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

May 20, 2019

Tim Orr,

Residential Services, Island Health.

Dear Tim Orr:

**Re: Comox Valley Seniors Village**

This letter is a follow-up to our March 13 letter that raised concerns about a serious failure to follow critical procedures during a recent Norovirus outbreak at Comox Valley Seniors Village. We outlined numerous concerns about its operations and requested that you personally take responsibility for a full scale review of this facility and resolution of the problems described. We now respectfully request that Island Health exercise its full authority to remedy the situation and assume operational responsibility for this facility.

It is our strong belief that the prolonged, ongoing challenges to bring this facility within compliance are indicative of a larger endemic problem for Retirement Concepts regarding this facility. As such, the improvement required will likely not be achievable on a sustainable basis if at all. We see no evidence that they are taking the need for corrective action seriously or acting expeditiously despite being assessed "high risk". To continue futile efforts to work with this facility, as currently operated, only serves to prioritize the business needs of Cedar Tree and Pacific Reach over the welfare of those vulnerable seniors entrusted to their care. It has reached the point where the residents' well being must be of paramount concern. Severe and irrevocable consequences are both appropriate and needed given this service provider's continued critical failures to meet the terms of its contract and the regulatory standards.

**Oversight:**

Since our letter, we were encouraged by the response from Island Health management and the Licensing Office. We now know that Island Health informed the facility about the cleaning protocol during the outbreak but that the facility did not perform the cleaning. The family of a resident who passed away during the outbreak has advised that they now understand that the protocol was not properly followed in how they were permitted access to the room to retrieve his personal belongings.

We understand that the Licensing Office was aware that the facility was operating without both a manager and a director of care for several months since last September and there had been ongoing follow-up investigations. After we raised the question of the lack of online reports since March 12 2018, a total of seven reports from March 7 to May 3 2019 have been posted yet nothing for the interim period. It is not clear how proactively involved Island Health was during the events leading up to and during the outbreak. We can only trust that you are working to strengthen your internal management

systems and oversight capability toward preventing a recurrence of a similar situation given the serious resident and public health risks involved.

**Non-Compliance:**

Based on the investigation reports, it appears that there are ongoing, repeated non-compliance issues. In total, there have been 22 different contraventions reported and there are currently 12 contraventions according to the May 3 report. A number of these could have been easily addressed within a week or two at most. Retirement Concepts' lack of timely and proactive resolution of the contraventions when first cited suggests to us that they do not take the need for corrective action seriously. While the Licensing Office plays a valuable role to identify compliance issues and bring routine compliance matters under control, we question whether it is realistic that a compliance driven process can bring about the kind of management performance turnaround required for Comox Valley Seniors Village.

The investigation reports appear to be missing important contraventions applicable to this facility. There is no longer a policy and procedures contravention and yet even if the documentation is in place, surely there is a contravention with respect to ensuring it is communicated and the employee compliance required by the regulation. Prior contraventions that are no longer reported, but we believe still applicable, include restraint without permission, no care plan within 30 days, no recreation, nutritional plans not updated, no oral health plan, and perhaps, failure to report an incident to the Medical Health Officer. Most of these are included in the April 26 Pacific Reach Health and Safety Action Plan with May 15 dates assigned suggesting compliance has not been met.

**New Complaints:**

Last week, we attempted to contact the Licensing Office to report two new complaints regarding Wing 1F where our family members are located. Due to the Licensing Office's changes, with the responsible officer now based in Victoria, we were unable to reach anyone and have only now initiated the process. These concerned 1) maintenance and cleaning of filth around a mouldy window and a broken window that is taped and 2) that Wing 1F residents are now being fed minced even if they only require soft food. This appears to be a time saving solution for the kitchen, however, for some residents (especially with dementia) it unnecessarily interferes with their swallowing reflex and digestion. It needs to be said that one of these meals was an inedible concoction of minced battered fish.

Most importantly, we would like to make a complaint about the inadequate staffing coverage and recent shift changes that have further reduced the number of care hours already significantly below the paid required minimum per resident. Table 1 (attached to this letter) is our summary of the shifts for Wing F1 just prior to May 12 and the changes we understand were made effective May 12. By our calculations, Wing 1F receives 2.63 care hours per resident when all shifts are filled whereas the Seniors Advocate reported that this facility receives funding for 3.11 hours. The May 12 changes result in a further reduction in care hours per resident from 2.63 to 2.43 hours. The reduced hours for Wing 1F reflect 1) a reduction in Nursing from two to one staff for wings 1F and 1D and 2) the elimination of the one Float staff dedicated to 1F and 1D that will now be covered by one Float staff for the entire building. These changes would also reduce the number of care hours for all building residents particularly, 1D residents. There may be other changes for the building that we don't know about.

It is important to emphasize that this is a unit of 16 residents with severe mobile dementia and other health issues. Any number of these residents experience sundowning in late afternoon through the evening. Five of the current 16 residents require two aides to provide care. Under the previous schedule, the evening shift from 3pm to 11pm had no extra float. This has already caused many instances, including breaks and care times, when the staff had no choice but to leave the residents, who require constant supervision, alone for prolonged periods of time. In the past week, on that shift, one resident suffered a severe fall with injuries while two residents were palliative. There is a resident who is prone to physical aggression toward other residents who has not been moved. While visiting and often because a care worker is unavailable, the families routinely need to act to maintain the safety of the residents including fall prevention. All of this suggests the need for Island Health to thoroughly verify the actual care hours provided per resident, the appropriate level of care provided through the 24 hour cycle and for types of care, and the facility's plans (long-term and interim) and timeline to meet the paid required minimum number of care hours for all residents and particularly, Wing 1F.

**Improper Records and Documentation:**

We believe that records confirming actions taken are sometimes falsified. We know that two weeks ago, a family member was recorded as having a bath that was not provided. This reflects an ongoing problem with misrepresenting information consistent with the documentation that wrongly confirmed that the resident rooms were terminally cleaned during the outbreak. It suggests the need for on site investigation to confirm the validity of the information the facility provides to Island Health.

The May 3 report removed the contravention regarding the bathing records not including monthly weight records for multiple residents. Given the above mentioned concerns about staff falsifying records including bathing records, we suggest that the veracity of the information provided supporting removal of this contravention may be questionable and/or not applicable for all residents.

**Staffing:**

Given the obvious lack of Retirement Concepts management oversight during the outbreak, the critical first step after the March 7 investigation should have been to stabilize the facility operations in order to bring it into compliance. Yet the facility continues to operate without adequate staff largely because staff become frustrated with the working conditions and leave. The recruitment plan, as stated in the Health and Safety Action Plan, is a generic plan that hasn't been effective for them and surely requires a different approach. It suggests head office support and involvement but this is not evident in practice or results. This lack of proactive management and staffing support suggests to us that Retirement Concepts may be fully delegating this responsibility to a new manager and therefore not regarding the need for ensuring adequate staffing seriously. A contributing factor may be the compensation structure and lack of financial penalties. As a consequence, the owners have been compensated for at least three management and/or professional staff for several months and various other vacancies carried for which they did not incur any costs.

In light of the above, it is difficult to reconcile the shift changes we previously referred to under "New Complaints". These changes appear to have permanently reduced the number of care hours that were already significantly below the paid minimum requirement per resident. As mentioned, these reductions were in critical areas, especially for Wing 1 F residents, of Nursing and Float staff coverage. This move suggests that the facility is not serious about meeting the paid minimum care hours

requirement through its recruitment efforts as outlined in its Health and Safety Plan. If intended to address a loss of staff on a temporary basis, hiring agency staff to cover the vacancies would be the better solution.

**Work Environment and Staff Retention:**

To stabilize operations would also require a focus on staff retention through building employee morale and trust. Instead, Retirement Concepts rolled out a new staffing and scheduling program requiring staff to resign and re-apply. It was handled in a top-down manner that disrupted what early improvements had been made. It did not properly inform the general manager so that he could manage the fall-out. A number of good staff saw this as "the last straw" and left. These actions and the shift changes as described above suggest to us that Retirement Concepts is taking a "business as usual" approach focused primarily on bottom line performance. This suggests to us that they are not taking the need to carefully and correctively manage the staffing situation seriously.

**Health and Safety Action Plan (April 26 2019):**

The Health and Safety Action Plan, as we understand it, is largely a response to the contravention for failure to provide this plan when requested during an investigation as well as a process for managing compliance with outstanding contraventions. It addresses many of the outstanding contraventions found during the 2017 through 2019 investigations and follow-ups. We believe it is deficient in several respects and suggests a lack of commitment to ensuring the “health and safety and dignity of persons in care”. Not only has it taken several weeks to develop but the organization appears to continue to operate in a manner that suggests that compliance is not urgent. Further, it appears to be a mechanical exercise of going through the motions without actually changing culture and behaviours. It is not evident from reading the plan whether requirements have been met or if progress has been made for deadlines that are scheduled as either immediate or required this month.

Most importantly, we see no evidence that a proper post incident investigation was conducted related to the recent outbreak that would identify root causes of the compliance failures and recommendations to prevent a future similar occurrence. It is our understanding that this would be the procedure for an Island Health operated facility and as such, question why it would not be a requirement for this facility given its serious breach of a critical public health protocol.

In our view, the Health and Safety Plan is incomplete and therefore, does not reflect a serious management commitment to health and safety to bring the facility into compliance. Contraventions in the April 25 and prior investigation reports that pertain to health and safety, but were not included in the plan, include fall prevention plans, staff immunization and criminal and character reference checks, consent for professional medical care, maintenance of resident weight records, and most importantly, employee performance reviews. The obvious ongoing lack of a rigorous performance management review process would be a significant contributing factor to employee performance issues in the areas of health, safety and dignity of persons in care. Without performance feedback and consequences, it is difficult to manage employee compliance with the standards and expected behaviours. Corrective action for such employee behaviours as verbal abuse toward residents is recorded in the plan for a performance review at some future date rather than conducting the review in a timely and relevant manner for it to be effective. It’s as if the tail is wagging the dog in that this compliance driven planning process appears to be holding up management action that then results in unresolved contraventions.

Lastly, the plan is intended to promote the dignity of persons in care which surely means confidentiality regarding their medical information. It is therefore, remarkable that this plan included the full name of the patient who did not receive appropriate wound treatment and was posted on the public front entry bulletin board for anyone to read.

**It's Now Time for Decisive Action:**

As a group of family members, some of whom remain involved after the loss of our loved one who resided in this facility, we feel a moral responsibility to do our part to provide a level of transparency on the serious issues with how this facility is operated. It is nevertheless a difficult process to endure at a time when we are facing the ill health and loss of our loved ones as we ourselves are getting older. We have understood and supported Island Health's need to follow a remedial process, however, it is now clear from our daily involvement that the "writing is on the wall" and it's time to take decisive action.

There are many caring, capable and hard working people employed at this facility. With appropriate organizational and managerial support, we believe that the new general manager can develop in his role. If a supportive work environment can be provided, we believe the many wonderful care workers will likely stay on and employee recruitment will prove easier.

Thank you for taking the time to consider our request and concerns. We hope this letter is helpful to your decision. We look to and depend on Island Health to ensure that your contract and licensed residential care facilities are operated to appropriate standards and to remove operators who consistently and seriously fail to meet their obligations. If Island Health is of the view that Comox Valley Seniors Village has not yet reached this point, it begs one of two questions: "How much longer?" or "How much worse does it need to be?"

Sincerely,

Delores Broten, Comox

Doug Malcolm, Courtenay

Greta Judd, Courtenay

Sharon Jackson, Merville

Bev Foster, Courtenay

Table 1

Table 1

**Comox Valley Seniors Village- Staff in Special Care Wing 1F**

Number of Residents in 1F= 16 residents and in 1D=20

Per Day Before May 12, 2019

| Job | Shift | Wing | # Staff | # Hours | # Residents | Hours/Resident | Variance* |
|---|---|---|---|---|---|---|---|
| Care Aides | 7am -3pm | 1F | 2 | 14 | 16 | 0.88 | |
| Care Aides | 3pm -11pm | 1F | 2 | 14 | 16 | 0.88 | |
| Float | 6am -2pm | 1F, 1D | 1 | 7 | 36 | 0.19 | |
| Night | 11am -7pm | First floor | 1 | 7 | 68 | 0.10 | |
| Nursing | 9am -9pm | 1F, 1D | 2 | 14 | 36 | 0.39 | |
| Recreation | 9am -5pm | Building | 4 | 27 | 136 | 0.20 | |
| | | | | | | 2.63 | - 0.48 |

Per Day Effective May 12, 2019

| Job | Shift | Wing | # Staff | # Hours | # Residents | Hours/Resident | |
|---|---|---|---|---|---|---|---|
| Care Aides | 7am -3pm | 1F | 2 | 14 | 16 | 0.88 | |
| Care Aides | 3pm -11pm | 1F | 2 | 14 | 16 | 0.88 | |
| Float | 6am -2pm | Building | 1 | 7 | 136 | 0.05 | |
| Night | 11am -7pm | First floor | 1 | 7 | 68 | 0.10 | |
| Nursing | 9am -9pm | 1F, 1D | 1 | 12 | 36 | 0.33 | |
| Recreation | 9am -5pm | Building | 3.80 | 26.60 | 136 | 0.20 | |
| | | | | | | 2.43 | - 0.68 |

* The Variance is the difference between the care hours provided and the paid required minimum for this facility of 3.11 care hours per resident

(Source: Seniors Advocate https://www.seniorsadvocatebc.ca/quickfacts/location/936F0)

This does not include the multiple incidents of being short staffed, for a few hours or an entire shift.

CC:

Mark Blandford, Executive Director Primary Care & Seniors Health, mark.blandford@viha.ca

Joel Verbruggen, Licensing Officer, Joel.Verbruggen@viha.ca

Dr. Richard Stanwyck, Chief Medical Health Officer, c/o Dorothy Gallacher, Dorothy.Gallacher@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

Ronna-Rae Leonard, MLA Courtenay-Comox, Ronna-Rae.Leonard.MLA@leg.bc.ca

Cheryl Damstetter, Vice President, Priority Populations and Initiatives, c/o Amelia Roy
amelia.roy@viha.ca

Dermot Kelly, Executive Director, Geography 1, c/o Jodi Donaldson
Jodi.Donaldson@viha.ca

Kathy MacNeil, President and CEO Island Health, CEOExecutiveAssistant@viha.ca

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