs complainants at the beginning of the complaints process to contact the LHINs if their complaints are related to these subsidized beds, it is unclear that the Authority can address issues where exemptions to the Act apply. We also found that neither the Ministry for Seniors and Accessibility nor the Authority track the number of patients designated as ALC in retirement homes. This meant that we were unable to determine how many of the 209 COVID-19 deaths and 989 infections of residents in retirement homes during our audit were patients designated as ALC.
- **Many retirement home residents have health profiles similar to patients in long-term-care homes but such data is not routinely collected by the Authority**. The Authority does not systematically collect information on the complexity of care needs required for retirement home residents. The Authority is also not aware of the types of the specific type of care services that residents receive from retirement homes, private care providers and government-funded home care. Using data from Ontario Health, we found that 52% of all retirement home residents received ongoing home-care services provided by the LHINs, assuming all retirement homes were at capacity in 2019/20, since the Authority does not systematically and regularly collect data on how many residents occupy available retirement home beds. We compared the level of care needed for retirement home residents to the level of those who lived elsewhere in the community and found

that of the 48,545 clients receiving home-care services in retirement homes in 2019/20, many have high care needs. For example, 21% are classified as complex patients who have one or more health or chronic illnesses with direct care needs that are unstable and unpredictable, compared with 13% who live in assisted living and 14% who live in their own home. The Authority informed us that a retirement home that is not capable of providing the level of care required by a resident may have the option to evict the resident. If the resident objects to the eviction, the dispute can be brought to the Landlord and Tenant Board, which oversees the *Residential Tenancies Act, 2006*.

- **Multiple parties have raised concerns about residents' care and staffing levels**. From 2017/18 to 2019/20, 55 or 7% of the concerns raised in written complaints to the Authority related to staffing levels and competency of staff and 399 or more than 50% related to resident care. Examples of these concerns included residents not being offered suitable meals, not being provided with personal hygiene services such as bathing and grooming, and instances where residents incurred bedsores that became infected. In 2019, the Ministry consulted the public on the seniors' strategy and noted that seniors and other stakeholders commented on the need to increase access to personal support workers and noted their high turnover rate. We noted that personal support workers working in retirement homes remain the lowest paid cohort, compared with personal support workers in other care settings.
- **The Authority has acknowledged that the level of care required by residents has been changing, but it does not have data to measure this change and assess its impacts**. Any information the Authority has on residents is derived primarily from its inspections, but also from inquiries from the public or mandatory reports made by retirement homes, which, for the most part, are self-reported by retirement homes or by complainants. The Authority does not regularly collect comprehensive data on retirement home residents, including their care needs, care services provided either by retirement home staff or external providers, or fees charged for these services. The Authority also does not systematically collect or analyze data such as staffing levels of internal retirement home staff or external providers; occupancy rates; and the financial position of retirement homes.
- **The Authority does not consider factors other than a retirement home's inspection history to determine the inspection frequency**. As a result, a home may not be inspected more frequently if there are no violations found even if the Authority has received more complaints or input from community partners, or detected history of harm at that specific home.
- **The Authority introduced new inspection procedures in April 2020 to focus more on infection prevention and control**. To better manage the risk of infection in retirement homes during COVID-19 outbreaks, the Authority created an inspection checklist that focuses on confirming the compliance of retirement homes' infection prevention and control measures with the Chief Medical Officer of Health's directive. Between March 15 and June 30, 2020, the Authority conducted 101 in-person inspections, 28 of which were focused specifically on infection prevention and control compliance. The Authority selected these 28 homes based on complaints received from the public or public health and plans to continue this approach. It noted that primary accountability of infection prevention and control rests with public health and therefore has not established a plan to inspect all retirement homes for infection prevention

and control measures implementation. The Authority was still in the process of assessing lessons learned when we completed our audit.

- **The Authority issued licences despite identified red flags**. We found that the Authority issued a licence despite identified concerns about the applicants. One of the Authority's licensing criteria is that the past conduct of an applicant affords reasonable grounds to believe that the home will be operated in accordance with the law, with honesty and integrity, and in a manner that is not prejudicial to the health, safety or welfare of its residents. We found, for example, that the Authority transferred ownership of an existing home to an applicant despite the fact that the applicant provided false and misleading information. The Authority took into account that the applicant was subsequently co-operative with the Authority, and imposed a penalty and issued the licence with conditions.
- **Five retirement home operators have still not installed fire sprinkler systems**. Another five retirement home operators have indicated to the Authority that they had installed the fire sprinkler systems but had yet to provide the final review report from engineers and municipal inspectors, before installation can be considered complete. As of January 2019, the Fire Code requires that retirement homes have automated fire sprinkler systems installed. The licences of these operators include conditions that are publicly reported by the Authority.
- **Retirement home staff and the public are often not aware that they should direct complaints to the Authority**. Stakeholder groups we spoke to during our audit indicated that staff who work in retirement homes have witnessed neglect and abuse, but may not know that they can report these incidents to the Authority. We found only four complaints in a three-year period came from former retirement home staff members. Our observation is consistent with what the Authority itself found in a June 2019 brand awareness survey of Ontarians aged 55 and over. Survey results showed that only 2% of the approximately 1,500 respondents knew that the Authority is responsible for protecting seniors living in retirement homes in Ontario. We also found that consumers cannot easily access information about complaints made about a retirement home, which limits their knowledge when making choices on which retirement home they or their loved one would select as their residence.
- **The Authority could inadvertently place the financial welfare of the operators ahead of the Authority's mandate to protect residents**. Retirement homes operate in an environment that includes intersections of both care and, in some cases, affordable housing options for seniors. In this context, the Authority informed us that it is mindful of its enforcement actions potentially placing financial pressure on struggling homes, and that it considers any unintended consequences to the residents, such as having to find new accommodations if a home ceases to operate, when determining whether to revoke a licence or refuse a licence to a home. Between 2017/18 and 2019/20, the Authority revoked and refused licences in 1% and 3% of the cases, respectively.
- **The Authority does not have a standard time frame for enacting recommendations from its Risk Officer's reports, nor does it track whether these recommendations have been applied**. As a result, some recommendations were either not yet implemented or implemented a few years later. The Risk Officer reports directly to the Authority's Board on the effectiveness of the Authority's administration of the Act and its regulation. The related reports provided to the Board also lack consistent time frames and timely status updates.

- **The Ministry cannot properly assess whether the Authority has effectively met its mandate**. The Ministry has not fully defined what documents it expects the Authority to submit on a regular basis for its review, has not requested the Authority to develop benchmarks to measure the Authority's performance toward effective operation, and has not charged the Authority oversight fees as required in the Memorandum of Understanding that sets out the roles and responsibilities between the two parties.

This report contains 26 recommendations, with 63 action items, to address our audit findings.

Overall Conclusion

The Retirement Homes Regulatory Authority has made considerable progress in establishing its operations since 2011, most notably in establishing a risk model that drives its inspection strategy and execution. While the risk model is necessarily based on the central risk factor of a retirement home's compliance history, the model is insufficient and would benefit from additional criteria to ensure emerging risks are identified. However, our audit concluded that the Authority does not yet have fully effective systems and procedures in place to carry out the evolving circumstances of its mandated activities to protect the security and safety of residents. These activities include licensing, complaint response, inspections, enforcement and public education in accordance with the *Retirement Homes Act, 2010* (Act) and its regulation.

We noted that there are areas where improvements are needed in the Ministry for Seniors and Accessibility's oversight of the Authority to ensure effective administration of the Act. We found that the Ministry does not ask for any updates regarding the status of the Authority Risk Officer's recommendations. Furthermore, the Ministry has not fully defined the information it expects the Authority to submit on a regular basis for its review.

We found that thousands of former hospital patients in retirement homes are not subject to Authority oversight. In other cases, residents who have complex needs similar to those who live in long-term-care homes are waiting in retirement homes but their care is not afforded the more stringent oversight that would be provided by the Ministry of Long-Term Care had these residents been placed in long-term-care facilities. Also, the Authority acknowledges that the level of care required by residents has been increasing, but it does not have data to measure this change and assess its impacts.

While the Authority introduced new inspection procedures to focus more on infection prevention and control in April 2020 to better manage the risk of infection in retirement homes during COVID-19 outbreaks, it had suspended its routine, proactive inspections of retirement homes that relate to other risks of harm, such as care and choices about care options.

The Authority has issued licences to some operators despite identified red flags that these operators did not meet the Authority's own licensing criteria and the Authority has allowed 10 operators to continue operating retirement homes without an automated fire sprinkler system or confirming that the sprinkler system has been fully installed.

We also found the complaints process needs to be better communicated and more transparent for consumers to shop for a retirement home more effectively.

OVERALL MINISTRY RESPONSE

The Ministry for Seniors and Accessibility (Ministry) would like to thank the Auditor General and her staff for their work on the audit and recommendations. The Ministry is committed to improving the lives of seniors and providing the supports and resources to help them live independently, ensuring their safety and security, connecting them to the community and helping them achieve greater financial security and social connections.

The Ministry welcomes the review of the effectiveness of the Retirement Homes Regulatory Authority (Authority)'s mandated activities including licensing, complaint-handling and enforcement; as well as the recommendations regarding the Ministry's systems and procedures to oversee the Authority and support long-term strategic planning for seniors' services.

The Ministry recognizes the importance of the Authority in fulfilling its responsibilities as set out in the *Retirement Homes Act, 2010* (Act) in a manner that protects, enhances and improves resident safety and rights.

The Ministry takes its responsibility for the Act and oversight of the Authority seriously and has recently begun to look at opportunities to enhance the retirement home regulatory framework, building on legislative amendments made in 2017 and 2020. As well, the Ministry has developed a proposed cross-government strategy to support older adults to age at home and in communities; remain healthy, active and socially engaged; stay safe and secure; and participate in the labour market and economy, if they choose. The Auditor's report and recommendations will assist the Ministry as we consider improvements to the Act, its regulation, and non-regulatory proposals that would strengthen protections and oversight as well as the cross-government strategy for aging Ontarians.

The Ministry will work closely with the Authority, the Ministry of Health, the Ministry of Long-Term Care, the Ministry of Municipal Affairs and Housing and other relevant partners to address each of these recommendations. The Ministry will request that the Authority provide an implementation plan, including proposed timelines, that outlines the specific steps the Authority plans to take to implement each recommendation and to ensure recommendations are addressed in a timely and responsive manner. The Ministry will closely monitor and track the implementation of each recommendation.

OVERALL RESPONSE FROM THE RETIREMENT HOMES REGULATORY AUTHORITY

The Retirement Homes Regulatory Authority (Authority) would like to thank the Auditor General and her staff for their work on the audit and recommendations. The Board and management of the Authority take the accountability to keep Ontario's seniors and vulnerable persons safe and enable their informed choices very seriously, as it does its role as advisor to the government on policy and impacts of legislation and regulation that affect this population. The Authority is committed to meeting its mandate to the fullest extent possible, and to sharing its progress in a robust and transparent manner.

The Authority participated fully in the Office of the Auditor General of Ontario's review process. The Authority welcomes the Auditor General's recommendations as they will help the organization to work with the Ministry for Seniors and Accessibility and other entities to address systemic and jurisdictional matters, to build on the Authority's strengths, and to continue to address opportunities for improvement as a modern regulator with its focus on positive outcomes for residents.

The Authority appreciates that the report recognizes the organization's considerable progress to date and encourages continued and accelerated focus on existing project initiatives, several of which are noted to be in alignment with its identified strategic priorities. The Authority is committed to furthering its understanding of retirement home residents and retirement homes through the collection, use, and sharing of information with the Ministry for Seniors and Accessibility and other ministries to inform policy decisions that will continue to improve the lives of seniors in retirement homes across Ontario.

The Authority is committed to developing a plan that will outline the necessary steps

to implement the recommendations so that they are addressed in a timely and responsive manner. Further, the Authority looks forward to collaborating with the Ministry for Seniors and Accessibility, the Ministry of Health, the Ministry of Municipal Affairs and Housing, the Ministry of Long-Term Care and other partners in addressing these recommendations.

2.0 Background

2.1 Overview

2.1.1 Seniors' Housing Options

Many seniors in Ontario live in group settings so that they can interact socially with others and obtain more care than they can receive at home. There is a diverse range of senior housing options in the province. Some options, such as long-term-care homes and social housing, are partially funded by the Ontario government; others, such as retirement homes, are not.

Options can include the following:

- Adult lifestyle communities provide independent living residences for retirees or semi-retirees. Lifestyle communities typically do not offer services related to personal care or medical requirements.
- Retirement homes are a form of housing where residents pay for accommodation and care services. Retirement homes do not receive government funding and residents pay the full cost of accommodation and care services. "Retirement home" is not a protected term, which means that residences are allowed to advertise to the public that they are a retirement home without having to be regulated by the Retirement Homes Regulatory Authority.
- Long-term-care homes are a form of housing where adults live and receive help with most or all daily activities and have access to 24-hour nursing and personal care. All personal and nursing care provided by long-term-care homes in Ontario are funded by the government. Residents are responsible for paying the cost of room and board.
- Supportive housing refers to independent apartments with access to services like housekeeping, personal support and health care available for free or at a reduced cost. Residents usually pay their own rent and any other living expenses.
- Assisted living is a form of living similar to retirement homes but are sometimes operated as not-for-profit residences by the federal government. They also offer a wider range of health care and support services for seniors with more demanding care needs.

According to the Canadian Mortgage and Housing Corporation, a distinguishing factor for these residences is whether or not they are overseen by provincial legislation.

2.1.2 Retirement Homes

Prior to 2010, retirement homes were not regulated in Ontario. A history of concerns, inquests and media reports on select retirement homes prompted the introduction of the *Retirement Homes Act, 2010* (Act) in 2010 and its approval by the Legislature. The Retirement Homes Regulatory Authority (Authority) was established in January 2011. The Ministry for Seniors and Accessibility (Ministry), formerly the Ministry of Seniors Affairs and the Ontario Seniors' Secretariat, has been responsible for oversight of the Authority since its establishment.

Retirement homes that meet the legislative definition are subject to licensing and must follow prescribed standards. The Act defines a retirement home as a residential complex or a part of a residential complex that includes rental units and is occupied primarily by persons aged 65 or older, occupied by or intended to be occupied by at least six people unrelated to the operator of the home,

and where the home operator makes at least two care services available (see **Section 2.3**), whether directly or indirectly, to the residents.

A residential complex means a building or related group of buildings with one or more rental units of living accommodation and common areas, services and facilities available for the use of residents.

The definition of retirement homes excludes premises or parts of premises governed or funded under certain outlined Acts and programs, such as the *Long-Term Care Homes Act, 2007* and the Community Homelessness Prevention Initiative.

Retirement homes are privately owned by either for-profit or not-for-profit organizations or by operators that may be sole proprietors, partnerships or corporations. About 94% of the homes are for-profit and 6% are not-for-profit. Residents pay rent and fees to the retirement homes to receive accommodation and a choice of care options they wish the home to provide, and they live in these homes as tenants. Costs vary depending on what the resident and the home agree to. Residents can pay from $1,500 to $6,000 per month for rent and basic care services such as meals and medication administration. Additional services provided by the home, such as dementia care, may cost extra.

As noted, the nature of homes within the definition of a retirement home varies significantly. As a consequence, the Authority is in a position to address not only the care provision by the home operators, but may also need to consider feedback from local community partners related to alternative affordable housing options and home care options when evaluating its regulatory actions.

Appendix 1 sets out the key differences between retirement homes and long-term-care homes. **Figure 1** shows the profile of residents in licensed retirement homes and long-term-care homes in Ontario. As shown in **Figure 1**, while retirement home residents are less likely to have dementia than those living in long-term-care homes, they are more likely to have chronic diseases including hypertension (high blood pressure) and diabetes.

The wait list for long-term-care beds in Ontario has steadily increased over the last decade. In our 2012 audit, *Long-term-care Home Placement Process*, we noted that the long-term-care wait list increased by almost 85% between March 2005 and March 2012, to about 32,000 people. The Financial Accountability Office of Ontario projected in October 2019 that the long-term-care wait list would increase to 40,200 by 2020/21 and then drop to 36,900 by 2023/24 as new long-term-care beds come into service.

The Ministry of Finance predicted in its Ontario Population Projections, 2018-2046, that the number of seniors aged 65 and over will almost double

Figure 1: Comparison of Residents between Ontario Retirement Homes and Long-Term-Care Homes

Source of data: Retirement Homes Regulatory Authority and Ministry of Long-Term Care

	Retirement Homes[1]	Long-Term-Care Homes[2]
Average age	86	84
% female	70	68
% male	30	32
% with hypertension	83	60
% with a form of dementia such as Alzheimer's disease	30	63
% with diabetes	29	27
% with four or more emergency department visits	10	2
% with no emergency department visits	46	67

1. Based on McMaster University's data for the period of October 26, 2017, to October 26, 2018, provided to the Retirement Homes Regulatory Authority (Authority) in September 2019 as a result of a two-year research partnership with the Authority, McMaster University and the Institute for Clinical Evaluative Sciences to understand the profile of Ontario's retirement home residents.
2. Data as of December 31, 2019.

from 2.4 million in 2018 to 4.6 million by 2046, and the proportion of the population aged 65 and over will rise from 16.9% to 23.4%, with the number of Ontarians aged 75 and over more than doubling from 1.1 million to 2.8 million by 2046. With an aging population and high accommodation wait lists, an increase in both long-term-care homes and retirement homes is needed to meet current and future demand for senior residency and care.

2.2 Retirement Homes Regulatory Authority

The Authority is a not-for-profit administrative authority established under the *Retirement Homes Act, 2010* (Act). It became operational in 2011. It is self-funded through annual and licensing application fees paid by licensed retirement homes.

A Memorandum of Understanding, first established in 2011 and last reviewed and amended in October 2018, sets out the details of the roles, duties, responsibilities and accountability framework between the Authority and the Ministry established in the Act. The Authority provides policy advice, grants licences, oversees compliance and enforcement, conducts inspections, responds to complaints, educates retirement homes, consumers and the public about the Act, and maintains a public registry of licensed retirement homes. The Ministry is responsible for developing and maintaining policy, legislation and regulation. It is also required to oversee the Authority to confirm that it carries out its duty of protecting the public and fulfills its mandate.

2.2.1 Board of Directors and Governance

The Act states that the number of appointees appointed by the government cannot constitute a majority of the number of directors required to be on the Board. Currently, a nine-member Board of directors consisting of four government-appointed directors and five members elected by other Board members governs the Authority. The Minister designates the Chair of the Board and the Board appoints the Vice-Chair. The Board is accountable to the Ministry for the Registrar's and Authority's performance.

Between 2016/17 and 2019/20, Board members together received on average remuneration totalling about $111,000 annually.

Under the Act, in addition to the Registrar, the Board shall appoint two other statutory officers—the Risk Officer and the Complaints Review Officer. These officers report directly to the Board. The Risk Officer is responsible for independently reviewing, monitoring and assessing the effectiveness of the Authority's administration of the Act. The Complaints Review Officer is responsible for reviewing the reasonableness of the Registrar's consideration of complaints and his or her decision to take no further action (see **Section 2.5**).

The Board appoints the Registrar, who is also the Chief Executive Officer, and heads the Authority in its day-to-day operations. The current Registrar has held this position since June 2018. **Appendix 2** shows the organizational structure of the Authority.

All provinces have legislation governing retirement homes or similar senior living facilities. While the majority of other provinces have a ministry department or a health authority directly responsible for these facilities, Ontario's approach is unique in its establishment of a self-funded administrative authority to oversee the retirement home sector.

In July 2020, upon the approval of a bill that aimed to make improvements to multiple administrative authorities to protect consumers, the Act was amended to require the Authority to inform and advise the Minister promptly with respect to information that could affect its ability to perform its duties, and about matters that would likely require the Minister's action. The Authority's specific responsibilities or "objects" were also amended to require the Authority to suggest to the Minister any amendments to any Ontario legislation that it considered would further the purposes of the Act or would assist the Authority in administering the Act and the regulation. As well, the Minister could issue an order requiring the Authority to

make available to the public information regarding compensation it pays to its Board members, officers and employees. When we completed the audit, neither party had executed these new powers.

2.3 Care Services Provided by Retirement Homes

Although the Authority's core focus is the oversight of care services in a retirement home context, the organization is also in a position to work with the Ministry and others to provide advice and insight to help address complex and evolving system issues with respect to seniors' housing, including affordable housing.

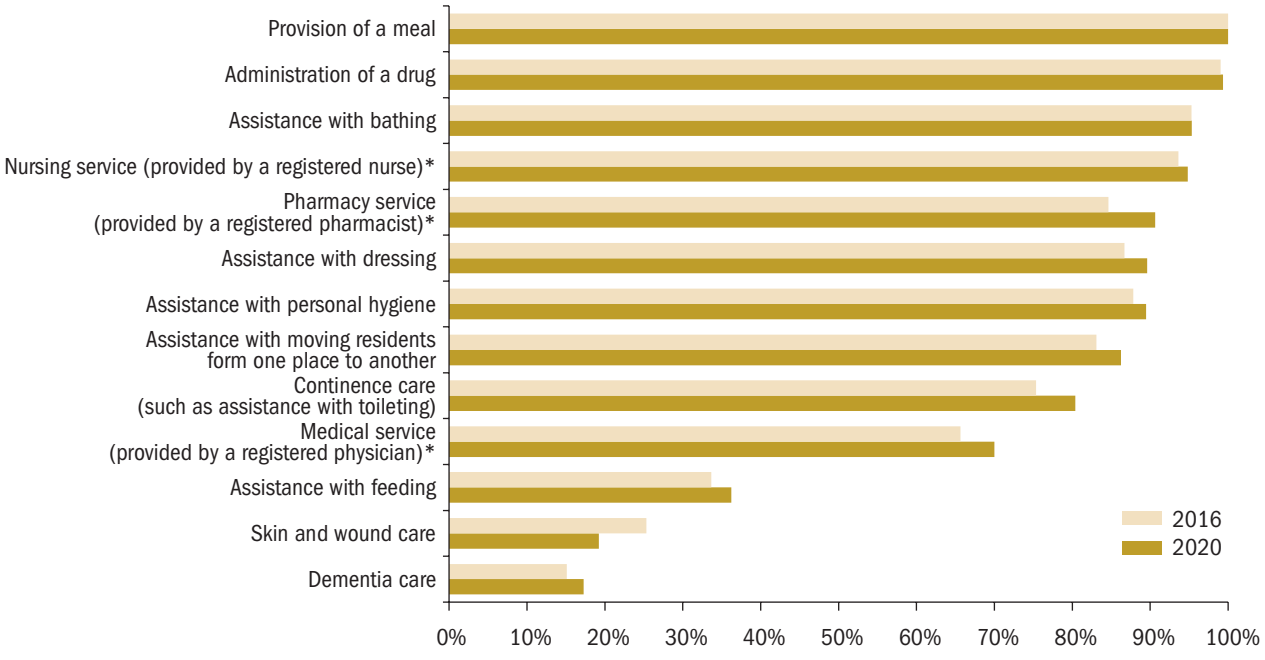
Unlike long-term-care homes that provide 24/7 nursing care, retirement homes are defined as making available a minimum of two of the 13 care services prescribed in the Act and its regulation. Retirement homes can operate as congregate settings outside of the Act only if they offer fewer than two services. Similarly, homes that do not offer two or more services but have residents who receive home-care services are not regulated under the Act because the retirement home itself is not the one providing care. In establishing the threshold of two care services, the province tried to capture the broad scope of accommodation and care services offered by retirement homes, given that some retirement homes offer minimal services and others offer a broad range of services.

Figure 2 shows the 13 care services that retirement homes may provide to residents. As of March 2020, licensed retirement homes in Ontario on average offered 10 of the 13 services to their residents, with 4% of the retirement homes providing all 13. Another 60% of the retirement homes offered between 10 and 12 services.

A resident can choose to receive care services either from retirement home staff or external providers, which may include private providers or those that are publicly funded by the Ministry of Health. The Ministry of Health, through the 14 Local Health Integration Networks and their contracted service providers, provides home and community care to eligible Ontarians who require care

Figure 2: Percentage of Retirement Homes That Offered Regulated Care Services in Ontario, as of March 31, 2020 and 2016

Source of data: Retirement Homes Regulatory Authority



* Service may be provided in-house or off-site.

in their home, including retirement homes, free of charge, to the home-care client. Such care primarily consists of personal support services, nursing and therapy services. Where government-funded services are not readily available because of a lack of resources, retirement home residents may choose to purchase services from the retirement home or from external private care providers. One or more agency or service provider organizations could be involved, providing various services.

Almost all retirement homes provide meals and administer drugs at a minimum, but only 35% assist residents with feeding, 19% provide skin and wound care and 17% provide dementia care. In comparison, residents of long-term-care homes are to receive help with most or all daily activities and have access to 24-hour nursing and personal care. Residents and families expect more nursing and personal care to be provided in a long-term-care home than they would typically receive in a retirement home, without supplemental external services being purchased.

The Act requires retirement home operators to ensure that their staff have the proper skills and prescribed qualifications to perform their duties. For example, under the Act, a retirement home shall ensure that a resident's plan of care is approved by a person acting under the supervision of a physician or a nurse. The Act also requires that all staff who provide direct care receive training related to abuse recognition and prevention, mental health issues, behaviour management and operation of personal assistance service devices. Retirement homes are responsible for the hiring and training of their staff. The Authority's inspectors review training records to assess skills and qualifications of staff as part of their inspection process and observe how staff perform their duties to confirm that there is compliance with the Act.

2.4 Licensing

Each retirement home operator must obtain a licence to operate from the Authority for each home location in Ontario. The Authority's Registrar is responsible for assessing licence applications and issuing licences. The Registrar considers factors shown in **Figure 3** in his or her assessment.

Figure 3: Retirement Home Licensing Application, Review and Decision

Prepared by the Office of the Auditor General of Ontario

Retirement home owner submits a completed application to the Retirement Homes Regulatory Authority (Authority)

Registrar of the Authority assesses*

- competency to operate responsibly in accordance with the *Retirement Homes Act, 2010*
- past conduct
- ability to provide care services

Registrar's licensing decision

- issue licence
- issue licence with conditions that the home must take to be in good standing
- refuse to issue licence

* The risk criteria for the assessment include the following: compliance; policies and operating plans; sector experience; standing of potential owners and workers with their regulatory health colleges, such as nurses, physicians and pharmacists; care service readiness, including affiliations and partnerships, such as for home care services; offences and convictions; operating history; and honesty and integrity

As shown in **Figure 4**, as of March 2020, there were 770 licensed retirement homes in Ontario, a 2% increase from two years prior. Some homes are issued a licence that includes certain conditions the home must meet to remain in good standing. Examples of such conditions include installing an automatic fire sprinkler system in the home or employing an experienced and qualified person who is responsible for ensuring compliance with the Act.

About 60% of the homes which have 72% of the suites, are operated by chains, while the remaining 40%, having about 28% of the suites, are operated by independent operators. The Authority defines a chain home as one that has two or more homes under common ownership. Independent homes

Figure 4: Number of Licences Issued to Retirement Homes, March 31, 2018–March 31, 2020

Source of data: Retirement Homes Regulatory Authority

Licences	March 31, 2018	March 31, 2019	March 31, 2020	% Change
Issued without Conditions	747	750	748	0.1
Issued with Conditions	6	6	22	267[1]
Total	**753**	**756**	**770[2]**	**2**

1. Beginning January 2019, all retirement homes must be equipped with automatic fire sprinkler systems to meet new *Ontario Regulation 213/07 Fire Code* requirements. The majority of licences issued with conditions relate to homes that do not yet meet this requirement and must notify the Retirement Homes Regulatory Authority on the status.
2. The increase in the number of retirement homes is mostly due to new builds.

Figure 5: Examples of Retirement Home Profiles

Prepared by the Office of the Auditor General of Ontario

Size	Eight beds in a century country home	46 suites in a three-storey building	287 suites in a seven-storey building
Room type	Private rooms	Private studios	Studio, one- and two-bedroom suites
Ownership type	Sole proprietor	Corporation	Corporation operating as part of a chain
Location	Small town in rural Ontario	Mid-sized city	Large, urban city

Type of care services provided	• Administration of drugs
	• Pharmacy service
	• Provision of a meal
		• Administration of drugs
		• Assistance with:
		  ◦ bathing
		  ◦ dressing
		  ◦ moving residents from one place to another
		  ◦ personal hygiene
		• Medical service
		• Nursing service
		• Pharmacy service
		• Provision of a meal
			• Administration of drugs
			• Assistance with:
			  ◦ bathing
			  ◦ dressing
			  ◦ moving residents from one place to another
			  ◦ personal hygiene
			• Continence care
			• Dementia care
			• Medical service
			• Nursing service
			• Pharmacy service
			• Provision of a meal

Amenities	• Library • Personal laundry service • TV lounge	• Café • Faith programs • Guest room • Recreational programs	• Bistro • Fitness room • Games room • Library • Physiotherapy • Salon • Theatre
Co-location with a long-term-care home	No, standalone	Yes	No, standalone

tend to have fewer suites than chain homes—an average of 59 suites in each home compared with 101 suites, respectively. As of March 31, 2020, 55 chains owned retirement homes in Ontario. Chartwell Retirement Residences and Revera are the two largest chains, with 94 and 68 licensed retirement homes respectively. **Figure 5** shows the sample profiles of three different retirement homes.

Figure 6: Complaints Received by the Retirement Homes Regulatory Authority, 2015/16–2019/20

Source of data: Retirement Homes Regulatory Authority

	2015/16	2016/17	2017/18	2018/19	2019/20	5-Year Avg
# of written complaints received by the Authority[1]	55	73	95	99	79	80
# of concerns raised in complaints received by the Authority[2]	136	274	280	239	241	234
Average # of concerns per complaint	2.47	3.75	2.95	2.41	3.05	2.92

1. Includes all formal complaints submitted to the Authority. The Authority does not initiate the complaint process until a written complaint is received. When a complaint is received by telephone, or the complainant does not provide sufficient information, the Authority informs the complainant of expectations, scope of the Authority and whether the complaint is out of scope, and informs the complainant of the appropriate regulatory body that could address the complaint. If the complainant chooses not to proceed with a formal written complaint, the Authority does not investigate the complaint under the formal complaint process, but may investigate it under the mandatory report process if the allegation meets criteria for investigation (as described in **Figure 8**).
2. As determined by the Authority, for example, a complaint with concerns relating to an unsanitary room, inadequate care and missing meals would be split into three concerns.

The Authority maintains a publicly accessible database that includes information on licensed retirement homes, including licence status, care services offered and inspection reports. This database is updated daily with licensing and inspection information.

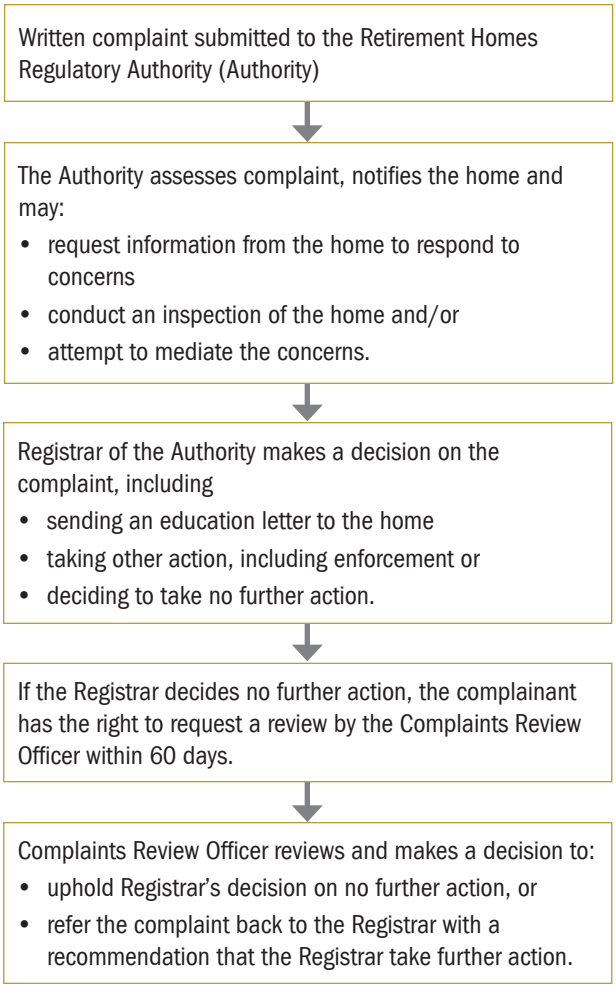
2.5 Complaints Against Retirement Homes Received by the Authority

Complaints about retirement homes may come from residents, their families or the public. For the last five years, the Authority received on average 80 complaints a year as shown in **Figure 6**. The Authority has the ability to adjudicate only on complaints relating to contraventions of the *Retirement Homes Act, 2010*.

The Registrar of the Authority decides whether to take action against a home after the review of a complaint. If the Registrar decides to take no further action, the Act specifies that the complainant may request a review of this decision to the Authority's Complaints Review Officer. Between 2017/18 and 2019/20, 11% of complaints were requested for review. The Officer then either determines that he or she is satisfied with the Registrar's decision or refers the complaint back to the Registrar with a recommendation for further action, which the Authority then acts on by investigating further. The Officer's decisions are final and cannot be appealed. **Figure 7** describes the complaints process.

Figure 7: Retirement Homes Complaints Process*

Prepared by the Office of the Auditor General of Ontario



* The Authority introduced an early intervention process in January of 2020 to address potential complaints that may be resolved before a formal complaint is filed. This includes advising a potential complainant regarding the home's complaints process, contacting the home to ensure they respond to the complaint or advising the complainant of mandatory reporting inspections for allegations of abuse or neglect. If the potential complainant remains dissatisfied after pursuing these avenues, they have the choice of subsequently pursuing the formal complaint process.

2.6 Retirement Home Inspections and Compliance

The Act requires the Authority to inspect retirement homes at least once every three years for compliance with the Act and its regulation to protect residents. Inspections are supposed to focus on residents' rights, care and safety. There are four types of inspections for licensed retirement homes and one type for unlicensed homes, as described in **Figure 8**. In 2019/20, the Authority's 13 inspectors (14 in 2017/18) conducted 978 inspections, as shown in **Figure 9**. The Authority publishes inspection reports on retirement homes on its website.

While "mandatory report" inspections (to inspect an allegation such as harm or risk of harm to residents) make up 49% of all inspections performed between 2017/18 and 2019/20, routine inspections were the next most common type at 44%. Routine inspections focus on areas of the Act that frequently relate to more serious risk of harm, such as resident safety, care and choices about care options. Examples of areas covered in these routine inspections include:

- Do staff react appropriately to any responsive resident behaviour?
- Are written records kept for assessments and plans of care for residents?
- Is the menu posted and does the meal provided follow the menu?
- Are written records kept for medication administration?
- Are there any maintenance issues that could cause harm to residents in the common living areas? (For example, reviewing the home's maintenance log).

Since April 2017, the Authority has used a risk model to determine the frequency of its inspection activities. The risk model includes an assessment of each retirement home based on the probability and severity of harms associated with each citation, as derived from inspection data collected by the Authority since its inspection program began in 2012. **Figure 10** shows that, as of April 2020, more than half, 54%, of the retirement homes were assessed as low risk, followed by medium-risk homes at 33% and high-risk homes at 4%. Another 9% were new homes that the Authority has yet to conduct the inspections needed to calculate a risk score.

The Authority maintains a schedule to determine when newly licensed homes should be re-inspected that considers the risks identified in the first inspection after the issue of a licence. The Authority's policy is to conduct routine inspections of high-risk homes about every six months, medium-risk homes about every 18 months, and low-risk homes about every 30 months. Any other types of inspection performed are in addition to this frequency schedule.

The Authority is also responsible for determining whether the homes have an infection prevention and control policy in place and whether the retirement home staff have been trained on the policy.

Ontario's 34 public health units, co-funded by the Ministry of Health and municipalities, are responsible for conducting infection prevention and control assessments of retirement homes.

2.7 Enforcement

When a retirement home (or an operator if the home is not licensed) is found to have breached certain provisions of the *Retirement Homes Act, 2010* or its regulation, or when the Authority identifies through its internal processes, such as referrals from inspections, that a retirement home has acted in a manner that may warrant enforcement action, the matter is referred to the Authority's enforcement department for review. A referral to the enforcement department can also occur when the licensing department intends to recommend that the Registrar refuse a licence or issue a licence with conditions.

In instances where the licensee does not follow the requirements in the Act to cease to operate in an orderly fashion, regardless of whether this is due to a revocation, licence refusal or some other causes by the operator, the Authority must then work with other community partners, such as the LHIN, to

Figure 8: Types of Inspections by Retirement Homes Regulatory Authority

Prepared by the Office of the Auditor General of Ontario

Type	Focus of Inspection	Notification	Interval
Routine	• Priority areas of the *Retirement Homes Act, 2010* (Act) relating to resident safety, care and choice about their care options • Not all areas of the Act and its regulation are addressed	Usually one day's notice	At least once every three years. Frequency is influenced by retirement homes' "risk rating," which is based on amount and severity of non-compliance found during previous inspections.
Complaint	Investigating the complaint filed through the complaints process, as described in **Figure 7**.	Unannounced	When there is a formal complaint that a retirement home is contravening the Act
Mandatory Report	Investigating an allegation	Unannounced	When the Retirement Homes Regulatory Authority (Authority) receives reports of harm or risk of harm to residents from improper treatment, abuse or unlawful conduct; or reports of misuse of residents' money. The Authority targets to investigate mandatory reports within five days of receiving the allegation.
Unlicensed	Whether the residence meets the definition of a retirement home	Unannounced	When there are reasonable and probable grounds to believe that a facility is operating as a retirement home
Compliance	• Determining whether the home is compliant with the Act • Inspections focus on identified risk areas • Are often follow-up inspections subsequent to one of the inspections listed above	Unannounced	When previous processes, such as inspections or enforcement activities, have identified areas for follow-up

Figure 9: Number and Types of Inspections Conducted,[1] 2017/18–2019/20

Prepared by the Office of the Auditor General of Ontario

Type	2017/18	2018/19	2019/20
Mandatory Report	607	588	509
Routine[2]	662	448	391
Complaint	30	43	34
Unlicensed	32	24	28
Compliance	8	29	16
New Licence[3]	0	2	0
Total	**1,339**	**1,134**	**978**

1. See **Figure 8** for explanations of the types of inspections.
2. Decrease year-over-year is due to two factors: a decrease in the overall risk profile of the homes as illustrated in **Figure 10** and an effort to address a routine inspection backlog in 2017/18 created by having implemented a new inspection protocol specifying inspection frequency based on the homes' risk score.
3. Inspections of retirement homes prior to issuing a licence are not typical. In 2018/19, the Retirement Homes Regulatory Authority Registrar requested that a retirement home apply for a licence because of an unlicensed home inspection. At the request of the Registrar, the Authority conducted two inspections on the same retirement home to determine whether to issue a licence. The Authority found that, among other issues, the home failed to maintain the home in a safe and hygienic manner and denied the licence.

Figure 10: Retirement Homes in Each Risk Category, 2018–2020

Source of data: Retirement Homes Regulatory Authority

Risk Level	Inspection-Informed Risk Score[1]	Routine Inspection Frequency[2]	% of Total Homes[3]		
			2018	2019	2020
Level 4: New home Level 4+: New home with a high risk	n/a – not enough data to calculate risk score[4]	First routine inspection within six months of issuing a licence. If the first inspection results in a high-risk score or a critical finding, the second routine inspection will occur within six months. Otherwise, the second inspection will occur within 12 months.	14	10	9
Level 3: High	120 or greater	Every six months	10	6	4
Level 2: Medium	20 or more but less than 120	Every 18 months	42	36	33
Level 1: Low	Less than 20	Every 30 months	34	49	54
Total			**100**	**100**	**100**
# of Retirement Homes			**753**	**757**	**770**

1. The risk score can range from 0 to 1,000. It is based on the likelihood of harm from historical inspections and the severity of the harm according to the *Global Burden of Disease Study 2015*.
2. Since April 2012, the *Retirement Homes Act, 2010*, has required the Retirement Homes Regulatory Authority to inspect licensed retirement homes at least once every three years.
3. Data is as of April 2, 2018, April 1, 2019 and April 1, 2020, respectively. The number of homes varies day-to-day depending on the status of licences.
4. The Authority conducts three inspections of a new home before assessing its risk level as either low, medium or high.

help relocate the residents. It may, in certain circumstances, make use of its Emergency Fund (see **Section 2.8**) to help residents find alternative care or accommodation.

2.8 Emergency Fund

The *Retirement Homes Act, 2010* requires the Authority to establish an Emergency Fund. The Fund was established in 2012/13 and consists of the Authority's contributions from its operations, interest income accrued and administrative penalties. The Authority has imposed administrative penalties totalling about $90,000 on retirement homes that have contravened legislative requirements since 2012/13. As of March 31, 2020, the Fund balance was about $615,000, up from about $566,000 five years prior.

The regulation made under the Act states that the Authority is to hold this Fund in trust for the benefit of residents and former residents approved by the Registrar to receive a payment, and it sets out the criteria for payments into and out of this Fund. Examples of criteria for payments include loss or damage to a retirement home that has resulted in an emergency situation in which residents have incurred costs to find, move to or pay for alternate accommodation or to access alternative care.

The Act allows residents or former residents to receive a maximum of $2,000 if the Registrar of the Authority determines the residents are eligible for the payment. As of May 29, 2020, this maximum was increased to $3,500 as part of the government's efforts to support seniors living in retirement homes during the COVID-19 pandemic. In the month of June 2020, subsequent to the regulatory amendment, the Authority received 12 claims for relocation and accommodation from its Emergency Fund, and paid between $300 and $3,500 for each of these claims.

3.0 Audit Objective and Scope

The objective of our audit was to assess whether the Retirement Homes Regulatory Authority (Authority) has effective systems and procedures in place to:

- carry out its mandated activities, including licensing, responding to complaints, inspections, enforcement and public education in accordance with the *Retirement Homes Act, 2010* (Act) and its regulation to protect retirement home residents from harm, including providing support to public health authorities with respect to infection prevention and control; and
- measure and publicly report on the effectiveness of its activities.

In addition, we assessed whether the Ministry for Seniors and Accessibility (Ministry) has effective systems and procedures in place to:

- oversee the Authority to ensure that it effectively administers the Act; and
- support and inform long-term strategic planning for seniors' services, including housing needs, to help seniors stay as independent, active and socially connected as possible.

In planning for our work, we identified the audit criteria we would use to address our audit objectives. We established these criteria based on a review of applicable legislation, policies and procedures, internal and external studies and best practices. Senior management at the Authority and the Ministry reviewed and agreed with the suitability of our objectives and associated criteria as listed in **Appendix 3**.

We conducted our audit substantially between January 2020 and August 2020. Our audit work was primarily conducted at the Authority, the Ministry and selected retirement homes in Ontario. We focused on activities of the Authority and the Ministry in the three-year period ending March 31, 2020, as well as months subsequent to the declaration of the COVID-19 pandemic up to August 31, 2020. We obtained written representation from the Authority and the Ministry that, effective November 13, 2020, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

At the Authority and the Ministry, we conducted the following work:

- reviewed applicable legislation, agreements, reports, program guidelines and policies, inspection files, other internal files and meeting minutes;
- interviewed senior management and appropriate staff at the Authority, the Authority's Board Chair and members, a sample of members of the Authority's Stakeholder Advisory Council—a group that provides input to the Board but is not a committee that reports to the Board—and the Risk Officer and the Complaints Review Officer, both of whom are independent of the Authority's management and report directly to the Board; and
- examined and analyzed financial, licensing, complaints, compliance and outbreak data.

To observe how Authority staff conduct inspections of retirement homes, we accompanied Authority inspectors and visited three retirement homes in February 2020. At two of these homes—one large and one small—we observed the process that inspectors followed for routine inspections. Specifically, we observed the approach the inspectors took to verify the number of suites in the retirement home; review residents' plans of care to confirm they were developed in accordance with the Act; ensure that medication was appropriately secured and that staff were properly trained; review the home's falls log; review whether retirement home staff were trained on policies; and speak to residents to identify other areas on which they need to focus. At a third home, we accompanied an Authority inspector to observe how an inspection of an unlicensed home compared with a licensed home. In that home, we observed how the inspector approached the inspection, which involved applying their judgment in considering prior interactions with the home and its operator, and we obtained an understanding of the factors the inspector considers before concluding an inspection.

Additional work that we did is listed in **Appendix 4.**

We conducted our work and reported on the results of our examination in accordance with the applicable Canadian Standards on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. This included obtaining a reasonable level of assurance.

The Office of the Auditor General of Ontario applies the Canadian Standard on Quality Control and, as a result, maintains a comprehensive quality-control system that includes documented policies and procedures with respect to compliance with rules of professional conduct, professional standards and applicable legal and regulatory requirements.

We have complied with the independence and other ethical requirements of the Code of Professional Conduct of the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

4.0 Detailed Audit Observations

4.1 Oversight Gap Leaves Vulnerable Residents More at Risk in Retirement Homes

In Ontario, patients may be designated as alternate level of care (ALC) if they do not require the intensity of resources or care provided in a hospital setting. Patients designated as ALC may be discharged to long-term-care homes, shelters or group homes, or to their own homes, which could be a retirement home. Local Health Integration Networks (LHINs), in partnership with hospitals, are involved in discharging patients designated as ALC who require home and community services into what is considered to be the most appropriate care setting, based on a patient's needs and preferences as well as available resources.

The Retirement Homes Regulatory Authority (Authority) oversees retirement homes under the *Retirement Homes Act, 2010* (Act). However, we found that when beds are governed or funded by other ministries under statutes or programs outlined in the Act, the Act specifies that those beds are not subject to oversight by the Authority.

Such people include those staying in retirement home spaces that are funded by local governments, other ministries and patients designated as ALC who have been discharged from hospitals into a retirement home bed that is subsidized directly by the province or by a hospital under the Ministry of Health's short-term transitional-care program. This gap in oversight means there is no regulatory oversight body regularly inspecting the care of patients in these beds such as inspecting whether or not plans of care have been set up and updated on a regular basis. As such, any poor quality of care could go undetected and increase the risk of harm and abuse to vulnerable residents occupying these spaces. While the Authority responds to issues raised related to the conduct of a licensee irrespective of whether the home includes any patient designated as ALC, it is not clear that the Authority can address the issues where exemptions to the Act apply.

Ontario Health informed us that if a patient designated as ALC is discharged to a retirement home, a discussion with a discharge planner or social worker and the patient and their family will take place as part of discharge planning. If this patient requires home-care services, a LHIN care co-ordinator will determine eligibility and create a service plan in collaboration with the patient and their family and caregivers. Ontario Health informed us as well that the LHIN care co-ordinator would then be responsible for regularly reviewing the care plans for patients who receive home care. However, if a patient designated as ALC does not receive home care, then they are considered a retirement home resident and the retirement home is therefore responsible for setting a plan of care and ensuring that these plans are updated on a regular basis.

Our audit found that the Authority does not collect data on the number of patients designated as ALC who are housed in a retirement home. According to data provided by Ontario Health, 8% or 4,201 of all patients designated as ALC discharged from hospitals were discharged to retirement homes during 2019/20, up from 6.7% or 3,466 in 2015/16. We confirmed that there was no increase in the early months of COVID-19 in the number of patients typically being discharged from hospitals to retirement homes. The World Health Organization declared COVID-19 as a global pandemic on March 11, 2020. From March 11 to August 31, 2020, of the total of 21,760 patients designated as ALC who were discharged from hospitals, 1,675 or 7.7% were discharged to retirement homes.

The first reported outbreak of COVID-19 in a retirement home was on March 22, 2020. Between then and August 31, 2020, a total of 989 residents in retirement homes were confirmed infected. Of that number, 209 residents died (see **Appendix 5** for a list of outbreaks with confirmed cases, recoveries and deaths among residents and staff). We were unable to determine how many of the deaths and infections were patients designated as ALC because neither the Ministry for Seniors and Accessibility nor the Authority track the number of patients designated as ALC in retirement homes.

4.1.1 Ministry of Health Does Not Inspect Beds nor Systematically Address Complaints in Its Transitional Care Program

Retirement homes may also house residents who are funded by the Ministry of Health's short-term transitional-care program, which began in 2017/18. However, neither the Ministry of Health nor the Authority inspected these retirement home beds.

The retirement home-based short-term transitional-care program uses vacant retirement home spaces to provide temporary accommodation and care to patients designated as ALC or at risk of being designated as ALC to free up hospital space while they wait for space in their destination of choice, such as long-term care. From 2017/18 to 2019/20, the Ministry of Health provided more than $40 million to more than 26 retirement homes under this program to provide care, and in some cases accommodation, for 2,357 patients, some of whom were designated as ALC. On average, a patient staying in a retirement home under this program stays for 81 days.

We also found that the LHINs and the Ministry of Health, which subsidize these beds in retirement homes, do not systematically collect complaints related to these beds because they expect any complaints to be directed to the Authority. Ontario Health noted that these arrangements are between hospitals and the retirement homes; the LHINs are not involved in the process. The Authority will respond to issues raised related to the conduct of a licensee irrespective of whether this includes a subsidized patient; however, the Authority indicated that it is not clear that it can address issues relating to subsidized beds where exemptions to the Act apply. Similarly, the Authority's position is that it receives and accepts complaints from subsidized residents in retirement homes but, in practice, it informs complainants at the beginning of the complaints process whether their concerns are outside of the Authority's jurisdiction and advises them to contact the LHINs for further assistance. As a consequence, some complaints are never formally filed to the Authority. In our review of complaints from 2017/18 to 2019/20, the Authority recorded only one formal complaint related to a subsidized bed. The Authority deemed the complaint to be out of its scope and notified the complainant that the complaint could not be addressed through its complaints review process.

We reviewed the complaints that the Ministry for Seniors and Accessibility received in the last three years related to retirement homes. None of them were identified as being related to subsidized beds.

The Ministry of Health and the LHINs informed us that they received 18 complaints in the last three years related to subsidized beds in retirement homes; however, as many of these are not under

the LHIN's authority, complaints were generally referred to the Authority. The LHINs' position is that the Authority should first and foremost receive complaints about retirement homes and the Ministry of Health and hospitals will be involved where the Ministry has funded hospitals to operate these beds.

We reviewed the complaints that the Patient Ombudsman received in the last three years related to retirement homes. We identified one complaint as being related to a subsidized bed and the complainant was able to file a complaint about the hospital to the Patient Ombudsman, given that the hospital had a formal relationship with the retirement home. The Patient Ombudsman informed us that if it receives a complaint specifically related to a retirement home, it will generally refer the complaint to the Authority.

People residing in retirement homes who are designated as ALC and in a subsidized retirement home bed, such as one funded under the short-term transitional care program, are unlikely able to discern where they should direct their complaints.

RECOMMENDATION 1

To eliminate the inspection and complaint-handling gap and to protect residents in retirement home beds that are exempted from the Retirement Homes Regulatory Authority's oversight under the *Retirement Homes Act, 2010*, some of whom are designated as alternate level of care, from harm and neglect, regardless of who is funding the beds, we recommend that the Retirement Homes Regulatory Authority and the Ministry for Seniors and Accessibility, in conjunction with the Ministry of Health, the Local Health Integration Networks, and other ministries, governments and parties that fund these spaces in retirement homes:

- clarify the responsibility of inspection and complaint handling of spaces occupied by patients designated as alternate level of care and subsidized beds in retirement homes;
- inspect homes with such residents as soon as possible to ensure that they are safe and are being properly cared for;
- regularly inspect these homes and track and address complaints related to subsidized beds; and
- clearly and effectively communicate the complaints process to residents and their families for residents in subsidized beds.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) agrees with the need to eliminate any gaps in oversight arising from exceptions in the *Retirement Homes Act, 2010* to protect residents designated as alternate level of care in retirement homes from harm and neglect.

The Authority believes it is well-positioned to oversee forms of subsidized suites in licensed retirement homes using a risk-based approach and incorporating these suites into its complaints-handling process. We look forward to collaborating with the Ministry for Seniors and Accessibility, the Ministry of Health, Ontario Health and the Local Health Integration Networks (LHINs) to proceed expeditiously with:

- clarification on the responsibility for inspection and complaint handling of subsidized beds in retirement homes;
- eliminating statutory barriers to the sharing of information between agencies responsible for protecting residents (for example, LHINs, Public Health, Landlord and Tenant Board and hospitals); and
- robust communications to residents and families regarding rights and protections, and the complaints process.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility (Ministry) supports this recommendation and agrees with the importance of ensuring that there are appropriate protections for all residents in

retirement homes, including those in subsidized suites. The Ministry will work with the Retirement Homes Regulatory Authority, the Ministry of Health, Ontario Health and other partners to clarify responsibility for inspections and complaint-handling for these subsidized beds, address gaps in inspections and resident complaint-handling, and communicate oversight responsibility and the complaints process to these residents and their families.

4.2 Needed Level of Care Rising

4.2.1 Growing Number of Retirement Home Residents Have Health Profiles Similar to Those in Long-Term Care

Retirement homes are intended to be residential spaces within the community, not health-care institutions like long-term-care homes. However, our audit found that an increasing number of the retirement home residents who receive government-funded home-care services have needs similar to those who live in long-term-care homes.

All Authority inspectors we interviewed concurred that they have observed an increase in the level of care needs in retirement homes; however, the Authority does not collect information on the complexity of care needs required for retirement home residents. The Authority is also not aware of the specific types of care services that residents receive from retirement homes, private care providers and government-funded home care.

Ontario Health tracks complexity scores, which measure the level of care needs, of retirement home residents only if they receive home-care services, but the Authority does not obtain this information from Ontario Health. Based on a one-time report produced in September 2019 through an ongoing partnership with McMaster University, the Authority estimates that almost 43% of all retirement home residents received ongoing home-care services for a period of time typically longer than a year, provided by the LHINs in October 2017 to October 2018. We obtained more current data from Ontario Health and found that this percentage grew to 52%, assuming all retirement homes were at capacity in 2019/20. We could not perform this analysis based on occupancy data because the Authority did not have reliable information on occupancy (see **Section 4.4.4**).

We compared the level of care needed for retirement home residents to the level of those who lived elsewhere in the community by requesting home-care complexity scores from Ontario Health. We found that of the 48,545 clients receiving home-care services in retirement homes in 2019/20, many have high care needs:

- 52% are classified as chronic patients who have one or more health or chronic illnesses with direct care needs that are stable and predictable, compared with 43% who live in assisted living and 34% who live in their own home.
- 21% are classified as complex patients who have one or more health or chronic illnesses with direct care needs that are unstable and unpredictable, compared with 13% who live in assisted living and 14% who live in their own home. These patients have conditions such as multiple complex psychosocial issues, unmanageable behavioural/mental health issues, possible clinical conditions or moderate to late-stage dementia. These health issues are comparable to those experienced by seniors living in long-term care homes.
- 86% who accessed home-care services required ongoing care compared with 13% who needed home care for short-term purposes. The remaining 1% relate to individuals who do not require admission to a caseload for ongoing care co-ordination or where a complexity score was not specified.

4.2.2 Number of Retirement Home Residents Waiting for Long-Term Care Climbed 62% between 2016 and 2020

Stakeholder groups we spoke to during this audit indicated that an increasing number of people in retirement homes are waiting for long-term-care placements. We confirmed this view by obtaining long-term-care wait list data from Ontario Health, which shows that while the overall wait list for long-term-care homes rose 43% from 26,857 on March 31, 2016 to 38,313 on March 31, 2020, the number of people waiting in a licensed retirement home climbed 62% from 6,201 on March 31, 2016 to 10,074 on March 31, 2020 as shown in **Figure 11**. Our analysis above excluded people who were already in a long-term-care home waiting to be transferred to another home; Ontario Health includes these individuals on the long-term-care wait list.

This growth not only surpassed the increase in the overall number of people on the wait list, but also the increase in those waiting for long-term-care homes in the community—which includes people's own homes—and in a hospital. This trend confirms that more seniors with heavier care needs have chosen to live in retirement homes, and retirement homes are now housing people who require higher care needs that long-term care is likely better suited and designed to provide. According to data from Ontario Health, as of March 31, 2020, 26% of people requiring long-term care were waiting in retirement homes, compared with 23% as of March 31, 2016.

Both the Office of the Chief Coroner and the then Ministry of Health and Long-Term Care (now the Ministry of Health) raised concerns as early as 2009 about placing people with higher care needs in retirement homes that may not have the sufficient resources and expertise to assist them:

- The 2009 annual report of the Office of the Chief Coroner's Geriatric and Long-Term Care Committee highlighted a case where a senior patient received care in a retirement home through a pilot alternate-level-of-care program. The patient had significant care needs that were difficult even for a long-term-care home to meet; one of the long-term-care homes in the patient's preferred geographic area had rejected their application because of those needs. Instead, the patient was moved into a retirement home and ultimately died. The Coroner noted that it was evident that the private-care home did not possess the expertise, care and services necessary to provide for the resident's needs. The Coroner recommended that programs in Ontario retirement homes that provide care to frail elderly residents awaiting placement in long-term care should be held to the same standards for care services as a licensed long-term-care home. The Authority indicated that the standards of care as set out in the *Retirement Homes Act, 2010* would differ from those set out in the legislation governing long-term-care homes, even though some retirement home residents have health profiles similar to those in long-term care. Plans of care for retirement home residents would detail the care services that the resident is entitled to receive, the planned care services to be provided by the retirement home, the intended goals of the care services they have chosen

Figure 11: Number of People Waiting for Long-Term Care on March 31 by Patient Location, 2016–2020
Source of data: Ontario Health

	2016	2017	2018	2019	2020	5-Year % Increase
Community	17,074	19,449	20,409	21,824	24,325	42
Hospital	3,582	3,864	3,866	4,129	3,914	9
Retirement home	6,201	7,413	8,546	9,155	10,074	62
Total	**26,857**	**30,726**	**32,821**	**35,108**	**38,313**	**43**

and directions for staff who provide that care and, with the consent of the resident, the care services to be provided by external care providers, including details of the services and the goals those services are intended to achieve. In comparison, the *Long-Term Care Homes Act, 2007* and its regulation outline care standards that are more prescriptive and include minimum standards; for instance, long-term-care residents are required to be bathed at a minimum twice a week.

- In a 2016 internal memo, the Ministry of Health and Long-Term Care acknowledged that it received many calls from the public related to hospitals not permitting patients to wait in the hospital until there was a vacancy in a long-term-care home of their choice and informing patients that they must go home or to a retirement home once they are designated as alternate level of care. It also identified the risk to residents waiting in retirement homes for long-term care placement, including those discharged from hospitals.

To identify concerns about the welfare of residents, Authority inspectors observe interactions between residents and staff. Based on these observations, inspectors may follow up on specific legal requirements, such as reviewing assessments and plans of care, behaviour management or staff training. However, the Authority is not mandated to do anything beyond this, such as requiring additional training for staff in retirement homes that offer a more intensive level of resident care. The Authority indicated that the obligation is solely on retirement homes to provide the appropriate level of training for the services it offers.

In January 2020, the Authority began to develop and assess how separate retirement home licence classes could address the risk that the existing regulatory model does not discern homes with higher-risk residents from homes with more independent residents. However, this work is still on hold because of the COVID-19 pandemic. We explain this work further in **Section 4.5.1**.

4.2.3 Multiple Parties Have Raised Concerns about Resident Care and Staffing in Retirement Homes

Of the concerns raised in written complaints received by the Authority from 2017/18 to 2019/20, 55 or 7% related to issues regarding staffing levels and competency of staff, and 399 or more than half related to resident care. Examples of these concerns included residents not being offered suitable meals, not being provided with personal hygiene services such as bathing and grooming, and instances where residents incurred bedsores that became infected.

Similarly, in 2019 public consultations conducted by the Ministry on seniors' strategy, seniors and other stakeholders identified that seniors want to continue living at home and in the community as they age. However, to do so, more support is needed to age in place, including greater access to personal support workers. They also noted that high turnover rate among personal support workers working in the community affects the quality of care and trust between seniors and service providers.

Retirement home residents and their family members are free to direct their own care according to their preference. They can choose to receive care services from retirement home staff, home care funded by the LHINs, or privately hire their own care workers. Multiple stakeholder groups that we interviewed informed us that many care staff are not full-time workers and are employed at multiple locations.

Personal support workers working in retirement homes remain the lowest paid cohort, compared with personal support workers in other care settings. Factors including the historic, overall lower intensity of care needed in retirement homes and a mostly private-sector industry likely contributed to the lower pay. In October 2020, the government announced a temporary pay increase that further widened the wage gap between retirement home workers and those who deliver publicly funded personal support services,

if retirement homes did not of their own accord increase the wages of their workers.

Inspectors from the Authority informed us that they have identified during inspections that retirement home staff have concerns over staffing ratios. The Act does not mandate staffing ratios, as the regulation focuses on setting care, safety and administrative standards that retirement homes must consider when determining staffing levels. As such, the Authority does not directly evaluate staffing ratios as part of its inspection process of retirement homes.

We reviewed a June 2020 Ministry working document related to the seniors' strategy that was under development. In the working document, the Ministry was considering partnering with the Ministry of Health and the Ministry of Long-Term Care to address staffing issues concerning personal support workers, nurses and other support staff. However, the Ministry did not specify the actions it would need to take to address staffing issues in retirement homes. The Ministry informed us that it continues to work with other partner ministries, such as the Ministry of Health, to address staffing issues in retirement homes.

The Authority also informed us that if a retirement home is not capable of providing the level of care required by a resident, the retirement home is required to assist the resident to access external care providers to meet their care needs. However, unlike long-term-care homes, residents of retirement homes may be evicted if the retirement home cannot provide the level of care required by the resident. If the resident objects to the eviction, the dispute can be brought to the Landlord and Tenant Board, which oversees the *Residential Tenancies Act, 2006*. From 2017/18 to 2019/20, the Authority received 20 formal written complaints related to residents being evicted from retirement homes or residents with care needs so intensive that they were required to transfer to long-term care. The Authority referred five cases to the Landlord and Tenant Board but investigated the remaining cases because the complaints also touched on potential contraventions of the *Retirement Homes Act, 2010*. Of those complaints, the Authority ultimately cited two homes for violating the Act, provided one home with an education letter and was still investigating two homes when we completed our audit. The Authority determined that the remaining 10 homes did not violate any section of the Act.

We discuss further concerns with staffing during the COVID-19 pandemic in **Section 4.4.2**.

RECOMMENDATION 2

To protect residents of retirement homes who may require increasing levels of care, and in some cases to the extent of the level of care provided in long-term-care homes, we recommend that the Retirement Homes Regulatory Authority work in conjunction with Ontario Health, the Ministry of Long-Term Care and the Ministry for Seniors and Accessibility to:

- resume and accelerate its work to develop different and appropriate approaches to regulate different types of retirement homes with consideration of the evolving resident health profiles;
- examine, reassess and identify the most efficient and cost-effective way to deliver support services in retirement homes for the safety and protection of residents;
- implement an inspection process (assigning clear roles and responsibilities), as soon as possible that sufficiently addresses the increasing complexities and levels of care required for residents in retirement homes; and
- take more timely and rigorous compliance support or enforcement actions against retirement homes that do not provide adequate care services to residents.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation. The Authority will:

- collaborate with the Ministry for Seniors and Accessibility (Ministry) in its comprehensive review of the *Retirement Homes Act, 2010* (Act), other government agencies, industry and public stakeholders to support efficient and effective approaches to resident care without compromising reasonable care standards proportionate to a resident's needs;
- provide advice to the Ministry in its review of the Act to identify statutory amendments that would provide the Authority with flexibility to address the evolving nature of care service delivery in retirement homes;
- accelerate development of a purposeful approach to regulatory oversight of varying and evolving business models that ensures residents are protected, while eliminating any barriers to innovation and avoiding unnecessary red tape;
- continue its ongoing Regulatory Program Modernization Project, which includes more flexible approaches to inspections that take into account the compliance history and risk assessment of individual homes and their resident population;
- seek opportunities to improve systems and processes and focus more resources as necessary to ensure that non-compliant licensees are more efficiently escalated to, and assessed by, enforcement when appropriate; and
- continue to assess licensees and hold them accountable on their obligation to assist residents in accessing external care providers should a resident's needs exceed the care services offered by the retirement home.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility (Ministry) has started a comprehensive review of the *Retirement Homes Act, 2010*. As part of this review, the Ministry will work with the Retirement Homes Regulatory Authority and key partners, including the Ministry of Health and the Ministry of Long-Term Care, to identify opportunities to enhance protections for retirement home residents, especially those who may require increasing levels of care.

4.2.4 Authority Does Not Consistently Collect Needed Retirement Home or Resident Data; Unable to Assess Needed Care

During our audit, the Authority acknowledged, based on its interaction with the retirement home sector, that the level of care required by residents has been changing, but it does not have data to measure this change and assess its impacts. As a result, the Authority has limited ability to analyze and assess elements in the retirement home industry that may be useful to address shifting needs and issues facing both the retirement homes sector and aging residents.

In terms of resident data, any information the Authority has on residents is derived from its inspections, inquiries from the public or mandatory reports made by retirement homes. Such information is, for the most part, self-reported by retirement homes or by complainants. The Authority does not regularly collect comprehensive data on retirement home residents, including their care needs, care services provided either by retirement home staff or external providers, or fees charged for these services. The Authority is also not aware of the types of care services that residents receive from retirement homes, private care providers and government-funded home care.

The Authority also does not systematically collect or analyze data such as staffing levels of internal retirement home staff or external providers; occupancy rates; and the financial position of retirement homes.

We also found that the Authority does not systemically collect information from other ministries and organizations that also provide senior care in retirement homes. As shown in **Appendix 6**, while other government organizations such as the

Ministry of Long-Term Care, Ministry of Health or Ontario Health collect the following information, neither the Authority nor the Ministry for Seniors and Accessibility obtain access to it:

- number of individuals living in retirement homes waiting to be placed in long-term-care homes (see **Section 4.2.2**);
- number of patients designated as alternate level of care or short-term transition care beds patients in a particular retirement home, which typically represent residents with high care needs (see **Section 4.1**);
- the type of care services provided to individuals and the number of hours of each type of care service required by individuals receiving government-funded home care in retirement homes; and
- care not provided as planned to individuals receiving government-funded home care in retirement homes.

The Retirement Homes Act, 2010 currently allows the Authority to collect data on the types of care services the licensee makes available in the home; clinical and functional profiles of residents of the home; and the licensee's operation of the home and compliance with the Act, subject to established processes and criteria and the Minister's approval. The Act, however, does require data collected on the profiles of residents of the home be de-identified to preserve the privacy of residents. Nevertheless, the Authority's position is that the provision does not specifically enable the exchange of information among regulators; it believes it is limited in its ability to share with and obtain data from other organizations. In 2017/18, the Authority commenced the process of seeking designation under the *Regulatory Modernization Act, 2007*, which would help it to share information with other regulators. The Ministry informed us that this work was put on hold in 2018 but has since resumed; this work was still ongoing when we completed our audit.

RECOMMENDATION 3

To allow it to make more effective, timely, data-driven decisions to strengthen the oversight of staffing and care services provided in retirement homes and support the Ministry for Seniors and Accessibility (Ministry) in developing policy on senior housing and care, we recommend that the Retirement Homes Regulatory Authority:

- work with the Ministry to obtain the necessary approvals to collect needed information as soon as possible;
- in conjunction with the Ministry, establish processes to collect data on residents and retirement homes from other relevant organizations with consideration of appropriate processes to respect the protection of personal health information; and
- commence the collection, analysis and use of this information to inform policy development in this sector.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority had, prior to the audit completion, begun drafting the criteria for data collection for submission to the Minister for Seniors and Accessibility. These criteria, if approved, will support the implementation of a Request for Information Policy that contains processes and procedures that the Authority will use to obtain information from licensees as required by the legislation. Once approved, the Policy is expected to enable the Authority to collect information to facilitate timely and evidence-based decision-making.

The Authority will also collaborate with the Ministry for Seniors and Accessibility in its review of the Act by providing advice and supporting the development of a proposed approach to enable effective data collection, allow for improved data sharing with its

community partners and inform data-driven decision-making.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility's review of the *Retirement Homes Act, 2010* will include the development of a proposed approach to improve the collection and use of information in order to allow for more effective, timely and data-driven decisions.

4.3 Inspections

4.3.1 Routine Home Inspection Frequency Determined Based on Incomplete Factors

The Authority's risk assessment model for inspections (see **Section 2.6**) determines the risk of harm for each subsection of the *Retirement Homes Act, 2010* and its regulation, based on the severity of harm and number of violations at homes in the past. However, the Authority's risk assessment model does not consider factors outside of inspection history that could also influence the frequency of inspections; such factors include complaints, input from community partners, history of harm at a specific home where there are no violations related to the harm, provision of home care within retirement homes or residents in a retirement home waiting for long-term care. This means that under the Authority's current model, retirement homes with risk factors that are not connected to a history of violations of the Act or its regulation are not required to be inspected more frequently than other homes.

For example, both the Authority and public health units' responsibilities include inspecting for infection prevention and control measures at retirement homes. However, despite the public health units' expertise and specialization in infection prevention and control, the Authority does not consider the results of public health units' inspections in its risk-based approach. Likewise, frequency of complaints could indicate management issues at a retirement home. However, the frequency of routine inspection is not increased unless the complaints lead to violations of the Act or its regulation.

The Authority and its Board have reviewed the appropriateness of the Authority's risk model on an annual basis since its introduction in February 2017. The annual review includes updating the risk for each provision with newly collected inspections and harms data and assessing potential new risk factors.

RECOMMENDATION 4

So that risks and harm to retirement home residents can be more effectively reduced through more frequent and risk prioritized inspections, we recommend that the Retirement Homes Regulatory Authority expand the factors considered, beyond just inspection history, in its risk model for selecting homes for more frequent inspection.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority has been annually reviewing and refining its risk model since it was first introduced in 2016, and it agrees that continuing to expand the data and factors included in the risk model will contribute to making the model increasingly robust. The Authority will seek to include relevant data to support risk assessment of harm outside of its information collected through inspection. The Authority looks forward to using information obtained through information sharing with other agencies to provide for a more comprehensive approach to risk assessment based on an enhanced level of information that previously has not been available to the Authority.

4.3.2 Authority Continues to Adjust COVID Risk Inspection Model

As part of its work to measure retirement homes' ability to prevent and manage a potential outbreak,

the Authority developed a risk assessment model, separate from its other risk model that it uses to determine routine inspection frequency. The Authority was continuing the process of refining the COVID-19 risk model and assessing all homes' preparedness when we completed the audit in August 2020.

The COVID-19 risk model, which the Authority began developing in April 2020 and continued to refine, considered factors such as the retirement home's staffing level, supply of personal protective equipment, and information from community partners such as public health, home staff and the public. The Authority incorporated some elements of the regular risk model (see **Section 2.6**) in the COVID-19 risk model. For example, many homes assessed as low risk in the regular model were deemed to have low COVID-19 risk. As of September 30, 2020, about two-thirds of the licensed retirement homes were assessed as having low COVID-19 risk. The COVID-19 risk model, effective in September 2020, is presented in **Appendix 7**.

The Authority prioritized its outreach to higher-risk homes as assessed by its COVID-19 risk model and made more frequent contact with them, both in-person and via the phone. As of mid-August 2020, the Authority had contacted all medium- and high-risk retirement homes at least once, and still needed to reach out to more than 200 low-risk homes.

4.3.3 More Sharing of Information on Infection and Prevention Control Inspections Needed between Public Health and the Authority

Retirement homes are required under the *Retirement Homes Act, 2010* to complete an annual consultation with local public health units to ensure that their infection prevention and control program is appropriate. Before COVID-19, the Authority's inspectors were checking whether the retirement home had infection prevention and control policies and whether retirement home staff were trained on the policies by reviewing training records. However, the Authority did not check whether an infection prevention and control program had been created and was being followed at retirement homes unless concerns were observed while in the homes.

To better manage the risk of infection in retirement homes during COVID-19 outbreaks, the Authority introduced new inspection procedures in April 2020 to focus more on infection prevention and control. Specifically, it created an inspection checklist that focuses on confirming the compliance of retirement homes' infection prevention and control measures with the Chief Medical Officer of Health's directive. Between March 15 and June 30, 2020, the Authority conducted 101 in-person inspections, including 28 inspections to specifically assess compliance with infection prevention and control measures. The remainder of the inspections were mostly inspections to investigate allegations. The Authority selected the 28 homes based on complaints received from the public or public health; these homes covered various COVID risk levels from low to medium to high. As of September 30, 2020, the Authority had assessed 31 retirement homes as being high risk in their ability to prepare for COVID-19. The Authority also informed us that, going forward, it does not intend to inspect all retirement homes for infection prevention and control but will continue to inspect retirement homes based on tips it receives from the public or concerns from public health, which retains primary accountability for infection prevention and control oversight in retirement homes.

According to the public health units we interviewed, some public health units assess all the retirement homes in their catchment area for their infection prevention and control preparedness, while others contact a portion of them. They also informed us that it was not always possible to perform joint inspections of retirement homes with the Authority. The Authority was in the process of assessing lessons learned when we completed our audit.

Retirement homes are required to develop emergency plans as a part of the licence application. The Authority verifies whether retirement homes have

planned for emergencies as part of its proactive, routine inspections. Emergency plans are not intended to incorporate pandemic emergency plans.

RECOMMENDATION 5

To confirm that retirement homes have appropriate infection and prevention controls in place, we recommend that the Retirement Homes Regulatory Authority:

- put processes, including continuing use of its COVID-19 checklist, in place to assess whether all retirement homes have appropriate practices on infection prevention and control;
- routinely obtain data from public health officials on issues or concerns in retirement homes;
- regularly incorporate into its inspector training any lessons learned from public health inspections;
- going forward, request that retirement homes incorporate pandemic plans in their emergency plans that also address the requirement to include a personal protective equipment supply.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority has updated its routine inspections process to incorporate infection prevention and control assessment in alignment with the infection prevention and control guidelines it released concurrent with the resumption of its routine inspections that recommenced in November 2020 (after their suspension in March 2020 due to COVID-19).

The Authority will continue to collaborate with local public health units, which have primary jurisdiction over compliance with requirements for infection prevention and control, and explore options with the Ministry for Seniors and Accessibility and Public Health Ontario to obtain access to public health orders and data on a prioritized basis. Any high-level learnings and/or insights from the public health data obtained will be incorporated into inspector training.

The Authority will also continue infection prevention and control compliance inspections on a risk-informed basis with priority given to those homes in receipt of public health orders.

4.3.4 Most Proactive Routine Inspections Were Conducted within Required Time Frames, but Pandemic Created Backlog

In each of the years between 2017/18 and 2019/20, the Authority conducted an average of 500 routine inspections of retirement homes. These proactive inspections focused on areas of the Act that relate to risk of harm, such as resident safety, care and choices about their care options. As of February 2020, prior to the declaration of the pandemic, there was a backlog of only 16 proactive retirement home inspections. Four of these homes were either being renovated or were subject to a licence revocation order. Of the remaining 12 homes, the Authority was an average of 41 days behind the inspection date determined by its risk model as described in **Section 2.6**. In two cases, the delay was almost three-and-a-half months behind the scheduled inspection date. Given the volume of inspection conducted, and the level of staff, these delays appeared to be reasonable and manageable.

In the first week of March 2020, the Authority suspended all proactive inspections because of the COVID-19 pandemic. Instead of conducting routine inspections, the Authority focused on a work-from-home approach and calling retirement homes about their outbreak preparedness. Starting April 16, 2020, the Authority surveyed each retirement home on its level of readiness and obtained COVID-19 case data from homes already in outbreak. We discuss these activities further in **Section 4.4.4**.

Despite suspending proactive inspections of retirement homes, the Authority continued three other types of on-site inspections: mandatory

report, complaint and compliance. Between March 15 and June 30, 2020, the Authority conducted 101 of these three types of inspections. On average, these inspections were conducted within five days of the inspector being assigned, compared with 10 days in 2019.

As of June 2020, the Authority had deferred 93 planned proactive retirement home inspections. About 95% (or 88) of these homes were assessed as low risk. Inspections of the remaining five homes, which were assessed as medium risk, have been delayed up to 14 months past their originally planned dates. None of the deferred inspections were of high-risk homes. When we completed the audit, the Authority had still not determined a restart date for proactive inspections.

RECOMMENDATION 6

To return to its proactive, routine inspection process focused on resident safety, care and choices about their care options, we recommend that the Retirement Homes Regulatory Authority:

- establish an appropriately prioritized action plan that includes targeted timelines to clear the backlog of proactive routine inspections, enhanced with additional infection prevention and control coverage;
- conduct the required inspections; and
- monitor its compliance with this plan.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation and has taken the following action toward the end of the audit:

- communicated with licensees on August 27, 2020, outlining its expectations of retirement homes for a "Return to Normal" on items it had temporarily paused in March 2020 due to the COVID-19 pandemic; and
- resumed routine inspections on an unannounced basis as of November 9, 2020 and shared a communication to licensees on this resumption.

The Authority has in place a prioritized plan for routine inspections and will monitor execution using its pre-existing method for measuring and monitoring any backlog of routine inspections according to its risk model schedule.

A review of the risk model was under way when the audit was completed, which will update inspection volume forecasts. A time frame for addressing any outstanding inspections will be finalized concurrently with the model update.

4.3.5 Inspectors Assigned Varying Caseloads; Fewer but Longer Observation Inspections Conducted

We found that Authority inspectors had varying caseloads and the Authority did not monitor whether they were performing the expected number of inspections. We also found that, in 2019/20 (before COVID-19), almost all of the inspectors on average conducted fewer than the Authority's informal target of 10 inspections per month.

In 2019/20, each inspector performed seven inspections per month on average and the individual inspector monthly caseload ranged from five to 10 inspections. The Authority does not set a formal target for the number of inspections each inspector should complete in a year; however, it generally plans on 10 per month per inspector. The Authority indicated that a number of factors contribute to the number of inspections performed, such as when inspectors are in locations that require more travel, when they get involved in more complex inspections, or when they need to contribute to other project work such as improving the inspection processes.

We found that, between 2017/18 and 2019/20, the lowest caseload of an inspector was an average of five per month. As well, the caseload of each inspector dropped between 3% and 36% in those years, depending on the inspector. The reduction

in inspector caseloads is consistent with the 27% reduction in the overall inspections performed over this period, from 1,339 to 978. We examined the cause of the drop, and noted that the primary reason was that the Authority conducted 41% fewer proactive inspections after the introduction of its risk-based inspection program in April 2017 (described in **Section 2.6**). As well, in July 2019, the Authority implemented a new approach to conducting proactive inspections, whereby the inspectors focused less on reviewing home policies and more on direct observation of retirement home operations. This new approach has required inspectors to do more upfront preparation and to conduct more detailed observations of conditions and care provided within the home. The Authority also indicated that inspectors needed to address issues brought to its attention from the public through inquiries in addition to completing their normal inspection duties. We analyzed the duration of each inspection in 2019/20 compared with a year earlier and noted that this aligned with our data which showed that on average, each inspector spent 37 days compared with 30 days on each inspection.

RECOMMENDATION 7

To fully self-assess and monitor its inspection process for coverage and distribution of work, we recommend that the Retirement Homes Regulatory Authority continually monitor inspector caseloads, revisit caseload targets and reassign cases as needed.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation and will continue to manage its inspector caseloads, and reassigning cases as needed.

The Authority has observed an increase in the number of issues addressed through inquiries, and inspectors are involved in completing such inquiries as well as conducting inspections. Inspectors also participate in and lead other activities and initiatives in support of the Authority's legislative mandate. The Authority will complete a review of applicable targets for volumes to ensure that inspection resources are optimally deployed across these processes, while sustaining a focus on outcomes for residents.

4.4 Impact of COVID-19

COVID-19 cases were detected in Ontario retirement homes at the end of March 2020. By August 2020, one in five retirement homes had had confirmed cases of COVID-19. Much of the work undertaken by the Retirement Homes Regulatory Authority, the Ministry for Seniors and Accessibility and other government entities to help protect residents and staff in retirement homes was still ongoing when we completed the majority of our audit work in August 2020. **Appendix 8** shows each party's roles and responsibilities in dealing with COVID-19 while delivering accommodations, health services and care services to seniors living in retirement homes.

4.4.1 Authority Took Over Two Retirement Homes; Revoked Licences when Operators Refused to Co-operate

On May 29, 2020, the government issued an emergency order to allow the Authority to appoint a manager to a retirement home in the event of a COVID-19 outbreak. This supplemented the Authority's pre-existing power to appoint a manager of a home where the Registrar has reasonable grounds to believe that a licensee has contravened a requirement of the Act and the licensee cannot or will not properly manage the operations of the home. From the first reported outbreak in a retirement home on March 22, 2020 to that date, 933 residents were confirmed as infected; of that number 191 residents died. In the same period, 421 staff were confirmed infected, all of whom recovered.

The Authority determined that operators of two retirement homes were not managing the homes

properly or could not do so without assistance in the context of the COVID-19 pandemic; one on May 15 and the other on May 27. Both homes had numerous non-compliance issues prior to COVID-19. For example, one home was repeatedly cited for failure to implement a behaviour management strategy, resulting in a resident regularly wandering from the home. This same home also experienced a serious COVID-19 outbreak due to poor infection prevention and control practices—16 residents died in that home. For one of these homes, the Authority had revoked its licence but the operator was appealing the revocation and therefore the home continued to operate as a licensed home at that time. The Authority therefore issued orders to take over management of these two homes to protect their residents.

However, the Authority experienced significant challenges in finding qualified managers to take over the operations of these two homes amid staffing shortages in the health sector during COVID-19. In addition, one home that did not have a competent operator in the Authority's view had limited funds and could not afford to pay a manager. In this case, the Authority absorbed the expense and paid for the selected manager.

The effectiveness of the imposed managers was limited, as the operators were unwilling to co-operate. For example, the managers were not able to access funding to hire qualified staff, upgrade facilities and purchase required supplies. The Authority subsequently revoked the licence of one of these two retirement homes. The other retirement home abandoned its appeal of the prior revocation of its licence. The Authority worked with LHINs and other community partners to relocate the residents in these two homes.

We noted that the emergency order to allow a governing body to temporarily assume or appoint management of a long-term-care home in the event of a COVID-19 outbreak was enacted on May 12, 2020, more than two weeks before the same emergency order was enacted for retirement homes. The Ministry advised us that the delay was due to legal considerations, but the government eventually concluded that the benefit would outweigh the legal risk. In comparison, the long-term-care sector is not overseen by an independent regulator so the same legal consideration did not apply.

RECOMMENDATION 8

To minimize the safety, health and other impacts to residents and families of residents in retirement homes that undergo management orders, we recommend that the Retirement Homes Regulatory Authority:

- establish a back-up network of qualified management candidates that can be quickly deployed to retirement homes during times of crisis;
- establish criteria for making emergency funding available should managers deployed to a retirement home under management order require justifiable financial resources; and
- in conjunction with the Ministry for Seniors and Accessibility, ensure that residents in retirement homes are protected in a manner consistent with residents in long-term-care homes in circumstances of public health threats during and beyond the COVID-19 pandemic.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority has developed an initial formal roster of qualified management candidates who could be deployed quickly to retirement homes during crises. This roster was in place as of October 2020.

The Authority will explore options for emergency funding for circumstances where managers identify the need for financial resources with due consideration given to mitigating the financial impact on residents.

In its role as advisor, the Authority will collaborate with the Ministry for Seniors and Accessibility through its review of the *Retirement Homes Act, 2010* to identify and address any necessary actions required to ensure equity in protections for seniors living in retirement homes that were identified during the COVID-19 pandemic.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility's review of the *Retirement Homes Act, 2010* will look for opportunities to address gaps that were identified during the COVID-19 pandemic. As part of this review, the Ministry will work with key partners, including the Ministry of Health and the Ministry of Long-Term Care, to co-ordinate consistent protection measures.

4.4.2 Staffing Constraints during Pandemic Resulted in Some Residents Receiving Insufficient Care

Further to the staffing concerns we discuss in **Section 4.2.3**, multiple Authority inspectors and industry representatives on the Authority's Board noted in their interviews with us that in the early months of the COVID-19 pandemic in spring 2020, external care providers refused to enter retirement homes for fear of infection. As a result, retirement homes lacked replacement staff for homes experiencing an outbreak.

In addition, one retirement home in the Erie-St. Clair region had 15 personal support workers providing home-care services to about 40 residents at the time the home had a COVID-19 outbreak. At that point in time, those personal support workers were also providing services to other clients in the community. During the outbreak, the Local Health Integration Network (LHIN) prioritized residents with complex or end-of-life care needs to have their care continue to be provided by a smaller number of personal support workers. The remaining residents were called to discuss whether or not they would agree to have their services reduced or put on hold while the LHIN worked with the local public health unit to assess the degree of the virus spread. Any resident who requested their service continue, continued to receive home-care services; however, the LHIN indicated that many residents requested their services be put on hold. The Canadian Armed Forces was not deployed to this retirement home. While the Authority received only one allegation of harm about this home between March 11, 2020 and August 31, 2020, it concerned improper care due to infected staff working in the facility. The Authority then referred the concern to the local public health unit so that it could verify the home's compliance with infection prevention and control requirements. As well, this home was among the 10 retirement homes with the highest number of residents confirmed to have COVID-19 as of August 31, 2020. A total of 37 residents and 10 staff were reported by the retirement home as having contracted COVID-19. Six residents died from the outbreak.

In addition, commencing March 30, 2020, the Chief Medical Officer of Health issued a directive that retirement homes be closed to visitors, with the exception of essential visitors. The Ministry of Health defined an essential visitor as a person performing essential support services or health-care services, or a person visiting a very ill or palliative resident. Retirement homes had to comply with the directive and therefore denied access to family members who did not meet the definition of an "essential visitor." The Authority informed us that retirement homes were concerned that visitors could bring COVID-19 in from the community and so restricted visitors from entering the home, sometimes even if these visitors were "essential visitors" under the directive and provided care to residents.

As of June 18, 2020, the Chief Medical Officer of Health directed that homes could allow visitors for residents if the home was not experiencing an outbreak. On September 2, 2020, the Ontario government issued a visitors policy to clarify that essential visitors include caregivers who "support feeding, personal hygiene and meaningful connection for

long-term-care homes." On September 8, 2020, the Ontario government released relevant guidance for retirement homes to reflect the same directive.

We found that between March 11 and August 31, 2020, during COVID-19 outbreaks, the Authority was notified a total of 219 times about improper or incompetent treatment or care that required an investigation or an immediate inspection of the home. These issues occurred across multiple homes and were largely resolved in the summer when the number of retirement homes with COVID-19 outbreaks trended downward and retirement homes were better able to co-ordinate work among external care providers, retirement home staff and family members providing care.

With respect to assessing residents' care needs, long-term-care homes in Ontario were exempt from immediately updating residents' plans of care unless there was a substantial change. Similarly, retirement homes continued to be required to update plans of care when there was a change in the resident's care needs; however, retirement homes were allowed to pause routine reassessments of care plans for about half a year. On March 15, 2020, the Authority communicated to retirement homes that the regular assessment of care plans every six months was not required. The Authority indicated that this was done to alleviate administrative burden on retirement homes. On August 27, 2020, the Authority communicated to retirement homes a "return to normal" and expected the homes to complete the six-month reassessments of their residents by September 28, 2020.

The Ministry, as well as stakeholder groups we interviewed during our audit, indicated that it was aware of some instances in which residents did not receive care services, such as baths, to the same standard or frequency as provided prior to the pandemic because of staffing shortages. The Authority included reviewing staffing shortages in retirement homes as part of its COVID risk assessment. Starting in April 2020, the Authority would immediately contact the home's administrator and key community partners, usually the LHIN or public health, to assess the situation. Depending on the circumstances, the Authority would follow up with the home and/or relevant partners at least every two weeks.

Many residents may have family members or friends who provide critical personal care and support, such as feeding and dressing, in lieu of paying the retirement homes or external care providers to provide these services for them. Given that in Ontario, personal support workers are not regulated health-care workers and gain experience working in retirement homes and other settings, a family member or a friend also gains experience assisting their loved one.

Retirement Homes Identified Their Employees as the Main Source of Infection

While stakeholder groups we spoke to during the audit noted that home-care workers moving from home to home to work did not have the necessary personal protective equipment, thus posing a risk to residents, our review of the Authority's analysis using self-reported data from retirement homes conveys that external care providers were not the primary source of infection in the majority of the outbreaks at retirement homes. Based on the Authority's analysis of data it collected from retirement homes, using data up to August 31, 2020, the first known case in an affected retirement home was an unknown source in 3% of the cases, a resident in 39% (residents could have contracted the virus when in the community, such as when visiting relatives or running errands), a retirement home employee in 49%, and an external care provider in 9% of the cases. However, this data was self-reported from retirement homes and has not been independently verified. As such, it is difficult to draw absolute conclusions about the source of outbreaks.

During our audit, four for-profit retirement living operators were facing class-action lawsuits related to their response to COVID-19 in some of their long-term-care homes. Sienna Senior Living, Revera, Oxford Living and Chartwell Retirement Residences are among the large chains that operate both long-term-care homes and retirement homes

in Ontario. Together, they operate almost 200 retirement homes in Ontario. **Appendix 9** shows the details of the allegations. Overall, the plaintiffs had concerns with these home operators' staffing levels, isolation and control measures to contain the outbreak, and availability of personal protective equipment for staff and residents.

RECOMMENDATION 9

To protect retirement home residents from the risk of neglect, we recommend that the Retirement Homes Regulatory Authority communicate and support retirement homes in ensuring that family members and friends providing critical personal care and support to retirement homes residents are able to do so during the pandemic, as long as appropriate infection prevention and control procedures are followed.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation and recognizes the vital role that families and friends fulfill in critical personal care and support of residents. The Authority will continue to communicate actively and support retirement homes in adhering to public health directives and guidance, including appropriate infection prevention and control procedures for visitors. The Authority will continue to collaborate with the Ministry for Seniors and Accessibility and provide advice related to changes in the Visitors Policy for retirement homes.

4.4.3 Authority Did Not Make Public the Number of Resident and Staff COVID-19 Cases in Retirement Homes until September 2020

Our audit found that while the Authority daily publishes on its website a list of homes where a COVID-19 outbreak has been declared, for the first six months of the pandemic it did not make public the number of residents and staff who tested positive or died. The Authority started publishing total cumulative COVID case data of both residents and staff, including deaths, in September 2020. But this data is not broken down by retirement home. As a result, the public cannot readily find out the extent of COVID outbreaks in various retirement homes.

The Authority indicated that it was unable to obtain case data from public health agencies because public health did not release the case data, citing reasons such as patient privacy. It instead had to rely on self-reported data from licensed retirement homes that it had begun collecting regularly since April 15, 2020 to track COVID-19 cases in Ontario's retirement homes.

As shown in **Appendix 5**, as of August 31, 2020, the Authority's data on COVID-19 showed that more than 20% of retirement homes experienced a COVID-19 outbreak:

- There were 185 COVID-19 outbreaks recorded in licensed retirement homes between March 22, 2020 and August 29, 2020.
- Outbreaks in 179 homes were resolved, including 14 homes that experienced an outbreak twice, and two homes had their licences revoked during the pandemic because of their poor handling of the outbreak (see **Section 4.4.1**).
- Six homes had an active outbreak.
- There were 989 confirmed resident cases and 491 confirmed staff cases for a total of 1,480 cases.
- The total death count was 209 residents and no staff.
- A total of 1,241 cases were resolved and 30 cases were still active.

RECOMMENDATION 10

To better inform the public about the extent of COVID-19 cases in retirement homes, we recommend that the Retirement Homes Regulatory Authority:

- work with the Ministry for Seniors and Accessibility and the Ministry of Health to

obtain available validated data directly from the Ministry of Health or directly from local public health agencies; and

- publish outbreak data on a weekly basis or more frequently as available, by retirement home, on the number of residents and staff who test positive or die.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) has been providing information about COVID-19 in retirement homes to the public on its website. From April 2020 through September 2020, the Authority published on its website daily a list of homes where a COVID-19 outbreak had been declared. Since July 2020, the Authority has made its data sets publicly available on its online "RHRA COVID-19 Dashboard." In addition to the reported active and resolved outbreak data, since September 2020, the dashboard, updated daily, has included reported cumulative staff and resident cases of COVID-19 and associated deaths.

While the official record of COVID-19 case information is collected and compiled by Public Health Ontario, the Authority collects this data to inform our ongoing efforts to support the retirement home residents and communities through this difficult time. We have made this data available to keep the public, including residents, families, researchers and health-care professionals, informed on how the pandemic is affecting licensed retirement homes. Ontario seniors benefit from having easy-to-access information and education needed to make informed choices when researching retirement homes.

The Authority will work with the Ministry for Seniors and Accessibility (Ministry) and the Ministry of Health on directly obtaining validated data. The Authority will also collaborate with the Ministry in its review of the Act to identify opportunities to enhance the information available to residents and families by addressing any data collection gaps that were identified during the COVID-19 pandemic.

MINISTRY RESPONSE

As part of its review of the *Retirement Homes Act, 2010*, the Ministry for Seniors and Accessibility will be looking for additional opportunities to enhance information available to residents and families, and address data collection gaps that were identified during the COVID-19 pandemic.

4.4.4 Authority Has Incomplete Data on Occupancy for Supporting COVID-19 Planning Options

Prior to April 2020, the Authority did not track the occupancy level of retirement homes. In May 2020, the Authority requested that retirement homes self-report their occupancy rate to help the Ministry for Seniors and Accessibility plan its strategy during the pandemic to provide for retirement home staff and resident testing. This collection of information was a one-time exercise and retirement homes' responses were optional: 54 retirement homes did not respond to the Authority's survey. The Authority therefore had to estimate the occupancy rate for those 54 homes by assuming that they were 70% to 80% occupied. It estimated that overall capacity was about 73% in retirement homes.

We reviewed the occupancy data that retirement homes reported to the Authority and found that 37 retirement homes reported more residents than their reported capacity, which was not reasonable. The Authority did not follow up. The Authority informed us that it was aware of the margin of error as the data was not verified, and that the Ministry for Seniors and Accessibility—to whom the Authority submitted this data on May 25, 2020—was aware that the data was self-reported when it was planning its strategy to provide COVID-19 testing for retirement home staff and residents.

RECOMMENDATION 11

To identify alternative accommodations for patients should future waves of COVID-19 overwhelm long-term-care homes and hospitals, and for residents who need to be moved from retirement homes that are affected by outbreaks, we recommend that the Retirement Homes Regulatory Authority:

- work with the Ministry for Seniors and Accessibility to require retirement homes to provide monthly occupancy information (and any related requirements) to the Retirement Homes Regulatory Authority; and
- collect occupancy rates of retirement homes on a monthly basis to be used for monitoring and planning outbreak responses that may be needed during the COVID-19 pandemic.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority recognizes and agrees that it is uniquely positioned to collect information from Ontario's retirement homes in support of the province's pandemic planning and response. The Authority has contemplated including this kind of data when submitting the criteria for data collection for approval by the Minister for Seniors and Accessibility and in the drafting of its Request for Information Policy. Concurrent with seeking the applicable authority, the Authority will assess the feasibility of options related to the data collection process with consideration of its own current technology capabilities; cost efficiency; and minimizing administrative burden on licensees whose priority of protecting and caring for their residents is paramount.

4.4.5 Ontario Required Retirement Homes to Adopt Mandatory Infection Control and Prevention Measures to Limit Spread of COVID-19

During the first wave of COVID-19, the Ministry of Health's Chief Medical Officer of Health issued directives to both retirement homes and long-term-care homes to protect staff, residents and visitors from exposure to the virus. **Appendix 10** shows the infection prevention and control measures required by these directives as well as various pieces of legislation. To complement the directives, the Authority released guidelines to retirement home operators related to visits, short-stay absences, tours and new admissions.

In our audit, we compared Ontario's timeline for putting retirement home infection prevention and control measures in place with that of other Canadian provinces. Overall, we found that the provinces adopted different measures in different times.

We found that Ontario enacted the directive to retirement homes to allow only essential visitors within two weeks of when other provinces did so—Ontario was later than some but earlier than others. For example, although later than British Columbia, Ontario's practice was similar to that of a British Columbia regional health authority, which issued a directive asking assisted living facilities to restrict visitors to essential visits only, which include compassionate care, such as those receiving end-of-life care or with critical illness.

Ontario also adopted relevant infection prevention and control measures for retirement homes based on the direction of the Chief Medical Officer of Health. These other measures included directives to retirement homes to actively screen residents, staff, volunteers and visitors, allow only essential visitors in homes, limit the number of retirement home staff workplaces, refuse residents permits to leave the home for short-stay absences, and require all staff and essential visitors to wear masks. Based on our discussion with local public health units and the Authority, a retirement home's ability to comply

with the Chief Medical Officer of Health directives had a direct impact on whether the home could prevent or limit the spread of COVID-19 outbreaks.

Ontario adopted a province-wide approach to make these infection prevention and control measures mandatory for all retirement homes while some provinces, such as British Columbia, made some of these measures "advisory," or allowed for individual public health units to make more localized directives for retirement homes. For example, with respect to refusing residents permits to leave the home for short-stay absences, we noted that this measure was mandatory and consistent with long-term-care homes in Ontario, mandatory in Quebec and only advisory in British Columbia and Alberta. But since different provinces define and regulate senior living settings differently, we could not definitively conclude on whether these measures and the timing of their adoption had any impact on COVID-19 incident rates.

We also noted that the Ministry for Seniors and Accessibility provided about $20 million in funding to licensed retirement homes in the spring of 2020 through the Ontario Retirement Communities Association, which represents about 95% of the retirement residence operators in Ontario, but for this initiative was asked to distribute funding to all operators of licensed retirement homes. This funding was to cover some of the costs that retirement homes incurred in order to comply with infection prevention and control directives and to increase staffing to back-fill front-line staff and provide services to residents such as helping those in quarantine to purchase groceries. According to the Association, as of the end of October 2020, all licensed retirement homes that had completed the required paperwork, representing about 99% of licensed retirement homes, had received and spent this funding.

4.5 Retirement Home Licensing

4.5.1 Level of Care Prompts Authority to Review Licences

All retirement homes are currently issued the same licence. The *Retirement Homes Act, 2010 (Act)* does not distinguish between the different ways that retirement homes are run and different resident health-care needs. The Authority informed us that it began to develop and assess how separate retirement home licence classes could address the risk that the existing regulatory regime does not discern homes with higher-risk residents from homes with more independent residents in January 2020, after we began our audit.

The Authority identified that the following issues need to be addressed in order to establish separate licence classes:

- **Increasing level of care required by some residents:** Retirement homes are already offering accommodations to patients designated as alternate level of care from hospitals to address the shortage of long-term-care beds (see **Section 4.1**). However, it is unclear which legislation—the *Retirement Homes Act, 2010*, the *Public Hospitals Act* or the *Long-Term Care Homes Act, 2007*—should and could be used to protect seniors in new transitional care services (for example, patients who no longer require the intensity of resources or services provided by hospital and are admitted to a retirement home). These new and aging residents of retirement homes require a higher level of care than was required to be provided by or available at retirement homes in the past.
- **Emerging models:** New models of housing and care delivery raise questions about what kinds of protection are needed for senior residents. These emerging models include home-sharing, shared ownership, multi/intergenerational living, naturally occurring retirement communities and life-leases.

- **New development financing:** Some homes change their operating models to avoid the criteria of a retirement home under the *Retirement Homes Act, 2010* because there are higher financing costs for new developments designated as a retirement home as opposed to other models, such as supportive housing. This will affect their residents because they may need to move as their care needs change and necessary supports are not in place.
- **Regulatory burden:** Some homes have very independent residents where regulatory requirements may be beyond what is needed. For example, the Act requires all homes to reassess every resident's plan of care every six months.

At the time of our audit, the Authority had still put this work on hold because of the COVID-19 pandemic.

4.5.2 Authority Issued Licences Despite Identified Red Flags Regarding Applicants' Integrity, Finances

As of March 2020, about 3% or 22 of all licensed retirement homes were subject to conditions, with the majority related to the installation of automatic fire sprinkler systems (see **Section 4.5.3**).

The *Retirement Homes Act, 2010* requires that the Registrar consider three criteria when deciding whether to issue a licence (see **Figure 3**). One of the criteria is that the past conduct of an applicant affords reasonable grounds to consider whether the home will be operated in accordance with the law, with honesty and integrity, and in a manner that is not prejudicial to the health, safety or welfare of its residents.

Between 2015/16 and 2019/20, the Authority issued a total of almost 300 new licences and refused eight applications at various stages of its decision-making process. In most of these eight cases, the Authority properly refused these applications because of concerns about the applicant's competence in operating retirement homes and the applicant's ability to operate the home with honesty and integrity.

However, we found that the Authority granted licences after weighing the licensing criteria, but it may have been prudent to refuse them:

Example 1: In November 2018, the Authority reviewed an application to transfer ownership of an existing home and found that the applicant provided false and misleading information. Although this individual indicated that they had neither been charged with nor convicted of a criminal offence, the Authority found that they had, in fact, been previously charged with assault and uttering threats. Those charges were dismissed, but they were convicted of refusing to provide a breath sample. The Authority requested that the applicant submit further documentation including their driver's abstract. Based on this information, the Authority ordered the applicant to pay a $500 administrative penalty and issued the licence, subject to conditions. The conditions required the applicant to retain a person with experience in a senior position at the home to ensure compliance with the Act and its regulation and to notify the Authority immediately of any change in that individual's contractual status with the licensee. However, this licensee failed to notify the Authority in late 2019 that the individual's contractual status changed. Although the Authority had inspected this home six times prior to July 2020, it was not until then that it became aware of this issue, over half a year later.

Example 2: The Authority issued a licence in July 2018 to an applicant whose family member had a history of financial mismanagement operating long-term-care homes that resulted in bankruptcies. The family member also had about $130 million in unpaid debts to creditors. The Authority issued a notice of intent to impose a condition that this family member not be permitted to be involved in the finances or supervision of the operations of the home. However, because of the tight turnaround requested by the applicant, as well as internal process and personnel changes at the Authority, the notice of intent was issued concurrently with the licence when it would normally be issued separately. In effect, the licence was issued without a condition.

The Authority has since issued three enforcement actions to this retirement home for issues related to non-compliance with the Chief Medical Officer of Health's infection prevention and control directive, as well as for defaulting on its mortgage payment and placing the home's residents at risk of displacement. In November 2020, the Authority issued a notice of intent to revoke the licence. The family member in question also operated another licensed retirement home that was inspected by the Authority 12 times until the licence was revoked.

The Authority assessed both homes in Example 1 and 2 as high risk.

We also found that the assessment criteria do not specifically include that the applicant must provide proof of financial viability to operate a retirement home.

RECOMMENDATION 12

To strengthen the licensing process of retirement homes, and the safety and protection of residents that may require different levels of services as its primary focus, we recommend that the Retirement Homes Regulatory Authority:

- accelerate and complete the development of its licence classes;
- update its licensing procedures to include conducting applicant background checks to identify any indication of financially irresponsible conduct and proof of financial viability;
- develop a communications strategy to remind applicants that they are obligated to monitor their licence conditions and report changes as needed to the Authority; and
- follow up on a timely basis on any licence conditions made.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

In January 2020, the Authority began work to assess options related to distinct licence classes. Such licence classes would allow for greater flexibility and ability to respond to the evolving nature of the seniors housing sector. As well, the regulatory response to these realities, including costs to residents, would be strengthened. The work on licence classes was put on hold in order to redirect resources to the Authority's COVID-19 pandemic response.

The Authority will:

- resume its work on licence classes on a priority basis as part of its future operations development plan;
- collaborate with the Ministry for Seniors and Accessibility in its review of the Act to examine approaches to strengthening the licensing framework for retirement homes;
- further develop its licensing forms and related procedures to identify indications of financially irresponsible conduct; set standards and develop related educational tools to clarify expectations regarding licensee obligations to operate retirement homes in a financially responsible manner; and explore methods of assessing financial viability; and
- communicate through existing channels to homes about financial responsibility and engage with the industry association to understand the training and other supports that may be available for use by homes.

In September 2020, the Authority expanded its capacity to address issues related to ongoing compliance monitoring for certain issues, including compliance with licence conditions. This expanded capacity will facilitate timely follow-up for conditions and other similar actions where ongoing monitoring of compliance apart from inspections is required.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility's review of the *Retirement Homes Act, 2010* will examine approaches to strengthen the licensing framework for retirement homes in Ontario.

4.5.3 Five Licensees Operating without Required Automatic Fire Sprinkler Systems

As of August 2020, 12 retirement home operators had licence conditions stating that they had not yet installed automatic fire sprinkler systems that effective January 1, 2019 were required under the Ontario Fire Code. These licences all included a condition that required the operator to provide a monthly progress report on the status of the installations. The Authority indicated that the licence conditions were intended to provide public transparency with respect to fire sprinkler system status because it publicly reports the conditions on these licences. However, we found that the condition does not include a time frame. The Authority explained that it did not impose time frames because the Ministry's subsidy program to assist homes that needed financial support to install the fire sprinkler systems was still under way after January 2019.

Subsequent to our audit, the Authority informed us that five of these 12 homes still did not have working sprinklers on either some floors or the entire facility; it revoked the licence of one home; it was in the process of revoking the licence of one home; two homes were awaiting third-party validation that the sprinklers were installed; and three homes were awaiting sign-off by the municipality, which is required for the Authority to recognize that the sprinklers were fully installed.

RECOMMENDATION 13

To protect retirement home residents from the risk of fire, we recommend that the Retirement Homes Regulatory Authority:

- impose a deadline for all licensees that have not completed the installation of their fire sprinkler systems to have this done as soon as possible; and
- if a licensee does not comply, follow up with enforcement action where appropriate.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority has placed conditions on the licences of all homes that have not yet installed automatic fire sprinkler systems. The Authority will monitor the installation progress of all homes that do not have a sprinkler system and communicate a timetable for completion to homes that have not made significant progress, failing which further enforcement action may be taken suitable to the specific circumstances of each home.

4.5.4 234 Retirement Homes Previously Deemed Not Requiring Licence Under Review

As of July 2020, we found that the Authority was in the process of reviewing 234 homes it had previously assessed as not meeting the definition of a retirement home to determine its next steps in reassessing whether these homes were operating as a retirement home without a licence.

Some congregate living settings in Ontario function similarly to a retirement home as defined in the *Retirement Homes Act, 2010* but because they do not meet the Act's strict definitions of a retirement home, they are not subject to the Authority's regulatory oversight. The Authority can conduct inspections of a residential complex to determine whether it is operating as a retirement home without a licence only if there are reasonable and probable grounds to do so. The Authority has a procedure to follow up on tips regarding unlicensed homes. Starting in early 2020, the Authority began to expand that procedure to include more ongoing monitoring of unlicensed homes based on assessed risk, in collaboration with community partners.

When the COVID-19 pandemic began in March 2020, the Authority recognized that there was an increased risk to seniors and vulnerable residents, even in homes that do not require a licence. In May 2020, the Authority reviewed its approach on

unlicensed homes and updated it to include the following:

- assess the likelihood that the status of previously identified unlicensed homes had changed and therefore could lead to a potential risk to residents; and
- categorize unlicensed homes into different groups based on the Authority's previous involvement with the homes and assign priorities to the groups, depending on the assessed probability that homes in that group could potentially be within the Authority's jurisdiction.

The Authority was following up with homes within the prioritized groups at the completion of our audit. The result of this work could lead to licensing or enforcement actions. The Authority indicated that its plan for subsequent waves of COVID-19 includes action regarding these homes by sharing with the Ministry, public health and the Ministry of Municipal Affairs and Housing for awareness of other types of locations.

RECOMMENDATION 14

To protect consumers from unknowingly purchasing accommodation and care services from retirement homes that could possibly be unlicensed and unregulated under the *Retirement Homes Act, 2010*, we recommend that the Retirement Homes Regulatory Authority:

- expedite the completion of its strategy to follow up on the 234 retirement homes that may possibly require a licence and take appropriate enforcement actions as required; and
- expedite the consideration and reduction of the potential risk to these homes in subsequent waves of COVID-19 by either addressing the risk or bringing these risks to the attention of the Ministry for Seniors and Accessibility.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) will assess, on a risk-informed basis, which of the 234 congregate settings as of July 2020 that previously did not meet the legislative definition of a retirement home under the *Retirement Homes Act, 2010* (Act) may now be subject to the Act due to a change in their circumstances. The Authority will follow its established enforcement process to take action where warranted.

In its role of advisor, the Authority will inform the Ministry for Seniors and Accessibility (Ministry) of the scope and scale of the risk to seniors living in these congregate settings that do not meet the legislative definition of a retirement home. Further, the Authority will collaborate with the Ministry on its review of the Act to support the establishment of appropriate oversight of congregate settings.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility's review of the *Retirement Homes Act, 2010* will consider approaches to improve protection for consumers who may be unknowingly purchasing accommodation and care services from homes that are not licensed under the Act.

4.5.5 Authority Rejecting Licence Applications, Imposing Penalties and Prosecuting Have Not Always Worked as a Deterrent

We found that the Authority has increased its enforcement efforts for managing retirement homes in the last three years; however, the tools it has at its disposal such as turning down a licence application and imposing financial penalties have not always stopped an owner from continuing to operate an unlicensed home.

Figure 12: Enforcement Actions Taken against Retirement Homes by Retirement Homes Regulatory Authority Registrar, 2017/18–2019/20

Source of data: Retirement Homes Regulatory Authority

		# of Actions[1]		
		2017/18	2018/19	2019/20
Warning letter	Given a written warning[2]	16	10	16
Notice — Intent	Given written notice of Registrar's intent to refuse to issue a licence to an applicant or of intent to impose a condition on a licence at or after the time the licence is issued	2	29[3]	26
Notice — Decision	Given written decision to refuse to issue a licence to an applicant, or of decision to impose a condition on a licence at or after the time the licence is issued	1	7[3]	22
Order to cease operations or apply for a licence	Order served on an operator to cease to operate a premises as a retirement home or to apply for a licence if Registrar believes on reasonable grounds that a retirement home is being operated without a licence	6	9	8
Compliance order	Ordered to do something or refrain from doing something to achieve compliance with the *Retirement Homes Act, 2010* (Act)	2	4	8
Management order	Ordered to employ or retain, at the home's expense, one or more persons acceptable to the Registrar to manage or assist in managing all or some of the operations of the home	1	2	0
Administrative penalty	Ordered to pay a financial penalty for breaching a requirement of the Act ($10,000 is the maximum)	4	4	5
Revocation order	Order revoking licence	0	5	3
Total		**32**	**70**	**88**

1. One retirement home can account for more than one action in a single year; for example, it could receive a warning letter and compliance order in the same year.
2. One retirement home could account for more than one warning letter in a single year. A warning letter typically gives the home until its next inspection to comply, but the date of the inspection is not given.
3. As of January 1, 2019, all licensed retirement homes in Ontario must be equipped with automatic fire sprinkler systems to meet Ontario Fire Code requirements. The majority of the increases in notices issued in this year were related to installation of fire sprinklers.

Enforcement actions taken by the Authority increased from 32 in 2017/18 to 88 in 2019/20 (**Figure 12**). Almost all of the increase in enforcement actions in 2019/20 was the result of the number of notices issued related to a new regulatory requirement under the *Fire Protection and Prevention Act, 1997* for homes to install fire sprinkler systems (see **Section 4.5.3**). Between 2017/18 and 2019/20, the Authority revoked a total of eight licences, representing about 1% of the operating licensees, and refused in total five licence applications, representing 3% of the incoming applications. From March 2020 to August 2020 during COVID-19, the Authority issued management orders to two retirement homes (see **Section 4.4.1**).

The Act permits the Authority to serve an order on a retirement home to either cease operation or apply for a licence, and the Authority has done so on 24 occasions between 2017/18 and 2019/20. We found, however, that issuing an order was not always effective in managing problematic retirement home operators.

For example, in July 2013, the Authority decided to refuse a licence to an applicant because of multiple concerns, including:

- abuse and neglect of several of its residents;
- not having the required policies and procedures;
- the owner misled the Authority during inspections of the home; and
- the home did not pay the fees required under the Act.

However, after being refused a licence, the owner still continued to operate as an unlicensed retirement home. Since July 2013, the Authority has been involved in several proceedings against the owner of the home, including appeals to the Licence Appeal Tribunal, the levying of a total of $30,000 in administrative penalties on three occasions, and two prosecutions regarding the owner's continued operations of the unlicensed retirement home, which led to two jail sentences.

In October 2019, the Ontario Court of Justice ordered the home to not admit any residents 65 years of age or older. While the home is still operating, it had been complying with the court order at the time of our audit.

The Authority had to go through a time-consuming court process to ensure that there were legal grounds to govern this home. The Authority also incurred about $477,000 in legal costs to date in relation to this home. The Authority's enforcement tools such as financial penalties and refusing to licence the home did not stop the owner from operating in another form that does not contradict the Court Order the Authority obtained so the Authority will be required to continue to monitor this home. The Authority has published a conviction summary related to this case on its website.

Penalty Limited to Maximum of $10,000

The Act allows the Registrar to impose an administrative penalty of up to $10,000 on retirement home operators who have contravened legislative requirements. In practice, the Authority typically levies penalties between $500 and $10,000. We compared this maximum amount with penalties allowed in legislation pertaining to other administrative authorities and found that while the Authority's penalty limit is the same as that of the Technical Standards and Safety Authority and the Travel Industry Council of Ontario, other authorities set higher amounts. For example, the disciplinary committees—either already in place or once established—of the Real Estate Council of Ontario, the Condominium Management Regulatory Authority of Ontario and the Bereavement Authority of Ontario may order a fine of up to $25,000 for these authorities' licensees. In addition, a penalty of up to $200,000 may be levied under the *Environmental Protection Act, 1990*. Within Canada, we found that Alberta can impose fines of up to $100,000 on supportive living accommodation and British Columbia can issue fines up to $10,000 for community care and assisted living.

Authority Mindful of Not Letting Enforcement Actions Lead to Pressure on Homes

In determining enforcement actions—if any—to address inspection findings, the Authority says it is mindful of the pressures that it could place on already struggling homes.

The Authority also informed us that in considering whether to take enforcement action or refuse to license a home that may result in the closure of a home, it considers any unintended consequences to the residents. These consequences for residents may include:

- not being able to find alternative and affordable housing;
- not being able to access care services; and
- the negative physical and/or emotional effects of being displaced if the home were to close.

The Authority's considerations do not impact whether or not there is a finding of non-compliance during an inspection.

While it is important to be mindful of the impacts on residents, there is the risk that the Authority may be inadvertently weighting the financial welfare of the operators higher than the Authority's mandate to protect residents of these homes.

RECOMMENDATION 15

To improve the Retirement Homes Regulatory Authority's effectiveness in overseeing the retirement home sector and protect public safety, we recommend that the Authority work

with the Ministry for Seniors and Accessibility to critically assess the effectiveness of its enforcement tools. In particular, an increase of the maximum administrative penalty amount allowed under the *Retirement Homes Act, 2010* could be considered.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority will work with the Ministry for Seniors and Accessibility in its review of the *Retirement Homes Act, 2010* to critically assess the effectiveness of the enforcement tools and to identify additional regulatory processes that are available to other regulatory authorities that could help to achieve desired compliance outcomes.

4.5.6 No Minimum Amount of Insurance Required to Cover Residents' Housing, Care Costs in Event of Displacement

We found that the regulation under the *Retirement Homes Act, 2010* does not require licensed retirement homes to obtain a specified minimum amount of extra expense insurance to reduce the risk that they would be unable to provide accommodation and care to residents in the case of damage to a home.

The regulation requires all retirement homes to have extra expense insurance that would cover the costs of alternative housing and care services for every resident for at least 120 days in the event there is a loss of or damage to the home (such as by a fire or flood) and the licensee is unable to safely provide other accommodation or continuing care to residents. We found that homes had no set coverage amount for this insurance, even though an expert consultant contracted by the Authority in July 2019 recommended that a minimum limit of $7,500 per resident may be appropriate. At that time, the Authority had determined that about 37% of retirement homes had coverage for less than this amount.

The Authority indicated that coverage for each resident could range from a few hundred dollars to millions of dollars, depending on the home. As well, it has assessed that currently the risk is not great enough for it to support a change to the regulation on the amount of extra expense insurance coverage required for its licensees. Its view is that merely having any extra expense insurance mitigates the risk.

We reviewed all cases of expired extra expense insurance policies as flagged by the Authority's document management system in September 2020 and found that 25 retirement homes had expired policies. All other homes had insurance that had not expired. One home's policy had expired over 334 days but the Authority informed us that this home was closed temporarily for renovations. Excluding this home, the length of time that coverage had expired for the 24 homes averaged 31 days and ranged from two days to 130 days. The Authority has an internal policy to refer homes with more than a 31-day insurance lapse to its enforcement department for follow-up. For nine homes that had a longer than 31-day expiry lapse, the Authority, as of September 30, 2020, was still conducting additional follow-ups prior to escalating to its enforcement department. The Authority believed that these homes had experienced delays in providing certificates because of COVID-19-related issues.

RECOMMENDATION 16

To reduce the risk to retirement home residents that could be affected by loss or damage to their homes, we recommend that the Retirement Homes Regulatory Authority:

- request that retirement homes renew policies 30 days prior to expiry and notify the Authority that ongoing coverage of residents is available;
- assess current research, and as necessary supplement, to derive an appropriate specific minimum amount of extra expense insurance coverage for licensees to obtain; and

- recommend a regulatory change that either specifies a minimum amount of extra expense insurance coverage to the Minister for Seniors and Accessibility or provides authority for the Authority to set a minimum amount of extra expense insurance coverage.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) accepts this recommendation.

The Authority will complete an assessment of its current research on an appropriate minimum amount of insurance, and will undertake further research as necessary to establish an appropriate minimum standard for implementation. Additionally, the Authority will work with the Ministry for Seniors and Accessibility as part of its review of the *Retirement Homes Act, 2010* on a revision to the regulation that will appropriately enable the implementation of a minimum standard for extra expense insurance coverage.

4.6 Complaints

4.6.1 Public May Not Know It Should Direct Complaints to the Authority

Multiple stakeholder groups we spoke to during the audit indicated that staff who work in retirement homes have witnessed neglect and abuse, but may not know that they can report these incidents to the Authority. This lack of knowledge about the Authority limits the Authority's ability to effectively execute its mandate to protect residents.

The Authority received 79 formal written complaints in 2019/20, down from 95 in 2017/18 and 99 in 2018/19. The Authority explained that the decline was partly due to its new process introduced in January 2020 that focuses on early intervention to resolve potential formal complaints. We found only four complaints in this three-year period came from former retirement home staff members. Our observation is consistent with what the Authority itself found in a June 2019 brand awareness survey of Ontarians aged 55 and over. Survey results showed that only 2% of the approximately 1,500 respondents knew that the Authority is responsible for protecting seniors living in retirement homes in Ontario.

To improve outreach to the public and increase awareness of the Authority's mandate, the Authority launched an education and awareness campaign in January 2020. The campaign includes social media and Google search advertisements to attract consumers to the Authority's website where they can find support tools for retirement home selection.

RECOMMENDATION 17

To enhance the public's knowledge and awareness of the Authority's oversight role for the retirement home industry and to minimize safety risks to retirement home residents, we recommend that the Retirement Homes Regulatory Authority develop a more comprehensive communications strategy to specifically target groups that include residents and families, retirement home staff, and the public about its role, emphasizing how complaints can be best brought to its attention or to the attention of other appropriate parties.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority has implemented an education and awareness campaign that includes paid advertising targeted to retirement home residents and their families, as well as others with interest in the sector. The campaign also seeks to leverage media coverage to incorporate messages that encourage the public to report any harm or risk of harm to retirement home residents. While the original campaign plan was suspended in March 2020 to redirect resources to the Authority's COVID-19 response, the campaign re-launched in early October 2020 and focused on messages about reporting concerns

Figure 13: Written Complaints Received by Retirement Homes Regulatory Authority Registrar and Appealed to Complaints Review Officer, 2017/18–2019/20

Source of data: Retirement Homes Regulatory Authority

	2017/18	2018/19	2019/20	3-Year Avg
# received by the Authority[1]	95	99	79	91
# outstanding as of Aug 24, 2020	0	0	25	n/a
Average # of months to resolve	2.5	6.8[2]	4.0	4.6
Complaint Referrals to Other Regulatory Bodies				
# to Landlord and Tenant Board	11	10	3	8
# to Local Health Integration Networks	2	1	1	1
# to local fire department/Office of the Fire Marshal	3	0	0	1
# to health regulatory colleges	3	1	5	3
Total	**19**	**12**	**9**	**13**
Average # of months for the Authority to issue decision letter	2.2	3.3	2.5	2.7
Concerns[3]				
# of concerns raised in complaints received by the Authority[4]	280	239	241	253
# of concerns validated by the Authority to be in contravention of the *Retirement Homes Act, 2010* or its regulation	52	69	32	50
% of concerns validated as contraventions	19	29	21	23
Complaints Review Officer[5]				
# of complaints appealed to Complaints Review Officer	9	9	11	10
% of complaints appealed to Complaints Review Officer	9	9	14	11
% of cases in which Complaints Review Officer upheld Registrar's decision	78	56	67	67
Average # of months for the Complaints Review Officer to complete review	2.9	5.0	4.6	4.2

1. Includes all formal complaints submitted to the Authority. The Authority does not initiate the complaint process until a written complaint is received. When a complaint is received by telephone, or does not provide sufficient information, the Authority informs the complainant of expectations, scope of the Authority and whether the complaint is out of scope, and informs the complainant of the appropriate regulatory body that could address the complaint. If the complainant chooses not to proceed with a formal written complaint, the Authority does not investigate the complaint under the formal complaint process, but may investigate it under the mandatory report process if the allegation meets criteria for investigation (as described in **Figure 8**).
2. According to the Authority, the delays were caused by staffing issues, which were addressed in late 2018.
3. As determined by the Authority, for example, a complaint with concerns relating to an unsanitary room, inadequate care and missing meals would be split into three concerns.
4. Includes 118 concerns from 71 complaints that the Authority deemed to be not within its jurisdiction.
5. Cases appealed to the Complaints Review Officer during the fiscal year, which could include complaints initially made in a previous fiscal year.

regarding harm or risk of harm to residents, residents' rights and the Authority's role in resident protection. The Authority will sustain, and where needed expand, these efforts as part of a multi-year campaign to raise awareness among residents and families, retirement home staff, and the public about its role and how to raise complaints related to retirement homes.

4.6.2 Authority Does Not Have Complaint Turnaround Time Targets

We found that the Authority does not set or publish targeted turnaround times to inform consumers on what to expect when they lodge a complaint about a retirement home. As shown in **Figure 13**, between 2017/18 and 2019/20, the Authority took an average of four-and-a-half months to resolve formal written complaints received by the Authority. When

complainants then chose to request a review of the decision to the Authority's Complaints Review Officer, cases took another four months on average to resolve. For the five complaints that the Officer did not find the Registrar's decision to be reasonable and requested the Registrar to further investigate, the Authority took another eight months on average to investigate before reaching its final decision.

The Authority explained that the decision delays were partly a result of the time complainants took to gather documentation as well as staffing issues, the latter of which were resolved as of late 2018.

As of July 23, 2020, 24 written complaints that had been filed prior to April 2020 were still unresolved with an average delay of nine months from the time the complaint was filed. The Authority attributed the further delays for outstanding cases to the COVID-19 outbreak.

4.6.3 Public Must Discern Where to Send Complaints That Are Outside Authority's Jurisdiction

The Authority addresses complaints relevant to the welfare of residents in retirement homes only within the parameters of the *Retirement Homes Act, 2010*. For other issues such as residential tenancy issues (within the purview of the Landlord and Tenant Board) or concerns about incompetent care (within the purview of the related health regulatory college), the Authority will give general advice to the complainant but they must find the appropriate organization on their own, even though their concerns pertain to a retirement home.

Between 2017/18 and 2019/20, the Authority took about two-and-and-half months on average from the time a complainant filed a formal written complaint to reach a decision from its own investigation and to inform the complainant in writing to direct their concern to the relevant regulatory body. These complaints often related to urgent health and safety matters such as inadequate care and medication administration issues.

As soon as it receives a complaint, the Authority verbally informs complainants about its jurisdiction and other relevant regulatory authorities, but it does not inform them in writing until after it completes its investigation. At that point, the Authority provides contact information in writing only for the Landlord and Tenant Board and not for other regulatory bodies such as the College of Nurses of Ontario. The Authority also does not communicate with regulatory bodies to confirm that they have received the complaint.

We also found that the Authority informs the public on its website that it does not oversee issues relating to employer/employee relationships, rent and evictions, and power of attorney disputes. Accordingly, it refers the public to contact the appropriate parties, but it does not inform the public about other parties, such as the Local Health Integration Networks, the Office of the Fire Marsal or health regulatory colleges. Based on our review of formal written complaints, these parties are also helpful to the public who have filed a formal complaint to the Authority about concerns that may be within the purview of these other parties.

In addition, when a complainant files multiple concerns with the Authority and some concerns are not within its jurisdiction, the Authority issues a decision letter only after all concerns have been examined. It does not issue a separate decision letter for concerns that could have been resolved more quickly, such as those that should be redirected to another regulatory body.

RECOMMENDATION 18

To provide for more clarity and timely responses to retirement home residents, family members of residents, or other persons who may have concerns about retirement homes, we recommend that the Retirement Homes Regulatory Authority:

- develop a form letter containing contact information for other regulatory bodies and send the letter to all complainants at the

earliest opportunity before it investigates the complaints;
- establish a process to refer complaints not within its jurisdiction directly to the appropriate regulatory body and follow up with the complainant and the other regulatory body to ensure that the complaint has reached the appropriate organization;
- update its website to include contact information of relevant regulatory bodies to address concerns that the public commonly brings to the Authority's attention but are outside of the Authority's jurisdiction;
- establish a performance indicator to measure turnaround time for investigating and resolving complaints, set and review targets on an annual basis and monitor relevant performance; and
- publish expected service standards about its complaint resolution process and its actual performance against these standards on its website.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) agrees with the importance of responding to persons with concerns about retirement homes in a clear and timely manner, and with reducing any administrative barriers that impair the complainant from having their complaint heard and adjudicated.

The Authority will refine its existing processes for intake of complaints to provide contact information to other regulatory bodies and referral of inquiries not within its jurisdiction to the appropriate regulatory body. The Authority recognizes the importance of removing barriers to access for complainants who are referred to other regulatory bodies, and will provide advice to the Ministry for Seniors and Accessibility as part of its review of the *Retirement Homes Act, 2010* regarding the removal of barriers to information sharing among the Authority and other regulators as it relates to enhancing complaints handling.

While recognizing that there is significant variation in the complexity of complaints the Authority receives, and that information gathering to adjudicate complaints can be delayed due to availability of interviewees, the Authority will develop a framework to measure turnaround times for investigating and resolving complaints. The Authority will set baselines for these metrics and subsequently review and monitor the performance against the target on an annual basis, which will be published on the Authority's website. These indicators and standards will necessarily focus on responsiveness to complainants and promptly escalating issues that pose a significant risk to residents.

4.6.4 Complaints about Retirement Homes Difficult for Consumers to Access

Consumers cannot easily access information about complaints made about a retirement home, which limits their knowledge when making choices on which retirement home they or their loved one would select as their residence. The Authority's online database does not provide complaints' information for individual homes nor for all retirement homes in total.

The Authority's practice is to publish complaint details within an inspection report after it has validated a complainant's concerns that the retirement home has failed to comply with the *Retirement Homes Act, 2010* (Act) or its regulation. The Authority's substantiation process often involves collecting evidence that an event underlying the complaint occurred, but this may not always be available. For example, an interaction between a resident and a home operator or staff would not produce any evidence that the Authority can collect after the fact. The Authority noted that its staff make reasonable determination about whether an event transpired and whether it needs to take any subsequent actions. Between 2017/18 and 2019/20, the

Authority concluded that only 23% of the concerns raised in written complaints it received were contraventions of the Act or its regulation.

The Act requires the Authority to inspect a retirement home when there is suspected harm or risk of harm to residents because of improper care, abuse, neglect or unlawful conduct. However, information about the nature of these violations is not easily accessible for retirement home residents and their families because they would have to read through each inspection report to identify each violation at a home.

Furthermore, we analyzed the Authority's data on complaints and found that 56 homes were subject to multiple complaints between 2017/18 and 2019/20—and they were therefore more likely to be problematic. However, only 15% of the complaints related to them were deemed valid after investigation and therefore disclosed in published inspection reports on the Authority's website. While it is important to eliminate unsubstantiated complaints, there is a risk that consumers are not fully informed that multiple complainants have had concerns about a home, even if they did not result in a finding, which can inhibit their ability to make informed decisions when choosing a retirement home.

We reviewed all 273 complaints filed with the Authority between April 2017 and March 2020 and noted that the public raised a total of 760 concerns. As shown in **Figure 14**, more than half of the concerns raised by complainants related to resident care, which included abuse and harm, meals, medication administration and hygiene. Another 13% of the concerns raised by complainants were regarding maintenance of the retirement home facility. Toward the end of our audit, in September 2020, the Authority informed us that it had begun to track this information. However, as the Authority did not analyze complaints data, complaints that the Authority could not substantiate were not used in inspector training to identify areas of interest.

The Authority's Risk Officer (see **Section 2.2.1**) also identified the limited use of overall complaints data in his 2019 report, and recommended that the Authority enhance its public reporting on complaints-related data by reporting a breakdown of common complaints areas. The goal of the recommendation is to improve educational outreach and help consumers make informed choices.

RECOMMENDATION 19

To more clearly and effectively communicate information about retirement home complaints to existing and future residents and family members, and to improve the effectiveness of retirement home inspection choices by inspectors, we recommend that the Retirement Homes Regulatory Authority:

- publish data publicly and regularly on common complaint areas raised by consumers about the retirement home industry;
- publish the nature and quantity of complaints filed with the Authority for each retirement home on the Authority's website while respecting the privacy of the complainant;
- analyze complaint trends to identify significant areas of focus and to better inform its selection of retirement homes for routine inspections; and
- establish a training module for the retirement home sector and update training for its inspectors based on the most frequent and significant complaints raised to identify areas of focus for inspections.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority agrees that residents, prospective residents and their families can benefit from even greater transparency related to complaint areas and trends. The Authority will expand on its current practice of publishing an annual analysis of complaints and trending and make this information available with greater frequency and detail. The Authority will

Figure 14: Concerns Raised Through Written Complaints Received by Retirement Homes Regulatory Authority Registrar by Category, 2017/18–2019/20

Source of data: Retirement Homes Regulatory Authority

Concern Category[1]	Open[2]	No Citation	Citation[3]	Total	Citation Rate (%)
Resident Care					
Abuse/zero tolerance policy for abuse and harm	1	29	14	44	33
Access to external care providers	0	3	2	5	40
Behavioural management	6	27	9	42	25
Eviction from retirement home/resident required to transfer to long-term care	3	16	3	22	16
Infection prevention and control	0	4	0	4	0
Meals	5	39	15	59	28
Medication administration	4	37	12	53	24
Plan of care[4]	9	23	13	45	36
Risk of falls	9	19	9	37	32
Care – other[5]	13	49	26	88	35
Subtotal	**50**	**246**	**103**	**399**	**30**
Non-Care Services					
Missing or inadequate services[6]	2	22	8	32	27
Theft/damage of resident property	2	16	5	23	24
Subtotal	**4**	**38**	**13**	**55**	**25**
Administration					
Complaints process	4	34	12	50	26
Emergency plan	0	9	0	9	0
Facility maintenance	7	85	7	99	8
Family notification[7]	2	7	4	13	36
Fee	8	31	4	43	11
Staffing level or competency – administrative staff	0	14	1	15	7
Staffing level or competency – care staff[8]	7	31	2	40	6
Other	7	24	6	37	20
Subtotal	**35**	**235**	**36**	**306**	**13**
Total[9]	**89**	**519**	**152**	**760**	**23**

1. Categories determined and classified by the Office of the Auditor General of Ontario.
2. Complaints for which the Authority had not issued a decision letter as of August 24, 2020.
3. Concerns validated by the Authority to be in contravention of the *Retirement Homes Act, 2010* or its regulation. The Authority notes that where a concern did not result in a citation, it may have been already addressed by the home, and it serves to prevent future issues as the home is now more aware of how to handle the situation.
4. Plan of care issues such as inadequate assessment or dietary requirements not followed.
5. For example, hygiene, misdiagnosis and medical negligence.
6. Reduction or inadequate non-care services paid by residents such as laundry, shuttle service and pool operating hours.
7. For example, a family member was not notified of an injury or death.
8. Includes director of care, personal support workers, registered nurses and registered practical nurses.
9. Includes 118 concerns that the Authority deemed to be not within its jurisdiction. When those concerns are excluded, the total citation rate increases to 27%.

augment its current practice of reporting the enforcement measures taken against a home that originated with a complaint to include the nature and quantity of complaints for each home with appropriate context. The Authority's annual complaints analysis currently informs the frequency of routine inspections, and the Authority will reinforce complaints trends with inspectors through additional training. The Authority will amend its existing complaints-related compliance assistance module, as well as other modules as appropriate, to reflect common complaint areas.

4.7 Information on Pricing of Rent, Care Services and Performance History Not Easily Available to Consumers

Our audit found that publicly available information on prices for retirement home services was difficult to obtain online. In our review of related complaints received by the Authority we found there have been only four instances over the last three years where residents complained about the rising price of care services and price increases when ownership changed. However, the *Retirement Homes Act, 2010* indicates that residents have a right to know what care services are provided in the home and how much they cost. When conducting research on retirement homes, seniors or their family members considering different accommodation options cannot easily compare costs of living without visiting retirement homes in person.

We randomly selected a sample of 10 chain homes and 10 independently operated homes and looked for pricing information on their websites. We found that 75% of the sampled retirement homes did not have pricing information available online. The homes that did disclose pricing information online published only the cost of accommodation and not care.

As well, neither the *Retirement Homes Act, 2010* nor the *Residential Tenancies Act, 2006* define what constitutes a fair price for care services. Stakeholder groups we spoke to during this audit indicated that affordability of housing is becoming a critical issue for seniors. There are no organizations or statutes that prevent retirement home residents from being charged unreasonably high prices for care services. The *Residential Tenancies Act, 2006* sets out the rights and responsibilities of both landlords and tenants, and the Landlord and Tenant Board receives complaints of disputes between landlords and residents (including those in retirement homes) regarding rent and other aspects of that Act. Between 2017/18 and 2019/20, the Authority referred 50 complaints to the Landlord and Tenant Board about retirement homes, 10 of which were disputes regarding rent. The remaining complaints related to concerns such as evictions and inadequate services that are not covered in the *Retirement Homes Act, 2010*.

To assist potential residents and their families in selecting a reliable retirement home, the Authority is developing a public report card that is intended to provide real-time performance measurement data for each retirement home. During our audit, the Authority had not yet determined how the performance of these homes would be measured; however, it informed us that it does not intend to include pricing because retirement home costs are not within its mandate, but the Authority is considering including information on homes' performance on complying with legislation and regulation. At the completion of our audit, the Authority was still assessing its plan for a public report card.

RECOMMENDATION 20

To better inform and protect consumers when purchasing accommodation and care services from retirement homes, we recommend that the Ministry for Seniors and Accessibility:

- evaluate whether the Retirement Homes Regulatory Authority should have oversight of retirement home care services fees and consider proposing amendments to the

Retirement Homes Act, 2010, as appropriate; and

- request the Authority to require all licensed retirement homes to make price lists (for rent and services) available—both in paper form and electronically—when asked by phone, online, through emails or in person.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility (Ministry) agrees that there is an opportunity to enhance the information available to consumers when making decisions about their care and accommodation options.

Retirement homes are subject to both the *Retirement Homes Act, 2010*, which governs care and safety in retirement homes, and the *Residential Tenancies Act, 2006*, which governs the landlord-tenant relationship, including rents and fees in retirement homes (referred to as care homes in the *Residential Tenancies Act, 2006*), including service fees.

The *Retirement Homes Act, 2010* reinforces and reiterates the obligations and protections of landlords and tenants under the *Residential Tenancies Act, 2006* and notes the primacy of the *Residential Tenancies Act, 2006*.

Given this regulatory framework, the Ministry will work with the Ministry of Municipal Affairs and Housing, which has primary responsibility for the *Residential Tenancies Act, 2006*, to explore measures to better inform and protect consumers purchasing accommodation and care services from retirement homes.

RECOMMENDATION 21

To better inform and protect consumers when purchasing accommodation and care services from retirement homes, we recommend that the Retirement Homes Regulatory Authority accelerate its efforts to develop a public report card for each retirement home.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

The Authority will resume developing a public report card, commencing with enhancing the information currently contained in the Retirement Homes Database to make existing information more accessible and user friendly, and subsequently with a standard evaluation.

4.8 Board and Ministry Lack Sufficient Oversight of Authority's Activities

4.8.1 Authority's Board Had Vacancies for More than 30 Months between 2017 and 2020

Over the past four years, the Authority's Board of directors had its full complement of nine members only between April 2016 and October 2017 and after July 2020. While many of the Board of Directors indicated they faced challenges in making quorum at meetings because they did not have a full board for the majority of the past four years, there were no instances where quorum was not made.

When we began our audit in January 2020, the Authority had three provincial appointment vacancies on its nine-member Board—one since December 2017 and the remaining two from December 2019. During our audit, all three vacancies were filled: The Minister appointed one director in May 2020 and the remaining two directors in July 2020.

4.8.2 Authority's Board Has No Consumer Protection Representation

In February 2012, the Authority's Board established a Stakeholder Advisory Council (Council) as required under its MOU with the Ministry. The Council provides advice on matters relating to the Authority's mandate and prepares an annual report of its activities to be included in the Authority's

annual report. The Council is not a committee of the Board and has no decision-making power. The Board appoints members to the Council for their relevant knowledge and experience in the retirement homes sector. The Council consists of a diverse group, which includes at least one retirement home resident, a retirement home licensee, regulated health professionals and individuals with seniors' interests in mind.

While the Authority's Board members collectively met the competencies and governance requirements, as of August 2020, the Board does not have a member who represents either a seniors' organization or is an individual who advocates for seniors. During a few meetings in 2017/18 and 2018/19, the Council discussed suggesting that there be an individual with seniors' interests in mind on the Board. It included this suggestion in the 2019 and 2020 Stakeholder Advisory Council Annual Report to the Board. Board members indicated that, while the Board supports the idea, the Board currently does not have an individual with seniors' interests in mind because the required competencies and governance requirements were not met. The candidate whom the Board elected in the 2019 recruitment process is an executive of a retirement home who met the qualifications outlined in the MOU.

We interviewed some Stakeholder Advisory Council members to obtain their views on whether the Authority's Board would benefit from someone advocating for retirement home residents. Their opinions were mixed: While a retirement home resident representative could help provide direct consumer feedback to the Board and enhance decision-making on important matters affecting the sector (such as fee increases), the representative would still need to have defined governance competencies to perform well as a Board member. As well, an individual with seniors' interests in mind could be more beneficial than a resident representative in that they could speak more freely on important matters and would not have to fear losing their residency in a retirement home.

The Authority has established competency criteria for Board members; each member is assessed on governance, knowledge of the regulatory environment and individual skills. The Chair and Vice-Chair are assessed on additional areas such as leadership, performance management and influence. We analyzed the background and composition of the Authority's Board and found that, at the time of the audit in August 2020, four of the nine Board members were current or former retirement home industry executives, as shown in **Appendix 11**. In previous years, industry executives also represented a significant portion of the Board—four of nine members in 2017/18, 2016/17 and 2015/16. With this composition history, we examined decisions made by the Board to determine whether its decisions favoured the retirement homes industry rather than seniors. We found no such instances where the Board made biased decisions favouring the industry.

RECOMMENDATION 22

To improve effective governance and the Board of Directors' oversight of the Retirement Homes Regulatory Authority's operation, we recommend that the Ministry for Seniors and Accessibility work with the Public Appointments Secretariat to propose appointees to the Board with seniors' interests in mind or request the Board Chair to consider such individuals as current directors' terms expire.

MINISTRY RESPONSE

The Retirement Homes Regulatory Authority (Authority)'s Board of Directors is expected to act in the best interests of the public and residents and to fulfill the mandate of the organization set out in the *Retirement Homes Act, 2010* (Act) in accordance with the Act's fundamental principles—that residents are entitled to live with dignity, respect, privacy and autonomy, in security, safety and comfort and can make informed choices about their

care options. The Ministry for Seniors and Accessibility (Ministry) appreciates the Auditor's confirmation that the Board is acting in accordance with this expectation.

When making appointments to the Board, the skills and experience necessary to fulfill this purpose are considered. However, the Ministry recognizes that there is an opportunity to work with the Authority to broaden the list of skills and competencies to include consumer/resident/tenancy knowledge.

4.8.3 Ministry Cannot Properly Assess whether Authority Effectively Met Mandate

The Ministry does not fully monitor the Authority to confirm that it meets all of its obligations under the MOU between the two parties. The MOU sets out the roles and responsibilities of the two parties, as summarized in **Appendix 12**. The Ministry is responsible for conducting reviews of the Authority and its operations and recommending policy and regulatory changes as a result if needed.

We highlight the following areas for improvement with the Ministry's oversight of the Authority:

- T**he Ministry has not fully defined what further documents it needs the Authority to regularly submit to it for oversight purposes**. As outlined in the Act and the MOU, the Authority is required to submit certain documents such as the annual report and business plan to the Ministry on a regular basis for oversight purposes. The current MOU, which was last reviewed in October 2018, has a placeholder schedule for the Ministry to further define the documents it expects the Authority to submit on a regular basis for its review. The Ministry originally expected this schedule to be finalized by January 1, 2020, but it deferred the development of this schedule to align with updates to legislation that the government passed in July 2020. Nonetheless, the schedule was still not completed when we completed our audit work.
- **The Ministry has not requested the Authority to develop benchmarks to measure the Authority's performance toward effective operation.** While the Authority publishes key activity data with prior-year comparisons in its annual report, it does not set benchmarks for this data. This means the Ministry does not have an appropriate baseline to which it can compare the Authority's performance in key risk areas. For example, the Authority publicly discloses the year-over-year results of a province-wide public survey to assess the public's awareness of whether there is a regulatory body that is responsible for licensing retirement homes in Ontario and whether licensing is mandatory for retirement homes in Ontario. However, the Ministry is only able to compare current-year to prior-year results and not against a benchmark on an issue as key as raising awareness of the Authority—we discuss the implications of this in **Section 4.6.1**. At the time of our audit, the Ministry told us a timeline has yet to be set for the Authority to adopt full performance measurement—almost a decade after its inception.
- **The Ministry does not charge the Authority oversight fees as required in the MOU**. The MOU states that the Authority is to pay the Ministry oversight fees. The administrative authority model is meant to be cost neutral to the government. The purpose of an oversight fee is to recoup the government's cost to provide legislative and accountability oversight. At the time of our audit, an oversight fees schedule was still not developed in the MOU. The Ministry informed us that it deemed these fees not applicable at the inception of the Authority, and it maintained that position when it reviewed the MOU in October 2018. However, the requirement is still included in the MOU. The Ministry has never calculated or charged the Authority oversight fees. In comparison, other administrative authorities and delegated administrative authorities

such as the Electrical Safety Authority and the Bereavement Authority of Ontario, pay oversight fees to their oversight ministry.

RECOMMENDATION 23

To improve its ability to oversee the Retirement Homes Regulatory Authority (Authority) to confirm that it is operating in accordance with the *Retirement Homes Act, 2010* and the Memorandum of Understanding between the Authority and the Ministry for Seniors and Accessibility (Ministry), we recommend that the Ministry:

- develop a schedule of reporting requirements with input from the Authority and update the Memorandum of Understanding accordingly;
- request the Authority establish targets for its performance indicators, and require the Authority to publish actual versus targeted performance annually; and
- assess the level of resources it requires to oversee the Authority and determine whether it needs to levy an oversight fee—if not, the Memorandum of Understanding should be updated to reflect this fact.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility (Ministry) recognizes that effective oversight processes and measures are important tools to assess whether the Retirement Homes Regulatory Authority (Authority) is achieving its mandate under the *Retirement Homes Act, 2010*. The Ministry will continue to work closely with the Authority to review and strengthen the Memorandum of Understanding and respond to the recommendations by:

- developing as part of the Memorandum of Understanding, a schedule of reporting requirements with input from the Authority that includes a formalization of current practices;
- requesting the Authority establish targets for its performance indicators, and publish actual versus targeted performance each year in its annual report; and
- deciding whether to require the Authority to pay a fee to cover the costs of Ministry oversight and updating the Memorandum of Understanding accordingly.

4.8.4 Authority Did Not Monitor Implementation of Risk Officer Report Recommendations

The Authority does not have a standard targeted time frame for enacting recommendations provided in Risk Officer reports, nor does it have a specific process to track the application of these recommendations. As a result, some recommendations were either not yet implemented or implemented several years later.

As explained in **Section 2.2.1**, the Risk Officer reports directly to the Authority's Board on the effectiveness of the Authority's administration of the Act and its regulation. Between 2014/15 and 2018/19, the Risk Officer issued annual reports covering topics such as the inspection process, Emergency Fund payments, and the compliance support program for retirement homes.

The Authority indicated to us that its business plans incorporate the Risk Officer's recommendations but may not specifically establish a targeted time frame to phase them in. While the Board receives and reviews the Risk Officer's annual report, the Authority does not report the status of implementation of the Risk Officer's recommendations to the Board. The Ministry for Seniors and Accessibility also does not ask for any updates regarding the status of the Risk Officer's recommendations. We identified the following examples of recommendations by the Risk Officer that have not been implemented in a timely manner:

- In 2014/15, the Risk Officer recommended that the Authority identify third-party organizations that have a role in overseeing or

are otherwise involved in retirement homes and review their accountability to identify gaps and reduce potential regulatory and reputation risk. These third parties include public health, the Office of the Fire Marshal and other regulatory authorities. During our audit, the Authority informed us that because the Act prohibits it from sharing personal information externally, it would not put this recommendation into effect. However, we noted that the Act has an exemption on the requirement on the Authority to preserve secrecy under certain circumstances; for instance, if permitted or required under another law.

- In 2015/16, the Risk Officer noted that the Authority inspectors did not look beyond written retirement home policies on abuse and neglect to determine what steps are actually in place to mitigate the potential for such risks. The Risk Officer also noted that there were no defined practices or actions that homes must take to anticipate and prevent incidents of abuse and neglect. The Act specifies the content that should be included in the retirement home policies regarding abuse and neglect, but does not prescribe the form of the policies. Retirement homes must therefore create their own individual policies to meet the legal requirements. During our audit, the Authority indicated that it had developed modules to address this in its compliance assistance program, but has delayed their launch in order to focus on COVID-19 priorities. In October 2020 the Authority launched one of these modules—on behaviour management—to assist retirement home operators to address this risk.

RECOMMENDATION 24

To improve the safety and protection of retirement home residents and to support the work and effectiveness of the Risk Officer, we recommend that the Retirement Homes Regulatory Authority:

- establish targeted time frames to phase in the Risk Officer's recommendations;
- track the enactment of these recommendations; and
- report this information to the Board of Directors and to the Ministry for Seniors and Accessibility semi-annually.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) supports this recommendation.

In late September 2020, the Authority's Board of Directors confirmed the scope of the Risk Officer's work for 2020–2021, which contemplates the actions outlined in this recommendation. The Authority will proceed with its previously identified plans to develop and implement time frames to phase in recommendations from the Risk Officer and to track implementation of the recommendations. As part of its accountability and regular reporting, the Authority will provide this information to the Board of Directors and to the Ministry for Seniors and Accessibility.

4.8.5 Ministry Has Limited Role Determining Policy for Seniors on Housing, Delivery of Care Services

Ontario has one of the highest life expectancy rates in Canada based on 2017 data published by Statistics Canada, at 84.4 years for females and 80.4 for males. This compares with British Columbia (84.6 for females and 80.1 for males) and Quebec (84.2 for females and 80.6 for males). As Ontarians have a high life expectancy, it is paramount that seniors are supported in their later years. The Ministry for Seniors and Accessibility has a mandate to help seniors stay independent, active and socially connected.

Multiple ministries are responsible for delivering services to seniors in a variety of settings, including

long-term-care homes, retirement homes and in the community. For example, the Ministry of Long-Term Care oversees long-term-care homes that some seniors in the community, including those in retirement homes, may need to access in the future. The Ministry of Health oversees the Local Health Integration Networks, which provide funding for home care services that may be delivered to seniors living in retirement homes, as well as their own homes. The Ministry of Municipal Affairs and Housing is responsible for social housing, affordable housing and supportive housing.

The Ministry for Seniors and Accessibility acknowledges that it is responsible for developing an updated seniors' strategy in Ontario. *Ontario's Action Plan for Seniors* was released in November 2017, building on a 2013 action plan and 2012 report called *Living Longer, Living Well*. It outlined how to support seniors in living healthy and productive lives while reducing hospital readmissions and pressure on long-term-care homes. At the time of our audit, the Ministry had not yet finalized its work on an updated strategy, although it expects to communicate more details publicly at the end of 2020 or early 2021.

Despite taking responsibility for the seniors' strategy, the Ministry informed us that it is not responsible for determining policy relating to seniors' housing or congregate care. The Ministry indicated that it will consider exploring and investing in new models of seniors' housing when a new seniors' strategy is implemented, but the Ministry of Municipal Affairs and Housing will lead the seniors' housing strategy.

RECOMMENDATION 25

To improve the co-ordination and effectiveness of overall services to seniors in Ontario in an environment where multiple ministries are involved in providing services and care to this population group, we recommend that the Ministry for Seniors and Accessibility:

- seek the responsibility to serve as the lead ministry that will work with all applicable ministries that have a mandate to provide or oversee the provision of seniors' congregate living and care services to develop a co-ordinated seniors' housing policy framework that defines the health, independence and financial profile of seniors for whom these settings are intended, or identify another ministry that will act as the lead; and
- incorporate in its seniors' strategy specific actions to undertake to achieve various goals and a timetable for these actions.

MINISTRY RESPONSE

The Ministry for Seniors and Accessibility (Ministry) acknowledges the need for a co-ordinated seniors' housing policy framework and will work with all applicable ministries to determine how to implement the recommendation.

In the *2019 Ontario Budget: Protecting What Matters Most*, the government announced that "the province will be developing a new cross government strategy to improve the lives of seniors and provide the supports and resources to help them live independently, ensure their safety and security, connect them to the community and help them achieve greater financial security and social connections." This commitment was reiterated in the 2019 Fall Economic Statement.

To inform the cross-government strategy, the Ministry undertook extensive, province-wide consultations in the summer of 2019 and has collected feedback to inform the strategy and improve the lives of older Ontarians to:

- age at home and in communities;
- remain healthy, active and socially engaged;
- stay safe and secure; and
- participate in the labour market and economy, if they choose.

The Strategy is being developed with multiple ministry partners including the

Ministry of Health, the Ministry of Municipal Affairs and Housing, and the Ministry of Long-Term Care, which have the accountability for supportive housing, seniors housing and long-term care homes.

4.9 Authority Lacks Financial Capacity to Fully Meet Regulatory Mandate

The Authority does not receive funding from the Ministry. It finances its operations primarily by collecting fees from the retirement homes that it regulates. In 2019/20, the Authority received about $8.0 million in revenue, $7.6 million of which was from annual fees that all retirement homes are required to pay, with the remainder being licence application fees and other miscellaneous revenue.

According to the Authority's internal fee-setting policy, which formed a part of the MOU between the Authority and the Ministry, the Authority can adjust its fees to provide for "a moderate surplus of revenues over expenses to allow for contingencies and unplanned events." The Authority needs to notify the Minister prior to making fee changes but does not require the Minister's approval.

The Authority operated with an annual surplus between 2015/16 and 2018/19 and incurred an annual deficit in 2019/20, as shown in **Figure 15**. There was a general decline in annual surplus between 2015/16 and 2019/20, primarily because expenses increased 40% during this period while revenue increased by only 8%.

The Authority has increased its annual licensing fees every January since 2014. As of January 1, 2020, the annual fee rate was $10.09 per suite per month,

Figure 15: Summary of Retirement Homes Regulatory Authority's Financial Information, 2015/16–2019/20 ($)

Source of data: Retirement Homes Regulatory Authority

	2015/16	2016/17	2017/18	2018/19	2019/20
Revenues	7,363,935	7,516,297	7,722,238	8,085,826	7,940,781
Expenses	6,249,261	6,866,475	7,554,950	7,823,440	8,686,163
Operational surplus	1,114,674	649,822	167,288	262,386	(745,382)
Net increase/(decrease) to Emergency Fund balance (see below)	(7,134)	5,751	25,146	94	17,303
Total surplus	**1,107,540**	**655,573**	**192,434**	**262,480**	**(728,079)**
Emergency Fund (Fund)					
Opening Fund balance	273,414	566,280	572,031	597,177	597,271
Administrative monetary penalties collected during the year[1]	13,040	4,844	17,500	24,500	9,500
Interest income collected during the year[2]	5,665	5,681	7,646	12,004	13,579
Contributions to the Fund[3]	300,000	–	–	–	–
Total additions to the Fund	**318,705**	**10,525**	**25,146**	**36,504**	**23,079**
Disbursements from the Fund[4]	25,839	4,774	–	36,410	5,776
Closing Fund balance[5]	**566,280**	**572,031**	**597,177**	**597,271**	**614,574**

1. Administrative monetary penalties are a form of enforcement action the Retirement Homes Regulatory Authority (Authority) can take on retirement homes that do not comply with the *Retirement Homes Act, 2010* (Act). According to the Act, all administrative monetary penalties shall be contributed to the Fund each year.
2. According to a Regulation made under the Act, the entirety of its interest income earned is contributed to the Fund each year.
3. One-time contributions are recommended by a Board committee, taking into consideration annual risk assessments. Such contributions were made in 2012/13, 2013/14 and 2015/16 since the creation of the Authority.
4. According to the Authority's internal policy, the Board has authorized the Registrar for a maximum of $1.5 million to be paid out of the Fund within a 12-month period. The Authority can concurrently draw down its unrestricted and restricted funds if this Fund is insufficient for payouts.
5. The Authority's targeted balance is $500,000 in any given year.

up from $9 per suite per month as of July 1, 2012, when the fees were first levied on retirement homes. This represents a 12% rate increase over more than eight years, or an average of 1.4% per year.

The Authority recorded about $473,000 in licence application fees in 2019/20. These fees, at $5,000 plus $25 per suite to a maximum of $10,000 per newly licensed retirement home, have not changed since January 2014. Prior to January 2014, the licence application fees were $800 for homes with 20 or fewer suites and $1,200 for all other homes.

RECOMMENDATION 26

To collect sufficient fees to cover the Retirement Homes Regulatory Authority's mandated activities to protect current and former retirement home residents, we recommend that the Retirement Homes Regulatory Authority annually reassess the appropriateness of its fees or identify other revenue sources to cover its operating expenses in performing more inspections and other mandated activities.

RESPONSE FROM THE AUTHORITY

The Retirement Homes Regulatory Authority (Authority) agrees with this recommendation.

Annual reassessment of its fees is a practice that currently exists within the Memorandum of Understanding in the Authority's Fee Setting Policy.

The Authority will continue to work within this framework to address shortfalls in the funding required for resources and infrastructure to continue to meet its mandated activities, including to implement the recommendations in this report.

Additionally, as part of its future strategic and business plans, the Authority will work to identify and assess other viable revenue sources to cover operating expenses for its mandated activities.

Appendix 1: Comparison of Retirement Homes and Long-Term-Care Homes

Prepared by the Office of the Auditor General of Ontario

	Retirement Homes	Long-Term-Care Homes
# of licensed homes	770[1]	627[2]
# of homes operating both Retirement Home and Long-Term-Care Homes	101[3]	n/a
# of residents	58,500[4]	77,199[2]
Average age	86 years[5]	83.5 years[2]
Capacity # of residents	80,200[1,6] (average 104; lowest 6; highest 646)	78,797[1] (average 126; lowest 9; highest 543)
Funding source	No government funding. Residents pay the full costs for rent and care.	Funded by provincial government with a resident co-payment.
Costs to residents	Vary depending on what the resident and the home agree to. Residents can pay at least $1,500 to $6,000 per month for rent and basic care services such as meals and medication administration. Additional services provided by the home, such as dementia care, may cost extra. Residents choose their care services.	As of July 2019, resident co-payment was between $1,900 to $2,700 per month depending on type of room, such as basic, semi-private or private.[4] Includes accommodations, 24-hour nursing care, help with daily living activities and meals. The Ministry of Long-Term Care also provides funding to long-term-care homes.
Ownership	For-profit: 94%[1] Not-for-profit: 6%[1]	For-profit: 57%[2] Not-for-profit: 27%[2] Municipal: 16%[2]
Resident eligibility	There is no special health eligibility requirement set out in the *Retirement Homes Act, 2010*, because people reside as tenants under the *Residential Tenancies Act, 2006* and choose their services.	There are minimum care needs required for residents to be eligible. Home and Community Care Support Services, formerly Local Health Integration Networks and Community Care Access Centres, will determine eligibility in accordance with law and government policies.
Health status of residents	Residents have varying needs but generally need less care than in long-term-care homes.	More people are entering long-term-care homes at a later stage of their conditions. They have more complex health issues and are more physically frail. A larger proportion have dementia and many more have psychiatric diagnoses along with dementia. Over 85% of long-term-care home residents need extensive or complete daily assistance with activities such as eating, bathing or toileting.
Supportive and medical care	Retirement home chooses which services to offer. Residents may purchase any of the services offered such as drug administration or assistance with bathing. Alternatively, residents may have external providers offer the services including government-funded home and community-care services. On average, retirement homes offer 10 care services.[5]	24-hour nursing care, restorative care, dietary services, medical service accommodations.

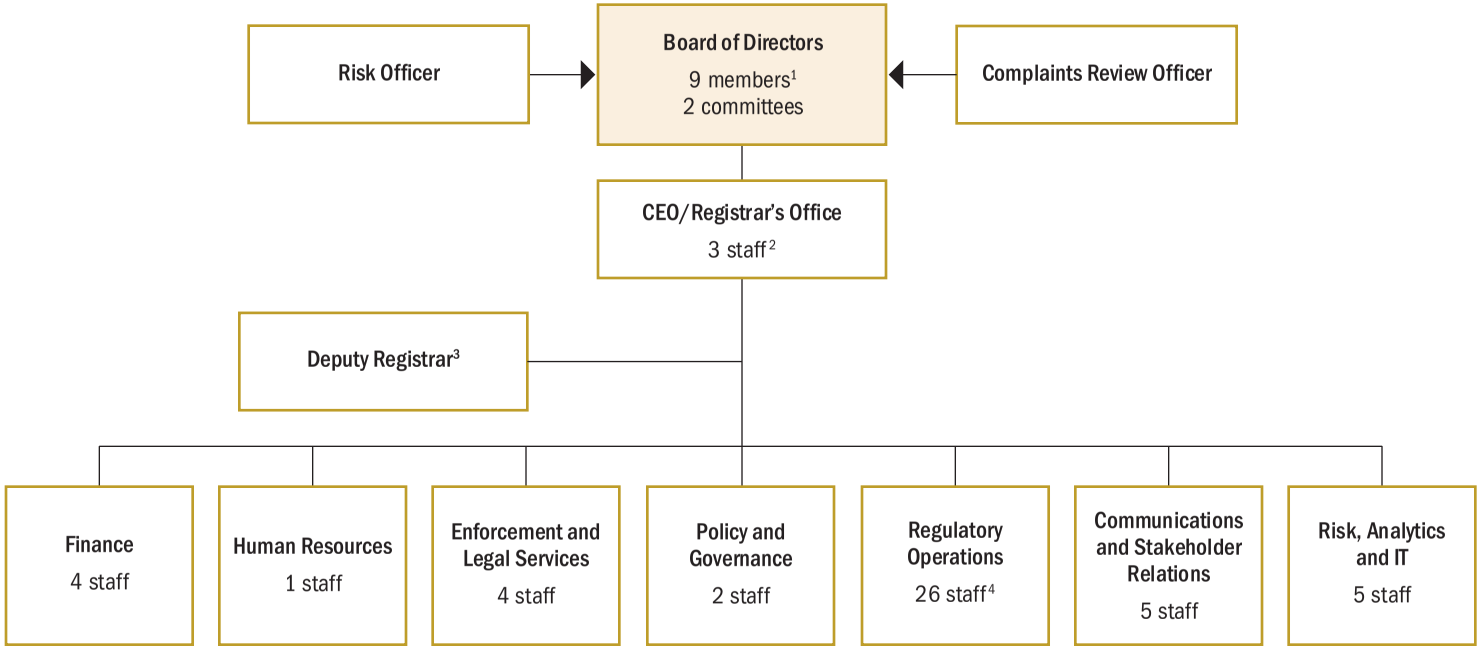
	Retirement Homes	Long-Term-Care Homes
Legislation	*Retirement Homes Act, 2010*, administered by the Retirement Homes Regulatory Authority on behalf of the government. Tenancy agreements are governed under the *Residential Tenancies Act, 2006*, administered by the Ministry of Municipal Affairs and Housing with the Landlord and Tenant Board resolving any disputes.	*Long-Term Care Homes Act, 2007*, administered by the Ministry of Long-Term Care
Requirements/Standards per Applicable Legislation		
Have a family council	No	Yes
Have a resident's council	Allowed, but up to the residents if they want to establish one	Yes
Report unnatural/unexpected deaths (i.e., residents dying from complications of a fall, or choking, as opposed to someone naturally dying due to old age) to the Office of the Chief Coroner	Yes	Yes
Have a physician/medical director on site	No	Yes
Have a Registered Nurse on site	No	Yes
Have a director of care on site	No	Yes, must have a Director of Nursing and Personal Care who is a Registered Nurse
Have fire sprinkler installed in each living unit	Yes	Yes, by 2025
Have admission criteria	No, but homes have an obligation to ensure they can meet the care needs of a resident when admitting	Yes, the person must have care needs that require 24-hour nursing care, frequent assistance with activities of daily living, and on-site supervision to ensure his or her safety or well-being
Provide a minimum # of hours of nursing services	No	No
Specify # of residents per care service provider	No	No
Have a falls prevention program	Yes	Yes
Publish inspection reports publicly	Yes	Yes
Provide care services using in-house staff	Sometimes, resident can obtain services from private providers.	Yes
Prepare plan of care at admission	Yes	Yes
Reassess plan of care at regular intervals	Yes, at least every six months	Yes, at least every six months
Review plan of care upon return from hospital	No	No
Have a complaints process	Yes	Yes
Ability to evict residents	Yes, but residents have protection afforded by the *Residential Tenancies Act, 2006*, which adjudicates evictions through the Landlord and Tenant Board	No

	Retirement Homes	Long-Term-Care Homes
Requirements/Standards Related to Infectious Diseases (e.g., COVID-19)		
Report if there is an outbreak of infectious diseases (e.g., flu, gastro, COVID, etc.) to public health	Yes	Yes
Report # of cases of infectious diseases to public health	Yes	Yes

1. Data as of March 31, 2020.
2. Data as of December 31, 2019.
3. Data as of June 5, 2020, determined jointly by the Retirement Homes Regulatory Authority (Authority) and our Office using a list of long-term-care homes from August 2019, matching locations of retirement homes and long-term-care homes based on facility address and licensee information.
4. Estimated occupancy as of May 25, 2020.
5. See **Figure 2** for care services offered in licensed retirement homes.
6. While two people could live together in a retirement home suite, the Authority indicated that in reality about 80% of the suites are occupied by singles. In contrast, capacity of long-term care is measured in number of beds.

Appendix 2: Organizational Structure of Retirement Homes Regulatory Authority, July 2020

Prepared by the Office of the Auditor General of Ontario



1. There were three vacant Minister-appointed positions as of January 2020 when we began our audit. One position had been vacant since December 2017 and two positions had been vacant since December 2019. These positions were all filled during our audit, in June and July 2020, retroactively to May and July 2020.
2. Includes the Registrar and two support staff.
3. Role was approvied by the Board on June 9, 2020. The Authority was evaluating reporting structure when we completed the audit.
4. Includes 13 inspectors; the remaining staff have responsibilities, which include intake of complaints and licensing retirement homes.

Appendix 3: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

Retirement Homes Regulatory Authority (Authority)	
1.	Licensing and inspection activities are efficiently and effectively executed such that the retirement home sector complies with legislative and regulatory requirements and protects residents from harm, including supporting public health authorities with respect to harm resulting from exposure to infectious diseases such as COVID-19.
2.	Complaints and incidents in retirement homes are documented and reviewed and timely corrective action is taken when required.
3.	Current information on the retirement home sector and the Authority is provided on a timely basis to inform and educate the public, residents and the retirement home sector.
4.	Resources are allocated with due regard for economy and efficiency to fulfill mandated responsibilities.
5.	Accurate, timely and complete information is regularly collected and analyzed to help guide management decision-making.
6.	Meaningful performance measures and targets to assess the effectiveness of the Authority are established, monitored and publicly reported, and corrective actions are taken on a timely basis when issues are identified.
Ministry for Seniors and Accessibility (Ministry)	
1.	The Ministry follows effective processes to monitor and address the Authority's performance in protecting retirement home residents from harm and in regulating retirement homes.
2.	The Ministry collaborates with other relevant ministries and health system partners, engaging the Authority as appropriate, to strategically plan for seniors' services, including housing for seniors, and address identified risks faced by retirement home residents, including implementation of infection prevention and control in retirement homes and incorporating lessons learned from other similar sectors.
3.	Governance structure and processes are in place to effectively oversee the Authority's ability to fulfill its mandated responsibilities.

Appendix 4: Additional Work Conducted for Our Audit

Prepared by the Office of the Auditor General of Ontario

We conducted the following additional work:

- obtained information and data from Ontario Health regarding the use of retirement homes for hospital patients and the provision of home care services to retirement home residents;
- obtained internal documents and data from the Ministry of Long-Term Care regarding its long-term-care home inspection process, resident profile, and analysis of older adults waiting for admission to long-term-care homes while residing in retirement homes;
- obtained program details and data from the Ministry of Health on an initiative called "short-term transitional care," which leverages vacant retirement home spaces to provide accommodation and deliver care to patients upon discharge from the hospital while they wait for space in their destination of choice, such as long-term care;
- interviewed representatives from seven of the province's 34 public health units that are responsible for managing respiratory and enteric outbreaks in retirement homes to understand how their work relates to the Authority's. These health units were Halton; Kingston, Frontenac, Lennox and Addington; Leeds, Grenville and Lanark; Niagara; Ottawa; Thunder Bay; and Toronto. Five of these public health units reported almost 60% of all retirement home COVID-19 cases as of June 24, 2020, and two of them had very few or no cases;
- interviewed representatives from the industry associations that represent the retirement home sector—the Ontario Retirement Communities Association and AdvantAge Ontario;
- interviewed representatives from stakeholder groups, including the Advocacy Centre for the Elderly, the Ontario Health Coalition, the Ontario Personal Support Workers Association, the Ontario Nurses' Association; and the Registered Nurses' Association of Ontario;
- interviewed representatives and obtained perspectives from the Licence Appeal Tribunal and the Landlord and Tenant Board on matters that are brought to their attention relating to retirement homes;
- interviewed a researcher from McMaster University whose research focuses on seniors and geriatric care to support development of better models of care and decision support systems for seniors;
- interviewed a representative from the National Institute on Ageing at Ryerson University, a think tank focused on Canada's ageing population; and
- researched how other Canadian provinces and territories deliver and operate congregate living services for seniors, including how they implement infection prevention and control measures, to identify areas for improvement in Ontario.

Appendix 5: Number of Confirmed and Recovered COVID-19 Cases and Deaths of Residents and Staff in Licensed Retirement Homes, March 22, 2020—August 31, 2020

Source of data: Retirement Homes Regulatory Authority

	Retirement Home	Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
				Residents	Staff[1]	Residents	Staff	Residents	Staff
1.	Terrace Gardens	Mar 22	Apr 29	9	<5	6	<5	<5	0
2.	Seasons Welland	Mar 24	May 19	29	11	19	11	10	0
3.	Supples Landing Retirement Residence	Mar 25	Apr 23	<5	0	0	0	<5	0
4.	Landmark Village Signature Retirement Community	Mar 25	May 6	37	10	31	10	6	0
5.	Les Promenades	Mar 26	May 18	12	5	8	5	<5	0
6.	Christie Gardens	Mar 26	May 19	20	<5	17	<5	<5	0
7.	Park Place Seniors' Suites[2,3]	Mar 27	Apr 11	0	0	0	0	0	0
8.	Park Place Retirement Residence[3]	Mar 27	Apr 11	0	0	0	0	0	0
9.	Anson Place Care Centre	Mar 27	Jun 25	25	6	21	6	<5	0
10.	Maplewood Retirement Community	Mar 28	May 1	10	5	8	5	<5	0
11.	Grand Wood Park	Mar 28	May 19	16	0	12	0	<5	0
12.	Amica Riverside	Mar 28	May 20	24	15	22	15	<5	0
13.	Carolina Retirement Residence	Mar 29	Jun 2	46	13	38	13	8	0
14.	Seasons Strathroy	Mar 29	Apr 23	<5	0	<5	0	0	0
15.	Beattie Manor	Mar 30	Apr 22	<5	0	<5	0	0	0
16.	Highview Residences Kitchener	Mar 30	Apr 28	13	11	6	11	7	0
17.	Lifetimes on Riverside	Mar 30	May 19	22	10	18	10	<5	0
18.	Telfer Place[2]	Mar 30	Apr 6	0	0	0	0	0	0
19.	Lundy Manor	Mar 31	May 31	56	12	38	12	18	0
20.	Greenwood Court	Mar 31	May 11	<5	<5	0	<5	<5	0
21.	Mountainview Residence	Mar 31	Apr 28	62	18	52	18	10	0
22.	V!VA Whitby Shores Retirement Community	Apr 1	Apr 20	<5	0	<5	0	0	0
23.	Norfolk Manor	Apr 1	May 14	22	8	15	8	7	0
24.	Amica Georgetown	Apr 2	Apr 24	<5	0	<5	0	0	0
25.	The Cardinal Retirement Residence	Apr 2	May 3	32	<5	25	<5	7	0

Retirement Home		Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
				Residents	Staff[1]	Residents	Staff	Residents	Staff
26.	Douglas Crossing Retirement Community	Apr 2	May 19	10	6	7	6	<5	0
27.	Park Avenue Manor Retirement Home	Apr 2	Apr 20	0	<5	0	<5	0	0
28.	Lanark Lifestyles Retirement Residence	Apr 2	Apr 23	0	<5	0	<5	0	0
29.	Forest Hill Place[3]	Apr 2	Apr 24	0	0	0	0	0	0
30.	Chartwell Lansing Retirement Residence	Apr 3	Apr 22	0	<5	0	<5	0	0
31.	Queens Estate Retirement Residence	Apr 3	Apr 24	18	7	14	7	<5	0
32.	Chartwell Willowdale Retirement Residence	Apr 3	Jun 2	15	7	13	7	<5	0
33.	Chartwell Van Horne Retirement Residence	Apr 3	Apr 28	0	<5	0	<5	0	0
34.	Chartwell Waterford Retirement Residence	Apr 3	Apr 13	<5	0	<5	0	0	0
35.	Scarborough Retirement Residence	Apr 4	May 18	5	5	<5	5	<5	0
36.	The Village of Humber Heights	Apr 5	Jun 11	48	20	31	20	17	0
37.	Murrays Millwood Manor Inc.	Apr 6	Apr 20	<5	0	<5	0	0	0
38.	Amica On the Avenue	Apr 7	May 12	<5	0	<5	0	0	0
39.	The Russell Hill Retirement Residence	Apr 8	May 11	<5	<5	<5	<5	<5	0
40.	Granite Landing	Apr 8	Apr 24	0	<5	0	<5	0	0
41.	Chartwell Clair Hills Retirement Community	Apr 8	Apr 19	<5	<5	<5	<5	0	0
42.	Chartwell Deerview Crossing Retirement Residence	Apr 8	Apr 20	0	<5	0	<5	0	0
43.	New Horizons Tower	Apr 9	Jun 1	32	17	24	17	8	0
44.	Bradgate Arms	Apr 9	May 31	15	12	11	12	<5	0
45.	Spruce Hill Lodge	Apr 10	May 10	<5	<5	<5	<5	0	0
46.	Canterbury Place Retirement Residence	Apr 10	May 20	14	18	8	18	6	0
47.	Sunrise Senior Living of Unionville	Apr 11	May 15	14	11	10	11	<5	0
48.	Kingsberry Place Seniors Residence	Apr 11	Apr 21	<5	0	<5	0	0	0
49.	The Waterford Retirement Community – Ottawa[2]	Apr 11	Apr 20	0	<5	0	<5	0	0
50.	L'chaim Retirement Homes Inc.	Apr 11	May 31	18	7	11	7	7	0
51.	Hazelton Place Retirement Residence	Apr 12	May 7	<5	0	<5	0	0	0
52.	Cite Parkway Retirement Residence	Apr 12	May 1	0	<5	0	<5	0	0
53.	Orchard Villa	Apr 13	Jun 11	23	9	18	9	5	0
54.	Briarfield Gardens	Apr 13	Apr 30	0	<5	0	<5	0	0
55.	Buckingham Manor	Apr 14	Apr 28	0	<5	0	<5	0	0

Retirement Home		Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
				Residents	Staff[1]	Residents	Staff	Residents	Staff
56.	Richview Manor Retirement Living	Apr 14	May 16	13	12	11	12	<5	0
57.	Chartwell Pickering City Centre Retirement Residence	Apr 15	May 13	8	<5	7	<5	<5	0
58.	Horizon Place	Apr 15	May 15	<5	<5	<5	<5	<5	0
59.	Sunrise Senior Living of Mississauga	Apr 15	May 19	0	<5	0	<5	0	0
60.	Harold and Grace Baker Centre	Apr 16	May 24	<5	<5	<5	<5	<5	0
61.	St. Mary's Gardens	Apr 16	May 7	0	<5	0	<5	0	0
62.	Chartwell Regency Retirement Residence	Apr 17	May 29	14	<5	12	<5	<5	0
63.	Chartwell Martha's Landing Retirement Residence[3]	Apr 17	Apr 27	0	0	0	0	0	0
64.	The Claremont	Apr 17	May 7	<5	<5	<5	<5	<5	0
65.	Bramalea Retirement Residence	Apr 17	May 5	<5	0	<5	0	0	0
66.	Advent Forestview Retirement Residence	Apr 17	Jun 2	<5	<5	<5	<5	0	0
67.	Barrhaven Manor	Apr 17	May 1	0	<5	0	<5	0	0
68.	Marian Residence Retirement Home	Apr 17	Apr 27	0	0	0	0	0	0
69.	The Village of Winston Park	Apr 17	May 8	0	<5	0	<5	0	0
70.	Victoria Place	Apr 19	May 12	23	7	19	7	<5	0
71.	Delmanor Glen Abbey	Apr 20	May 3	0	<5	0	<5	0	0
72.	Stone Lodge	Apr 22	May 5	<5	0	<5	0	0	0
73.	Park Place Seniors' Suites[2,3]	Apr 22	May 2	0	0	0	0	0	0
74.	Amica Bayview Village	Apr 23	May 14	0	<5	0	<5	0	0
75.	Belmont House	Apr 23	May 11	0	<5	0	<5	0	0
76.	Sepoy Manor[3]	Apr 25	Apr 30	0	0	0	0	0	0
77.	Highland Place	Apr 26	May 6	0	<5	0	<5	0	0
78.	Chartwell Empress Kanata Retirement Residence	Apr 27	Jun 6	28	15	24	15	<5	0
79.	Chartwell Valley Vista Retirement Residence[3]	Apr 27	May 12	0	0	0	0	0	0
80.	Greenway Retirement Village	Apr 27	May 12	<5	0	0	0	<5	0
81.	The Village of Tansley Woods	Apr 28	May 8	0	<5	0	<5	0	0
82.	The Westwood	Apr 28	Jun 1	6	<5	5	<5	<5	0
83.	Delmanor Elgin Mills	Apr 28	May 19	0	<5	0	<5	0	0
84.	Bayview Retirement Home	Apr 28	May 28	<5	<5	<5	<5	0	0
85.	St. Elizabeth Retirement Residence	Apr 28	May 11	<5	0	<5	0	0	0

Retirement Home		Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
				Residents	Staff[1]	Residents	Staff	Residents	Staff
86.	Brierwood Gardens[2,3]	Apr 29	May 13	0	0	0	0	0	0
87.	Kingsway	Apr 30	Jun 6	24	5	20	5	<5	0
88.	Kensington Village Retirement/Nursing Home	Apr 30	May 19	<5	0	<5	0	0	0
89.	Adelaide Place Retirement Community[3]	Apr 30	May 5	0	0	0	0	0	0
90.	Chartwell Whispering Pines Retirement Residence	May 1	May 14	<5	<5	<5	<5	0	0
91.	Amica Swan Lake	May 2	May 23	0	<5	0	<5	0	0
92.	Chartwell Rockcliffe Retirement Residence[2]	May 2	May 26	<5	0	<5	0	0	0
93.	Red Oak Retirement Residence	May 2	May 20	0	<5	0	<5	0	0
94.	Traditions of Durham Retirement Residence	May 2	Jun 9	<5	0	<5	0	0	0
95.	Bough Beeches Place	May 3	May 25	0	<5	0	<5	0	0
96.	Doon Village Retirement Residence	May 4	May 11	<5	0	<5	0	0	0
97.	Chartwell Wynfield Retirement Residence[2]	May 4	May 17	<5	0	<5	0	0	0
98.	Chartwell Lord Lansdowne Retirement Residence	May 4	May 18	<5	0	<5	0	0	0
99.	Casa Dolce Casa	May 4	May 25	<5	<5	<5	<5	0	0
100.	Chartwell Muskoka Traditions Retirement Residence	May 4	May 17	<5	0	<5	0	0	0
101.	V!VA Thornhill Woods Retirement Community	May 4	Jun 10	6	<5	<5	<5	<5	0
102.	Chapel Hill Retirement Residence[2]	May 5	May 20	0	<5	0	<5	0	0
103.	Chartwell Scarlett Heights Retirement Residence[2]	May 5	May 15	0	<5	0	<5	0	0
104.	King Gardens	May 5	May 25	<5	<5	0	<5	<5	0
105.	Chartwell Oak Park LaSalle Retirement Residence	May 5	May 16	0	<5	0	<5	0	0
106.	Chartwell Avondale Retirement Residence	May 5	May 22	0	<5	0	<5	0	0
107.	Chartwell Kingsville Retirement Residence	May 6	May 19	<5	0	<5	0	0	0
108.	Leaside[2]	May 7	May 27	<5	<5	<5	<5	0	0
109.	Chartwell Grenadier Retirement Residence	May 7	May 31	<5	<5	<5	<5	0	0
110.	Parkview Meadows Christian Retirement Village – Southview[2]	May 7	May 22	<5	0	<5	0	0	0
111.	Royal Brock Retirement Living Inc.	May 8	May 23	<5	<5	<5	<5	0	0
112.	The Westhill	May 8	Jun 2	<5	<5	<5	<5	0	0
113.	The Annex	May 9	May 23	0	<5	0	<5	0	0
114.	Chartwell Oak Park Terrace Retirement Residence	May 9	May 21	<5	0	<5	0	0	0
115.	Villa Da Vinci Retirement Residence	May 9	May 16	<5	0	<5	0	0	0

Retirement Home		Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
				Residents	Staff[1]	Residents	Staff	Residents	Staff
116.	Dolce Vita Retirement Living	May 9	May 21	<5	0	<5	0	0	0
117.	The Dunfield Retirement Residence	May 9	May 20	0	<5	0	<5	0	0
118.	Kawartha Heights Retirement Home	May 10	May 25	0	<5	0	<5	0	0
119.	Exeter Villa	May 10	May 20	0	<5	0	<5	0	0
120.	Rosslyn Retirement Residence[4]	May 11	May 30	64	22	48	22	16	0
121.	Fergus Place	May 11	May 22	0	<5	0	<5	0	0
122.	Constitution Place[3]	May 12	May 28	0	0	0	0	0	0
123.	The Briton House	May 12	May 26	<5	<5	<5	<5	0	0
124.	Kawartha Lakes Retirement Residence	May 12	Jun 1	0	<5	0	<5	0	0
125.	Weston Gardens Retirement Residence	May 13	Jul 3	29	14	27	14	<5	0
126.	Cedar Crossing Retirement Community	May 15	May 29	<5	0	<5	0	0	0
127.	Village on the St. Clair	May 15	May 28	<5	0	<5	0	0	0
128.	Luther Village on the Park-Sunshine Centre	May 16	May 31	<5	<5	<5	<5	0	0
129.	Leamington Mennonite Home	May 16	May 21	0	<5	0	<5	0	0
130.	Chartwell Stillwater Creek Retirement Residence	May 16	Jun 12	0	<5	0	<5	0	0
131.	Empire Crossing Retirement Community	May 16	Jun 1	<5	0	<5	0	0	0
132.	Amica Peel Village	May 16	Jun 8	<5	<5	<5	<5	0	0
133.	Embassy West Senior Living	May 17	Jun 9	0	<5	0	<5	0	0
134.	First Place Hamilton	May 18	Jun 2	<5	<5	<5	<5	0	0
135.	Waverley Mansion	May 18	Jun 4	<5	<5	0	<5	<5	0
136.	Chartwell Wynfield Retirement Residence[2]	May 19	Jun 4	<5	0	<5	0	0	0
137.	Village Manor[4]	May 20	Jun 5	<5	0	<5	0	0	0
138.	Amica Bayview Gardens	May 21	Jun 4	0	<5	0	<5	0	0
139.	Riverview Heights Retirement Residence	May 21	Jun 3	<5	0	<5	0	0	0
140.	Riverbend Place	May 21	Jun 7	<5	0	<5	0	0	0
141.	Aberdeen Gardens Retirement Residence	May 23	Jun 4	<5	0	<5	0	0	0
142.	Dom Lipa	May 25	Jun 7	<5	<5	<5	<5	0	0
143.	Chartwell Queen's Square Retirement Residence	May 25	Jun 8	<5	0	<5	0	0	0
144.	Retirement Suites by the Lake	May 26	Jun 10	<5	<5	<5	<5	0	0
145.	Robertson House	May 26	Jun 22	<5	<5	<5	<5	0	0

Retirement Home	Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
			Residents	Staff[1]	Residents	Staff	Residents	Staff
146. Sunrise of Thornhill[2]	May 27	Jul 4	9	8	9	8	0	0
147. Chapel Hill Retirement Residence[2]	May 28	Jun 10	0	<5	0	<5	0	0
148. Lynde Creek Manor	May 30	Jun 11	0	<5	0	<5	0	0
149. Beechwood Manor	May 30	Jun 12	0	<5	0	<5	0	0
150. Chelsey Park Retirement Community	May 30	Jun 17	<5	0	<5	0	0	0
151. Amica Erin Mills[2]	Jun 1	Jun 14	0	<5	0	<5	0	0
152. The Village of Erin Meadows[2]	Jun 1	Jun 18	0	<5	0	<5	0	0
153. Chartwell Scarlett Heights Retirement Residence[2]	Jun 3	Jun 21	0	<5	0	<5	0	0
154. Port Credit Residences	Jun 8	Jun 20	0	<5	0	<5	0	0
155. Country Meadows Retirement Residence	Jun 11	Jun 19	<5	0	<5	0	0	0
156. Leaside[2]	Jun 11	Jul 3	0	<5	0	<5	0	0
157. Telfer Place[2]	Jun 15	Jun 29	0	<5	0	<5	0	0
158. Parkwood Suites	Jun 18	Jun 27	<5	0	<5	0	0	0
159. Devonshire Retirement Residence	Jun 29	Jul 12	0	<5	0	<5	0	0
160. Southbrook Retirement Community	Jul 5	Jul 17	0	<5	0	<5	0	0
161. Amica Westboro Park	Jul 5	Jul 14	0	<5	0	<5	0	0
162. The Village of Erin Meadows[2]	Jul 10	Jul 30	<5	<5	<5	<5	0	0
163. Augustine Villas Retirement Home and Assisted Living	Jul 10	Aug 15	0	<5	0	<5	0	0
164. Brierwood Gardens[2]	Jul 11	Jul 24	0	<5	0	<5	0	0
165. Jardin Royal Garden Inc.	Jul 16	Jul 29	0	<5	0	<5	0	0
166. Redwoods Retirement	Jul 17	Aug 3	0	<5	0	<5	0	0
167. The Village of Riverside Glen	Jul 18	Jul 30	0	<5	0	<5	0	0
168. Chartwell Oak Ridges Retirement Community	Jul 19	Jul 28	0	<5	0	<5	0	0
169. Sunrise of Thornhill[2]	Jul 21	Jul 31	0	<5	0	<5	0	0
170. Billingswood Manor[2]	Jul 21	Aug 12	<5	0	<5	0	0	0
171. Georgian Residences	Jul 23	Aug 4	<5	<5	0	<5	<5	0
172. Chartwell Leamington Retirement Residence	Jul 23	Aug 4	0	<5	0	<5	0	0
173. Oakpark Retirement Community[3]	Jul 27	Aug 4	0	0	0	0	0	0
174. The Waterford Retirement Community – Ottawa[2]	Jul 28	Aug 8	0	<5	0	<5	0	0
175. Thorncliffe Place Retirement Home[3]	Aug 8	Aug 13	0	0	0	0	0	0

Retirement Home		Outbreak Reported	Outbreak Resolved	# of Confirmed Cases		# of Recovered Cases		# of Deaths	
				Residents	Staff[1]	Residents	Staff	Residents	Staff
176.	Chartwell Harwood Retirement Residences	Aug 10	Aug 24	0	<5	0	<5	0	0
177.	Amica Erin Mills[2]	Aug 10	Aug 27	<5	<5	<5	<5	0	0
178.	The Shoreview at Riverside[3]	Aug 10	Aug 25	0	0	0	0	0	0
179.	New Beginnings Rest Home[5]	Aug 10	n/a	18	<5	0	0	<5	0
180.	Billingswood Manor[2,5]	Aug 17	n/a	5	<5	0	<5	0	0
181.	Parkview Meadows Christian Retirement Village – Southview[2]	Aug 18	Aug 30	0	<5	0	<5	0	0
182.	Auberge Plein Soleil[5]	Aug 22	n/a	0	<5	0	0	0	0
183.	Chartwell Rockcliffe Retirement Residence[2,5]	Aug 25	n/a	<5	0	<5	<5	0	0
184.	The Village of Arbour Trails[5]	Aug 26	n/a	0	<5	0	0	0	0
185.	Landmark Court[5]	Aug 29	n/a	<5	0	0	0	0	0
Total				**989**	**491**	**757**	**484**	**209**	**0**

1. Examples of staff include registered nurse, personal support workers and cleaning staff.
2. Homes that had more than one outbreak.
3. For homes without any staff or resident cases, the local public health units declared an outbreak as a precaution when an external care provider known to work at the home tested positive. The external care provider would not have been counted as staff and therefore did not show up in the case counts.
4. The Authority revoked this operator's licence on June 1, 2020. At the completion of our audit, the revocation was being appealed.
5. Home with active outbreak as of August 31, 2020.

Appendix 6: Data Collected on Retirement Homes and Retirement Home Residents

Prepared by the Office of the Auditor General of Ontario

Data	Ministry/ Organization Responsible for Collecting Data	Does the Retirement Homes Regulatory Authority (Authority) Obtain Data?	Does the Ministry for Seniors and Accessibility (Ministry) Obtain Data?	Importance of Monitoring this Data for Oversight of Retirement Homes	Section(s) in the *Retirement Homes Act, 2010*, (RHA) and Memorandum of Understanding (MOU) between the Ministry and Authority that support the collection of data
Retirement home capacity (# of suites in a particular retirement home)	Retirement Homes Regulatory Authority	Yes	Yes	Allows the Authority to determine the supply of seniors housing by geographic location to project future needs of the retirement home sector Allows the Ministry to work with other ministries, such as the Ministry of Municipal Affairs and Housing, to improve policy decisions regarding the supply and demand of seniors housing considering trends in seniors housing identified by the Authority	**RHA s. 108** (1) The Registrar may at any time request a licensee of a retirement home to give the Registrar, within the time period specified by the Registrar, information that the Registrar specifies in accordance with processes and criteria that the Authority establishes and that the Minister approves and that relates to [...] (c) the licensee's operation of the home and compliance with this Act. 2010, c. 11, s. 108 (1); 2017, c. 25, Sched. 10, s. 26 **RHA s. 16(d)** The objects of the Authority are to advise the Minister on policy matters relating to retirement homes. **MOU** 7(3) The Minister shall make reasonable efforts to engage the [Authority] throughout the policy development process

Data	Ministry/ Organization Responsible for Collecting Data	Does the Retirement Homes Regulatory Authority (Authority) Obtain Data?	Does the Ministry for Seniors and Accessibility (Ministry) Obtain Data?	Importance of Monitoring this Data for Oversight of Retirement Homes	Section(s) in the *Retirement Homes Act (RHA), 2010*, and Memorandum of Understanding (MOU) between the Ministry and Authority that support the collection of data
Occupancy/ vacancy and rental rates of retirement homes	Data not collected[1]	No	No	Allows the Authority to determine the sufficiency of supply of seniors housing to project future needs of the retirement home sector by geographic location and monitor the affordability of senior housing Allows the Ministry to work with other ministries, such as the Ministry of Municipal Affairs and Housing, to improve policy decisions regarding the supply and demand of seniors housing and housing affordability considering trends in seniors housing identified by the Authority	**RHA s. 108** (1) The Registrar may at any time request a licensee of a retirement home to give the Registrar, within the time period specified by the Registrar, information that the Registrar specifies in accordance with processes and criteria that the Authority establishes and that the Minister approves and that relates to [...] (c) the licensee's operation of the home and compliance with this Act. 2010, c. 11, s. 108 (1); 2017, c. 25, Sched. 10, s. 26 **RHA s. 16(d)** The objects of the Authority are to advise the Minister on policy matters relating to retirement homes. **MOU** 7(3) The Minister shall make reasonable efforts to engage the [Authority] throughout the policy development process
# of individuals living in retirement homes awaiting placement into long-term-care homes	Ontario Health[2]/ Ministry of Long-Term Care	No	No	Allows the Authority to determine the number of retirement home residents whose care needs are at levels typically provided by long-term-care homes, which are subsidized by the Ministry of Long-Term Care Allows the Authority and the Ministry to work with the Ministry of Long Term Care to address wait list for long-term-care homes	**RHA s. 108** (1) The Registrar may at any time request a licensee of a retirement home to give the Registrar, within the time period specified by the Registrar, information that the Registrar specifies in accordance with processes and criteria that the Authority establishes and that the Minister approves and that relates to [...] (b) clinical and functional profiles of residents of the home if the profiles are de-identified **MOU** 7(7) The Minister may, where the Minister deems appropriate, work with other ministries in facilitating [...] relationships with the RHRA [Authority]

Data	Ministry/ Organization Responsible for Collecting Data	Does the Retirement Homes Regulatory Authority (Authority) Obtain Data?	Does the Ministry for Seniors and Accessibility (Ministry) Obtain Data?	Importance of Monitoring this Data for Oversight of Retirement Homes	Section(s) in the *Retirement Homes Act (RHA), 2010*, and Memorandum of Understanding (MOU) between the Ministry and Authority that support the collection of data
# of residents placed in retirement home spaces subsidized by other ministries, such as the Short-Term Transitional Care beds[3] funded by the Ministry of Health	Various provincial ministries and local governments	No	No	Allows the Authority to understand the profile of residents living in retirement homes and provide the necessary oversight through the inspection and complaints process in conjunction with the Ministry of Health and Ontario Health	**RHA s. 108** (1) The Registrar may at any time request a licensee of a retirement home to give the Registrar, within the time period specified by the Registrar, information that the Registrar specifies in accordance with processes and criteria that the Authority establishes and that the Minister approves and that relates to [...] (b) clinical and functional profiles of residents of the home if the profiles are de-identified
Type of care services provided to individuals and # of hours of each type of care service required by individuals receiving LHIN-funded home care in retirement homes	Ontario Health[2]	No[4]	No	Allows the Authority to understand the care needs required by residents living in retirement homes to monitor the supply and demand of care services Allows the Ministry to understand the care needs required by seniors and to facilitate any working relationships between the Authority and care service providers such as those funded by the Local Health Integration Networks	**RHA s. 108** (1) The Registrar may at any time request a licensee of a retirement home to give the Registrar, within the time period specified by the Registrar, information that the Registrar specifies in accordance with processes and criteria that the Authority establishes and that the Minister approves and that relates to, (a) the types of care services that the licensee makes available in the home; (b) clinical and functional profiles of residents of the home if the profiles are de-identified; **RHA s. 16(d)** The objects of the Authority are to advise the Minister on policy matters relating to retirement homes. **MOU** 7(3) The Minister shall make reasonable efforts to engage the RHRA [Authority] throughout the policy development process

Data	Ministry/ Organization Responsible for Collecting Data	Does the Retirement Homes Regulatory Authority (Authority) Obtain Data?	Does the Ministry for Seniors and Accessibility (Ministry) Obtain Data?	Importance of Monitoring this Data for Oversight of Retirement Homes	Section(s) in the *Retirement Homes Act (RHA), 2010*, and Memorandum of Understanding (MOU) between the Ministry and Authority that support the collection of data
Type of care services provided to individuals and # of hours of each type of care service required for individuals receiving privately funded care in retirement homes	Data is not collected	Data is not collected	Data is not collected	Allows the Authority to: • understand the care needs required by residents living in retirement homes to monitor the supply and demand of care required • quantify the financial impact of privately funded care to retirement home residents Allows the Ministry to understand the care needs required by seniors and the affordability of care services required by seniors	**RHA s. 108** (1) The Registrar may at any time request a licensee of a retirement home to give the Registrar, within the time period specified by the Registrar, information that the Registrar specifies in accordance with processes and criteria that the Authority establishes and that the Minister approves and that relates to, (a) the types of care services that the licensee makes available in the home; (b) clinical and functional profiles of residents of the home if the profiles are de-identified; **RHA s. 16(d)** The objects of the Authority are to advise the Minister on policy matters relating to retirement homes. **MOU** 7(3) The Minister shall make reasonable efforts to engage the RHRA [Authority] throughout the policy development process
Care not provided as planned to individuals receiving LHIN-funded home care in retirement homes	Ontario Health[2]	No	No	Allows the Authority insight to missed care[5] in a particular retirement home setting	**RHA s. 67** (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect[6] the residents. 2010, c. 11, s. 67 (2).
Care not provided as planned to individuals receiving privately funded care in retirement homes	Data is not collected	Data is not collected	Data is not collected	Allows the Authority insight to missed care[4] in a particular retirement home setting	**RHA s. 67** (2) Every licensee of a retirement home shall ensure that the licensee and the staff of the home do not neglect the residents. 2010, c. 11, s. 67 (2).

Data	Ministry/ Organization Responsible for Collecting Data	Does the Retirement Homes Regulatory Authority (Authority) Obtain Data?	Does the Ministry for Seniors and Accessibility (Ministry) Obtain Data?	Importance of Monitoring this Data for Oversight of Retirement Homes	Section(s) in the *Retirement Homes Act (RHA), 2010*, and Memorandum of Understanding (MOU) between the Ministry and Authority that support the collection of data
Financial information (for example, profit and loss statements, cash flow statements and liquidity analysis) of retirement home operators	Data is not collected	Data is not collected	Data is not collected	Allows the Authority to assess the financial viability of retirement home operators to avoid circumstances where retirement homes are shut down and residents are displaced	**RHA s. 35** The Registrar shall issue a licence to operate a specific retirement home to an applicant if, in the opinion of the Registrar, the applicant has complied with section 34 and the following criteria have been met [...] **RHA s. 37** (1) In order to determine whether the criteria in paragraphs 1 to 4 of section 35 have been met, the Registrar may, (a) make inquiries and conduct investigations into the character, financial history and competence of any licensee [...]

1. Although data is not routinely collected, in an effort to obtain data to update the COVID-19 testing strategy for retirement homes, the Authority collected occupancy data self-reported by retirement homes on a one-time basis on May 25, 2020
2. Information collected by Ontario Health is provided to the Ministry of Health.
3. Short-term, transitional-care-bed patients are patients who can move from a hospital bed to a transition-care bed in the community (such as a retirement home) to receive appropriate care until they are ready to return home or move to the appropriate setting.
4. In 2018, the Authority entered into a two-year research partnership with McMaster University to produce a one-time report to understand the health status of retirement home residents, who provides care services in retirement homes and the scope of those services. Other than this one-time study, information is not systematically collected.
5. Missed care is defined as necessary care that is omitted, either in part or whole, or delayed.
6. Per the *Retirement Homes Act, 2010*, "neglect," in relation to residents, means the failure to provide a resident with the care and assistance required for his or her health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Appendix 7: Retirement Homes Regulatory Authority COVID-19 Risk Assessment Model

Source: Retirement Homes Regulatory Authority

COVID-19 Risk Level	Criteria	Frequency of Follow Up	# of Homes as of Sep 30, 2020
High: Escalation to the Authority's leadership team	Any one of the below: • Surrender/potential abrupt closure • Staffing – majority of home staff has pending COVID test results or home indicates potential dire situation with staffing level, i.e., inability to have 2/3 of pre-pandemic staffing levels • Critical shortage of supply (1–4 days) of personal protective equipment (PPE), and the home does not have more supplies on the way • Concern from Public Health; Public Health has issued an order against the home or intends to do so imminently • >10% of home residents affected • Home does not have staff contingency plan • Ministry for Seniors and Accessibility/government attention • Media attention (at discretion of regulatory leadership team) • Unwilling to follow Directives or legislation—outbreak or not	Default frequency initially is daily. Regular touch base by phone with retirement home and relevant partners discretionary but no longer than 14 calendar days	31
Medium: Follow up	Does not meet high-risk criteria, but any one of the below is satisfied: • Outbreak—in outbreak but does not meet high-risk criteria • Long-term-care home attached to the home • Staffing concerns identified, but does not meet high-risk criteria • <7 days supply of PPE on hand and does not have plan to source • Meets high-risk criteria but has been de-escalated by regulatory leadership team. • Home is not compliant with Directives or legislation because it lacks knowledge or experience	Default frequency initially is daily. After touching base with the home and gaining information about the situation, can decrease frequency typically to weekly or bi-weekly; discretionary but no longer than 21 calendar days	116
Low: Follow up	Incident case has been opened because input received about a possible risk situation, but home has not met the thresholds for medium or high risk. Meets high-risk criteria but has been de-escalated by regulatory leadership team.	Default frequency initially is weekly. After touching base with the home and gaining information about the situation, can decrease frequency; discretionary but no longer than 14 calendar days	529
No follow up required (select proactive outreach cases only)	Proactive outreach or following manager approval; no concerns identified, or concerns all resolved	n/a	104

Appendix 8: Roles and Responsibilities of Ministries and Organizations Relevant to Retirement Homes and Seniors During COVID-19

Source: Ministry for Seniors and Accessibility

Minister for Seniors and Accessibility/ Ministry for Seniors and Accessibility (Ministry)	• Works with ministry partners, including the Ministry of Health and the Ministry of Long-Term Care, to set policies and guidelines to support prevention and containment of COVID-19 in retirement homes • Advocates for retirement home sector needs across government • Oversees the Retirement Homes Regulatory Authority and collaborates with it on data analysis and information sharing
Retirement Homes Regulatory Authority	• Communicates expectations to retirement homes • Addresses reports of harm or risk to residents • Prepares risk assessments of retirement homes for potential COVID-19-related crisis • Provides guidance to retirement homes to support compliance (such as screening, infection control, testing) • Works with local agency partners including public health to provide direction and support retirement homes in crisis • Issues enforcement orders to homes to ensure care needs of residents are met • Gathers and provides the Ministry with daily updates on outbreak data from retirement homes (homes are required to report this as per the emergency order O. Reg. 118/20).
Ministry of Long-Term Care	• Works with the Ministry for Seniors and Accessibility to set policies, develop and disseminate guidance and resources related to COVID-19 prevention and containment for long-term-care homes and retirement homes, using advice and direction from the Ministry of Health and the Chief Medical Officer of Health.
Chief Medical Officer of Health	• The *Retirement Homes Act, 2010*, regulation was amended in March 2020 to require all retirement home programs for infection prevention and control to follow the guidance, recommendations and directives provided to the homes by the provincial Chief Medical Officer.
Local Health Integration Networks (LHINs), now part of Ontario Health	• The province provided LHINs with the ability to direct home-care service-provider organizations to reassign and redeploy front-line staff to areas where they are most needed, including retirement homes. • The province provided the LHINs with the ability to seek Ministry approval to enter into an agreement to purchase some or all home-care services from a retirement home operator on a temporary basis. • Appoints care co-ordinators or care co-ordination teams to each retirement home as the point of contact for the retirement home • Establishes and expands full-time, shift-based care by LHIN-contracted service-provider organizations working in retirement homes • Collaborates with community partners to assist in crisis situations within retirement homes, including finding alternative accommodations in the community
Local Public Health Units	• Under the *Health Protection and Promotion Act*, local public health units (headed by the local medical officer of health) can use broad order powers. For example, they can require persons or a broad class of persons (for example, retirement home operators) to do or not do anything specified in the order in respect of a communicable disease. This can include requiring closing premises, isolating persons who may have the disease, and requiring persons subject to an order to be under the care of a physician or do anything so as not to expose others to infection. • If there is an outbreak, an order can require an institution (including a retirement home) to take any actions specified in the order for the purposes of monitoring, investigating and responding to an outbreak.
Hospitals	• On April 16, 2020, the government issued a memo to hospitals to temporarily pause discharging patients to long-term-care homes and retirement homes. On April 23, 2020, the government issued a memo to hospitals to resume discharging patients to retirement homes (but not long-term-care homes) if certain conditions are met.

Appendix 9: Long-Term-Care and Retirement Home Operators Facing Class-Action Lawsuits, June 2020

Prepared by the Office of the Auditor General of Ontario

Operator	# of Licensed Retirement Homes Owned in Ontario	Details
Sienna Senior Living	22	The law office of Thomson Rogers has issued a class-action proceeding claiming $20 million on behalf of two plaintiffs representing all residents of Altamont Care Community long-term-care home and their families. As of June 2020, 53 residents at Altamont had died as a result of contracting COVID-19 and related illnesses. The lawsuit alleges that Altamont: • failed to implement screening measures of its staff and basic social distancing practices, including separating infected and non-infected residents; • had severe under-staffing; and • failed to provide basic personal protective equipment to staff.
Sienna Senior Living and Revera	Sienna: 22 Revera: 68	Diamond & Diamond Lawyers issued a $150-million class-action lawsuit on behalf of six plaintiffs, including two whose fathers lived at Madonna Care Community long-term-care home and died after contracting COVID-19. As of June 2020, 47 residents and two staff members had died of COVID-19. The lawsuit alleges that Revera and Sienna were negligent in failing to: • follow acceptable practices regarding the prevention and containment of contagious respiratory illness, such as COVID-19; • properly and adequately plan for and respond to the COVID-19 pandemic; • have adequate staff within the homes to care for the residents in a safe and competent manner; and • communicate adequately with families of residents.
Chartwell Retirement Residences	94	Neinstein Personal Injury Lawyers issued a class-action lawsuit against Chartwell and has proposed that 27 of Chartwell's long-term-care homes be included in the lawsuit. The lawsuit alleges that facilities had systemic failures including: • inadequate infection outbreak planning; • inadequate screening and testing of residents, staff and visitors; • inappropriate isolation and control measures; • insufficient staff levels; • failures to transport patients to hospital; and • lack of appropriate personal protective equipment for residents and staff.
Oxford Living	15	Will Davidson LLP issued a $20 million class-action lawsuit against Oxford Living on behalf of a plaintiff representing all residents of Lundy Manor and their families. As of May 31, 2020, 18 residents at Lundy Manor had died as a result of contracting COVID-19. The lawsuit alleges that Lundy Manor had lax infection-prevention standards and held card games, communal dining and group events even as health authorities warned otherwise.

Appendix 10: Infection Prevention and Control Measures Required of Retirement Homes during COVID-19

Prepared by the Office of the Auditor General of Ontario

	Effective Date	Authority
For Staff		
Ensure sufficient personal protective equipment (PPE) is available	Mar 30, 2020	Directive #3[1]
Require staff to wear mask and/or other appropriate PPE	Mar 30, 2020	Directive #3
Actively screen[2] staff	Mar 30, 2020	Directive #3
		Other Authorities
Restrict movement between facilities	Apr 22, 2020	O. Reg. 146/20 under the *Emergency Management and Civil Protection Act*
For homes in outbreak, test selected staff	May 14, 2020	Ontario Public Health[3]
Provide training in infection control	Jun 8, 2010	*Retirement Homes Act, 2010,* s. 65(2)(h)
Provide hand sanitizer	Jun 8, 2010	O. Reg. 166/11, s.27(6)(7) under the *Retirement Homes Act, 2010*
For Residents		
Ensure sufficient PPE is available	Mar 30, 2020	Directive #3
Isolate infected residents	Mar 30, 2020	Directive #3
Isolate admitted and re-admitted residents for 14 days on arrival at home	Mar 30, 2020	Directive #3
Actively screen residents	Mar 30, 2020	Directive #3
Test residents within 14 days from arrival	Apr 8, 2020	Directive #3
		Other Authorities
For homes in outbreak, test selected residents	May 14, 2020	Ontario Public Health[3]
Provide information on maintaining proper hand hygiene and hand sanitizer	Jun 8, 2010	O. Reg. 166/11, s.27(6)(7) under the *Retirement Homes Act, 2010*
For Visitors		
Restrict non-essential visitors from entering homes when in outbreak	Mar 30, 2020	Directive #3
Actively screen[2] essential visitors	Mar 30, 2020	Directive #3
Require essential visitors to wear mask and/or other appropriate PPE	Mar 30, 2020	Directive #3
For Facility at Corporate Level		
Have a plan and use, to the extent possible, staff and resident cohorting as part of their approach to preparedness as well as to prevent the spread of COVID-19 once identified in the home	Mar 30, 2020	Directive #3
		Other Authorities
Consult with local medical officer of health or designate about identifying and addressing health-care issues in retirement home in order to reduce the incidence of infectious disease outbreaks in the home	May 16, 2011	O. Reg. 166/11, s.27(2) under the *Retirement Homes Act, 2010*

	Effective Date	Authority
Establish a written surveillance protocol to identify, document and monitor residents who report symptoms of respiratory or gastrointestinal illness	May 16, 2011	O. Reg. 166/11, s. 27(4) under the *Retirement Homes Act, 2010*

1. COVID-19 Directive #3 for Long-Term Care Homes under the *Long-Term Care Homes Act, 2007*, issued under Section 77.7 of the *Health Protection and Promotion Act.* On March 19, 2020, the regulation under the *Retirement Homes Act, 2010* was updated to require retirement homes to take all reasonable steps to follow existing and future COVID-19 directives issued to long-term-care homes.
2. For example, take an individual's temperature at regular intervals.
3. Testing of COVID-19 is administered by local public health units. On May 14, 2020, the Ministry of Health released a COVID-19 Provincial Testing Guidance Update. Symptomatic residents living in or persons working in congregate living settings should be tested as soon as possible if they are experiencing any symptom or sign compatible with COVID-19. In the event of an outbreak of COVID-19 in a retirement home, asymptomatic contacts of a confirmed case, determined in consultation with the local public health unit, should be tested including: all residents living in adjacent rooms, all staff working on the unit/care hub, all essential visitors who attended at the unit/care hub and any other contacts deemed appropriate for testing based on a risk assessment by local public health.

Appendix 11: Board of Directors of Retirement Homes Regulatory Authority, July 2020

Prepared by the Office of the Auditor General of Ontario

Member	Board-Elected or Minister-Appointed	Background	Member Since
1	Minister-appointed	Legal, tax	May 2020
2	Minister-appointed	Long-term care, Registered Nurse	Jul 2020
3	Minister-appointed	Military, engineering, manufacturing	Jul 2020
4	Minister-appointed	Governance, public policy	Dec 2013
5	Board-elected	Financial management	Jun 2018
6	Board-elected	Senior living sector,* municipal government	Dec 2012
7	Board-elected	Senior living sector*	Dec 2012
8	Board-elected	Senior living sector,* legal	Dec 2019
9	Board-elected	Senior living sector*	Dec 2012

* Senior executives of companies that operate retirement homes only or both retirement homes and long-term-care homes.

Appendix 12: Key Responsibilities of Ministry for Seniors and Accessibility and Retirement Homes Regulatory Authority in Their Memorandum of Understanding

Prepared by the Office of the Auditor General of Ontario

Responsibilities	Frequency
Ministry for Seniors and Accessibility (Ministry)	
Recommend regulatory changes to the Lieutenant Governor in Council and propose legislative changes to the Legislative Assembly	Not specified
Co-ordinate policy, legislative and regulatory reviews and make changes if necessary	Not specified
Conduct performance, governance, accountability or financial reviews (including audits) and recommend changes as a result	Not specified
Minister should meet semi-annually with the Board Chair	Semi-annual
Retirement Homes Regulatory Authority	
Provide Ministry with a three-year* strategic plan	Not specified
Provide Ministry with a business plan and annual report	Annually
Conduct an effectiveness survey of its stakeholders. The effectiveness survey of its stakeholders shall be facilitated by an independent third party	Once every three years
Appoint a Complaints Review Officer	Term of at least 3 years
Appoint a Risk Officer	Term of at least 3 years
Appoint a Registrar	Term length not specified
Establish an advisory committee to advise the Authority	Not specified
Provide Ministry with performance measures with year-over-year comparison if information is available	Quarterly
Maintain appropriate performance measurements, governance, and financial and risk management processes with sound internal controls	Not specified
Follow a communication protocol with the Ministry for serious incidents	Ongoing
Hold a general meeting open to the general public	Annually

* While the MOU requires a three-year strategic plan, the Ministry and the Authority agreed to a five-year plan.

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