Box 1270
Comox BC V9M 7Z8
Ph: 250-339-6117
Email: delores@watershedsentinel.ca

July 9, 2019

Attention: Tim Orr, Director, Residential Services

Dear Tim Orr,

Re: Comox Valley Seniors Village

In our second letter dated May 20 2019, we requested that Island Health exercise its full authority to remedy the situation at this facility and assume full operational responsibility in place of its owner and its operator, Pacific Reach. We appreciate that there are obvious reasons as to why your reply did not address this request and possibly sensitive reasons unknowable for us. We would like to follow up on your offer to meet with Mark Blandford and you. In the meantime, recent events have made this third letter necessary. This includes a near death event last Friday due to the staff's failure to recognize the symptoms of pneumonia for a resident with advanced dementia.

We envision the possibility that this facility could eventually meet the minimum standards of the regulation on paper but not in practice. On a daily basis, we see the reality on the ground and what happens when Island Health is not on the premises. We need assurance that Island Health will stay the course and maintain pressure on this facility for some time thereafter until there is evidence of substantive change that has been sustained over time and is sustainable. It has become painfully clear to us that the Island Health system relies on an affiliate to operate ethically but this is difficult to regulate and enforce.

Given its recently introduced funding to increase the number of care hours per resident, the provincial government clearly considers the minimum standard of care to be significantly related to the number of care hours provided for each resident. We therefore can't understand why it is not enforceable under regulation and so difficult to enforce contractually for this and other facilities to ensure that an affiliate provides the number of care hours that it is paid by the province to provide.

We are also most concerned about what appears to be a general lack of interest, on the part of the facility owner, its operator and also, Island Health, about determining what went wrong to prevent future similar failures during an outbreak at this or any other facility. It suggests a lack of commitment to health and safety and to ensuring it doesn't happen again.

Recent Developments and Concerns:

Since our last letter, the Licensing Office has placed conditions on this facility's license with deadlines to be met for each. We are encouraged by this development but also concerned that contraventions have been removed in the last inspection reports. This has the appearance of an improving situation that is most definitely not the case. The families now recognize the necessity for formal complaints. We are now following the process and making a concerted effort to report unresolved complaints to the Licensing Office.

Our group is now expanding to include more family members and garner community support. Concern is mounting that, despite intensified scrutiny by Island Health and without apparent consequences, this facility has been allowed to provide a level of care significantly below what it is being paid to provide. We are increasingly concerned about whether the recourses available to Island Health to enforce regulatory and contractual compliance with an affiliate can be effective in removing a persistently "bad actor".

Further, we can't help but ask: **What would have happened to address the problems at this facility if the family members had not brought their concerns to the attention of Island Health in their first letter?** In other words, are the oversight protections for residents of affiliates sufficient and/or effective? Even then, the process for oversight is multi-phased and prolonged before any corrective action can occur and yet the situations can often warrant immediate intervention. This was not an easy thing for us to do and would be difficult for most. We first needed to learn that we could not trust the system to protect our loved ones. If the system's integrity is truly dependent on an organized effort by families of the persons in residential care, the consequences for our most vulnerable seniors in this and the many outsourced residential care facilities is a serious matter for concern. It calls into question the very feasibility of outsourcing residential care.

The following near death event, that occurred on Friday (July 5) through Saturday morning, illustrates our concerns that there is an endemic problem with the management for this facility and that Island Health is not doing enough to bring this facility into compliance:

> The care staff in 1F failed to recognize the symptoms of pneumonia for a resident with advanced dementia until a casual staff LPN came on duty on Friday afternoon, became concerned, and called the ambulance. The paramedics treated him with oxygen and antibiotics [treatment was provided on arrival at emergency] *SINCE REVISED FOR ACCURACY. The pneumonia was at such an advanced stage that the emergency physician was initially reluctant to treat him due to his degree of discomfort. It is therefore likely that his pneumonia symptoms went unnoticed for a period of days and despite his rigors that presented for almost all of Friday. It is noteworthy that his spouse had recently intervened to ensure that he was being properly dressed. She had found him in pajama bottoms and a skimpy tee shirt late in the day and was told they weren't dressing him to save time. It is not known if this exacerbated his pneumonia at an early stage of its development.

At 12 midnight, the spouse of the resident in 1F wrote an email to the director of care stating that her husband who has dementia "was doing this [rigors] all day and we all talked about it but your staff did not recognise it as a symptom" and attached https://patient.info/doctor/rigors-pro. The director of care responded at 2:14 am saying "I will add to the careplan for staff to regularly give him warm blankets throughout the day and also to ensure that he has warm clothing. Do you know what time during the day he often gets this?" The spouse replied at 6:03 am saying: "He is in the hospital with pneumonia." The director of care did not reply further.

New Information About Outbreak Management Failures:

We have mentioned what we have learned about the outbreak management failures in our communications with Island Health as we have learned about them. As the facility was closed, we have limited access to information. We are extremely concerned that there has been no thorough, formal investigation of the failures by the facility or Island Health through the outbreak debrief process or otherwise. In the meantime, the institutional memory is being lost due to the high rate of staff turnover.

We have attempted to familiarize ourselves with the Outbreak Management requirements on Island Health's website which we understand are the minimum requirements for this facility. We also understand that through IPAC (Infection Prevention and Control), Island Health provides a management structure and expert oversight for outbreaks for Island Health operated facilities but not for affiliates such as Seniors Village. The management structure is not part of the online toolkit yet the failures at this facility were largely the result of a lack of management structure for responding to an outbreak.

The family that was permitted entry to the facility to retrieve the belongings of their family member, who was affected by the virus and died during the outbreak, have now shared more details. They were asked to suit up at the front of the facility and pass through a large area before entering the affected ward and then retrace their steps in contaminated personal protective equipment afterward. The handwashing protocols were not advised or enforced. The terminal clean had not been performed and therefore the items they took home were likely contaminated. These are obvious violations that could have spread the virus to other unaffected residents of the facility and to the community at large. Further, the family's observations about the laundry situation suggest that these protocols were also not followed.

We have now learned that there were occasions when the care-aides in 1F did not feed the residents adequately in this special care ward affected by the virus. The health issues related to feeding and hydration for advanced dementia patients exposed to or suffering from the virus should have been of paramount concern. We understand that this was a result of a vicious circle for the care aides forced to make choices between cleaning and providing care for very ill and dying advanced dementia patients. They were required to perform cleaning tasks that would normally be the responsibility of the housekeeping staff during an outbreak. As a result, the cleaning did not get done as required but what cleaning was done was sometimes at the expense of feeding the residents.

Without a dietician or a director of care on staff during the outbreak, it seems some 1F residents were put on minced diet without assessment. Presumably this decision was made to make things easier for staff during the outbreak but without a knowledgeable understanding of the individual residents' specific needs. One resident, in particular, requires the sensation on his mouth of solid food softened in a liquid to stimulate his swallowing reflex. As a result of the change in diet during the outbreak, he choked and almost died as evident by his inability to breathe and turning colour over a prolonged period before a first aid response could be provided. A care aide managed to perform a forceful Heimlich maneuver for the resident while still somewhat strapped to a restraining chair. We do not know if this is an event that is required to be reported or if it was reported.

Housekeeping management, including inappropriate assignments of housekeeping duties to the care aides, was at issue during the outbreak. As previously confirmed, the cleaning protocol was not followed and the terminal clean was not performed but signed off on as completed. Further, the carpets were vacuumed against the protocol. The families are concerned that, with the current management in place for housekeeping and the continued transfer of housekeeping and now food service responsibilities to care-aides already working short-staffed, this is a perfect storm for serious failures during the next outbreak.

<u>Family Council Meeting:</u>

A special Family Council meeting was held on June 20, 2019. It was led by Colin Montgomery (the facility's new general manager) with Paul Dhaliwal (the new regional manager) attending. This meeting was conducted in an orchestrated, highly controlled and directive manner that was full of misrepresentations and obtuse explanations. It was extremely offensive for the family representatives attending.

The set-up was changed from its usual circle seating arrangement and replaced with what meeting facilitation experts term a "confrontational style". Management were lined up at the front of the room opposing the family members seated in rows. This only allowed for two-way communication and did not allow family members to see or talk with each other.

Most critically, the meeting ran out of time to address its original purpose - the much anticipated presentation and discussion on the recent Norovirus outbreak.

The key points about the conduct of this meeting are as follows:

- Old business on the agenda was entirely skipped over to arbitrarily announce new Family Council rules and Montgomery declared himself as chair of Family Council under the new rules;
- Management then focused on a litany of blaming everyone else for everything wrong (the union, the government, the business environment, and as typical, the care aides);

- Every time, the family members asked them questions in order to address specific concerns, management changed the subject by changing the speaker and department under discussion;
- No actual information was proffered or provided in response to questions concerning the outbreak debrief and measures to provide the families with any form of reassurance that future outbreak management will be in compliance;
- The only response the families received to their concerns about past and future outbreak management was that they were not the managers at the time (Dhaliwal and Montgomery are recent hires since the outbreak and Montgomery has not yet received Island Health approval as general manager);
- When the family members asked about apparent recent staff cuts at the facility that seemed to have further reduced the already low hours for the special care ward (patients with advanced dementia who are the most disabled needing the most care and supervision), the meeting was told, in an apparent admission that they are deliberately providing fewer care hours than needed, that:
  - this was justifiable because the government funding is insufficient,
  - care aides stand around with arms crossed and do nothing,
  - staff don't give 24 hours advance notice that they are sick (presumably this is possible and requires less staff), and
  - that family phone calls bother nurses too much (family calls to nurses are now restricted to a few hours a day which means access to information is being denied to those with representation agreements which may require further action by the families to obtain the information they require); and
- When the family members asked about the lack of a staff pension plan as an impediment to staff recruitment and retention, the meeting was told that the union did not ask for a pension plan which is patently untrue.

On the last point, we have learned that during a private care tour of this facility, a Pacific Reach "sales representative" advised that while staff are paid less they are happy because they have a pension.

Whereas we had hoped for improvements, we are concerned that this constitutes a further breakdown of the Family Council and the benefits that can be derived when it is effectively managed with a continuous improvement mindset. Most regrettably, this facility's Family Council is not an effective vehicle to get things done. Yet, before we can make a formal complaint we are expected to follow this process. For example, we have continuously raised concerns over several months about there being no supervision whatsoever in 1F during shift changes aggravated by the fact that the facility was not properly designed for visual connection from the nurse station located outside the ward. This is still happening. 1F is a special care ward with advanced dementia patients who are more at risk of falling and to resident on resident aggression requiring constant supervision. As families, we are often required to intervene for the well being of the residents because no staff is available when it occurs. There are similar concerns in 1D.

Further Information on Number of Hours Provided vs Funded and Staff Recruitment and Retention:

In 1.5 months since our last analysis and four months since the outbreak, staffing remains considerably below that required to meet the care hours funded by Island Health.

We have confirmed the new staffing organization in place for all 136 beds at this facility based on staff counts and assignments on June 26 2019 (see Table attached). We calculate the planned staffing level at 83% of the care hours funded by Island Health. The facility, however, confirmed that staffing was at '100%' on this day and posted this information in several places around the facility (see Exhibit 1 attached). The use of 100% for a facility being planned for and staffed well below the level of care hours paid is misleading. It doesn't mean the facility is fully staffed; it just means that everyone on shift showed up for work.

As shown on the attached Table, the range of care hours for the four wing pairings is 2.53 hours to 2.73 hours and the facility average per resident is 2.62 hours. This means an average shortfall of .52 hours of care per resident per day provided for all 136 residents at this facility compared to the 3.14 hours we now understand is paid for residents in the 121 Island Health funded beds. Wings 1F and 1D receive an average 2.73 hours for 36 special care dementia patients which is only 12 minutes more than residents requiring and receiving the lowest level of care. These hours include the housecleaning and meal service tasks care aides are required to do daily.

The staff recruitment and retention problems encountered are of Retirement Concepts' own making. We would like to be optimistic about the recent new hires but are concerned that the gains made through an amped up recruitment effort will not be sustainable for this facility as it has made no gains in moving toward becoming a more respectful and attractive employer. This is particularly true given the current challenging business environment for residential care throughout much of British Columbia including the Comox Valley.

The effect of the new recruitment efforts is short lived as staff continually resign rather than work under what can only be described as a very negative, unsupportive management style. We are deeply concerned that by next flu season, the staff available will be insufficient to properly manage an outbreak. Many of the new hires are recent graduates. The new general manager, who was not employed at the time of the outbreak, prepared the outbreak debrief report and attributed the outbreak management failures to the inexperience of staff just newly out of school and not the failures of management to provide oversight, additional resources, training and experienced staff to the situation. This culture of fear and blame is morale destructive for all staff but would be particularly so for new graduates.

Further Information About Conditions of Care:

While the particulars are difficult to share in a letter, we look forward to our meeting(s) with you and your Island Health colleagues to more fully address our concerns. Even though there are two directors of care working within the facility for the past three months, serious health and safety matters remain unresolved despite repeated family efforts. These pertain to repeated falls out of bed, negligent attendance to incontinence allowing sores to develop and apparently go improperly treated, and the lack of continuous and adequate supervision of the 1F and 1D special care advanced dementia patients. The director of care has just posted a sign in the facility that suggests that continuous supervision, while hoped for, is not a requirement (see Exhibit 2 attached).

Our Requests for Remedial Action:

As previously stated, we believe that Island Health's efforts to remediate this facility are futile and have requested that Island Health assume full responsibility for the management and operations of this facility. The ongoing and unresolved health and safety concerns, management actions described above in terms of the Family Council meeting, staffing changes without required staffing increases that push more non-care jobs on care aides, a management culture of failure to accept responsibility, fear and blaming (the worst of all possible management styles in a business environment where qualified residential care staff are difficult to recruit and retain), all add up to an endemic problem with the management of this facility.

It doesn't take a management guru to conclude that it is an impossible situation to resolve with the current management in place from the top executive down. Furthermore, it is an organizational culture that would take a good new manager and turn them into a bad manager in order to keep their job. The claims made by Dhaliwal and Montgomery that they will manage the next outbreak properly, with no indication that they even know what went wrong and what to do, give us no comfort. By then, they may not even be the ones in charge and in the meantime, the much needed management structure and training will not be in place. Everything we have observed to date tells us that when there is another outbreak, it will be as bad or worse than the last.

This is an intolerable situation for our loved ones entrusted to Island Health's care at this facility as allowed to operate. It is evident that we can't even trust this facility to provide appropriate care during non-outbreak conditions. Surely, independent oversight is an absolute requirement for the next time the facility is closed due to an outbreak and we, as the families and representatives are unable to check on the well-being of our family members, identify problems and report them to Island Health. **As families, we need to know that someone responsible somewhere understands what is wrong, knows what needs to be done, and is committed to getting it done and providing proactive oversight on an ongoing and sustainable basis.**

If Island Health will not assume full responsibility for the management and operations of this facility during the next 12 months, then we request the following:

- That Island Health apply its full outbreak management expertise and capability to prepare this facility for a future outbreak by involving IPAC to put an outbreak management structure in place, train management and staff including the management responsible for housekeeping and housekeeping staff, and provide oversight if an outbreak occurs and on the same basis as for an Island Health operated facility;

- That Island Health conduct a thorough, independent post-incident investigation (with outbreak management expertise) that interviews the staff directly involved (and families who were permitted access) to determine the cause of the failures and the full extent of the impact on the residents involved and develop all appropriate actions for the facility and Island Health to properly prepare for a further outbreak and fully report the results and action plan to the families;

- That for at least a 12 month period, the Licensing Office remain fully and intensively involved with frequent inspections and maintain the conditions on the license and all contraventions on record as outstanding, regardless of usual processes for removing them, for them to be confirmed and reconfirmed over this period to ensure that compliance is being maintained at regular and/or required intervals, and ensure that sustainable compliance has been demonstrated over time before removing them;

- That Island Health, with the benefit of insight gained from the failures at this facility, strengthen its requirements for and oversight of affiliate facilities to close the gap between what it requires and does for facilities it operates vs. affiliates to ensure the same standard of care and protections for all residents of Island Health residential care facilities and in doing this, include a management structure and training requirements that affiliates are required to follow in its online toolkit;

- That Island Health ensure that all residents who require incontinence care are provided a medical examination and review of their care program by a competent and independent healthcare professional to ensure that they are receiving appropriate care and medical treatment for any conditions that have developed;

- That Island Health work with the facility to develop and implement a plan (including electronic surveillance if practicable) to ensure adequate and continuous supervision of all advanced care patients in the facility and ensure that the risk for those residents who repeatedly fall is appropriately assessed and addressed; and

- That Island Health enforce consequences, particularly financial, for this facility's owner as a disincentive in order to prevent further compliance failures and to send a message that this will not be tolerated given this owner pocketed the funds intended for three senior positions for more than

six months in contravention of the regulation and has continued to operate for more than a year at well below the funded care hours per resident levels estimated at over $1,000,000 in annualized savings (profit) based on June 26 2019 staffing levels for this facility.

Meeting:

As per your suggestion, now that Mark Blandford has returned from holidays, we would very much like to meet. We would also strongly encourage you to make a tour with us of the facility including 1F. We would also like to meet with Dr. Enns, Medical Health Officer with key Licensing Office management and the licensing officer involved present in the meeting. We have many questions about your process and what we can expect. As mentioned, we also have many observations and serious concerns including about current conditions at this facility, that are difficult to convey in a letter, but we can address in a meeting.

Lastly, we appreciate that you might need to suggest we also consult with Ms. Deneka, but don't understand how this would be helpful. As you know we previously declined to do this and explained our reasons at the time. As chief operating officer for Pacific Reach, she is personally responsible for the serious management failures during the outbreak and the problems that continue to this day.

As previously stated, we hold Island Health accountable for ensuring the safety and well being of our family member residents of this facility and believe that Pacific Reach should not be allowed to continue to operate this facility. As such, we perceive no value in our direct involvement in your efforts to work with your affiliate to address its woefully substandard performance**.**

We look forward to hearing from you, at your earliest convenience, regarding our requests for remedial action and to schedule this meeting.

Sincerely,
Delores Broten, Comox
Doug Malcolm, Courtenay
Greta Judd, Courtenay
Sharon Jackson, Merville
Bev Foster, Courtenay
Bruna Audia, Courtenay
Ruth Barry, Courtenay
Margaret Watson, Comox
Ali Doi, Comox
Joan van der Holt, Courtenay
Peggy Stirrett, Comox

cc:

Mark Blandford, Executive Director Primary Care & Seniors Health, mark.blandford@viha.ca
Joel Verbruggen, Licensing Officer, Joel.Verbruggen@viha.ca
Dr. Richard Stanwick, Chief Medical Health Officer, richard.stanwick@viha.ca
Dr. Charmaine Enns, Medical Health Officer Comox Valley, charmaine.enns@viha.ca
The Honourable Adrian Dix, Minister of Health, HLTH.Minister@gov.bc.ca
Stephen Brown, Deputy Minister of Health, hlth.dmoffice@gov.bc.ca
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Anne Kang, Parliamentary Secretary for Seniors, anne.kang.MLA@leg.bc.ca
Isobel Mackenzie, BC Seniors Advocate, info@seniorsadvocatebc.ca
Board of Directors, Island Health: Alana Nast, Anne Davis, Anne McFarlane, Claire Moglove, Fred Pattje, Leah Hollins, M.J. Whitemarsh, Qwul'sih'yah'maht – Robina Thomas, Ron Mattson, Wahmeesh – Kenneth Watts, c/o Louise Carlow, louise.carlow@viha.ca
Comox Valley Record, editor@comoxvalleyrecord.ca
Decafnation.ca, george@decafnation.net

Table and Exhibits:

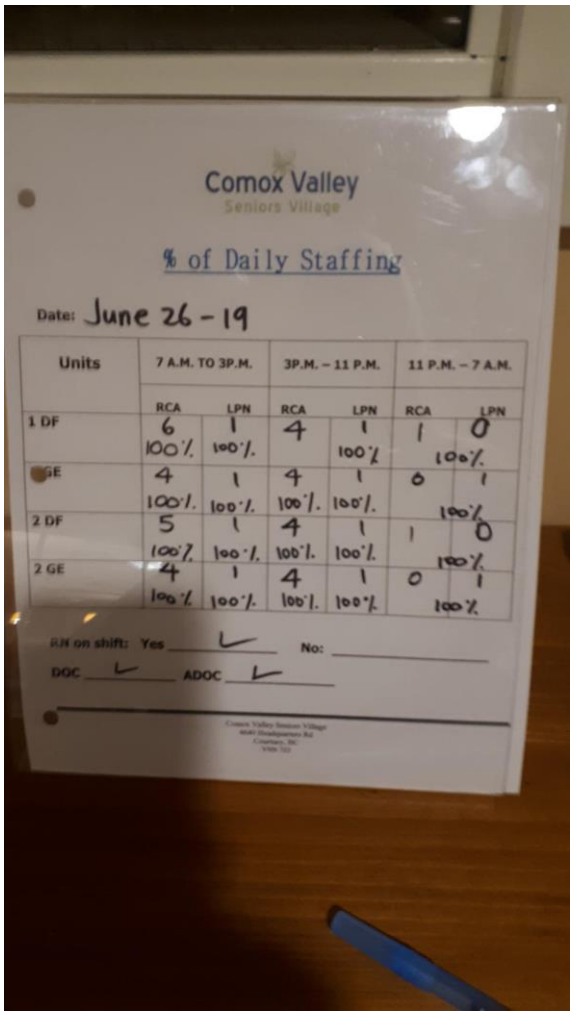
Table:

Comox Valley Seniors Village Staffing On June 26 2019

Wings	Number of Residents	Care Aides Full Time Shifts			Hours per Resident Care Aides/		
		7 am- 3pm	3 pm- 11pm	11pm- 7 am	Nursing	Other	Total
1 D&F	36	7	5	1	2.53	0.20	2.73
1 G&E	32	5	5	1	2.41	0.20	2.61
2 D&F	36	6	5	1	2.33	0.20	2.53
2 G&E	32	5	5	1	2.41	0.20	2.61
	136	23	20	4	2.42	0.20	2.62

Other represents an average per resident allocation of a total of 27.2 hours of recreation, dietician and physiotherapy care
Number of Hours Funded Per Resident Per Day (Assumed): 3.14
Number of Hours Provided Per Resident Per Day (June 26 2019): 2.62
Variance: .52 hours per resident per day

Exhibit 1



Comox Valley
Seniors Village

% of Daily Staffing

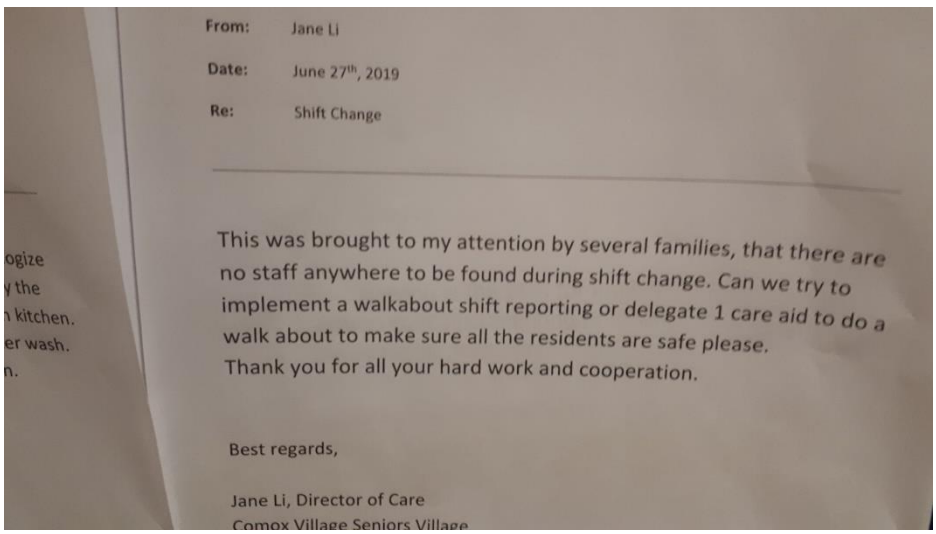
Date: June 26 - 19

Units	7 A.M. TO 3P.M.		3P.M. – 11 P.M.		11 P.M. – 7 A.M.	
	RCA	LPN	RCA	LPN	RCA	LPN
1 DF	6 100%	1 100%	4	1 100%	1	0 100%
GE	4 100%	1 100%	4 100%	1 100%	0	1 100%
2 DF	5 100%	1 100%	4 100%	1 100%	1	0 100%
2 GE	4 100%	1 100%	4 100%	1 100%	0	1 100%

RN on shift: Yes ✓ No: _____

DOC ✓ ADOC ✓

Exhibit 2



From: Jane Li

Date: June 27th, 2019

Re: Shift Change

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y the
kitchen.
er wash.
n.

This was brought to my attention by several families, that there are no staff anywhere to be found during shift change. Can we try to implement a walkabout shift reporting or delegate 1 care aid to do a walk about to make sure all the residents are safe please.
Thank you for all your hard work and cooperation.

Best regards,

Jane Li, Director of Care
Comox Village Seniors Village