Public Report

Ombudsman Saskatchewan
Promoting Fairness

Caring in Crisis

An investigation into the response to the COVID-19 outbreak at Extendicare Parkside

August 2021

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Thanks to the entire team at Ombudsman Saskatchewan
who contributed to this report.

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Promoting Fairness

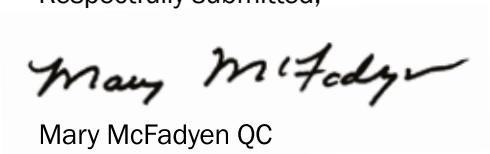
August 2021

The Honourable Randy Weekes
Speaker of the Legislative Assembly
Province of Saskatchewan
Room 129, Legislative Building
2405 Legislative Drive
Regina, Saskatchewan S4S 0B3

Dear Mr. Speaker:

In accordance with subsection 38 of *The Ombudsman Act, 2012*, it is my honour and privilege to submit to you a report titled *Caring in Crisis: An investigation into the response to the COVID-19 outbreak at Extendicare Parkside*.

Respectfully submitted,



Mary McFadyen QC
OMBUDSMAN

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Introduction

Saskatchewan reported its first presumptive case of COVID-19 on March 12, 2020. On March 17, 2020, Saskatchewan's Chief Medical Health Officer signed the first of what would be a long series of public health orders to control the transmission of COVID-19. Among other things, the order restricted visitors to long-term care homes, hospitals, personal care homes and group homes to family visiting for compassionate reasons. The next day, on March 18, 2020, with 16 confirmed and presumptive cases, the Province of Saskatchewan declared a state of emergency. Since then, each day, with few exceptions, the Ministry of Health has reported on new COVID-19 cases and, sadly, news of those who have died from it.

By May 2020, with new daily case numbers remaining in single and low double digits – the Government of Saskatchewan began Phase 1 of its Re-Open Saskatchewan Plan. There was, however, already talk of a second wave and the need to be prepared. A June 19, 2020 public health order lifted restrictions to align with Phase 4 of the Re-Open plan. Effective June 22, 2020, indoor private gatherings could increase to 30 people if two meter distancing could be maintained. The number of new cases remained low during the summer months and into the early fall. By September 30, 2020, 1,913 people had contracted COVID-19 in Saskatchewan and 24 people had died.

Starting in the fall, cases in Saskatchewan began to increase. Over the Thanksgiving weekend, 106 people tested positive, which was unprecedented at the time. On October 13, 2020, responding to what he referred to as a dramatic rise in cases in recent weeks, Saskatchewan's Chief Medical Health Officer announced that the maximum allowable private indoor gathering size would be halved from 30 to 15 as of October 16, 2020. During the October 13, 2020 COVID-19 update, he commented that, "It is very hard to physically distance four people in an average room, let alone 15."

On November 5, 2020, Saskatchewan reported its first ever triple-digit daily increase in cases, bringing the total cases to 3,536 – more than double the total cases from September. The size of indoor private gatherings was reduced to 10 people. By November 19, 2020, the total cases in Saskatchewan had risen to 5,651 and 32 people had died. The next day, on November 20, 2020, a COVID-19 outbreak was declared at the Extendicare Parkside special-care home in Regina.

By the time the Parkside outbreak was declared over, 194 of its 198 residents had tested positive for COVID-19. Thirty-nine of those residents died of COVID-19. Three other residents who had tested positive for COVID-19 died during the outbreak, but their cause of death was deemed not to be COVID-19. One hundred thirty-two Parkside staff also contracted COVID-19 and four staff members at Regina Pioneer Village who provided care to the transferred Parkside residents also contracted COVID-19.

The public has a right to know how this happened. There were warnings of a second wave, there were public health orders and measures to protect residents in long-term care from COVID-19. So, what happened? And what else, if anything, could have been done to prevent this tragedy?

The Scope of Our Investigation

On January 29, 2021, the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health wrote to the Ombudsman asking that we investigate and report on the circumstances surrounding the Parkside outbreak including Extendicare's preparedness and adherence to public health orders. The Ombudsman replied, advising that we would investigate Extendicare Parkside's handling and response to the COVID-19 pandemic and outbreak, as well as the Saskatchewan Health Authority's and the Ministry of Health's oversight of Extendicare Parkside and their support of its handling of the outbreak.

As an officer of the Legislative Assembly of Saskatchewan appointed under *The Ombudsman Act, 2012*, the Ombudsman's mandate is to investigate, either on her own initiative or in response to complaints, the administrative actions and decisions of provincial ministries, agencies of the government, publicly-funded health entities and municipal entities. To effectively carry out our mandate, we must be independent and determine how and what we investigate. We gather facts and consider how ministries and agencies administer their programs and services. After an investigation, the Ombudsman may make recommendations if, among other things, she is of the opinion that a ministry, agency of the government or a publicly-funded health entity has acted, failed to act, or made decisions that were unreasonable, unjust, wrong, oppressive, contrary to law, improperly discriminatory, or that were based on a mistake of law or fact. The Ombudsman's role is to investigate whether entities are carrying out their duties fairly and reasonably according to the legislation governing them.

We have no authority to investigate or question the medical decisions made by health care professionals during the pandemic. Nor is it the role of the Ombudsman to comment on or recommend what public services and programs the government will provide or how it should allocate public money. These are matters of governance and public policy for the Legislative Assembly and the government to decide. Once these decisions have been made, however, our role is to then examine whether there are reasonable administrative processes in place to ensure they are implemented fairly and reasonably, and if so, whether they are being followed.

This report covers three areas:

Long-Term Care in Saskatchewan: Before discussing what happened at Parkside, and the roles the Ministry, the Authority and Extendicare played in trying to prevent, and then respond to the outbreak, we have set out a high-level summary of how the long-term care system in Saskatchewan is structured, including the key roles and responsibilities they each have, how they are connected and interdependent, and how they are not.

The Outbreak: We believe it is crucially important to share what we have learned about what happened to the residents and staff at Parkside – to, as best we can, based on the information provided to us, shed light on how COVID-19 got into Parkside, how it spread, and how Extendicare, the Authority and the Ministry responded to it.

Addressing the Pandemic and the Risk of Outbreaks: The crux of our work is considering whether the Ministry, the Authority and Extendicare took reasonable steps before the outbreak to get administrative policies and processes in place to effectively deal with the risk of an outbreak, whether they effectively implemented them, and whether they were as prepared as possible when the outbreak happened.

Our Investigative Process

NOTICE OF INVESTIGATION

On February 8, 2021, we gave Extendicare official notice under *The Ombudsman Act, 2012* of our intention to investigate its handling and response to the COVID-19 pandemic, including whether it met provincial and Authority requirements and standards. We also gave the Authority and the Ministry notice that we intended to investigate their role in providing governance, oversight and support for Extendicare's handling of the COVID-19 pandemic, including the outbreak.

INITIAL DOCUMENT REVIEW

In response to our initial requests for information, Extendicare, the Authority and the Ministry submitted over 20,000 emails, letters, meeting summaries, reports, plans, policies, procedures, guidelines, directives, orders, newsletters, agreements, meeting notices, technical bulletins, reviews, audits, training materials, contact tracing records, and other documents regarding their respective and collective responses to the pandemic and the Parkside outbreak.

These documents generally confirmed that the onset of the pandemic required the entire health sector responsible for the provision of long-term care to rapidly adapt and respond to ever-changing information and data about the transmission of SARS-CoV-2 (the virus that causes COVID-19) and what to do to prevent and control the spread of COVID-19. It required numerous administrative actions and decisions to be made on a daily basis. There is no aspect or detail connected to the administration of long-term care in Saskatchewan that was not affected in some way by the need to address the pandemic.

THE FOCUS OF OUR INVESTIGATION

We decided to focus on the administrative decisions and actions made and taken by Extendicare, the Authority and the Ministry regarding five key matters that exemplify the challenges and opportunities they had to prevent Parkside's residents and staff from getting COVID-19 and to respond effectively to the outbreak:

General Pandemic Planning and Management: Though Parkside could have experienced a COVID-19 outbreak at any time, as it happened, Extendicare, the Authority and the Ministry had 254 days, or a little over 8 months from when the pandemic was officially declared, to establish, update and implement their policies, orders, standards and practices to ensure long-term care residents were being cared for in the best, safest way possible, given the circumstances.

Parkside's Physical Layout and Limitations: Parkside has 34 4-bed rooms, which Extendicare, the Authority and the Ministry knew meant a much higher risk of COVID-19 spreading among residents. As the Chief Medical Health Officer told all of us repeatedly as the weather turned cooler in the fall of 2020, the risk of spreading COVID-19 is greater in closed indoor spaces.

Supply and Use of Procedure Masks: In his request, the Minister asked us to review the circumstances that led to further transmission of COVID-19 within Parkside including the proper use of personal protective equipment (PPE). We also received submissions about a number of PPE-related issues, for example, whether Extendicare's decision to supply Parkside's staff with disposable vinyl gloves (instead of nitrile gloves) was reasonable, whether all of Parkside's care staff had been properly fitted for N95 respirators, whether it properly audited its staff's donning (putting on), doffing (removing) and disposal of PPE, and whether its supply chain was delivering PPE that met provincial standards. We acknowledge these are important issues and encourage Extendicare and the Authority to review them further with the goal of making any necessary or advisable improvements to their processes. We decided, however, to focus on Parkside's supply and use of procedure masks, specifically whether Parkside complied with the Authority's continuous masking principles and guidelines, which we think demonstrates how the Authority and Extendicare worked together (or in isolation) in the lead up to the Parkside outbreak.

Limiting the Spread of COVID-19 From Resident to Resident: Residents in long-term care homes have to rely almost entirely on their care providers to keep them safe and healthy. This became even more true during the pandemic when residents' families or friends, many of whom, in normal times, come into the homes to provide some additional care and support to their loved ones, were restricted from doing so. Protecting residents during the pandemic also required changing their daily routines – limiting their social interactions and outings, maintaining social distancing and ensuring they wore masks (if possible based on their physical health and cognitive functioning) when social distancing was not possible. It also meant serving meals differently, either in smaller groups in shared dining rooms, or in their rooms.

Staff and Staffing: One of the most significant decisions affecting the long-term care sector generally and the operation of Parkside specifically, was the April 17, 2020 public health order that restricted long-term care staff from working in more than one health care facility during the pandemic. Given the inherent transmission risk due to having close contact with residents while providing care, the order was designed to reduce the risk of spreading COVID-19 across multiple sites. This "staff cohorting" requirement, coupled with the general increase in demand for the services of health care personnel, along with the fact that much of Parkside's staff are not part of the same collective bargaining agreement as other privately-operated and Authority-operated facilities, meant that Parkside had a limited pool of qualified health care personnel it could rely on for its daily operations or in the event of an outbreak. Further, once the outbreak hit, many of Parkside's staff were required to self-isolate, either because they got COVID-19 or because they were considered a close contact of someone who did. The loss of so many of its staff resulted in the Authority agreeing to temporarily take over Parkside – to bring in its own staff to handle the outbreak. We investigated how this happened and whether it was preventable.

INTERVIEWS

We conducted over 100 interviews. They included Extendicare officials, Parkside staff and management, Authority officials, Ministry officials and union representatives. In our view, they were generally forthcoming and honest. Many staff and officials expressed great, ongoing personal distress about what had happened. We also spoke with family members of Parkside residents who passed away during the outbreak. While many of them were not

able to visit Parkside during this time, we wanted to give them an opportunity to provide any information or insights they wished to share with us. Some of their comments are included in this report.

In most cases, our interviews raised more questions, so we asked the Ministry, the Authority and Extendicare to submit further information to answer them and documents to support their answers.

SUBMISSIONS FROM EXTENDICARE, THE AUTHORITY AND THE MINISTRY

We prepared an initial draft of this report with our tentative findings and recommendations and provided it to Extendicare, the Authority and the Ministry to give them an opportunity to make whatever submissions to us they wanted, for example, about the accuracy, completeness or relevance of the information we relied on, the soundness of the reasons for our findings and conclusions, and the reasonableness of our tentative recommendations. Not only is this step a fundamental part of a fair investigation process, it is also an opportunity for us to learn from those who were actually involved in getting Parkside and the rest of the long-term care sector ready to deal with the pandemic, and who dealt with the Parkside outbreak firsthand. All three of them provided written representations which have been considered in this report.

Long-Term Care in Saskatchewan

In Saskatchewan, long-term care includes nursing and personal care services for people who are unable to fully care for themselves at home and whose needs cannot be met by home-based or community-based services. Long-term care is provided in special-care homes designated by the Minister of Health under *The Facility Designation Regulations*. According to the list we received from the Authority, there are currently 151 designated special-care homes in Saskatchewan, 112 of which are operated by the Authority itself. The remainder are privately operated by either non-profit or for-profit organizations under contracts with the Authority. There are also long-term care beds in 10 non-designated facilities (e.g., hospitals and integrated care facilities). In this report, we use “special-care home” and “long-term care home” interchangeably.

MINISTRY OF HEALTH

According to the Government of Saskatchewan’s website, the Ministry of Health “is committed to a health system that puts patients first by providing Better Health, Better Care, Better Value, and Better Teams for Saskatchewan people.”

Under *The Provincial Health Authority Act*, the Minister of Health is responsible for the strategic direction of the health care system in Saskatchewan. This includes establishing goals and objectives for the provision of health services in the province, developing methodologies and establishing performance measures and targets to promote the effective and efficient utilization of health services, and the development, implementation and evaluation of provincial health care policies.

The Minister of Health also has the authority to determine the Authority's organization and internal management – including its organizational structure and management responsibilities, the appropriate level of its administrative services, and the percentage of its budget that may be spent on administrative expenses. The Minister of Health also determines the health services the Authority is to provide.

The Minister of Health's key responsibility, however, is administering the allocation of resources for the provision of health services in the province. This is primarily done through allocating funding to the Authority and administering payments to health care professionals under *The Saskatchewan Medical Care Insurance Act*. Each year, the Authority submits a financial and health services plan to the Minister of Health, who then determines the amount of annual funding the Authority will receive, the health services the Authority will provide with the funding, and any performance measures or targets the Authority must achieve. In practice, this takes the form of what we were told is an 'accountability letter' which includes a number of schedules that outline some of the reporting and other requirements the Minister expects the Authority to meet. In 2019-20, the Ministry transferred $3.598 billion in general operating funding to the Authority, plus an additional $110.8 million in capital funding and funding for targeted programs and services.

One of the Minister of Health's other key roles in the long-term care system is the designation of facilities as special-care homes under *The Facilities Designation Regulations*. By doing this, the Minister of Health requires special-care homes to comply with any prescribed standards and guidelines such as the *Program Guidelines for Special-care Homes* and *The Housing and Special-care Homes Regulations*.

The Provincial Health Authority Act, The Critical Incident Regulations, 2016, and the *Saskatchewan Critical Incident Reporting Guideline, 2004,* require any serious adverse health event, including loss of life, that occurs and is related to a health service provided by or a program operated by the Authority or a health care organization, to be reported to the Minister and investigated by the health service provider. The purpose of these reviews is to learn from errors that have been made in providing care so that they will not be made in the future. The deaths and illness of Parkside's residents during the COVID-19 outbreak are, in our view, adverse health events that should have been reported and investigated by Extendicare as critical incidents.

As well, under *The Public Health Act, 1994*, the Minister of Health designates a person to be the chief medical health officer, as well as designating other medical health officers employed by the Authority. Medical health officers play a very significant role in the control of communicable diseases such as COVID-19. In addition to the public health orders issued by the Ministry's chief medical health officer, the Authority's medical health officers may make orders they consider necessary to address the risk to health presented by a communicable disease including, for example, ordering a person to self-isolate.

With complete legislative control over how much funding the Authority gets and which health services the Authority provides, along with total legislative authority over which operators are allowed to run long-term care homes and the standards they are required to meet, the Minister of Health is ultimately accountable to the public for how the entire long-term health care system functions, and how health care services in long-term care homes are delivered in Saskatchewan. Despite this, the Ministry's special-care home consultants, directors, executive directors, and assistant deputy ministers we spoke with consistently told us that they have no direct relationships with the long-term care sector. Instead, they

were universally clear with us that the Authority is the "operational arm" of the health system, so it is directly responsible for long-term care home operations and for monitoring the performance of long-term care home operators.

For example, we were told that the Ministry was not directly involved in the development of any of the pandemic-related policies and procedures the Authority implemented. Ministry officials told us the Ministry did, however:

- Provide the Authority with additional pandemic-related funding
- Advise the Authority of national guidance it believed the Authority should consider when developing its pandemic-related policies
- Give general guidance regarding the public health orders it issued
- Regularly meet with Authority officials on pandemic-related questions, concerns and demands
- Update the provincial Communicable Disease Control Manual
- Make legislative and regulatory changes related to the handling of the pandemic

Other than the public health orders being made by the Chief Medical Health Officer and the various decisions made in relation to them, the Ministry told us its role was primarily to liaise with the Authority regarding the operational decisions the Authority was making in connection with the pandemic. Ministry officials told us they appointed staff to various pandemic-related Authority taskforces, committees and teams, but that they did not take any active role. Instead, they were appointed so the Minister of Health and the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health could be kept aware of the challenges, discussions, and decisions the Authority was making. We were told that since the Ministers are accountable for the health care system as a whole, they have a right and a need to know what the Authority is doing in response to the pandemic or a specific outbreak.

Every Ministry official we spoke to was also clear with us that they did not give Extendicare or any other long-term care home operator any direct support to help them through the pandemic. We were told that the Ministry has no direct contact, interaction, or relationship with the long-term care sector, and that the sector (including Extendicare) is under no obligation to provide the Ministry with any pandemic-related updates or reports. While the Ministry enacted public health orders during the pandemic, it took no direct steps to ensure, for example, that special-care home operators like Extendicare implemented the restrictions imposed by the orders. Some Ministry officials told us that, until the Parkside outbreak was declared, they were not aware of the challenges Extendicare was having in implementing the public health orders in its facilities.

While it may be generally true that the Ministry does not directly engage with long-term care home operators in a consistent or systemic way and instead expects the Authority to do so, as the 'governing arm' of the health sector, it does meet with and make decisions affecting specific long-term care home operators from time-to-time. For example, senior Extendicare officials met with senior Ministry officials during the pandemic (August 2020) to discuss, among other things, implementing regular, on-site rapid COVID-19 testing as had been done in Ontario.

Importantly, regardless of how removed the Ministry's staff are from the day-to-day administration of long-term care homes (and, therefore, significantly limited in their understanding of the challenges long-term care homes face generally, or what they were

confronted with because of the pandemic), the Ministry makes critical and profound systemic decisions with fundamental implications for long-term care home residents and the professionals who care for them.

As outsiders trying to learn about the Ministry's role in the long-term care sector and being generally aware of its total statutory and regulatory control over all major aspects of the health system, we were genuinely surprised by how little responsibility or accountability the Ministry's officials we spoke with believe they have to the Authority or long-term care home operators regarding the proper functioning of the long-term care system. In the eyes of the public, it is the Ministers whom we hold accountable if something goes wrong in the health sector. We do, however, acknowledge that the Ministry does not necessarily have the expertise or human resources to stay fully informed of all the issues, challenges and opportunities in the sector, and so it must rely on the Authority's expertise and knowledge of how the sector operates to inform its decisions.

SASKATCHEWAN HEALTH AUTHORITY

The Saskatchewan Health Authority was created in December 2017. It assumed all the assets, rights, and obligations (including all contracts) of the 12 former regional health authorities. With over 40,000 employees, it is by far the largest public sector organization in the province.

Under *The Provincial Health Authority Act, t*he Authority's board members are responsible for administering its affairs and conducting its business. They are appointed by the Lieutenant Governor in Council. The Authority also employs a Chief Executive Officer – who must be approved by the Lieutenant Governor in Council – who is responsible for the general management and the conduct of the affairs of the Authority.

The Authority is responsible for the planning, organization, delivery and evaluation of the health services that it provides (as determined by the Minister). This includes (among other things) assessing the health needs of Saskatchewan residents, coordinating the health services it provides along with those provided by other health service providers (including special-care home operators), assisting the Minister of Health in the development and implementation of health policies and standards, developing human resource plans for the health care system and other provincial health system initiatives, and complying with any directions, policies or guidelines issued or established by the Minister of Health.

The Provincial Health Authority Act provides that health services, including long-term care, are provided either directly by the Authority or through contracted health care organizations. The Act requires the written contracts the Authority enters into with health care organizations to contain certain provisions. For example, they must contain provisions regarding the health services to be provided, the funding to be provided, any performance measures and targets to be achieved, and what reports the health care organization is required to make to the Authority. The Act says that the agreements must also require the health care organizations to comply with legislation and regulations.

Long-term care is administered by the Authority under three divisions – Integrated Northern Health, Integrated Rural Health and Integrated Urban Health. In the Integrated Urban Health division, there are two Executive Directors of Continuing Care, one in Saskatoon and one in Regina, who are responsible for long-term care in their respective areas. We were

told that the Regina and Saskatoon areas manage their respective long-term care portfolios generally as they were managed by the former Saskatoon and Regina Qu'Appelle Regional Health Authorities. This is to say, despite its title, the management of long-term care in the Authority's Integrated Urban Health division is not yet integrated.

EXTENDICARE

Extendicare (Canada) Inc. is incorporated under the *Canada Business Corporations Act* and registered to conduct business in Saskatchewan. It is a subsidiary of Extendicare Inc., which is a publicly-traded company with a head office in Markham, Ontario. Extendicare (Canada) Inc. is a "publicly-funded health entity" within the Ombudsman's jurisdiction by virtue of being prescribed under *The Provincial Health Authority Administration Regulations* as a health care organization that receives funding from the Authority to provide health services.

According to Extendicare Inc.'s 2020 annual report, as of December 31, 2020, its long-term care business included 58 long-term care homes, most of which are in Ontario and Alberta. The company's total revenue in 2020 from all its operations was $1.158 billion, $715.6 million of which was from its long-term care operations. Compared to 2019, its 2020 revenue from its long-term care business was up $71.8 million (11.1 percent). Extendicare owns and operates five special-care homes in Saskatchewan (three in Regina, and one each in Saskatoon and Moose Jaw.)

Parkside is a 228-bed long-term care home located in Regina. It is managed by an administrator who reports to a regional director located in Manitoba. It provides services under a Principles and Services Agreement with the Authority. The agreement recognizes it "is an independent organization and governed by its own board of directors." And, that this "independence includes the right to govern its affairs, manage its workforce, set direction, [and] establish and manage…its Resources." However, as a designated health care organization, Extendicare is required to conduct its activities and affairs in a manner that reflects, and is consistent with, the goals and objectives established by the Ministry and the Authority. With respect to the health services for which it is given funding by the Authority, it must provide the services in accordance with the agreement, and all relevant Acts, regulations and other laws. Extendicare receives annual funding from the Authority under the agreement to provide services at Parkside.

The Authority told us that the process to determine the annual funding it receives from the Ministry for long-term care homes varies based on methodologies previously used in the former health regions in which the homes are located. We were told that funding increases are primarily the result of increases in wages and benefits negotiated under the various collective bargaining agreements, plus additional non-salary items which were established years ago and are adjusted for inflation.

According to the Ministry, in 2019-20, it provided the Authority with funding for 8,704 long-term care beds (in all facilities – Authority-run or privately-operated) in Saskatchewan based on an average of $81,269 per bed per year ($707.37 million).

The Authority told us that, over the last 25 years or so, there has been no significant change to the process for the provision of operational grants and funding for long-term care. The global funding provided to it is based on the historical allocation from the provincial budget, based on the former regional health authorities and their individual programs. Over the last 25 years, the Ministry has provided base budget operating increases which the Authority allocates among its program areas as it decides is appropriate. The Authority told us, however, it can distribute resources within the overall global funding it receives. It told us it allocates funds to special-care homes based on the programs and services they provide. So, while homes like Parkside primarily provide regular long-term care, other homes provide specialized and complex care services and receive more funding as a result.

According to the Authority, in 2019-20, it provided affiliate long-term care home operators an average of $193.11 per bed per day (or $70,485.15 per bed per year.) In 2020-21, the Authority provided Extendicare funding for Parkside of $170.88 per bed per day (or $62,371.20 per bed per year). According to a November 3, 2020 letter from the Authority to Extendicare, Parkside was provided net operating funding of $14,220,299 for 2020-21.

In addition to the direct funding the Authority provides, Parkside also collects fees from its residents. Both the minimum and maximum fees it may charge residents are regulated by the Ministry under *The Special-care Homes Rates Regulations, 2011*. Effective July 1, 2021, the current minimum resident charge is $1,161 per month and the maximum is $2,883 per month.

The Authority distributed additional funding to Extendicare (along with all other long-term care operators in the province) to cover additional expenses associated with the pandemic. According to a December 11, 2020 letter from the Authority to Parkside's Administrator, Extendicare received COVID-19 funding support "based on $13.00 per bed which is the average cost per day reported by homes." Parkside received $811,395 for the period from April 2020 to December 31, 2020. In January, the Authority provided Parkside additional COVID-19 funding of $263,796 for the period of January to March 2021. The Authority also gave Extendicare an additional $178,084 of extraordinary COVID-19 funding in March 2021.

A *2020 Pandemic Cost Breakdown for Saskatchewan Homes* provided to us by Extendicare indicates that it spent an additional $1,133,921 at Parkside on pandemic-related staff and supply costs in 2020.

The Authority told us, not including the compensation it paid its non-unionized staff, it spent $438,509 responding to the Parkside outbreak - $418,156 on compensation for its in-scope staff and $20,353 on personal protective equipment.

The Outbreak

As early as March 3, 2020, the Authority was communicating with all long-term care home operators about the possibility of COVID-19 outbreaks in their facilities. Pandemic planning was underway. Because there were no vaccines yet, the Authority said it would be relying on "our established infection prevention and control practices in order to limit spread and protect the residents of our Long term care homes." Operators were told to review the symptoms of respiratory illness with staff and implement additional precautions, to remind staff about proper use of personal protective equipment (masks, face shield, gloves, etc.) and proper hand hygiene, and to tell staff to stay home if they were sick. Long-term care facilities were asked to review their pandemic plans and ensure they were up to date. By March 25, 2020, the Authority was also reaching out to long-term care homes to determine their PPE requirements.

Based on all the information provided to us, the following is a timeline of what were, in our opinion, the significant events leading up to and during the outbreak at Parkside:

NOVEMBER 11, 2020

First positive staff member has symptoms

A direct care worker working on Parkside's main wing told contact tracers they had a cough and a headache and felt dizzy as of November 11. They reported losing their sense of taste as of November 12. They told contact tracers that they lived alone, had not travelled, had not attended any mass gatherings, and had not been in contact with a COVID-19 positive person in the two weeks prior to the onset of their symptoms. They reported being out in public locations or at appointments seven times between November 9 and 16, and that they always wore a mask during their interactions. They told us that during this time period, their doctor told them to get tested for COVID-19, but they did not.

This direct care worker worked in close contact with residents at Parkside for two shifts beginning 48 hours before the worker showed COVID-19 symptoms on November 9 and 10, and then for eight more shifts while symptomatic on November 12, 13, 14, 15, 17, 18, 19 and 20. Though they wore a mask when interacting with residents, they reported working up close with residents in their rooms and during their meals – when residents were not wearing masks. This direct care worker also reported sitting unmasked within 6 feet of other Parkside staff who were also not wearing masks during breaks, but the worker could not remember who. In addition, they reported having close contact with three other specific Parkside staff, all direct care workers. This direct care worker was swabbed for COVID-19 on November 20 and began isolating on November 21.

Based on all the information we received, this was the first person to have COVID-19 symptoms at Parkside leading up to the outbreak.

NOVEMBER 15, 2020

Staff not social distancing from each other

Another direct care worker at Parkside reported socializing at a co-worker's house on the afternoon of November 15 along with three other Parkside employees, and was there for three hours. The next day, this direct care worker drove unmasked 20 minutes to work

with another unmasked Parkside direct care worker, and worked a full shift on Parkside's south wing. This direct care worker reported wearing a procedure mask while working with residents, but did not wear a mask during breaks. They reported not being within 6 feet of anyone during breaks. The two co-workers drove home together after work, again, both were unmasked.

NOVEMBER 16 & 17, 2020

Second positive staff member has symptoms

A Parkside management employee reported having symptoms –a mild 'tickle' cough– on November 16. They worked every day until November 22 when a positive test result came back. The employee told contact tracers about being in contact with two other management employees, and in close contact with three other Parkside employees.

Third positive staff member has symptoms

The direct care worker who had socialized with co-workers on November 15 and was car pooling while unmasked, came to work the morning of November 17 for a full shift. The worker reported having a headache, body aches and chills to the charge nurse at about 9:00 AM. Their temperature was normal, so they said they took some pain medication and kept working. While masked, they worked closer than two meters from three of their masked co-workers from between 15 to 60 minutes that day. The worker also passed medications to residents during this shift – none of whom were wearing masks. When the worker checked their temperature at home in the evening, they had a fever. They called Parkside and was advised to stay at home for 48 hours and then go get a COVID-19 test, which they did. The worker got a positive test result at 9:00 PM on November 20, 2020 and provided contact tracing information to Public Health the next day.

During their interview with us, this direct care worker told us while distributing medications to residents, they went to help other workers transfer a resident back into bed who had been found unconscious. This resident would be the first at Parkside to die from COVID-19. The direct care worker told us their interaction with the resident was a "couple days before…" "then… two days later… when I was working… I had symptom[s]." Since the worker reported having symptoms as of 9:00 AM on November 17, for their recollection to be correct, they would have had to have helped the resident to bed on November 15. However, they were not working that day. Further, the resident being found unconscious was recorded in the Resident Progress Notes, but not on November 15. Rather, November 17 entries note the resident was found slumped forward in their wheelchair, not responding to verbal stimuli, and was helped into bed at 8:30 AM. Given this, we find the worker's recollection is inaccurate. We find that they helped the resident back to bed the same day they reported having COVID-19 symptoms – not a couple days before.

First positive resident has symptoms, and first death

The first resident to test positive showed symptoms on November 17. The resident was in a private room in the main wing. At 8:30 AM, their oxygen saturation level was recorded at 94%. They were reported as being lethargic and sleepy, leaning forward to their lap, and not responding to verbal stimuli until transferred to bed. At 6:15 PM, the resident was "gurgly" and their oxygen saturation was 68%. They were given oxygen, but their oxygen saturation remained between 60% and 80%. Their consciousness level kept declining and they were not responding to verbal commands. By 7:20 PM, the resident's breathing was still "gurgly," so staff called and left a message for the doctor and updated the resident's family.

At 8:35 PM the resident was reported as having loud gurgly breathing and oxygen saturation of 60%. Parkside called for an ambulance. When EMS arrived, they used a manual resuscitator to help the resident breathe. This is known as an aerosol generating procedure for which additional safety precautions are to be taken. One direct care worker wearing a surgical mask and gloves (but not an N95 respirator or a face shield as required) was in the room during this procedure. The resident was swabbed for COVID-19 at the hospital. They passed away at 1:42 AM on November 18. They were the first resident associated with the outbreak to be swabbed, and to have their positive test result reported (at 2:00 PM on November 20). However, they were not the first positive case at Parkside.

NOVEMBER 18, 2020

Two more positive staff members have symptoms

Another direct care worker working on Parkside's main wing reported having COVID-19 symptoms starting on November 18. They told us they had "allergy-like symptoms" but thought they were from wearing the procedure masks that were provided, which they said they were allergic to. (The worker told us that when they complained, the supervisor wrote 'hypoallergenic' with a marker on the side of a box of masks and handed the box back to them.) They told us they were not screened upon arrival at work – but there was a sign on the door telling staff to self-assess and not to enter if they had COVID-19 symptoms. This accords with what other staff told us, that before the outbreak staff screening was done, in one worker's words, "on the honour system." This direct care worker told contact tracers about having a sore throat as of November 18, and then by November 20, having lost their sense of taste and smell, and having nasal congestion, and by November 21, having problems breathing. They kept working while symptomatic: on November 16, and then from November 19 until November 22, when informed of their positive test result.

The worker told us they took breaks in the break room where up to 10 people were allowed to congregate. However, like many others we spoke with, they said there were often more than 10 people in the break room, so it was not possible to maintain social distancing. They told us they sat in the break room, while symptomatic and unmasked, across a 2-foot table from other staff, who were also not wearing masks. The worker told us they also took breaks in the resident's lounge – a room near Parkside's front entrance – where they and other workers were within two meters of each other without masks on while they ate during their breaks.

Another Parkside employee, a support worker, reported having the onset of COVID-19 symptoms – a "little bit of a sore throat", cough, and fatigue – as of November 18. They worked on November 19 and 20 and reported having close contact with three co-workers – two support workers and one direct care worker. This employee was informed of their positive test result on November 25.

NOVEMBER 19, 2020

Second positive resident & five more positive staff have symptoms

On November 19, another resident, one direct care worker and four support workers had the onset of COVID-19 symptoms:

- The second positive resident had spent time with two family members in their car when they went to a medical appointment the morning of November 18. They all wore blue disposable masks but pulled them down frequently. The resident returned to

the room they shared with another resident in Parkside's north wing. The resident's progress notes state that at 1:30 PM, the resident started coughing while eating lunch. Contact tracers reported that the resident had a "wet cough" and fever on November 19. Parkside's notes confirm that the resident was "warm to touch" with a temperature of 38.8ºC by November 19 at 10:00 PM, and was placed in isolation for 24-hour surveillance at that time. However, a progress note from November 20 at 9:00 PM states that the resident was "moved to Room 321 – for isolation per public health direction." The contact tracer's notes state the resident was moved into isolation at 2:00 PM. Given these discrepancies, it is difficult to conclude when the resident was isolated. However, it is clear that their roommate was in their shared room with them on the same day they had the onset of COVID-19 symptoms, presumably when neither of them were wearing masks. The resident was swabbed on November 20 and a positive result came back the next day.

- A direct care worker reported having chest pain the evening of November 19 followed by a fever the next day. According to the Authority's records, they did not work after November 14 and went into isolation after receiving their positive test result.
- A support worker reported having a fever, sore throat, and dizziness beginning the evening of November 19. They reported working mainly on Parkside's main wing but might have worked on the south wing too, on November 17, 18 and 19. They reported always wearing a mask but worked with multiple residents who did not have masks on. The worker initially reported possibly having contact while not wearing a mask with a co-worker in the office they shared, but later reported always wearing a mask, and having no breaches of PPE other than taking the mask off when alone in the office, and not eating lunch with anyone on breaks. The worker identified no close contacts with any Parkside residents or staff and received a positive test result on November 21.
- Another support worker reported having a headache, a "scratchy" throat and congestion on November 19. They worked at Parkside on November 17 and 18 and reported wearing a mask on the floor at all times, denying any close contact with residents since the worker's time with them was limited and always under 15 minutes. However, this worker also reported sharing breaks unmasked and in close contact with one co-worker. The worker's positive test result came back on November 22.
- Another support worker working on Parkside's main and south wings began having chills and feeling dizzy on November 19. They reported wearing a mask at all times, except when on breaks, during which they sat within six feet of two other employees, one of whom was the support worker who had COVID-19 symptoms on November 18. The employee worked on November 19, 20, 21, and on the 22, when their positive test result was received.
- Another support worker had the onset of headache, dizziness, fever, chest pain, and shortness of breath on November 19. They worked at Parkside on November 17 and 19. The worker said they wore a medical mask at all times, except during breaks. They also said that that the break room was crowded and they would have been within six feet of co-workers who were also not wearing masks. Their positive test result came back on November 23.

NOVEMBER 20, 2020: THE OUTBREAK IS DECLARED

2 positive cases are confirmed, but 25 people already have symptoms

Note: An outbreak is declared confirmed when two or more people test positive.

Extendicare was informed of the first resident's positive COVID-19 test at 2:00 PM on November 20. The Authority issued a *suspected* outbreak notification at 2:46 PM. At 5:39 PM, Parkside's Administrator emailed residents' families to tell them a resident had tested positive, saying: "Our home has a comprehensive infection, prevention and control program and we have enhanced this even further since learning of the threat of the novel coronavirus in March."

At 7:33 PM, Extendicare's Senior Administrator emailed its National Director of Long-Term Care to notify her of the situation. Among other things, he said, "PPE is good for today[.]" And, "Dining is as per normal at this time." The National Director forwarded this email to the Vice President of Long-Term Care Operations and others, noting that Parkside may be reaching out for PPE over the weekend.

The direct care worker who had symptoms on November 17, got their positive test result at 9:00 PM. They were not working at the time and began self-isolating. Since there were then two confirmed cases, the Authority sent a confirmed COVID-19 outbreak notification at 9:28 PM. It notified Parkside that, effective immediately, limited exemptions to the staff cohorting rules for managers and mobile testing staff had been made to allow it to respond to urgently required needs related to the outbreak.

It is important to stress that by November 20, 13 Parkside residents and 12 employees already had symptoms and would subsequently test positive for COVID-19. Many of these staff members had continued to work while they were symptomatic. Some of them had close, unmasked contact with their co-workers, and some worked closely with residents who were not masked. Though this was the reality, no one knew it at the time.

NOVEMBER 21, 2020

3 confirmed cases; 31 people with symptoms; running out of PPE

At 3:33 PM, Parkside's Administrator emailed the Authority: "Things have changed since we first talked on Friday and…since our later Friday conversation. Public Health has us on total isolation all residents are isolated to their rooms effective today. In light of that we are ripping through more PPE." He asked the Authority to provide Parkside with 15 cases of N95 respirators, 10 cases of procedure masks, 1000 face shields, 10 cases of disinfectant wipes, 7 cases of gloves and 20 cases of disposable gowns "to keep [Parkside] afloat for about 5 days?"

Parkside began serving residents all their meals in their rooms, so the resident dining rooms became available for staff to take their breaks – the rule was one person per table, at least six feet apart. Also, staff cohorted in each wing were not supposed to take breaks with one another.

At 4:31 PM, Extendicare's Senior Administrator updated the Authority's Director Continuing Care in Regina and Extendicare's Regional Director for Manitoba and Saskatchewan as follows:

- Parkside then knew of 3 positive cases – the resident who had died, a resident in the north wing who was moved into an empty room, and one employee.
- All the main wing (54) and south wing (69) residents, and half of the north wing (75) residents had been swabbed. The rest would be swabbed that day.
- 78 employees had been swabbed. Five had been sent home to self-isolate because they had been deemed close contacts by Public Health.
- Staffing was stable: Nine continuing care aide shifts per day were added, recreation staff would help with meal service and in the evenings, extra housekeeping was added, and an extra evening laundry shift was scheduled. Fourteen continuing care aide students from the Saskatchewan Polytechnic would be starting in three days.
- Parkside did not have enough face shields, but Extendicare Sunset had given them 500.
- PPE donning and doffing audits were implemented.
- Positive residents would use fully disposable plates, cups, etc., which they were working on implementing for all residents.

At 4:42 PM, the Authority's Director of Continuing Care in Regina replied to the Parkside Administrator's request for PPE, saying they could try to get something there tomorrow, but asked if Monday was soon enough. Parkside's Director of Care replied at 4:52 PM that Monday would be soon enough.

According to the Authority's final Outbreak Summary, as of November 21, 2020, a further three residents and three staff had symptoms and subsequently tested positive for COVID-19. This meant that there were 31 cases (16 residents and 15 staff members), even though only three positive test results were known.

NOVEMBER 22, 2020

17 known positive cases (3 staff, 14 residents)

At 10:14 AM, the Authority emailed Parkside's Director of Care to check if it needed PPE sooner than Monday, as there were now more cases. At 11:30 AM, Parkside's Director of Care replied that it had enough for the day, but if the Authority could send PPE today, they would have it when they needed it.

Parkside moved all known positive residents together into its main wing, which was dubbed the "Red Zone." One staff member told us that, in their mind, this made no sense because it meant everyone had to walk through the COVID-19 positive hallway in the main wing to get to the south wing.

At 3:20 PM, Extendicare's Senior Administrator emailed its Vice President of Long-Term Care Operations to advise that the Authority was helping Parkside with supplies it needed and that he would be asking Extendicare's Director of Business Performance for PPE shortly. At 3:56 PM, Extendicare's Senior Administrator told its National Director of Long-Term Care that he and the Regional Director had decided that "due to the escalating circumstances" he and a Long-Term Care Consultant would be onsite at Parkside to support its staff. The National Director asked whether Parkside was "doing ok with staffing?"

In an email to the Authority and Extendicare officials sent at 4:06 PM, Extendicare's Senior Administrator noted that:

- 12 of the 54 residents in the main wing had tested positive, 13 including the resident who had passed away.
- Test results for the 69 residents in the south wing were still outstanding.
- All 75 north wing residents had been swabbed. One was positive and the other results were outstanding.
- 158 staff had been tested and, to date, three were confirmed positive.
- Staff testing results were not being provided to Parkside directly, so they had to call them individually.
- Public Health wanted lists of both positive and negative residents and positive staff, and wanted all residents cohorted.
- "Resident zero is being linked to positive [direct care worker] – [Direct care worker] had symptoms November 11th and never reported symptoms to Management. Continued to come to work on November 12-15th, off November 16th and worked November 17th -20th."
- Extendicare's Long-Term Care Consultant had advised that in 4 bed wards only gowns and gloves needed to be changed from resident to resident.
- All rooms would be deep cleaned once a positive resident had been removed and the front office would be deep cleaned.

At 5:16 PM, Extendicare's Vice President of Long-Term Care Operations and National Director of Long-Term Care emailed Extendicare's Director of Operations, the Senior Administrator and Regional Director to ask if Parkside was getting enough support from its internal resources – whether Extendicare's human resources staff were helping Parkside access Authority staff and whether its communications staff were helping with resident and family, and staff communications. He said he assumed Parkside was getting the support it needed, but if not, he would take steps to ensure it did.

According to the Authority's Final Outbreak summary, another five Parkside staff had symptoms and would subsequently test positive for COVID-19. Though it did not know it yet, Parkside now had 36 cases (16 residents and 20 staff members).

At 7:14 PM, Extendicare's Senior Administrator emailed its Director of Business Performance to ask for 15 cases of N95 masks, 10 cases of procedure masks, 1000 face shields, 10 cases of disinfectant wipes, 17 cases of gloves, and 20 cases of disposable gowns to be shipped to Parkside.

NOVEMBER 23, 2020

PPE shortage; more staff told to self-isolate

At 9:48 AM, the Authority's Contracting, Procurement & Supply Management division emailed the Director of Continuing Care in Regina (in response to Parkside's November 21 request for PPE) to say while the division was happy to help out, Parkside's request was not reasonable. He noted that, with the exception of N95 respirators, he expected Extendicare to be able to get all the PPE it needed from its own suppliers. He said he would be comfortable providing three boxes of N95 respirators, but to send 15 cases was just not feasible.

Two minutes later, Parkside's Administrator emailed Extendicare's Director of Business Performance asking that the Senior Administrator's PPE order from the evening before be doubled. The Director replied, first to say that the order had been made and he expected it to arrive in a few days, and then to confirm that he had doubled it.

In response to a 10:08 AM email from the Authority's Director of Continuing Care in Regina indicating its PPE request had been put on hold, at 12:20 PM, Parkside's Administrator advised that Parkside desperately needed N95 masks. Minutes later, the Senior Administrator also asked if the Authority could supply N95 masks because Extendicare did not have access to the N95 masks for which Parkside's staff had been fit tested. At 1:24 PM, the Authority's Director of Continuing Care in Regina asked its Procurement and Supply Management division to supply Parkside with 12 boxes of N95 masks immediately, which it did.

During a meeting (call) on November 23, 2020, Extendicare was told by medical health officers with the Authority that any masked Parkside staff (but not wearing a face shield) who had been within two meters of a COVID-19 positive person for a total of 15 minutes over a 24-hour period, would need to self-isolate. Eight management and administrative employees were instructed to self-isolate, either because they had tested positive or had been deemed to be a close contact of someone who had.

According to the Authority's final outbreak notification report, one more resident and three more staff members had symptoms and would eventually test positive for COVID-19. This brought Parkside's total cases to 40 (17 residents and 23 staff), though according to the Senior Administrator's information on this date, only 24 positive test results were known at that time (17 residents and 7 staff).

NOVEMBER 24, 2020

Questions about close contact definition; student care aides begin working

At 8:08 AM, Extendicare's Senior Administrator provided Extendicare's Vice President of Long-Term Care Operations (and several other Extendicare officials) with an update on the previous day's events. He said that Public Health had made 'major changes' to the close contact rules for staff, so any masked staff who had been in within two meters of a masked positive person for an accumulative 15 minutes in a 24-hour period were deemed to be close contact and required to self isolate unless the staff person was also wearing a face shield. He said he told Public Health that he anticipated losing 75- 100% of Parkside's staff if this rule was followed.

At 9:14 AM, Extendicare's Vice President of Long-Term Care Operations replied that he was going to arrange to have someone reach out to "SK Health" about the public health directive. A few minutes later, the Senior Administrator thanked him saying, "Yes please, they shut us and the SHA down. If the deciding [factor] on close contact is face shields why weren't we told this so we could have implemented it[?]"

At 1:45 PM, Parkside's Administrator emailed the Authority's Director of Continuing Care in Regina advising that it was waiting for its PPE order from Extendicare, which he was not hopeful would get delivered to Parkside that day. He asked for six cases of disinfectant wipes to get Parkside through until the morning. The Director replied at 2:20 PM that he had not indicated Parkside needed anything other than N95 masks when they spoke the day

before and that she thought asking for six cases for a couple of days was excessive. She asked him to give her a more realistic request, which she said she could get delivered if she could get confirmation in the next 10 minutes.

At 4:45 PM, the Senior Administrator advised Authority and Extendicare officials that Parkside was stable, noting that it had some staffing challenges that day and that he was bringing over another manager from Extendicare Elmview. Parkside's usual Administrator had volunteered to temporarily take over managing Elmview. The Senior Administrator also noted Parkside did not have enough environmental services and food services workers, and that Extendicare Sunset was looking at options as to which staff could be released to Parkside.

Students in the Saskatchewan Polytechnic's Continuing Care Assistant program began working on-site to help replace the Parkside staff who were in isolation.

According to the Authority's final outbreak report, there was another resident and three more staff members with COVID-19, for a total of 44 cases (18 residents and 26 staff members).

NOVEMBER 25, 2020

Second mass testing; Public Health pulls student care assistants from Parkside

Resident and staff mass testing was done again. Based on our review of resident test results, of the 162 swabs taken, 18 more residents would eventually test positive. According to the Authority's final outbreak report, three more staff also had the onset of COVID-19 symptoms. Again, though Parkside did not know it yet, Parkside's positive case count had gone up by almost 50% from the day before. There were 65 cases (36 residents and 29 staff members).

At 8:48 AM, the Authority's Director of Continuing Care in Regina emailed Extendicare's Senior Administrator and Parkside's Administrator noting if Parkside needed access to the Authority's labour pool, she would need to escalate it as soon as possible (Though it was not possible for Extendicare to access the Authority's labour pool).

At 10:41 AM, Saskatchewan Polytechnic's Program Head for its Continuing Care Assistant program advised Parkside's Director of Care that Public Health had decided 'learners' were not permitted to be on a unit during an outbreak, and it had been directed to immediately pull all students from Parkside. So, the students who had just started the day before all left.

At 10:56 AM, Parkside's Director of Care emailed Public Health to ask why it had ordered Extendicare to put a stop to its use of students from the Saskatchewan Polytechnic. She also asked for clarification on what she described as "different rules each time we turn around." She said some symptomatic staff who tested negative were being told they can return to work in 48 hours even though they were listed as close contacts to positive cases, while others who tested negative were either being told to isolate for 14 days because they had close contact with someone, or to only self monitor.

Despite Extendicare having no right to access the Authority's labour pool under the arrangements it had made with the unions representing its staff, at 2:22 PM, the Authority's Director of Continuing Care emailed Extendicare's Senior Administrator: "[A]s we discussed this morning, if you are going to run into difficulties with environ service workers and food

services workers you should give us a couple of days lead time. Here is the form. Although it is fairly general if you can be specific about shifts and days where your holes are that is preferable."

At 3:59 PM, Extendicare's Regional Director emailed the Authority saying, "[W]e are looking for…[an] audience with [Public Health] and our Chief Medical Officer to discuss [Public Health's] decision to 'hand cuff' our leadership team with discussion from our experience elsewhere. Physician to physician talking may help."

At 4:10 PM, Public Health clarified since the continuing care assistant students would only be working at Parkside for the duration of the outbreak, it had reversed its decision and they could work at Parkside as long as they were cohorted and followed the same processes as staff.

At 7:22 PM, the Authority's Executive Director of Continuing Care in Regina emailed Extendicare's Regional Director and others about Public Health determining that many of Parkside's staff had been close contacts of a COVID-19 positive person and were therefore required to self-isolate:

> The number of [positive] staff (15) and residents (18) is a significant concern and with lack of a clearly identified transmission source and potential that some infection control processes may have been breached, a cautious approach has been taken. I am respectful of the expertise of the Medical Health Officer and Public health team based on the current information available to them.
>
> I recognize the pressures the organization is experiencing and the incredible work the team is doing, with [Extendicare's Senior Administrator's] onsite leadership, to support needs from within your organization during this period. With the absence of so many clinical/care leadership team members, even with virtual support… being used, it does not meet the hands on needs.
>
> In noting the desire to meet again with the MHO, it would be helpful to understand if there is additional information to share that would help address the transmission risk concerns?

NOVEMBER 26, 2020

Realization that staff were not socially distancing

At 10:12 AM, an Authority Infection Prevention and Control official emailed various people, including Parkside's Director of Care to recommend that Parkside take steps to decrease COVID-19 transmission among staff, including staggering all breaks, using different break rooms for different wings/department, requiring staff to sign-in and sign out of the break rooms with dates and times (which she noted would be essential for contact tracing), and "Ensure there is 6 feet or 2 meters of space **between ALL staff at ALL times** in the break rooms…by…Using separate tables… And ensuring the number of seats per table are appropriate for table size" [emphasis in the original.] She said: "I know a lot of the facilities are doing these, but these recommendations need to be **enforced!** We have seen a significant number of staff that have been placed on self-isolation as close contacts in these situations" [emphasis in the original.]

At 9:41 PM, Extendicare's Senior Administrator advised Authority and Extendicare officials that:

- Positive residents had been cohorted on the main wing and one room on the north wing.
- He anticipated not having enough continuing care aide shifts for the weekend, so Parkside was interested in partnering with nursing and continuing care assistant students to help.
- Extendicare had ordered more large trays, tray carts, and overbed tables so residents could be fed in their rooms, plus six portable sinks and four mobile hand hygiene stands.
- 22 residents had confirmed positive test results: 20 in the facility and 2 in the hospital.
- 19 staff had confirmed positive test results and another 35 were directed to self-isolate.

Contact tracers had spoken with the Parkside staff who were symptomatic before November 20 and the Authority's Infection Prevention and Control officials had learned that some of them had not been socially distancing from other staff, in their cars, in their homes, and during their breaks at work.

NOVEMBER 27, 2020

More positive tests; concerns about uncontrolled cycle of transmission

According to the Authority's final Outbreak Summary, a total of 69 people (39 residents and 30 staff) now had the onset of symptoms, some of whom would not test positive until later.

At 7:03 AM, the Authority's Executive Director of Continuing Care in Regina began arranging for its Nutrition and Food Services division to provide Extendicare with the dietary equipment it required, such as food trays and carts.

At 1:14 PM, Extendicare's Senior Administrator told the Authority that it intended to transfer nine or 10 negative residents from Parkside's south wing to Extendicare Elmview to reduce the workload. He asked the Authority to arrange for them to be transported, noting that a meeting with Public Health was in order to get its opinion.

At 1:51 PM, an Authority Medical Health Officer wrote several Authority officials about what he called a "few key signals" about the causes of the outbreak, based on the Authority's contact tracing and investigative efforts so far:

1. Some staff come to work symptomatic, ignore signs or don't recognize them and work with the elderly.
2. Staff do the right things on the floor so to speak but not outside of that.
3. Spread occurs in lunchrooms, change rooms and driving to and from work, where no distancing is done, masks not worn and measures forgotten.
4. Staff socialize outside of work and have not kept smaller household bubbles.

Later that day, another Medical Health Officer wrote: "Transportation to and from work is also important. Staff car pool – and that can create concerns too when one of them tests positive."

About transferring residents to other facilities, at 2:07 PM, the Authority's Executive Director of Continuing Care in Regina wrote Extendicare's Senior Administrator and copied Public Health officials:

> Parkside is in a difficult space with escalated resident and staff cases and many more staff that are close contacts and out fo [sic] the work place. They cannot provide care safely in the current situation and we need to support a response, whether that is resources to support care in place, or movement. We need to support a plan to address needs, noting he [sic] labour pool challenge, but this is a critical need.

At 2:25 PM, apparently still unaware Extendicare could not access the Authority's labour pool, Parkside's Administrator sent an Authority *Covid-19 Pandemic Planning Labour Pool – Staff Needed* form to the Authority's COVID-19 labour pool general email account asking for continuing care aides to work at Parkside, writing "Please help us if you can."

At 6:36 PM, following a meeting between Extendicare and Public Health, a public health official expressed concerns about Parkside's decision to isolate the non-positive, close contact residents together in 2- and 4-bed rooms, saying the "cycle of transmission will continue uncontrolled." She said:

> A concern that I wanted to bring up is that as long as our non-positive, close contact residents are being isolated together in 2 or 4 bed rooms, the cycle of transmission will continue uncontrolled. Our best hope of slowing spread among residents at this stage is to place all of the non-positive residents in private rooms. Then if/when some of them become ill – the cycle stops with them as they would not be in close contact with others. It would not be a quick fix – we will find additional new positives in this group over the next 14 days BUT if we can find a way to isolate them in rooms of their own, we stand the best chance of protecting them.
>
> I appreciate that this is an extreme suggestion but I think Parkside is likely to present us with our most extreme outcomes. I bring this idea forward in hopes that it may also be considered.

The Authority's Executive Director of Continuing Care in Regina replied at 6:46 PM:

> In discussion of the vacant unit, that principle was the key focus but we know that to achieve that fully, we need 100+ rooms. I am very concerned about the tight congregate environment with the infrastructure at Parkside and want to support the possible outcomes for the residents and the staff.
>
> We will continue this discussion and look to [a medical health officer], you, Infection control and others to assist us and Extendicare in making the right decisions for all. We can review and discuss further Monday, and know [the Senior Administrator, Parkside Administrator] and Team are doing their best to put the safest processes in place based on the layout of their building.

Extendicare's Senior Administrator expressed his frustration a few hours later at 8:53 PM:

> The email that was sent by [public health] is another example of the confusion of direction from Public Health. Today I presented multiple scenarios to the SHA, IHICC and Public Health. We had some very engaging conversation and I thought we had a solid plan to move forward with.

> Then we have another person from Public Health state that the plan is not good enough and then propose a scenario that cannot be accomplished.
>
> I am struggling with the constant change of direction or opinion of change of direction from Public Health.

The Continuing Care Assistant students from the Saskatchewan Polytechnic returned for the evening shift.

In a November 27, 2020 letter to the Minister of Health, Extendicare's Vice President of Long-Term Care Operations asked the Minister to urgently reconsider supporting Extendicare's program of asymptomatic testing of long-term care staff, an issue that had been raised previously with the Minister in a June 19, 2020 letter. He said the number of resident and staff cases at Parkside was "cause for deep concern" and asked the Ministry for urgent assistance. As of then, still unaware that several Parkside staff had worked while symptomatic and had not followed proper masking and distancing protocols while interacting with each other, he wrote: "It is clear that symptom screening of staff is not enough to keep the virus out of homes given the well documented ability of this virus to spread through asymptomatic people. Given the current rate of community spread, it is essential that we begin testing all LTC staff weekly for COVID-19."

NOVEMBER 28, 2020

Moving positive residents for a second time

In a November 28, 2020 letter to Parkside's staff, Extendicare's Senior Administrator noted that by then they knew of 37 residents and 21 staff members who were positive for COVID-19. He advised that due to the flow of so much foot traffic on the main wing, they were going to shift all positive residents to the north wing. He reminded staff of how critical it was for them to continue to monitor themselves and to stay home if they were sick. He said that they were trying extremely hard to cohort staff to specific wings, but due to 55 staff either testing positive or self-isolating, they needed to move staff around.

A direct care worker told us they were moved from working with positive residents on the main wing to working with positive residents on the north wing, but two days later they were moved again to work with non-positive residents on the south wing, which they thought was strange as they had been working with positive residents. When we asked other direct care staff whether they were assigned to deal specifically with COVID-19 positive residents, they said this was true for the most part, but since there was a huge staff shortage, they got moved from a non-positive wing to the positive wing.

When we asked about the process of moving positive residents into the north wing, direct care workers told us when residents vacated a room, housekeeping would disinfect the bed, dresser and other things used by residents, but not the whole room. Another direct care worker told us they could not believe the residents were being moved around – positive and negative residents at the same time. They told us that not all residents were masked during the moves.

Another direct care worker told us they were given only one surgical mask per shift, plus a face shield, but were allowed to take an extra mask if the first one became soiled. Some direct care workers said they were directed to change their gloves when working hands-on

from one resident to the next, but not their mask, shield or gown. One worker said they were told to only change their gown if it became visibly soiled.

According to the Authority's Final Outbreak Report and Summary, as of November 28, 80 people had symptoms at Parkside (49 residents and 31 staff). Again, only 58 positive results were known at this time (37 residents and 21 staff).

NOVEMBER 30, 2020

More mass testing, 127 positive cases

More mass testing was done. According to the Authority's final outbreak report, 127 people had the onset of COVID-19 symptoms – 81 residents, 46 staff, though confirmation of the cases for people swabbed that day would not be available to Parkside for a few days yet.

At 12:36 PM, Parkside's Director of Care emailed Authority Public Health officials expressing her frustration about communication from the Authority's Public Health officials. Though she acknowledged that Public Health was very thin on resources, she said she needed officials to get back to her in a timely manner regarding testing, contact tracing and messaging to staff about when they were able to return to work (because she too was extremely short of staff).

DECEMBER 1, 2020

Concerns about Parkside are escalating

At 10:25 AM, the Authority's Director of Continuing Care in Regina emailed officials from the Authority's Integrated Health Incident Command Centre about Public Health's escalating concerns based on Parkside's staff reporting that they did not have enough PPE, there was not adequate spacing in break areas, plus general concerns around infection control practices. She said, given the range of concerns, the Authority was, with Parkside's support and approval, sending a team of infection control and safety professionals to Parkside to assess these concerns firsthand, noting that the team needed to go to Parkside no later than the next day.

DECEMBER 2, 2020

Authority's on-site assessment

According to the Authority's final outbreak report, 19 more people had symptoms and would test positive for COVID-19, bringing the total to 146 cases (88 residents and 58 staff).

Authority officials from Infection Prevention and Control, Public Health and Quality and Safety conducted an on-site assessment at Parkside. Although there were aspects of infection prevention and control of which Parkside was seen as doing well, they noted significant areas of concern, some of which were as follows:

Entrance & Screening: While Parkside had a dedicated screener checking staff temperatures and ensuring proper documentation was being completed, staff were not physically distancing while waiting to enter the building and were throwing used paper bags

in with dirty laundry at the entrance. Some staff reported being "harassed" if they needed to stay home because they were symptomatic.

Continuous Masking: Staff were all wearing masks and face shields but two staff were seen wearing 'double-masks.' A supply of single masks in paper bags suggested that staff were still only using a single mask per shift. The Authority wondered if all staff were replacing masks regularly as required throughout their shift. Some staff said they were only allowed one while others indicated no issues with getting additional masks.

Personal Protective Equipment: While all staff were wearing PPE and those on the COVID-19 unit (north wing) appreciated the rationale of the continuous gowning policy, the Authority noted that staff were inconsistent in following proper procedures: some were not tying their gowns correctly, some were not washing their hands between donning and doffing, some were wearing gloves in the hallway, some were 'triple gloving', and some were wearing gloves that did not fit. There was nowhere to store face shields during breaks, so staff were placing their face shields on paper towels and leaving them on break room tables along with other personal belongings while eating lunch.

Staff breaks and interactions: Given Parkside's infrastructure limitations, staff were trying to maintain proper social distancing while on their breaks, but the layout of the break rooms made it difficult, and the break rooms were also being used for storage. Also, staff assigned to different wings were using the same break rooms and there was no logging of 'ins and outs' into break rooms. Staff who smoked were not washing their hands before returning to work and possibly not socially distancing while in the smoking area. There was also some concern about whether staff were masking when carpooling to and from work.

Cleaning: Equipment was not being consistently wiped between each resident's use. While housekeeping staff were working diligently and recognized the importance of their role, the cleaning products and processes they were using were not assuring proper and consistent disinfection.

Infrastructure: Parkside's space constraints meant PPE supplies were stored in ways that created a high risk of cross-contamination. Additionally, resident rooms were too small to contain storage for contaminated items, and staff did not have enough room to properly store their personal effects (boots, winter coats, etc.).

Kitchen and Dining Areas: Staff from the COVID-19 wing and the non-COVID-19 wings were congregating in the kitchen area; food delivery equipment was not being disinfected properly. Uncovered beverages were being left unattended in the wings increasing the risk of contamination by residents walking by.

An Authority Infection Prevention and Control official emailed other Authority officials at 3:50 PM, expressing frustration with Parkside: "[F]rom Nov 23 I have made multiple attempts get updates from Parkside, and to be included in their outbreak meetings. I've gotten delayed responses from [Parkside's Infection Control nurse], and am still not included in their meetings." Another official replied: "This could be part of the problem… lack of engagement from the Parkside Infection Control staff." In reality, Parkside's Infection Control nurse (who was only employed part-time) had been helping with resident care because so many direct care workers had been placed into self-isolation.

In response to a 5:14 PM email from the Authority's Infection Control and Prevention flagging Parkside's staff using just one mask per shift, not socially distancing in the break room, and not consistently being cohorted on each wing as "significant issues", the Authority's Executive Director of Continuing Care in Regina replied at 6:30 PM (in part):

> ...I am very concerned about the issues, some which are broader Extendicare policy and we must address in a manner that supports both resident and staff needs.
>
> We need to reduce the workload and allow Extendicare staff the opportunity to have reasonable workloads and do their work safely and to provide the infection control and worker safety requirements to Extendicare. We may need to look at decanting a number of covid - residents to the vacant 4th floor [Regina Pioneer Village] unit and create a team there to provide care, to create this, for Parkside.
>
> I would see the SHA supporting the infection control and employee safety requirements initially, to help them create the plan to address deficiencies. If there is unwillingness to do so, there are employee safety processes under OHS but that would be a final resort. I have copied [the Director of Continuing Care] as she has affiliate oversight. I have also copied [two other Authority officials], so they is also aware, but am prepared to pull our Director team into discussions on how best to support this and to support Extendicare Parkside in being able to make the best possible decisions.

Physician's warning

Two physicians attended Parkside in the evening. We were told that this was the first time a doctor had been inside Parkside since the start of the pandemic. One of them wrote the Authority about what they had seen:

> We have a **Critical Situation**, and I don't think we are not responding enough!
>
> Parkside is our first big outbreak. [We] went in last night to help staff and round on patients in need. The gratitude in the patients and staff was overwhelming. They are overworked and tired. They have over 80 COVID positive patients and many staff off. We went in to listen to the staff and patients. We honestly did very little tweaking of medical plans except confirm advanced directives, reassured patients and I even phoned one anxious family member. It honestly does not take much to help.
>
> Why can't we stop the spread? 80 patients is a disaster! Is it PPE, is it staff fatigue, we need people on the ground to figure it out. The staff is just tired and surviving. Patients are dying and more without a doubt will die.
>
> Why are we not adding more resources to the Outbreak?
>
> We need to have our Go-Team up and running by next week!
>
> We can prevent acute admissions. We can reassure patients and family members. We can support the staff. We can reassure them that they are doing the right things and tweak some things.
>
> We have a big outbreak. A team can learn how to help, so the next response will be way better! I realize it is a LTC, Primary Health care, Assessment site collaboration but it is not happening. We all need to be in the same room and thrash it out, TODAY.
>
> Why are we waiting, we are watching the bus running away from us...
>
> WE need the GO team running by MONDAY!
>
> [Emphasis in the original.]

DECEMBER 3, 2020

Authority offers Extendicare Parkside advice and support

Of the nine swabs taken from residents on December 3, 2020, seven came back positive.

Authority officials met with Extendicare officials to discuss improved infection control, safety and transmission risk management processes. In an 11:53 AM email, the Authority summarized the situation and committed to providing Parkside with support:

> At this time there are over 80 covid + residents and 32 covid+ staff, with an addition 30 on isolation as close contacts. With recent increase in cases in the last 48 hours, the number of impacted staff may increase also. Infection Control, Public Health Inspectors, Safety and Public Health attended at the home yesterday and have come up with a number of recommendations to support improved infection control, safety and transmission risk.
>
> ...
>
> The following areas were discussed, leads identified to work with [Extendicare's Senior Administrator] and planning to occur today to support a response as soon as possible, within the next 24 hours to support needs over the coming weekend and next week:
>
> 1. Staffing – ...
>   - Will work with Extendicare to identify immediate needs and project over the next several days to support redeployment needs.
>   - Re-cohorting has resulted in some resources, but not sufficient to meet needs.
>   - Communication plan to support staff needs when re-deploying
>   - ... re-deployment needs will trigger slowdown, so work with [the Integrated Health Incident Command Centre in Regina] to coordinate
>   - Action – [The Authority's Director of Human Resources Business Partnerships] contacting [the Authority's Continuing Care branch] with options for next steps – meet later this morning
> 2. Increased clinical resource/nursing support –...
>   - Immediate response with 2 [out-of-scope] Clinical Managers responding to provide clinical resource support today and next few days to support daily rounding with residents
>   - Fit Testing, PPE refresh occurring today at 1:00 for these Clinical Managers
>   - 5 [Clinical Nurse Educators]/Resource Nurses identified to support this, potential for 1 EMS employee from LP
>   - This is part of a larger piece of work for a Regina "Go Team", escalating this work
>   - Action – [An Authority Director of Continuing Care] will coordinate meeting with [the Authority's Director of Primary Health Care] to set up structure and functions for clinical resource needs and staff needs
> 3. Daily physician support/rounding
>   - [Two physicians in Regina] rounded yesterday, primary focus was team support, much needed, focused on care management plans and some conversations with families to address their needs

- Not sure if daily physician rounding required, do need more clinical resource supports
- Require more coordinated and regular response of MRPs for virtual support and onsite visits
- Action – [Physician] will work with [Extendicare's Senior Administrator] on communicating with the Parkside physician group
- Covid -19 CC Order set – update being finalized, to be out by Dec. 4/20, [the Authority's Executive Director of Continuing Care in Regina] will check on with Clinical Standards

4. Daily planning process with Public Health to prepare and manage next steps, recoveries, internal movement to support needs
   - Participated in the walkthrough yesterday and key areas of needs – staff break rooms kitchen access, space issues and distancing, mask use and re-use may be adding to risk
   - A written report will be provided
   - Parkside requesting some additional planning support with Public Health related to recovering residents, other needs, in addition to daily line listing review
   - Action – [Extendicare's Senior Administrator] will follow up with Public Health on the recovery and resident management plan, and staff plan for recoveries
   - Public Health (post meeting) recommended a daily outbreak meeting with Parkside and a representative for each of these areas to facilitate timely response to need and next steps – [The Authority's Executive Director of Continuing Care in Regina will] confirm with [Extendicare's Senior Administrator] and identify leads to participate.

5. Safety, [Incident Control] and Risk Management – what additional measures can be in place to further reduce risk of transmission and any resources to help educate, implement, support.
   - Help required with PPE, education, auditing, space review options development, infection control recommendations
   - Participated in the walkthrough – report to be provided with recommendations
   - Action – Parkside requested to use SHA masking policy and stop re-using masks through the brown bag storage process – [Extendicare's Senior Administrator] will speak with Extendicare re: same
   - [The Authority's Director of Quality & Safety in Regina] – will work with [Extendicare's Senior Administrator] to support assignment of a [Occupational Health]/Quality specialist to support onsite [respirator fit] testing, PPE, other education and PPE/risk auditing, space review
   - Infection Control – [The Authority's Vice President of Provincial Programs] requested that [the Incident Command Post] Team review to see if [there is a] need to pull in resources from other areas to support response, [The Authority's Infection Control Practitioner in Regina] will follow up

6. External response – any decant needs to reduce high congregate environment in non-covid areas
    - Recognize 4-bed rooms mean spread will continue
    - Has it spread so much that a move at this point may not be helpful
    - Only help if can support in a private room with cohorted staff, dedicated resources, so that if someone moved becomes positive, it is reduced risk of transmission
    - Action – [Authority Director of Continuing Care], will provide info on [Regina Pioneer Village] private room space (unit fully vacated this week) and internal re-direction of staff to support needs
    - [The Authority's Executive Director of Continuing Care in Regina] – follow up with Rural- they are aware of the situation and will provide response on [Alternative Level of Care] space (for those covid – but risk factors), private rooms only to provide available space, with information for this afternoon. Follow-up with Extendicare and Public Health later today for a decision once available space and resources are identified.

7. Any family support needed?
    - Daily updates to family and to staff through several different processes, including email, calls and town halls
    - Physician support to address family questions, medical care concerns – [Extendicare's Senior Administrator] /[Physician] can determine [the Most Responsible Physician] role and role of clinical resource support to assist also
    - SHA communications aware and available to work with Extendicare as needed

In a 7:54 PM email, an Authority official confirmed that Parkside had then adopted the Authority's staff masking standard, that officials were going to Parkside first thing the next morning to assist in rolling it out, and that Parkside would have appropriate access to PPE from the Authority to support the roll out.

According to the Authority's final outbreak report, 158 people (94 residents and 64 staff) had COVID-19. 32 more staff with the onset of symptoms had not been detected yet.

DECEMBER 4, 2020

Authority asks its nurses to volunteer at Parkside

At 10:47 AM, the Authority's Director of HR Business Partnerships asked all of its operational managers to ask their registered nurses and registered practical nurses to volunteer to work at Parkside Extendicare: "The facility is currently in an outbreak and is need of RN and RPN support immediately."

According to the Authority's final outbreak report, Parkside had a total of 175 cases (101 residents and 74 staff) as of December 4, 2020. Two more residents died from COVID-19, one at Parkside and one in the hospital.

DECEMBER 5, 2020

Moving residents to Regina Pioneer Village; still struggling to get staff

This was one of the Parkside managers first day back at Parkside since being in isolation. They told us it was quite a different place than it was on November 21 when they left. They said it was like walking into a war zone.

Beginning on December 5 and continuing for the next several days, a total of 25 residents were transferred to an empty unit with private rooms at Regina Pioneer Village. Nineteen of those residents were already COVID-19 positive when they were transferred but the test results were not known, and five more would ultimately test positive for COVID-19 (24 out of 25). Four Regina Pioneer Village employees who provided care to these transferred residents also contracted COVID-19.

According to an update provided by an Authority Infection Control Practitioner, Authority officials participated in a call at 2:00 PM regarding Parkside's positive staff and staffing. They discussed providing Parkside with isolation carts (for holding PPE) so that its staff would not continue to risk inadvertently contaminating new PPE, which was still being stored in shoe caddies hung over resident room doors. Among other things, they also noted that Parkside's staff were still missing hand hygiene steps while donning and doffing PPE, and that the Authority was still trying to get staff relocated to Parkside.

At 2:59 PM, Extendicare's Senior Administrator emailed the Authority's Executive Director of Continuing Care in Regina to advise it was working towards having only two negative residents per room, but may still have 3 in a room.

At 8:31 PM, the Authority's Executive Director of Primary Health Care in Regina emailed other Authority officials about needing to update the Parkside audit (from December 2) "in order to assess [the] risk for volunteer SHA staff working in the facility." She advised Public Health wanted to see a number of…essential improvements "like break room configuration, screening and masking use, etc. before [it] is able to assess the safety."

According to the Authority's final outbreak report, Parkside had a total of 182 cases (104 residents and 78 staff) as of December 5, 2020. The fourth and fifth residents died of COVID-19, one at Parkside and one in the hospital.

DECEMBER 6, 2020

Corrective action required at Parkside; staff still needed

At 8:48 AM, an Authority Public Health official emailed other Public Health officials to suggest that they approach Parkside's staff about the following issues:

> 1) review the things we know have been areas of concern (breaks, lunches, out-of work contact). Doesn't need to be extensive, but an opportunity for staff to rethink whether those things may have been done without appropriate protections in place
>
> 2) General, non-judgmental questioning about breaches in practice when interacting with both patients and staff. I think with them seeing the high number of cases coming out of their workplace, they are more likely to be re-analyzing their own practices with a certain amount of anxiety. If given a reassuring opportunity to admit this with the expectation that it will make their workplace safer, perhaps some will take advantage of it.

> 3) Agree with [Medical Health Officer] - the reuse of masks is certainly a risk of self-exposure, but is not going to lead to significant risk to others unless the masks are very old (i.e. 1/shift is not likely to lead to significant additional staff exposures)
>
> If working backwards we are not finding many/any additional important contacts with this review step then I would not continue. The further back we go the less useful it will be, and if it starts off with fruitless efforts then it's not going to get better.

At 8:51 AM, the Authority's Director of Continuing Care in Regina advised other Authority officials helping to find Parkside staff that "[Integrated Health Incident Command] has required that we have a detailed checklist of deficiencies including those things that are already done…No staff can be deployed until this is complete as the unions are waiting for it."

At 11:29 AM, an Authority Medical Health Officer updated other members of Public Health working with Parkside about things that still needed to be done, including setting up an on-site command structure similar to an incident command process, on-site testing of swabs, offering daily testing to Parkside's staff, arranging for more medical (physician) support, finishing the relocation of negative residents to other facilities, and ensuring Parkside had enough PPE. He noted that staffing continued to be an issue.

At 5:37 PM, an Authority Infection Prevention and Control official advised other officials that Parkside's Director of Care told her it did not need Infection Prevention and Control's assistance at that time, but noted that IPAC would be touching base with Parkside daily at 10:30 AM. She further advised that Parkside had not been providing the Authority with its staff hand hygiene audits since at least October 2020. She flagged this as a concern, since IPAC had recently learned staff were missing hand hygiene steps when donning and doffing PPE. She also noted that Parkside's hallways were too small for the isolation carts the Authority wanted them to use.

Extendicare seeks more help from the Authority

In the evening of December 6, members of the Authority's Integrated Health Incident Command Centre and Continuing Care branch spoke with Extendicare leadership, including its Vice President of Long-Term Care Operations, Chief Medical Officer, and Regional Director for Manitoba and Saskatchewan. They reviewed the situation at Parkside and discussed the Authority's capacity to provide staffing support. The Authority confirmed it could provide physician, clinical and therapeutic resource teams, but was limited in its ability to provide frontline staff, because of its workers' PPE and safety concerns, but also because it meant unionized staff would be working outside of the Authority's Letter of Understanding regarding COVID-19 labour pools and staff cohorting with the unions. The Authority also raised concerns about Extendicare's PPE supply chain not providing products that met the Authority's standards. Extendicare replied that the Authority's PPE standards were set at an acute care standard and not sustainable in the long-term care sector – though, as the Authority noted, it had been sustaining the standard in all of its long-term care facilities for some time. Authority officials left the discussion with concerns that Extendicare's corporate leaders were taking an arm's length approach and were providing only minimal corporate support to its local staff.

Following the discussion, Extendicare's Regional Director emailed the Authority to ask it to supply Parkside with IV therapy services and supplies, respiratory technologist support, continued on-site infection prevention and control support, more PPE, and staff.

According to the Authority's final outbreak report, Parkside had 188 positive cases (105 residents and 83 staff). Three more residents died of COVID-19 at Parkside on December 6.

DECEMBER 7, 2020

More positive test results

According to the resident testing reports we reviewed, 91 residents were swabbed on December 4, 5, 6 and 7, 63 of whom tested positive for COVID-19. Most of the swabs were taken on December 7, so 45 of the positive test results did not come back until a few days later.

According to the Authority's final outbreak report, Parkside had a total of 238 cases (149 residents and 89 staff) by December 7. Three more residents had died of COVID-19 at Parkside.

DECEMBER 8, 2020

Authority and Extendicare enter co-management agreement for Parkside

On December 8, the Authority and Extendicare entered into a temporary agreement effective as of 5:00 PM under which the Authority assumed operational control of Parkside including, among other things, directing and overseeing its managerial staff and contracted physicians, providing supplemental Authority managerial staff to work at Parkside, and directing and overseeing all of its operations (such as staffing, policies, procedures and resident care plans) and, "Any other matter required for operation of Parkside as determined by SHA in its sole discretion." The agreement required all Parkside staff, whether employed by the Authority or Extendicare, to "follow all policies, procedures, standards and practices as directed by SHA in relation to resident care management, infection prevention and control, personal protective equipment and occupational health and safety[.]"

By the time the Authority took over Parkside's operations, 246 people at Parkside– 149 residents and 97 staff already had COVID-19.

According to emails among Authority officials, it ordered 400 face shields (for urgent immediate delivery) 59 cases of nitrile gloves (for delivery later in the day), and 2,500 gowns (for delivery the following day).

By 4:27 PM, the Incident Commander for the Authority's Integrated Health Incident Command Centre in Regina had set up and shared the structure for the Authority's Parkside Incident Command Centre to be operated on-site.

In an email to the Authority sent at 9:53 PM (Saskatchewan time), Extendicare's Chief Medical Officer asked the Authority to work with Public Health to approve asymptomatic COVID-19 positive Parkside staff to return to work immediately to care for the COVID-19 positive patients. He said the risks could be managed and the benefits would be significant. He said: "We should act immediately given the critical staffing situation." The Authority replied at 10:08 PM, noting that the Authority would ask its Integrated Health Incident Command Centre to consider the suggestion and follow up.

Another resident who had been sent to the hospital died of COVID-19.

DECEMBER 9, 2020

264 positive cases

This was the Authority's first full day of operations at Parkside under the co-management agreement. According to its final outbreak report, 18 more people had COVID-19 from the day before (14 residents and 4 staff members), for a total of 264 (163 residents and 101 staff).

At 8:12 AM, the chain of emails between Extendicare's Chief Medical Officer and the Authority from the day before, dealing with self-isolation periods, was forwarded to Public Health with the following comments:

> The bottom line is we have a serious and critical staffing situation at Parkside. I know there is precedence in other jurisdictions to shorten isolation time for COVID positive staff from 14 to 10 days. I believe Alberta is doing this already. ...but we would need your approval to consider.
>
> Shortening this duration would immediately free up a number of staff from Parkside to go back to work and alleviate some of this crisis. I would imagine the staff going back are just cohorted to the COVID+ unit.
>
> Please review and let us know ASAP. We can set up a discussion if that helps.

An Authority Medical Health Officer forwarded this chain of emails to Saskatchewan's Chief Medical Health Officer at 8:29 AM, stating that shortening the isolation period and bringing Parkside's staff out of isolation prior to the 14-day period was "not advisable in a setting where nearly 80% of residents are positive but NOT the staff working there."

In a 9:48 AM email to the Authority's Director of Continuing Care in Regina, its Executive Director, Nutrition and Food Services noted the unions had raised concerns about whether the PPE being delivered through Extendicare's supply-chain met the Authority's standards, and confirmed that the Authority was positioned to continue to supply Parkside with gloves, face shields and gowns indefinitely. The Director replied that the Authority should set up to do so for the next two weeks and, "Once the SHA Incident Command team takes over on the site, we will have clearer direction. Then they can sort out the Extendicare supply chain."

The Authority's Incident Commander – Regina Integrated Health Incident Command Centre (IHICC) sent an urgent email to Authority officials at 12:25 PM:

> Regina Parkside Extendicare is currently experiencing a severe, widespread outbreak of COVID-19 cases in its facility that includes residents and staff. **This is an emergency situation**. Human Resources is issuing a broadcast to request nursing staff to immediately assist at the facility. Please assess your area to identify any staff available to assist at Parkside immediately as well as over the next 5 days. Volunteers are asked to respond to the broadcast but can also call [phone number].
>
> This is an exceptional situation and your assistance is urgently required.
>
> [Emphasis in the original.]

In an email sent at 1:30 PM, a Medical Health Officer with the Authority in Regina advised that after discussions with the Chief Medical Health Officer, an interim waiver of the public health order would be issued to reduce the isolation period for COVID-19 positive Parkside workers from 14 days to 10 days, either from the onset of symptoms or, for asymptomatic cases from their positive test.

At 8:23 PM, the Commander of the Authority's Integrated Health Incident Command Centre in Regina wrote to other Authority officials to emphasize that the Authority's Public Health and Infection Prevention and Control needed to make immediate, clear decisions regarding the isolation, cohorting and re-cohorting rules for staff after they worked in a COVID-19 positive environment. Because Parkside was down approximately 18 registered nurses, 21 licenced practical nurses and six continuing care aides.

Another resident died of COVID-19 at Parkside.

DECEMBER 10, 2020

In an email to several Authority officials, the priorities for its Parkside Incident Command Centre were set out including in the areas of safety (cleaning and decluttering the site, improving infection prevention and control and PPE use), staffing (scheduling Parkside, Authority and external employees, physician scheduling, recruiting Authority staff and external resources, establishing daily staff huddles), an incident command centre for Parkside (integrating Parkside leadership into the structure, filling Incident Command Centre positions), and establishing a family liaison (coordinated with Extendicare).

Three more residents died of COVID-19 at Parkside.

DECEMBER 11, 2020 TO JANUARY 20, 2021

One resident at Parkside died of COVID-19 on December 11.

In a December 12 email, a consultant reported that Parkside's resident rooms did not meet relevant ventilation standards (CSA Z317.2: "The actual resident/care area of the resident rooms effectively get no ventilation." As a result, at 7:55 PM, the Authority's Emergency Operations Centre Commander advised that it was going to require all staff at Parkside to wear N95 respirators. Portable HEPA filters were installed.

One more resident died of COVID-19 at Parkside on December 12.

Another COVID-19 positive resident died at Parkside on December 14. One of the residents transferred to Regina Pioneer Village also died of COVID-19 that day.

According to the Authority's final outbreak report, as of December 15, 2020, there were 169 residents and 126 staff that were positive at Parkside. According to an Authority "Parkside Extendicare update," dated December 15, 2020, of the staff who tested positive, 27% reported working while symptomatic.

After December 15, there were an additional seven positive COVID-19 cases (one resident and six staff members).

Three residents died of COVID-19 on December 16, two at the hospital and one at Parkside.

Another resident died of COVID-19 on December 17 at Parkside.

Two more residents died of COVID-19 at Parkside on December 19.

On December 20, two more residents died of COVID-19, one at the hospital and one at Parkside.

Another four residents died of COVID-19 on December 21, two at the hospital and two at Parkside. This was the last day of any reported cases.

Another two residents died of COVID-19 on December 22, one at the hospital, and another at Regina Pioneer Village.

Another two residents that had tested positive for COVID-19 died at Parkside on December 23. The cause of death in one of these cases was deemed not to be COVID-19.

Another Parkside resident died of COVID-19 on December 24.

Another resident died of COVID-19 at Regina Pioneer Village on December 26.

Another resident who had tested positive for COVID-19 died on December 27, but cause of death was deemed not to be COVID-19.

On December 28, the Authority's Infection Prevention and Control division conducted another audit of Parkside's practices for among other things, PPE, supplies, hand hygiene, physical distancing, environmental cleaning, infrastructure (space constraints), and staffing practices. Most were found to be complete, with some measures still noted as 'ongoing', such as donning and doffing procedures, restocking of supplies, and hand hygiene practices.

In a December 31 email, Extendicare's Senior Administrator advised the Authority that Parkside had converted its 4 resident rooms to only two residents.

Another resident died from COVID-19 at Parkside on December 31.

Another resident died from COVID-19 at Parkside on January 5.

Another resident who had tested positive for COVID-19 died on January 12, but the cause of death was not COVID-19.

On January 7, 2021, Extendicare and the Authority extended their co-management agreement for a further 15 days to January 30, 2021. It was further extended to February 15, 2021.

JANUARY 21, 2021: THE OUTBREAK IS DECLARED OVER

An Authority Medical Health Officer declared the Parkside outbreak over on January 21.

According to the Authority's final outbreak report, 170 Parkside residents (out of 173) and 132 staff had contracted COVID-19. Of the 25 residents transferred out of Parkside to Regina Pioneer Village, 24 contracted COVID-19 and 4 staff members contracted COVID-19. So, out of the 198 residents living at Parkside, 194 contracted COVID-19.

Forty-two Parkside residents who got COVID-19 died during the outbreak – 39 from COVID-19 and three from other causes.

The Families

We reached out to the next-of-kin or person identified as the responsible person for all the Parkside residents who lost their lives during the COVID-19 outbreak. We were able to contact most of them. We wanted to give them an opportunity to express their feelings and share their experiences or impressions about their loved ones' care at Parkside. For the most part, they were glad we had contacted them, since it was the first time someone had reached out to them. Some shared very personal, emotional experiences. Many felt guilty that they were not able to do more for their loved ones. Because of the public health orders restricting visits, they could not go into the building to see what was happening. A few were reluctant to speak to us because they were concerned they could be identified in this report. We assured them we would not specifically identify them publicly. We have summarized their perspectives below.

PARKSIDE STAFF

Most of those we spoke to told us that, for the most part, before the pandemic, they had no issues with the care Parkside provided. Some even referred to the care as "exceptional." Even during the pandemic, given the physical demands and the pressure that staff were under, many felt the direct care staff did their best. However, many felt there was just not enough staff to care for and spend time with all the residents, that they were overworked, and that management did not support them properly or devote enough resources to the problem. A few did feel that Parkside did not provide proper basic care and were not surprised that Extendicare was unable to keep Parkside safe and free from COVID-19.

FOUR RESIDENTS PER ROOM

Many we spoke with had loved ones with dementia who lived in a 4-bed room. They said these rooms are small and having four residents in the room was disruptive; their loved ones would get agitated by someone else's behaviour, and there was no privacy. Many felt that sharing a room with others contributed to their loved ones' contracting COVID 19. They believed the situation could have been controlled better if everyone had their own room.

One family member whose mother shared a room with three other residents told us one resident slept all the time, another was cognitively sound but immobile, and the other was often agitated, yelling, screaming and throwing objects. For her mother, who had lived alone for most of her life, it was very difficult to suddenly be in a room with three roommates.

COVID-19 OUTBREAK MANAGEMENT

Some noted that Parkside had the benefit of eight months of seeing the devastation that occurred in other long-term care facilities in other provinces, so it should have been better prepared. Some also felt that Parkside waited too long to ask the Authority for help.

Others told us they were sure their loved one contracted COVID-19 from staff, because the residents were generally confined to their rooms. For those whose loved ones were confined

to a private room, they wondered how they got COVID-19. They said they must have got it from the staff because not enough precautions were being taken. One family member was under the impression that there was not enough PPE or that staff did not follow proper protocols. They felt it was staff who spread COVID-19 when they were going from one room to another.

One family member mentioned that they never saw residents wearing masks. They were unsure if their parent was ever given masks during the pandemic. They said they did not really know what Parkside did to try to stop the spread, because they were unable to visit their parent for a couple months prior to their death. One said:

> I do recall mom not wearing a mask and talking about it. I also recall the Halloween party pictures where none of the residents wore masks. This was a concern for me personally. I don't know if masks would be a bad or good thing for residents. Many would likely not keep them on or wear them properly, but maybe many of the residents could have wore them without issues.

MOVING RESIDENTS AROUND DURING THE OUTBREAK

We received comments about Parkside moving residents around the building once the outbreak was declared. Many thought it did not make sense to move all of the sick people to one place, but then have staff move from working with sick people to healthy people. One person told us that, because of COVID-19, Parkside took her mother out of her 2-bed room where she was with one roommate who was also negative and moved her into a room with three other people. Her mother had tested negative twice. After being moved, she tested positive. Another person shared that their mother shared a room with another COVID-19 positive roommate. They did not understand why they simply could not have just stayed put together in that room. And, then they moved other non-positive residents into her mother's room. In their view, this did not make sense. One person said that their loved one who was already living in the north wing initially tested negative, so they moved her to a different wing. Three days later when she tested positive, they moved her back to her old room.

Another family member told us that when his loved one tested positive and Parkside moved her to the north wing, he could no longer contact her as she no longer had access to her telephone. After he left many messages with management and, he said, made them angry, they eventually moved her phone.

THE FACILITY

Many family members commented that the building seemed run down and there was always a smell. Some felt the smell was because of the ventilation system. One felt that the smell was from dirty diapers being left lying around. Some commented that the furniture was old, the hallways were cluttered, and there was paint peeling off the walls. One said: "Seniors deserve more than a dumpy old building." Many commented that the facility did not always look clean. Some commented that even before the pandemic, Parkside conditions were terrible, stating: "It was dirty, towels strewn, and garbage left in areas."

COMMUNICATION ISSUES

Many felt that Parkside did well in communicating with families to explain what they were doing and to answer their questions. One confirmed that Parkside would email an update once a week to keep them updated on what the facility was doing to handle the pandemic.

Some told us that during the outbreak, staff were 'really good', facilitating FaceTime visits, providing updates on their loved ones, and sharing any issues. On the other hand, many felt communication was lacking and specific questions were not being answered. For example, some told us that once they started asking 'hard questions', Parkside management avoided them or were 'tied up'. One family member said they specifically asked Parkside management how COVID-19 got into the facility but never received an answer. One family member told us that no one from Parkside called to say their father had tested positive. Some commented that no one from Parkside personally reached out to them after their loved one died, and they only received an 'impersonal' card. We also heard of belongings not being returned, including meaningful mementos.

FEELINGS OF GUILT

Many people we spoke to felt guilty. One person told us that once the pandemic started, they couldn't hug or snuggle their mom which she thrived on and that she felt they had forgotten her. She spent the last few months of her life without love and affection from her family and ended up dying alone.

Feelings that the system failed their loved ones were also expressed. One family member said: "My mother worked all of her life, paid taxes, but the health system failed her badly." Another said, "Some residents had no choice but to go into care, they had to put their trust in government and care homes and they failed them."

Applicable Legal Standards and Rules

Before discussing our findings and analysis, it is important to establish the standards to which the Ministry's, Authority's and Extendicare's efforts should be held. What does it mean for them to have taken "reasonable steps" to address the pandemic and get ready to manage the outbreak? Many of the decisions made and actions taken to address the pandemic were based on consideration and re-consideration of the latest, still-evolving research into COVID-19. The Ombudsman's administrative fairness mandate does not extend to assessing the quality or significance of the epidemiological studies and research the Ministry, Authority or Extendicare relied upon, or whether the infection prevention and control measures they established were clinically effective. Our focus is instead on surveying the laws, administrative rules and standards they were required to follow and enforce, and what administrative rules and practices would be reasonable to have expected them to follow.

In his request to the Ombudsman, the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health asked that we consider whether Extendicare adhered to

The Housing and Special-care Homes Regulations, Extendicare's Principles and Services Agreement with the Authority, and the public health orders issued under *The Public Health Act, 1994*.

THE HOUSING AND SPECIAL-CARE HOMES REGULATIONS

Most of provisions of *The Housing and Special-care Homes Regulations* were repealed in 2000, 2003 and 2011. Of what remains, only a few sections seem potentially relevant to the Parkside outbreak. Two of these are as follows:

- Section 4 requires nursing care to be provided on a 24-hour basis by or under the direction of a registered nurse or a registered psychiatric nurse and supervised by a resident's personal physician or a nurse practitioner. Long-term care homes must employ at least one full-time registered nurse or registered psychiatric nurse.
- Clauses 7(b), (c) and (d) require residents to receive medical attention as needed, but in any event not less than once every year. A physician must be on call at all times for emergency care. The nurse in charge must secure immediate medical care for residents with serious illnesses, including arranging for them to be taken to the hospital when recommended by a physician or nurse practitioner. Clause 7(f) provides for residents with (or suspected to have) a communicable disease to be isolated or transferred to an appropriate facility.

We found no indication that Extendicare failed to adhere to these provisions, nor did anyone we talk to from the Ministry or the Authority raise any concerns about them to us.

A third provision of the regulations seems peripherally relevant:

- Subclause 11(a)(vi), requires long-term care homes to encourage and assist residents in taking their meals in the dining room, and to provide tray service to residents who are not able to eat in the dining room.

Encouraging residents to eat communally is, during a pandemic, of course, incompatible with complying with public health orders and advice about limiting the number of residents dining together to accommodate proper social distancing. If Parkside or any other special-care home could be said to have not complied with this requirement for these reasons, it was necessary and reasonable.

Interpreted broadly, providing tray service for residents who are unable to eat in the dining room would include when they needed to self-isolate or be cohorted as a result of an outbreak. Information we gathered indicates that when this became necessary during the Parkside outbreak, it did not initially have enough trays, carts and other equipment to fully implement it. However, Parkside and the Authority took immediate steps to ensure the shortfall was addressed as quickly as possible, and we were given no indication this had any significant impact on the spread of COVID-19 during the outbreak.

In summary, we found no evidence that Extendicare Parkside failed to adhere to *The Housing and Special-care Homes Regulations* except perhaps only to the limited extent that it was necessary to comply with public health orders.

EXTENDICARE'S PRINCIPLES AND SERVICES AGREEMENT

The April 1, 2012, Principles and Services Agreement between the Authority and Extendicare was negotiated and signed by Extendicare and the former Regina Qu'Appelle Regional Health Authority. The Authority, upon amalgamation in 2017, assumed the former region's contractual obligations under it. The Authority told us that it has been in discussions with the Provincial Affiliate Resource Group – which advocates on behalf of special-care homes in Saskatchewan (both prescribed affiliates and Extendicare) – to develop a new, standard principles and services agreement. It said it expected the process to be completed by late-2021 or early 2022.

General Contractual Relationship

As its title suggests, Extendicare's agreement with the Authority establishes what it calls the principles and expectations they are to follow and meet "in working towards mutually agreeable goals of accountability and improving their working relationship." With reference to how the Ministry refers to its purpose on its website, in the agreement, Extendicare and the Authority acknowledge they are "committed to working collaboratively" towards "achieving Saskatchewan's goals for a health system that provides *Better Health, Better Care, Better Value and Better Teams*" [emphasis added]. It is not clear, however, what this means, either in terms of what tasks or deliverables each of them is responsible to undertake and complete to achieve these goals, or how their progress towards them is to be measured.

In the agreement, the Authority contractually recognizes that Extendicare is an independent organization governed by its own board of directors, that it is autonomous and independent, and that this includes the right to govern its affairs, manage its workforce, set direction and establish and manage its own organizational principles and manage its own resources.

Extendicare's Compliance with the Authority's Policies, Standards and Practices

Despite its independence, the agreement requires Extendicare to take both the Ministry's (provincial) and the Authority's goals and directions into account in all matters. It has agreed that it is accountable to the Authority for the provision of the services "in the manner required by Applicable Laws and by this Agreement." And, that it is "responsible for ensuring its programs, operations and Services comply with (a) all Applicable Laws, (b) this Agreement and (c) all agreed upon policies between [it and the Authority]."

In another provision, Extendicare agrees "to implement such necessary and applicable standards and practices as determined by the [Authority] as being required and necessary to demonstrate quality provision of Services" – as long as they are "in all cases consistent with the standards and practices the [Authority] expects to be followed in respect to its own programs, operations, and services[.]"

We understand these provisions to mean, first, that Extendicare is obligated to comply with any of the Authority's policies to which it agrees to comply. And, second, it must also comply with the Authority's standards and practices to the extent the Authority decides is necessary. The agreement does not, however, explain how Extendicare's agreement with specific Authority policies is to be verified, or provide a clear process for the Authority to notify Extendicare that it must comply with certain standards and practices.

As a result, although the Authority gave Extendicare (including Parkside's management staff) copies of and/or online access to all the various policies, procedures, guidelines, work standards and training materials it produced or that were produced by the Ministry for long-term care homes regarding all manner of topics related to the management of the pandemic, we found no indication that the Authority ever formally asked Extendicare to confirm its agreement (or rejection) of any specific Authority policy, or any official notice under the agreement that it was requiring it to comply with any specific Authority COVID-19 specific standards or practices.

Authority staff responsible for working directly with Parkside told us, because Extendicare is an independent company, they did not have the authority to require it to comply with the Authority's continuous masking principles and guidelines – even though they knew it was not complying with them. Instead, they believed they could only 'encourage' it to comply. They gave no indication that they realized that the Principles and Services Agreement already required Extendicare to comply with necessary and applicable standards and practices of the Authority, or that they understood how the relevant provisions of the agreement were to work in practice.

This local sentiment was echoed by other more senior Authority officials, who told us that its policies, standards and practices, do not include either affiliate or non-affiliate long-term care home operators like Extendicare in their scope. The sentiment we heard was that the Authority is conscious of operators' need for autonomy, and that they do not have to formally adopt the Authority's policies, standards and practices. Even with respect to the new version of the principles and services agreement being developed, Authority officials told us they expect contracted operators will only have to comply with the underlying goals of the Authority's policies, standards and practices, though they were not clear yet how these goals would be identified for the purpose of ensuring operators meet them.

Still, when we asked, the Authority rejected the idea that it was or should be responsible for evaluating Extendicare's (or any operator's) policies and procedures to ensure they comply or are compatible with the Authority's policies, procedures, standards and practices. It said that the Authority does not have the resources to conduct such reviews, and, from a liability perspective, each operator needs to do its own due diligence to ensure it is meeting the threshold for compliance.

We appreciate that negotiating new contractual provisions under which the Authority expects to pay hundreds of millions of dollars to long-term care home operators over many years is a detailed and complicated process. We also appreciate that any such agreement ought to account for the risks associated with the services being provided and apportion liability between them according to their roles and abilities. However, regardless of how effective the Authority is at managing its potential liability relating to a long-term care home operator's negligence or other actionable fault, as the Parkside outbreak shows, neither the Authority (nor the Minister) can evade public accountability for any perceived failure of an operator, whether actionable or not.

Further, by not requiring operators to comply with Authority policies, standards and practices of universal application, and by not taking steps to ensure they are meeting the underlying goals of the Authority's policies, standards and practices, the Authority is, in effect, allowing for private long-term care operators to run their facilities without complying with Authority-approved standards and practices. This does not make sense to us purely

from the perspective of administering long-term care across the province in an integrated and consistent way.

In its submissions to us, the Authority highlighted that all long-term care home operators must comply with the Ministry's *Program Guidelines for Special-Care Homes*. And, it specifically drew our attention to Title 19.4 of Ministry's *Program Guidelines*, which requires long-term care homes to have to an infection control program. However, the *Program Guidelines* do not dictate every detail of every requirement. Many of the *Program Guidelines* are general in nature, require extensive elaboration to fully implement, and are, therefore, open to considerable interpretation. Title 19.4 is in fact a good example. In a little more than one page, it lays out the requirement for long-term care homes to have an infection control program. In contrast, Extendicare's Infection Prevention and Control Manual is 304 pages long. So, while we agree that the Ministry's *Program Guidelines* direct all long-term care homes to meet provincial standards, they are, in many instances, too general for either the Ministry or the Authority to be sure that each home is complying with them to a reasonable standard that the Authority would consider acceptable.

In our view, the Authority should collaborate with operators in the development or revision of standards and practices. There are no doubt benefits from bringing the entire sector's expertise and perspectives to bear on the process. We are not suggesting that each operator should not be allowed to implement certain specific practices into their facilities to better accommodate their residents' preferences. In this regard, we note that many operators are associated with faith-based organizations, whose facilities are preferred by some residents for the particular community and services they provide. But, leaving it up to each operator to entirely follow its practices – even regarding matters of universal applicability, such as the proper use and auditing of the use of personal protective equipment – can only result in fractured and inconsistent practices and standards across the system.

In our view, the Authority should update its standard-form Principles and Services Agreement and any schedules to it, without further delay, ensuring that it will require all long-term care home operators to provide care-related services in accordance with standards and practices of universal applicability that are acceptable to, if not established by, the Authority. It should then ensure it implements these standards and practices across the entire province as its existing contracts with operators become eligible for renewal, to ensure Saskatchewan residents receive consistent long-term care services no matter which home they choose or are required to live in.

Extendicare's Ability to Keep its Residents Safe

The agreement also requires Extendicare to take measures to keep its residents safe. If it deems the safety of its residents or staff to be in jeopardy for any reason, the agreement allows it to temporarily limit or adjust the service levels it provides while working cooperatively with the Authority in a timely fashion to resolve their concerns and any related issues (such as funding).

In our view, this means that Extendicare had the authority to insist that the Authority work with it to reduce Parkside's resident population before the outbreak as soon as it realized it could not effectively implement the Ministry's applicable social distancing rules because Parkside was too crowded.

Performance Measures and Targets

The Agreement includes a Schedule "E" of "Performance Measures and Targets" that Extendicare is required to achieve, but only two of them seem applicable to the pandemic: compliance with the Authority's Hand Hygiene Compliance Policy and related Work Standard and Audit Process; and the Ministry's *Program Guidelines for Special-care Homes* (plus any Authority policies related to them).

During their December 2, 2020 on-site assessment of Parkside, Authority Infection Prevention and Control officials noted that Parkside's staff were not consistently washing their hands between donning and doffing PPE, and were not washing their hands for 15 seconds. They also noted that residents' hands were not always being cleaned before they ate. Extendicare's Regional Director also told us that he was at times concerned that its hand hygiene/PPE audits were not meeting benchmarks.

After the outbreak was declared over, as the Authority and Extendicare worked towards transferring control of Parkside back to Extendicare, the Authority continued to stress the importance of Parkside meeting daily, weekly and monthly safety and infection control audit requirements, including among other things, hand hygiene practices among Parkside's staff. For example, in early 2021, it noted that a Parkside resident care coordinator was giving staff all ratings of 100% for handwashing techniques while training them on the techniques, instead of performing blind observations while they performed their normal duties, as was required.

To the extent the Authority had concerns that Parkside's staff were not following its Hand Hygiene Compliance Policy, Work Standard and Audit Process as required by the agreement, it appears it has been working with Extendicare since the outbreak to ensure its concerns are being appropriately addressed.

THE PROGRAM GUIDELINES FOR SPECIAL-CARE HOMES

Like all special-care homes, Extendicare is required by subsection 17(1) of *The Facility Designation Regulations* to operate its long-term care homes in accordance with the Ministry's *Program Guidelines for Special-care Homes*. The *Program Guidelines*, among many other things, include the following requirements related to pandemic planning and management:

- The Authority must ensure that there is a physician responsible for the care and treatment of the residents of each special-care home who is required to provide notifications related to communicable disease outbreaks as required in *The Public Health Act, 1994, The Disease Control Regulations,* the *Communicable Disease Control Manual* and other related policies and publications.

We found no indication that the Authority failed to comply with this requirement.

- The *Program Guidelines* repeat the requirement in *The Housing and Special-care Homes Regulations* that all residents must be examined at least once every year by a physician or a nurse practitioner. They require this examination to be a comprehensive assessment specific to the resident's age and medical condition, and the results of the examination to be documented on each resident's care record.

We did not review resident case records or ask Parkside to provide evidence that it complied with this provision. Nor did anyone we spoke to raise this as a concern. We

were told, however, that no physicians came to Parkside for most of 2020 and that nurse practitioner services were generally more in demand as a result, so it is possible not every resident was comprehensively assessed to the extent required by the *Program Guidelines*. However, even if this was the case, we were given no indication it had any specific impact on Parkside's response to the outbreak.

- To ensure the residents of special-care homes are living in a clean, safe and comfortable environment, and to ensure equipment and buildings are properly maintained and repaired, the *Program Guidelines* require special-care homes to recognize the significance good housekeeping and laundry services have in the prevention and control of infectious diseases, have initial and ongoing training of staff on the importance of good hand-washing, and have processes for regularly evaluating housekeeping, laundry and maintenance services.

Extendicare has extensive written policies and procedures that meet these requirements including:

- A *Maintenance Manual* covering both preventative and remedial maintenance of all building electrical, mechanical, plumbing, HVAC, fire alarms, carbon monoxide detectors and other systems, as well as other equipment such as washers and dryers, and kitchen ventilation hoods, ranges, fridges and freezers.
- A *Housekeeping and Laundry Services Manual* covering all aspects of these processes such as inventory management, supply room organization, cleaning products and chemicals, cleaning, washing and drying methods and frequencies, decontaminating surfaces, equipment and laundry, and using personal protective equipment.
- A *Hand Hygiene Policy* requiring each of its long-term care homes in Saskatchewan to participate in the Authority's hand hygiene programs and requiring all its staff to use proper hand hygiene before and after various resident care activities and interactions, such as after assisting residents with personal care, before putting on and after taking off gloves, and after removing any piece of personal protective equipment.

Extendicare's staff have online access to each of the policies and procedures in these manuals. In addition, Extendicare regularly notifies its staff of updates to all of its policies and procedures, either during a standard annual review process, or as new changes are implemented. It also has mandatory staff training, education processes and programs, and mandatory reporting and auditing processes intended to ensure staff comply with its policies and procedures.

- The *Program Guidelines* require each special-care home to establish an emergency preparedness plan in conjunction with the Authority which is to include procedures for dealing with a pandemic.

Extendicare has an extensive *Emergency Preparedness and Response Manual* containing detailed directives for planning and addressing all manner of potential emergencies in its facilities, including its *Corporate Pandemic Plan*. Its *Corporate Pandemic Plan*, which was revised on May 12, 2020 to address COVID-19 specifically, was required to be included as part of each of its homes' specific Emergency Preparedness/Disaster Plans. It required each home "to follow their province's provincial Pandemic Plan in addition to the Extendicare's Pandemic Plan[.]"

- Under the *Program Guidelines*, all special-care homes must develop, implement and regularly review and revise an infection control program to monitor, prevent, reduce and control the spread of infectious organisms to their residents, staff and visitors that includes procedures for the surveillance, identification, prevention, control, and reporting of infection; regular, ongoing staff education and training; processes for informing residents and visitors of the program and their responsibilities under it.

Extendicare's *Infection Prevention and Control Manual*, which it reviews and revises at least annually, includes detailed policies and practices related to infection prevention (cleaning and disinfecting, hand hygiene, staff and resident vaccinations, personal protective equipment, and airborne, contact and droplet precautions, isolation and staff illness, etc.). It also includes policies and procedures that each of its homes are required to implement regarding outbreak management (establishing an outbreak team, declaring, reporting and managing an outbreak, communications, etc.). As well, it specifically addresses several types of communicable diseases, including COVID-19.

- The *Program Guidelines* require the design and aesthetics of each special-care home to "be supportive of the resident care needs as well as their quality of life including…A cheerful and home-like environment to support the health needs of the residents, and the working environment of the employees, and shall be based on the *Design Guidelines and Standards for Long-term Care Facilities in Saskatchewan*[.]

The Ministry's *Program Guidelines* state that its *Design Guidelines and Standards for Long-term Care Facilities in Saskatchewan* are available from the Ministry's Capital Asset Planning Unit, Strategy and Innovations Branch. When we asked for a copy of them, the Ministry told us there were only draft guidelines developed in 2009 in connection with its announcement of several long-term care home replacement projects. So, even though the *Program Guidelines* have, for years, specifically required all homes to comply with the Ministry's design guidelines, it does not have any. When we raised this obvious discrepancy, the Ministry told us it is currently working on upcoming revisions to the *Program Guidelines* that will no longer refer to the design guidelines.

In summary, we find that Extendicare had formal, corporate-wide policies and procedures in place that met the requirements of the Ministry's *Program Guidelines for Special-care Homes*. In our Findings and Analysis below, we discuss the extent to which Parkside implemented and otherwise complied with them in its response to the pandemic and the outbreak.

THE PUBLIC HEALTH ACT, 1994

Among other things, *The Public Health Act, 1994* creates powers and duties related to the reporting, management and control of communicable diseases like COVID-19 and other serious public health threats. It establishes the powers and duties of the chief medical health officer and provides for the appointment of medical health officers. It also provides for the establishment of *The Disease Control Regulations*, under which Saskatchewan's Chief Medical Health Officer first designated COVID-19 as an emerging communicable disease, which was then later prescribed as a category 1 communicable disease.

The Public Health Act, 1994 authorizes the issuance of public health orders by the chief medical health officer. It also provides for other medical health officers (several of whom work for the Authority) to issue orders to specific people or businesses when they consider it necessary to decrease or eliminate health risks associated with a communicable disease. These orders can, for example, require anyone who may have been exposed to a communicable disease to isolate themselves immediately and to remain in isolation.

From March 16, 2020 to November 19, 2020 (the day before the Parkside outbreak was declared), Saskatchewan's Chief Medical Health Officer issued 34 public health orders, which Extendicare and the Authority were required to follow. These orders represent a very significant part of the Ministry's efforts to manage the pandemic and control the spread of COVID-19.

In our Findings and Analysis below, we discuss Parkside's adherence to specific public health orders that were applicable to its management of the pandemic and response to the outbreak.

Findings and Analysis

GENERAL PANDEMIC PLANNING AND MANAGEMENT

Following the H1N1 pandemic in 2009, the former Regina Qu'Appelle Regional Health Authority (RQHR) developed an *Outbreak Procedure Manual for LTC Homes*. This 150-page manual was revised in 2015 and 2016. It provided guidance on how homes should prepare to prevent and manage outbreaks of severe respiratory diseases, including establishing outbreak control measures, processes for using personal protective equipment, respiratory hygiene and etiquette, environmental controls (cleaning, laundry, etc.), transfers/admissions, outings, and details about managing residents, staff and visitors to limit the spread of severe respiratory illnesses.

On January 6, 2020, Extendicare transmitted annual revisions to its *Emergency Preparedness and Response Manual* to its staff, which included detailed directives for planning and addressing potential emergencies in its facilities, including pandemics.

On January 26, 2020, the day after Canada's first presumptive case of COVID-19, Extendicare activated its incident management system, a national, cross-disciplinary team led by its Director of Infection Prevention & Control, which Extendicare told us served, among other things, as a "central point of contact for homes, aggregating and distilling evolving public health information and requirements from many sources to facilitate home-level awareness and enable implementation."

On February 13, 2020, a Ministry news release notified health care providers that guidance documents on screening for respiratory illnesses, managing returning travellers, and policies on infection prevention and control measures were available on its website.

On March 3, 2020, the Ministry activated a health emergency operations centre, and the Authority sent a memo to the nursing staff of long-term care facilities in Regina to advise that pandemic planning was underway and information would be shared as it became available. Two days later, it convened a planning meeting to formalize operational response plans for COVID-19 cases in Saskatchewan. In a news release issued the same day, it stated: "The Ministry of Health has a pandemic preparedness plan developed to address influenza. Since COVID-19 is a respiratory illness, this plan will be adapted to respond to COVID-19."

Also, on March 5, 2020, the CEO of the Authority emailed all long-term care home operators in Saskatchewan to announce the upcoming activation of its emergency operations centre to support the province-wide response to the pandemic. Its emergency operations centre was activated on March 9, 2020.

In a March 11, 2020 presentation, the Ministry provided details about its *COVID-19 Preparedness Plan*. Using its 2009 H1N1 pandemic plan as a framework, its COVID-19 plan included local operational plans to address issues such as supply chain management, infection prevention and control, human resource management, and public health measures, among other things.

On March 12, 2020, Saskatchewan's Chief Medical Health Officer confirmed Saskatchewan's first presumptive case of COVID-19. A second presumptive case was confirmed the next day. On March 16, 2020, the province announced that primary and

secondary school classes would be suspended. On March 17, 2020, the Ministry reported the province's eighth presumptive case and issued its first public health order, suspending classes as of March 20, 2020, and restricting visitation at long-term care homes, among other things.

On March 18, 2020, the Government of Saskatchewan declared a state of emergency and announced several measures including, for example, prohibiting public gatherings of more than 50 people, limiting seating in bars and restaurants, closing gyms, fitness centres, casinos and bingo halls, implementing a work from home policy for government and Crown employees, and discontinuing non-urgent surgeries and procedures.

On March 22, 2020, the Authority distributed its Annex R to its Pandemic Plan entitled *Continuing Care and Residential Services (Mental Health Services and Personal Care Homes* to long-term care home operators in Regina, including Extendicare. It stated that its Continuing Care team would continue to support them and work to address their needs noting that, as it put new processes in place to address the pandemic, additional funding for operators may be required. It said, "Please do not let this be a barrier, advise [us] of your needs/concerns….and we will address [them.]" It emphasized that there was no room for lapses in homes' infection control practices.

The 53-page Annex R, described as "the oversight Pandemic Planning document for Continuing Care and Residential Services for Mental Health Approved Homes and Group Homes as well as Personal Care Homes," included an *Operational Plan – Home Specific* checklist of 60+ tasks across nine categories (pandemic management structure and decision-making, staff education and training, family communications, managing residents, infection control plans, supplies and resources, human resources planning, antiviral and vaccine, and surge capacity). The Authority expected every special-care home, including Parkside, to report on its progress towards completing all the tasks in the checklist.

The Authority's Continuing Care branch in Regina told us Extendicare responded to the request to complete the pandemic planning checklist by asking rhetorically whether the Authority really wanted all six binders of its pandemic plan. A Continuing Care official told us they believed they did not need to worry about Extendicare, that all they needed from it was an executive summary of its pandemic plan and for it to complete and submit the Annex R checklist for each of its homes in Regina.

In a March 24, 2020 PowerPoint presentation, Extendicare unveiled its formal communication process for providing its long-term care managers with policy decisions and directions and to answer their questions regarding the management of the pandemic. The process included long-term care managers such as Parkside's Administrator and Extendicare's Senior Administrator, regularly participating in tri-weekly conference calls.

The Authority's Director of Continuing Care in Regina emailed Extendicare's Regional Director, Senior Administrator, and Parkside's Administrator on March 27, 2020:

> Hi, I have reviewed [Extendicare's] high level corporate plan – it is too high level for our planning purposes. I only have 2 out of the 3 checklists but given where the other 2 facilities are at I am assuming that Parkside is in the same boat. I need more specific information on your plans a little closer to the ground especially when it comes to staffing, supplies.
>
> …

> Options: You give me site specific plans & sites specific daily updates … Or, you redo the checklists and anything you have marked in progress you put some detail about what that means.
>
> Come prepared to talk staffing and supply chain.

Beginning at least as early as April 1, 2020, the Authority arranged for long-term care home operators to participate in a daily huddle during which the Authority would distribute pandemic information and participants could ask questions. It followed up each huddle by emailing participants (including Extendicare's Senior Administrator) with a summary of the information presented, relevant attachments (policies, procedures, forms, guides, directives, etc.), and the answers to the questions posed.

On April 2, 2020, Extendicare's Senior Administrator provided the Authority with a copy of Extendicare's September 2017 version of its *Corporate Pandemic Plan* – a 13-page document focused on influenza pandemics. It stated: "Extendicare Corporate, LTC Homes and Home Care pandemic plans will be aligned with provincial influenza pandemic plans utilizing the tools and information provided in the provincial plans."

On April 7, 2020, the Authority's Director of Continuing Care in Regina confirmed with Extendicare's Regional Director that it could submit requests for reimbursement of its Saskatchewan homes' COVID-19 related expenses on a monthly basis and provided him with the appropriate form.

On April 8, 2020, the Authority's Director of Continuing Care in Regina provided all long-term care home administrators in Regina, including Parkside's Administrator, with a copy of the Authority's April 2, 2020 COVID-19 Outbreak Checklist noting that it expected some changes to it in the next few weeks.

On April 14, 2020, the Authority provided Parkside's Director of Care and Administrator, Extendicare's Senior Administrator, as well as its Long-Term Care Consultant assigned to support Saskatchewan, with a video explaining how to use the Authority's information systems to find COVID-19-related work standards and user guides for Extendicare's staff. The Authority encouraged Extendicare to use the system and to ensure information related to its operations was kept up to date in the system.

On April 16, 2020, the Authority's Executive Director of Continuing Care in Regina submitted a briefing note to its Emergency Operations Centre asking that contracted long-term care home operators be provided with additional funding (above what they were entitled to under their Principles and Services Agreements) to reimburse them for their actual COVID-19 related costs, particularly when public health orders resulted in increased costs beyond those initially anticipated.

On April 16, 2020, the Authority distributed a final version of its April 2, 2020 *COVID-19 Outbreak Checklist* to all special-care home operators in the Regina area (including Parkside).

On April 22, 2020, the Authority's Executive Director of Continuing Care in Saskatoon distributed a series of documents about pandemic readiness to Extendicare's Senior Administrator, indicating that the Authority expected him to provide periodic documentation regarding the readiness of Extendicare's homes to be able to respond to the pandemic. Similarly, on April 24, 2020, the Authority's Director of Continuing Care in Regina asked all long-term care home administrators in Regina (including Parkside) to provide executive

summaries of their larger pandemic plans and to complete the Authority's Annex R pandemic planning checklist.

According to an April 29, 2020 Pandemic Readiness Dashboard document prepared by the Authority, Parkside was the only Extendicare facility in Regina that had not completed the COVID-19 Readiness checklist as required by the Authority's Pandemic Plan. It had also not yet ensured it had the necessary personal protective equipment supplies and resources on hand to deal with an outbreak, or a human resources plan to maintain required services when working with reduced staff.

The Authority's Director of Continuing Care in Regina told us that by May 2020, it had become clear that the Authority needed to monitor Extendicare's Regina homes' progress to ensure they were actually completing the work necessary to accomplish the tasks in the Annex R checklist. The Authority reassigned a member of its human resources team to work with the Director and the homes to make sure their pandemic plans were implemented, and their progress was properly recorded and reported to the Authority on a weekly basis.

Extendicare revised its *Corporate Pandemic Plan* on May 12, 2020. It stated it was to be included as part of each site's Emergency Preparedness/Disaster Plan and required each facility "to follow their province's provincial Pandemic Plan in addition to the Extendicare's Pandemic Plan[.]" Among other things, its 34-page *Corporate Pandemic Plan* required each facility to have the following:

- *Staff Contingency Plan* – noting that from between 20% to 50% of staff could be absent due to staff becoming ill, staying at home to care for others, refusing to work, or being directed by public health to remain off work.
- *Inventory Plan* – noting the traditional supply chains may be disrupted, to identify required supplies and alternative supply chains, including a list of alternative suppliers.
- *Education* – of staff, volunteers, residents and families about the site's pandemic plan with a significant focus on infection and control practices and measures. Each site's director of care and infection control practitioner were responsible for providing education.

Extendicare's *Corporate Pandemic Plan* also discussed the principles of infection control and summarized its related policies, including acute respiratory infection screening that complies with local public health directives, respiratory hygiene and cough etiquette, hand hygiene, the use of personal protective equipment, safety handling and cleaning resident equipment, linen and laundry, cleaning and disinfecting touched surfaces, maintaining physical distancing, and ensuring facilities had appropriate signage.

Starting in May 2020 and over the summer, public health orders were adjusted. Restrictions and capacity limitations were eased on indoor and outdoor activities, public venues, retail stores and restaurants.

On July 8, 2020, Extendicare initiated an information sharing campaign called *Ride the Wave* for its staff about its preparations for a second wave of COVID-19. It was led by its National Directors of Quality & Risk and Quality & Systems. It involved re-purposing its tri-weekly pandemic calls among its long-term care managers and administrators. Extendicare told us it "included regular communication of Wave 2 preparedness directions to homes, based on learnings from COVID-19 outbreaks during Wave 1…includ[ing] detailed checklists for both pandemic planning and outbreak situations, as well as table-top/fire-drill exercises for staff to complete."

On July 31, 2020, the Authority emailed all long-term care home operators, including Extendicare, to recommend that they review and update their pandemic plans based on the Authority's newly published *Pandemic Plan Guide for Long-term Care Homes*. Essentially a pandemic plan checklist, the *Guide* emphasized the stockpiling of pandemic supplies, training of staff, determining how resident care would be managed, establishing an infection control plan (social distancing of residents, visitor restrictions, cohorting residents) and having a plan to address staff shortages due to illnesses, among other things.

In an August 5, 2020 *Ride the Wave* presentation, Extendicare provided its staff with information about several outbreak management topics, such as droplet/contact precautions, correct and safe practices for donning and doffing personal protective equipment, hand hygiene, cleaning, cohorting staff and residents, testing and contact tracing. It also introduced what it called an interactive resource guide with links to the most current province-specific resources for its long-term care staff in Saskatchewan (and other provinces). It specifically described the various Extendicare and provincial policies and procedures staff should follow to manage a COVID-19 outbreak, including establishing an outbreak management team, declaring an outbreak, internal and external communications, and universal personal protective equipment, among other things.

The Authority issued the third version of its *COVID-19 Response Guidance for Long Term Care Facilities* on September 25, 2020. It stated it was "meant to provide a set of interventions for LTC COVID-19 outbreaks, building on existing approaches to respiratory outbreaks, available evidence on COVID-19, and current regional experience with COVID-19 control in this setting." It detailed a number of requirements for long-term care operators and workers to follow to control an outbreak, for example:

- Ensuring staff comply with the *Authority's Continuous and Extended Use PPE Guidelines when caring for Residents suspected or confirmed to have COVID-19 in Continuing Care*, including using eye protection, and its Daily Fitness for Work Screening for Health Care Workforce directive.
- Actively monitoring residents for COVID-19 symptoms at least twice daily.
- If more than one resident is positive, isolating all residents in their rooms and following Droplet/Contact Plus precautions and using appropriate PPE (gown, mask, eye protection and gloves) to provide care.
- Isolating COVID-19 positive residents alone in their room to the extent possible, or when this is not possible, as a last resort, ensuring two meter distancing between bed spaces and keeping privacy curtains drawn.
- Engaging in thorough hand hygiene.
- Ensuring housekeeping does enhanced cleaning.
- Feeding residents in their rooms and serving positive residents last.
- Providing separate toileting and removing toothbrushes and denture cups from washrooms.
- Increasing the level of surveillance of other residents.
- Self-isolating positive staff for the longer of 14 days from the onset of symptoms or 48 hours after they stop having symptoms.
- Identifying close contacts and monitoring them for symptoms twice daily.
- Postponing visits to the home by any non-facility staff except for essential services, and closing the home to new residents or transfers.
- Cancelling all group activities and non-essential services.
- Ensuring staff are not working in other health care settings, cohorting staff to the outbreak unit until the outbreak is over, and restricting staff movement throughout the facility.

On October 1, 2020, Extendicare's Regional Director provided Parkside's Administrator and Director of Care, Extendicare's Senior Administrator, and several others, a number of documents as part of his summary of his September 30, 2020 touchpoint meeting with Extendicare's Saskatchewan long-term care homes. One of the documents was a description of Extendicare's COVID Response Team, which was described as being in response to the following situation:

> The Long-Term Care sector was recently challenged in managing outbreaks related to the COVID-19 pandemic. A report published in the Canadian Medical Association Journal states that 30% of LTC homes in Ontario experienced outbreaks during the peak periods of the pandemic (March 29 – May 20, 2020), with approximately 80% of Canadian COVID-19 related deaths happening in the LTC setting.
>
> Limited capacity and resources were significant factors in the challenge which COVID-19 presented to LTC homes across the country. By creating a stronger partnership between LTC and an enhanced support team, the COVID Response Team can share expertise to assist in preventing and managing outbreaks.
>
> With the potential of Wave 2 of the COVID-19 pandemic on the horizon, there is a need to establish a mechanism to provide timely and structured support to our LTC homes.

The document further noted:

> Given the potential growing number of LTC homes requiring urgent and comprehensive outbreak prevention and management support, there is a need for a more standardized response plan for COVID-19 across Extendicare LTC homes, Assist homes, and Esprit Communities. The solution must be structured in a way which is sustainable for Extendicare to operate.
>
> A CIHI study showed that in countries where LTC Rapid Response Control and Prevention Teams were utilized (in addition to all other policy and local responses), the percentage of COVID-19 deaths in LTC as a percentage of all COVID-19 deaths were lower than countries that did not add this approach to their total response.
>
> …
>
> Effective outbreak management is a product of a multipronged approach that requires immediate current state assessment, including a gap analysis to identify the unique needs of the specific LTC home. It then requires the development of an action plan that addresses the staff, resident, and physical environment needs guided by best practices.

It went on to describe at a high level the titles and roles of the members of its COVID Response Team who would work with each home's administrator, director of care, and other staff, and detailed a protocol for the Team's response to outbreaks based on three phases of severity:

> PHASE 1 – Spread is contained and only one resident/one staff remains positive
>
> …
>
> PHASE 2 - Spread is not contained and one additional staff or resident on the floor has tested positive/has respiratory symptoms
>
> …
>
> PHASE 3 – Spread is not contained, and more than two additional resident or staff member has tested positive/has respiratory symptoms

On October 26, 2020, the Authority emailed Parkside asking for its pandemic operational plan readiness spreadsheet saying it was the only one outstanding. After Parkside made its submission the following day, the Authority asked to review it with Parkside's Administrator and Director of Care because "there were quite a few outstanding items." Parkside's October 27, 2020 submission indicated that the following required items had still not been completed:

- The agency/organization has developed criteria to determine where and how people will be cared for in the event of a pandemic.

...

- A system is in place to report unusual cases of [influenza-like illness] and pandemic-related deaths to SHA officials and the MoH.

...

- During a pandemic, the agency/organization may reduce or delay some services to compensate for staff shortages or to prevent the spread of illness.

...

- Decisions about which services to reduce, curtail, or enhance are made based on direction from CMHO and EOC considering, residents' needs, infection control, prevention guidelines, and staffing needs.

...

- The roles and responsibilities of the SHA & agency/organization regarding distribution of infection control PPE supplies (e.g., masks, hand hygiene materials) are identified.
- The SHA & agency/organization should involve the funeral homes to develop a plan to manage a potential increase in deaths including storage of bodies.

...

- If cohorting is not possible, separating residents who are particularly vulnerable to complications from pandemic virus from residents with the virus

  NOTE: We have several semi private and 4 bed accomodations [sic]

...

- To prevent the spread of infection, have methods been considered to ensure recommended social distancing (2 meters) in communal areas and dining rooms.

  NOTE: Infrastructure does not allow this to happen on a regular basis, we are doing the best we can

  We have emptied a 4 bed ward on each wing to accommodate residents who may become infected with COVID as a means of preventing spread throughout the building

...

- Alcohol-based hand sanitizer for hand hygiene is available in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym)
- Sinks are well-stocked with soap and paper towels for hand washing.
- Signs are posted immediately outside of resident rooms indicating appropriate IPC precautions and required personal protective equipment (PPE).

- Facility provides tissues and facemasks for coughing people near entrances and in common areas with no-touch receptacles for disposal.
- Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided.
- Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
- Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.
- Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
- Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
- The facility has a process to monitor supply levels.
- The facility has a contingency plan that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages. Contact information for healthcare coalitions is available here: www.saskatchewan.ca

...

- A plan should be in place for managing staff shortages within the organization due to illness among staff or their family members.

  Cohorting has left us with some interesting challenges, we continue to recruit where possible

- Contingency staffing plans have been developed.

  We are recruiting where possible, there are no agency help available

...

- Priorities for providing: care, environmental services and dietary services, have been established.

...

- Anticipated supplies have been estimated and purchased (e.g. masks, gloves, hygiene products).
- A primary plan and contingency plan to address supply shortages have been developed, including detailed procedures for acquisition of suppliers through normal channels as well as requesting resources for replenishing supplies when normal channels have been exhausted.
- Plans include stockpiling at least one-month of supplies as directed by the system.
- Agency/organization plans include resources for dealing with mass fatalities including removal and storage of the deceased from the agency/organization.

FINDINGS

While the Authority and Extendicare both took steps to adapt their existing organization-wide infection prevention and control and emergency response policies and procedures in response to the pandemic, and both relayed their pandemic planning requirements to Parkside, as late as the end of October 2020, Parkside had not yet fully implemented many of the key requirements both the Authority and Extendicare had determined were necessary for it to be able to effectively respond to a serious outbreak.

Initially, the Authority's Continuing Care branch appears to have taken it on faith that Extendicare would ensure its homes in Saskatchewan, including Parkside, were ready to meet the challenges of the pandemic. However, by the fall of 2020, it seems it realized that its faith may have been misplaced, at least to the degree it was no longer confident in Parkside's state of pandemic readiness.

For Extendicare's part, while it is clear that it consistently disseminated up-to-date information to Parkside about what steps it needed to take to be ready for the pandemic and to respond to a serious outbreak, and had experts available for its local staff to consult with, it seems to have largely left it up to its local managers to get themselves ready in case of an outbreak. It is evident from the information we have reviewed that Extendicare consistently and frequently engaged its local management staff in discussions and sessions about all manner of pandemic-related topics. It is also clear that, as a company, Extendicare had learned a great deal about what it took to deal with serious COVID-19 outbreaks from its early experiences with them in its Ontario homes. Its national leadership ensured all its staff were told (repeatedly) of the importance of implementing effective pandemic plans and provided them with the policy documents and access to any training they needed to implement them.

However, despite the numerous steps its national and regional leaders took to prepare its homes to manage a serious outbreak – from its *Ride the Wave* program, to its engaging a human resource consultant specifically to support its Saskatchewan and Manitoba homes, to its weekly if not more frequent calls and follow up emails among its Saskatchewan homes and corporate team of leaders and consultants regarding how to manage the pandemic - there is little indication that Extendicare was effective in making sure Parkside was progressing towards successfully implementing a facility-specific pandemic plan. Simply put, despite all its corporate focus on communicating what needed to be done, Parkside was clearly not ready to manage a serious outbreak, and was not complying with the Ministry's public health orders regarding physical distancing among its residents or its staff. When we asked him to account for Parkside's pandemic readiness being lower than its Sunset, Elmview and Preston facilities into September 2020, Extendicare's Regional Director responsible for Parkside said, "I don't know. I can't speak to that."

PARKSIDE'S PHYSICAL LAYOUT AND LIMITATIONS

In his January 29, 2021 request, the Minister asked that the Ombudsman investigate the impact the condition of the Parkside facility had on the transmission of COVID-19 among its residents and staff.

Parkside was built in the 1960s. Its 228 bed spaces are comprised of 12 private rooms, 40 2-bed rooms, and 34 4-bed rooms, so when it is at full capacity, 136 residents are in 4-bed

rooms. The building includes a central core with administrative offices, a kitchen, dining rooms, laundry facilities, a resident lounge, and a staff room. This core is flanked by a north wing of resident rooms and two wings to the south: a main wing of resident rooms leads to a south wing of resident rooms, each of which include some additional common spaces.

Authority officials told us that Parkside has had consistently more outbreaks of all kinds year over year than other facilities because it has four residents in a room, it is generally "very crowded", and because the "infrastructure does not lend itself to disease control." Between January and July 2020, Parkside had 13 declared outbreaks (11 respiratory, one vomiting/diarrhea, and one scabies).

Discussions About Replacing the Facility (2010-2020)

Concerns about the age of the Parkside facility, it having four residents in shared rooms, and it needing to be replaced, have been discussed for a long time among the Ministry, the Authority and Extendicare. Extendicare has been lobbying the Ministry to replace its Parkside, Elmview, and Sunset long-term care facilities in Regina since at least 2010.

In 2011, the former Regina Qu'Appelle Health Region (RQHR) carried out high level evaluations of its long-term care facilities looking at, among several other things, the age of infrastructure. A 2011 functional assessment done for the RQHR by a third--party consultant gave Parkside a functionality score of +22 on a scale from -20 to +100, indicating that it had major functional issues, including infection control issues (shared accommodation with up to 4 residents per room), risk of injury in resident washrooms, inadequate resident dining space and lounges, and insufficient kitchen and equipment storage.

That same year, Extendicare approached the Ministry and the RQHR again about its proposal to replace its three Regina long-term care facilities, noting they did not meet the then current provincial draft design guidelines or its own standards for appropriate accommodations. It flagged shared resident rooms, crowded halls, crowded "congregate dining", lack of privacy and lack of storage among the challenges it faced. Extendicare proposed to finance the cost of the design and construction of the new facilities, in exchange for the Government of Saskatchewan reimbursing it 80% of the cost over a 25 to 30 year period. In April 2012, the project was approved in principle, but the Ministry was directed to develop more detailed financial information to support the decision. In the interim, the Ministry and the RQHR expanded their inquires to include the replacement of two other long-term care facilities in the region.

The RQHR's June 7, 2013 *Long-Term Care Quality Assessment* report about Parkside flagged issues such as air quality and building infrastructure as themes identified by Parkside's resident/family council.

In an October 16, 2013 email to the then acting Deputy Minister, a Ministry official advised that, according the Authority, "Extendicare may be nearing the point of deciding whether they will remain in the province, given the state of their facilities." She said that the Ministry had prepared a memo to Cabinet about the replacement of Extendicare's Regina facilities, and noted that the Ministry was concerned about "sole-sourcing" to Extendicare, meaning the Ministry was concerned about not using a competitive procurement process to seek

proposals for the replacement of Extendicare's Regina facilities (which is generally referred to as "single sourcing"). She said Extendicare had indicated it would not participate in a competitive tendering process for the replacement of its facilities.

In an October 17, 2013 email to the RQHR and the Minister of Health, the President of Extendicare expressed his frustration with its "three year effort" to replace its facilities in Regina with little progress being made in getting approval from the province.

In February 2014, the Ministry sought approval for a proposal for an integrated long-term care facility replacement strategy for the former RQHR. The 2014-15 provincial budget included "$1.5 million for planning associated with the Regina Extendicare Replacement and the long-term care expansion in La Ronge."

A June 5, 2015 RQHR *Long-Term Care Quality Assessment* report again identified, through its facility visits and discussions with residents/families that: "Facility Infrastructure and functionality remains a huge issue for Extendicare sites."

In January 2016, the Ministry was directed to provide Cabinet with options for replacing Extendicare's long-term care facilities in the former RQHR and Regina Pioneer Village, which is an Authority-run long-term care home. A February 5, 2016 discussion paper prepared by an RQHR Long-Term Care Steering Committee, noted Extendicare expected the province to reimburse 80% of the capital costs of its proposal, and recommended that the RQHR and the Ministry be "aligned" on a number of issues (risk management, quality of care, etc.) "to drive a procurement process."

A December 5, 2017 *LTC Renewal Program Business Plan* prepared for the RQHR proposed what it referred to as "critical" replacements of Regina Pioneer Village, and Extendicare's facilities at Parkside, Sunset and Elmview. A key factor was their outdated design and condition:

> Seventy per cent of the Region's LTC facilities are more than 40 years old. The outdated design of these facilities means the facilities no longer meet the needs of LTC residents. The majority do not meet the minimum standards set by the MoH and they present challenges to the control of the spread of infectious diseases, putting frail residents at risk. Additionally the outdated facilities do not address current demand allocation requirements where complex need requirements have shifted with the aging and longevity (e.g. dementia).

The Authority's *Long-Term Care Quality Assessments* of Parkside continued to flag its deteriorated state and poor design. In 2018, it concluded both physical and functional infrastructure were the most significant issues facing Parkside: "Ward beds, lack of lounge spaces and private spaces, lack of storage, duct tape on floors, etc. all have a negative impact on the environment for residents and families." Its 2019 assessment affirmed what was already known:

> The facility is old and in need of replacement due to pending infrastructure and large system (HVAC) failures. The current design with a large number of 4-bed rooms does not meet current standards of care or resident and family expectations for a home environment.

In February 2019, the Authority posted a request for proposals on *sasktenders.ca* for the provision of long-term care accommodations and services in Regina. Extendicare did not submit a proposal.

On June 13, 2019, and again on September 23, 2019, top Extendicare officials met with Ministry and Authority officials to again discuss the prospect of replacing Extendicare's three long-term care facilities in Regina. The Ministry advised Extendicare that replacing Regina Pioneer Village was its top priority, and that there was no timeframe for the replacement of Extendicare's facilities. Extendicare again warned it would have to consider the future of its long-term care facilities in Saskatchewan if the government would not commit to its proposal.

On August 26, 2020 (during the pandemic), Extendicare again met with and made a presentation to the Minister of Health seeking support and funding for its proposal to redevelop its long-term care homes in Saskatchewan.

Pre-Outbreak Concerns: Dining and 4 Residents Sharing a Room

Issues with Parkside's design and layout, including that there were four residents sharing rooms, and what that could mean if there was a COVID-19 outbreak were discussed among Authority officials as early as March 2020.

In late March 2020, the Ministry advised the Authority's Public Health officials that long-term care homes needed to move to serving residents in their rooms, if they were able. In internal emails among the Authority's Public Health and Continuing Care officials about dining guidance for long-term care homes (serving residents in their rooms or in a dining area with a maximum of 10 residents with 2 meters apart), it was noted that it was "almost functionally impossible" for Parkside to serve residents and keep them two meters apart.

In an April 30, 2020 briefing note to Authority executives, a Medical Health Officer (later the Co-Commander of the Authority's COVID-19 Public Health Incident Command Centre) and the Executive Director of Primary Health Care in Saskatoon compiled outbreak management information gathered from special-care homes (and personal care homes, among others) to identify which of them "presented a challenge in the past for outbreak management and prevention" and of those, which of them the Authority needed to reach out to for COVID-19 preparation and support. Among several other trends, they noted two that were relevant to Extendicare: "Physical layout (e.g. 4 beds to a room)...[and] "National corporations providing guidance which does not align with provincial recommendations."

In late May 2020, there were discussions about the 4-bed room situation should there be an outbreak, mostly in terms of having some empty rooms available to put residents in to isolate if they got COVID-19 (rather than reduce the number of residents actually sharing rooms). On May 27, 2020, the Authority's Executive Director of Continuing Care in Regina noted:

> The 4-bed ward situation is concerning due to the impact in a congregate environment should we have an outbreak and may need to plan a bit differently, including looking at capacity and development of separate space for those who may present with symptoms and how this may be addressed with movement outside of the home and when/how this may apply. These are more challenging

environments as we support pandemic readiness planning, would like your expert input/thoughts on this process. ...Parkside, at 228 beds, with only 12 private rooms, is the largest and most concerning.

It may be determined that the processes established related to covid outbreak management through the guidance document and checklist are sufficient, but thought this was worth a conversation before we sign off on the current plans.

A Public Health official replied:

This is a great question. We should be concerned about how we approach isolation for Covid when we have 3 & 4 bed rooms. The guidance on how to attempt to isolate in a shared room is there for when there is no other option – it is not our first choice and if there are other options available, I think we should explore those. A perfect example is the non-covid outbreak on Main wing at Parkside right now: ill people in 4 bed rooms with spread among 3 of the 4 roommates (so far) AND a number of those residents have either dementia or are non-compliant with isolation which is leading to further spread on the unit. We have seen zero (0) staff illness reported but transmission is continuing among residents for the past 3 weeks and it appears to be driven by the shared rooms and wandering/non-compliant residents.

To contain the spread of Covid in facilities with shared rooms we have a few key areas that should be considered and possibly planned for:

- Do we have any alternatives to place either covid + residents (or their roommates) when they share a room? If there is only one Covid + person, the priority would be to place them in a private room with private bathroom.
- If there are multiple residents ill – is it feasible to co-hort them in a shared room (2, 3 or 4 positive residents together) or if multiple rooms have ill people can they be placed in rooms down a common wing? I imagine the work of moving residents from room to room would be very labor intensive but having them grouped in one room or in one area would allow staff to be dedicated to caring for them while other staff care for those who are well.
- What options do we have if a covid + resident is a wanderer? Non-compliant and refusing to isolate? Are there alternate locations where we could move them?

There will be a need to include a wider group not only within the facility but also in the SHA in order to address the challenges these outbreaks will present. When these scenarios come up it would be nice to have an idea what options may be available.

Two days later, another Public Health official added (in part):

Our first goal if someone is + with covid is to isolate them – either in a private room of their own or they can be cohorted with others who are also +. We were wondering if it would be possible to establish isolation rooms within the facilities that have shared rooms so that in the event that a resident in a shared room was +, they could be moved out and isolated away from well residents. Ironically, an empty 4 bed room could be very helpful for just this purpose – it would allow up to 4 covid + residents to be cohorted together, with dedicated staff – away from well roommates and others on the unit. Room moves would not meet the need as we would not allow an unexposed resident to swap spaces with the Covid + as it would put them in contact with the exposed roommates (close contacts).

By June 16, 2020, the Authority's Public Health officials in Regina were discussing Extendicare's three Regina long-term care homes as "facilities of concern." They noted that 86% of Parkside's rooms were shared rooms: 40 2-bed rooms and 34 4-bed rooms. One official shared a summary of all facilities in Regina that had large numbers of shared rooms with Authority colleagues, "as there will be a need to address that before the fall." A medical health officer added the following to this conversation on June 17, 2020:

> Thinking along those lines and knowing you folks are looking at this, I wondered if there is a process to establish some capacity in our care facilities and Affiliates through a process not filling new empty beds until a capacity of 3 or 4 is created. With the Fall/winter being seen as a time of particular concern it would seem prudent to establish this capacity over the next 12-16 weeks, particularly in those facilities with extensive shared rooms.

The Authority's Executive Director of Continuing Care in Regina emailed several Authority officials responsible for working with Extendicare on June 19, 2020:

> I am connecting with all of you as know we each have homes with 4 bed ward style rooms…as this has been a big issue in Regina as the Extendicare homes also provide many of our short stay programs, resulting in very high levels of in/out movement, increasing risk. We have had significant discussion and it will require us to look at some different options for some of these needs, as well as looking at covid related care management space in each of those homes. We are meeting with Extendicare to discuss next Thursday, June 25th at 0800 to discuss.

Extendicare was also thinking about this issue. On June 25, 2020, Extendicare's Regional Director sent an email to other Extendicare officials, including Parkside's Administrator and the Senior Administrator, noting how shared wards would impact their ability to meet certain infection prevention and control practices. He said that more calls would happen between the Authority and Extendicare and to start thinking about the 3-4 bed wards and how they could reduce them. He added: "You can share with your [Directors of Care] if you want but no one else; these discussions have far reaching implications and we don't have much to share….in a vacuum, ppl may make their own narratives."

On June 26, 2020, Public Health officials had a further discussion via email:

> The impact of multi-bed rooms on COVID spread has been considered and I believe it is in recognition of this that the recommendation was made last week by [an Authority Medical Health Officer] that facililties [sic] with four bed rooms and other multi-bed rooms should plan for empty rooms where cases can be "decanted" to while they self-isolate. The effectiveness of this is contingent on early case identification.
>
> My thoughts here, reduced room density is certainly a useful intervention however it can be argued that with delayed identification and isolation of cases including cohorting staff to only one location and other public health measures, this may only make minimal impact.
>
> …
>
> What are the unintended consequences of moving all four bed units to two beds?

Another official added:

> We indicated earlier – think in May – that it would be good to have a vacant room or two that we can move positive COVID people or suspect COVID people to in order to get them out of a 4 or 2 bed room situation – might have been exposed already or not.
>
> ...
>
> However we have not heard if this might be considered.

On July 6, 2020, the Authority's Executive Director of Continuing Care in Regina replied:

> We are working on this and I will be putting an SBAR [Situation, Background, Assessment, Recommendation] forward to request approval for reducing beds in the large, multi-shared room environments such as Extendicare, provincially during this time. In addition, for Regina specifically, we are looking at re-locating the short stay high turnover beds out of the Extendicare sites, leaving only long term care, and managing these services in a different way. We will be engaging some of you in that discussion, if approved to move forward.
>
> We recognize this is one part of a multi-pronged approach to mitigate risk, but see it as value added, due to the very close contact of residents in the Extendicare environment, where maintaining physical distancing is very challenging.

On July 9, 2020, Extendicare notified the Authority that several Parkside residents had contracted scabies. By July 10 there were 21 suspected cases among residents. By July 16, 2020, Public Health in Regina had declared an outbreak. Three staff had been sent home with rashes. The Authority advised Parkside's Director of Care to implement a plan to address the outbreak including measures such as keeping residents on contact precautions, cleaning clothes, personal effects and the facility, and cohorting staff. Residents in all three of Parkside's wings got scabies. As is the Authority's usual process when dealing with scabies outbreaks, it initially suspended admissions to Parkside, so there were no new admissions from July 17 to August 22, 2020. Approximately 15 admissions occurred thereafter up to October 14, 2020, when the scabies outbreak was declared over.

Extendicare submitted to us that it repeatedly communicated the need to eliminate 3- and 4-bed rooms and to ensure only one or two residents per room.

Following a discussion they had the day before, on August 13, 2020, the Executive Director of Continuing Care in Regina advised Extendicare's Regional Director that it was discontinuing the 12-bed convalescent transition program at Parkside, acknowledging that it would involve some financial and staffing changes, but that it would free up some rooms.

Extendicare's Regional Director replied:

> I gave some thought to our discussion yesterday, and wanted to ask if you/SHA can put in writing what is the desired outcome of any changes to our overall census? As mentioned, freeing up a few rooms per site, while may be the simplest option, I am unsure it meets the ultimate goal of minimizing the impact of C19 when it enters our homes.

The Executive Director replied that the Authority's goal "is to minimize risk, keep it out of the LTC homes and if we do have a positive situation to mitigate risk and reduce scope of

impact....the suggestion of reducing capacity to create space for isolation needs is a first option to open that discussion." She added: "Bed reductions are a simple, first option to support an immediate response but ...[the Authority is] very open to discussing other ways to support safe, effective covid management."

The Authority's decision to eliminate the convalescent program at Parkside (coupled with its earlier decision to suspend sending new residents to Parkside as a result of the scabies outbreak) meant that Parkside had 30 empty beds as of November 20, 2020 when the COVID-19 outbreak was declared.

In an August 14, 2020 letter to all its staff, Extendicare's President said it would work with other provinces to introduce the measures in its plan for the second wave in Ontario "as needed." Noting that it could not fix or replace its older homes, he said that the company was not admitting more than two residents to 3- and 4-bed rooms in Ontario to limit transmission if an outbreak occurs.

Following up their earlier discussion, Extendicare's Regional Director emailed the Authority's Executive Director of Continuing Care in Regina on August 21, 2020:

> Thank you for discussing the SHA goals on reducing risk within our Homes if a Covid19 outbreak would occur. While we appreciate you have asked us to provide some scenarios about what that would look like, we are unable to do so without further clarification about funding.
>
> Any bed reduction strategy would need to be supported with funding to ensure as an organization, we don't experience any financial risk and are "kept whole".
>
> Our focus remains as it has been over the last 10 years, a need to redevelop our 5 LTC homes. To that end, our VP LTC Operations and CEO are continuing these discussions with Minister [of Health].

In an August 25, 2020 letter to the Authority's Executive Director of Continuing Care in Saskatoon, Extendicare's Vice President of Long-Term Care Operations said he understood from his discussions with the Minister of Health that there was no interest in Saskatchewan in replicating the Ontario's program of regularly testing asymptomatic staff, and that he continued to advocate for its adoption.

In preparation for a meeting with the Minister of Health the following day, to again discuss Extendicare's proposal to redevelop its facilities in Regina, Extendicare sent the Minister's office a 15-page PowerPoint presentation entitled "Redevelopment of Extendicare's Older Long-Term Care Homes in Saskatchewan" stating that it was removing its 3- and 4-bed rooms in its Ontario homes to mitigate the risks of COVID-19 infections, and that doing this in Saskatchewan would mean a loss of 96 beds – 68 of which were at one facility – Parkside.

On September 23, 2020, the Authority's Executive Director of Continuing Care in Regina advised Extendicare's Regional Director that it was setting up another meeting to follow up on, among other things "planning for addressing 4-bed ward impacts," and again asked Extendicare for feedback on its experiences elsewhere and then steps it took to address the issue that the Authority might learn from. The Regional Director replied on September 24, 2020:

> As for feedback from our experience in managing C19, what we have found and based on our last discussion a few weeks ago is a lot of time on planning and fine tuning our plans for pandemic readiness and working with the various RHA on areas of support.
>
> As for changes in occupancy, we have seen keeping 1 suite vacant for residents who test positive but this can only work if early detection occurs and only for 1-2 residents. Afterwards, we look at cohorting residents into "red zones". If we trully [sic] want to minimize the spreading and upheaval of residents moving throughout the home, reducing shared accommodation to only 2 per suite has proven beneficial to minimize those exposed.
>
> As mentioned, for us to consider reducing our census, it must be tied to financial compensation for lost revenue.

Despite both Extendicare and the Authority clearly acknowledging that Parkside's use of 4-bed rooms was cause for significant concern, and engaging in discussions both internally and with each other during the spring, summer and fall of 2020, they did not take the steps necessary to actually decrease their use before the outbreak.

FINDINGS

There is no question that from the beginning of the pandemic, the Ministry, the Authority and Extendicare were aware that Parkside would be in serious trouble if it were to have a major outbreak because so many of its residents were crowded into 4-bed rooms, and its building does not have adequate space for storage, among other flaws. They knew it did not have adequate space to isolate more than a few residents during an outbreak without taking drastic measures (which ended up happening) such as displacing residents on an emergency basis into other facilities and turning an entire wing into what was essentially a makeshift field hospital. They were also aware that this same overcrowding increased the likelihood of a major outbreak because it was impossible to maintain proper social distancing among its residents, for example, during meals. In fact, they have known of these issues for years and years, as exemplified by Parkside having consistently more outbreaks than other facilities over the years.

Despite this, when the COVID-19 outbreak was declared on November 20, 2020, Parkside still had 198 residents, many of whom were still living in 4-bed rooms. Even though the number of residents had dropped due to the scabies outbreak earlier in 2020 and the Authority's elimination of the convalescent program, there were still too many residents at Parkside. Since the outbreak, it now has only 160 residents, which ensures there are no more than two residents to a room. Given this, in our view, there appears to be no reasonable explanation for why Extendicare and the Authority did not reduce Parkside's resident population in mid-2020 before the outbreak.

Though Extendicare submitted to us that its fundamental approach to the pandemic was not to consider budgeting and financial considerations, it is clear from all the information we have reviewed that the loss in revenue associated with eliminating Parkside's 4-bed rooms money was an issue. To be clear, however, we find that this was a valid, legitimate concern to be addressed in the discussions between Extendicare and Authority.

With a pre-outbreak population of 198 residents, though the Authority continued to provide Extendicare core funding for all of Parkside's 228 beds, Extendicare had less revenue from the resident fees it was able to charge. With average resident fees of $1,500 per

month per resident, Parkside's 30 empty beds meant that its revenue was down about $45,000/month ($540,000/year.) To have only two residents per 4-bed room (which is the case now), Parkside's population can be no more than 160 residents, so its revenue from resident fees would be about $102,000/month ($1,224,000/year) less than if it was at its full 228-bed capacity. Also, if the Authority did take steps to reduce its core per-bed funding accordingly – which it has not done at the time of writing this report– its annual net operating funding would also drop, based on approved 2020-21 figures, from $14.2 million to $10.0 million. Overall, all other things being equal, operating Parkside with 160 beds instead of 228 beds would mean about 30% less revenue.

Unlike most other for-profit businesses who trade the risk of loss for the chance to profit, Extendicare's long-term care business model in Saskatchewan is nearly entirely based on it getting government funding from the Authority and collecting government-regulated fees from residents. The Authority largely dictates how much base operating funding Parkside gets each year, and the Ministry dictates how much (or little) it can charge residents. Since the Authority also largely dictates both how many residents it will have, and what services it can provide, Extendicare has almost no ability to effect Parkside's revenues (this also means that its profitability is almost entirely tied to its ability to manage its operating costs).

Given this, we find that it was not unreasonable for Extendicare to expect the Authority to negotiate reasonable adjustments to its funding in exchange for reducing its population to eliminate having four residents to a room. On this point, when we asked Extendicare's Regional Director why Extendicare did not reduce Parkside's population on its own, he told us that the decision had to be made by the Authority, which he said was "the gatekeeper" so to speak. He also said the other component to the decision was working through the process for making changes to services as detailed in its Principles and Services Agreement. He said that Extendicare "was willing to entertain a reduction, however, [it was] awaiting further information from the SHA about whether it would be approved and how does that impact our funding and our ability to still provide care and jobs."

Given its experiences with COVID-19 outbreaks in Ontario, and how well understood it was that it was essentially impossible for Parkside to effectively care for its Parkside residents safely during the pandemic if it continued to use its 4-bed rooms to capacity, it might have been reasonable to expect Extendicare – given its submissions to us that it took a leadership role in its discussions with the Authority about reducing its 4-bed rooms in Saskatchewan – to have insisted that the Authority move to help it reduce Parkside's resident population. On this point, its Principles and Services Agreement specifically allowed it to reduce its level of services if it believed it was necessary to keep its residents safe. That said, Extendicare is correct that it could not have made the decision to reduce Parkside's resident population unilaterally, because the Authority would have needed to find spaces for the displaced residents to live.

The Authority told us there was marked reduction in the demand for new long-term care spaces in the province in 2020. Because of this, it might be assumed that it could have more easily arranged for Parkside's residents to be relocated so they did not have to live in 4-bed rooms. However, we were told two factors – one particular to the Regina region and another related to the overall response to the pandemic – impacted the availability of long-term care space.

First, the Authority's Regina Pioneer Village facility is about as old as Parkside – its first phase was built in 1967. It is also similarly not up to currently acceptable standards. We

were also told it had black mold. For all the same reasons Parkside needs to be replaced, Regina Pioneer Village also needs to be replaced. As a result, over the past few years, the Authority has been steadily reducing Regina Pioneer Village's long-term care resident population from its original stated capacity of 512 residents to what its website says is now 390. This, it says, allows it to provide more activity, lounge and dining space, and single and double rooms, but it also allowed it to remediate the black mold. Reducing Regina Pioneer Village's population by 122 residents also means the Authority relies on Parkside and other facilities in the area to take on the additional resident capacity.

Second, starting during the early days of the pandemic, projections of worst-case scenarios for COVID-19 hospitalizations and deaths were at the very top of all our minds. The Authority's April 28, 2020 *COVID-19 Modelling and Health System Readiness Update* indicated that its worst case planning scenario was 262,000 cases, which was down from its original planning scenario of 335,000 cases. Mercifully, neither of these scenarios have played out. Nevertheless, the Authority created two field hospitals to support between 300 and 600 additional potential COVID-19 positive patients as part of its acute care system COVID-19 readiness plan. The field hospitals were intended to care for in-patients recovering from COVID-19 and to only be used if absolutely necessary. Authority officials told us that its focus on acute care capacity meant it was not as focused on dealing with crowded long-term care facilities like Parkside. So, while it planned for and implemented additional temporary acute care space to care for COVID-19 patients, it did not have a plan to eliminate Parkside's 4-resident rooms to mitigate the risk of them getting COVID-19. And even though it had 100s of empty beds across the province in case it needed them for acute care, using some of them so Parkside and other facilities did not have four residents to a room was not part of its plan.

We find that it was for these reasons that the Authority did not proactively move to reduce Parkside's population (until it was too late). Knowing how devastating the Parkside outbreak was, we find that the Authority and Extendicare ought to have eliminated Parkside's 4-bed rooms before the outbreak. While this would have meant making necessary adjustments to the management of long-term care spaces in Regina to drop Parkside's population to 160, and to negotiate Parkside's base funding, as it happened, it has ended up doing these things anyway.

For its part, though some of its officials told us they did not know of Parkside's struggles until after the outbreak, the Ministry was generally aware that overcrowded long-term care homes were at greater risk of spreading COVID-19 (the Ministry holds outbreak data for all long-term care homes in the province). This issue was first discussed during the rollout of the initial public health orders restricting indoor gathering sizes, which culminated in the Ministry working with the Authority to issue dining guidance documents for long-term care homes and other similar facilities. Further, given the Ministry's direct interactions with Extendicare about its proposal to replace its Regina facilities over the last 11 years (including specific meetings and discussions in 2020 before the outbreak), it is clear that the Ministry has known for years that Parkside is past the end of its useful life, is too crowded, no longer meets any relevant current standard for long-term care facilities (whether or not the Ministry has officially adopted them), and needs to be replaced.

The Ministry, the Authority, and Extendicare have all known for many years that Parkside is at the end of its useful life. Its 4-bed room layout, cramped dining spaces, and lack of storage resulted – ten years ago already – in it receiving a failing grade in a third-party professional functional assessment. However, it is not the only old worn-out long-term

care home in Regina: the Authority's Regina Pioneer Village also needs replacing, among others as we understand it. Discussions among Extendicare and Authority officials about the increased risk of transmission due to Parkside having four residents to a room and how to address it began early in the pandemic and well before the outbreak. Public Health acknowledged the problem needed to be addressed before the fall of 2020. By August 2020, Extendicare was taking steps in Ontario to only have two residents per room. However, it did not take these same steps in Saskatchewan.

Therefore, our answer to the Minister of Mental Health and Addictions, Seniors and Rural and Remote Health's question is, yes, the condition of the Parkside facility impacted the transmission of COVID-19 within the facility, including its residents sharing crowded rooms, its crowded office areas and break rooms, its narrow hallways, its general lack of adequate storage (we note that in June 2021, Parkside was using sea cans outside to store its PPE) – all things that the Ministry, the Authority and Extendicare have known about and have been discussing for the last 11 years.

Deciding whether it is wise to invest public money in Extendicare's proposal to replace its three Regina homes, or whether such a project should be sole sourced without a competitive procurement process, is far beyond the mandate of an Ombudsman. We summarized Extendicare's many discussions with the Ministry and the Authority over the years about its proposal only to make the point that, as of the beginning of the pandemic, all three of them clearly knew that keeping Parkside at its full, 228-bed capacity would present significant challenges for managing the spread of COVID-19 if it ever got into the home.

SUPPLY AND USE OF PROCEDURE MASKS

Procedure masks (also called surgical masks), along with disposable gloves, gowns and face shields, are personal protective equipment (PPE) that health care workers need to protect themselves from getting COVID-19. When and how health care workers put on, take off and dispose of masks and other PPE (called "donning" and "doffing") is also very important. This is because masks can become contaminated with SARS-CoV-2 when a worker is in close contact with a person with COVID-19 or when they are performing procedures that generate aerosols (sprays and vapours) or airborne droplets. Even if a worker is not in close contact with a COVID-19 positive person, their mask can become contaminated if they do not properly store it, don and doff it, and dispose of it.

Securing Adequate Supply

At the start of the pandemic, the health sector was concerned there would be a shortage of procedure masks. Most of us recall being told early on that we should not be buying procedure masks (the ones that are usually blue on the outside and white on the inside) or N95 masks (called "particulate-filtering facepiece respirators") so that health care workers would have access to what was at the time a scarce world-wide supply.

Towards the end of January 2020, Extendicare began centrally tracking PPE across its homes in order to monitor supply risks.

According to the Ministry, on February 14, 2020, it directed the Authority to increase its PPE inventory to ensure a six-month supply. By early March, the Authority announced

it was opening an Emergency Operations Centre where decisions about PPE supplies would be determined. By March 11, 2020, the Authority provided long-term care home administrators, including Parkside's Administrator, with information for them to share with their staff about PPE and how to properly use it. In a March 20, 2020 memo to all its staff, Extendicare's Incident Management System team stated:

> We continue to order all the supplies we can to ensure every team member is protected with appropriate Personal Protective Equipment (PPE) and we have advocated to provincial governments to increase our access to supplies. While we recognize there may be heightened concern for supplies, particularly for those who may interact with a resident/client/patient with symptoms, please know your safety is our priority.

By March 25, 2020, the Authority was reaching out to long-term care homes to determine their PPE requirements.

In an April 6, 2020 string of emails, Authority officials discussed the need to understand the supply-chain processes of contracted long-term care homes like Parkside regarding masks, since it was not getting its PPE through the Authority's supply chain. They wanted to understand each home's daily staffing numbers to get an estimate of the PPE supplies they needed. The Authority asked Parkside for details about its PPE suppliers, purchasing officials, and its daily staffing numbers.

Extendicare told us that, by April 6, 2020, it had secured a sufficient inventory of PPE to implement its own universal masking policy.

By April 7, 2020, a recommendation to the Emergency Operations Centre had been made to have all special-care homes (including privately-operated homes) be considered part of the Authority for the purpose of supplying them with PPE.

On April 16, 2020, the Authority emailed all Regina long-term care home administrators advising that the PPE taskforce (Emergency Operations Centre) had not yet approved the proposed plan for the supply of masks to provincial affiliates. Therefore, they were sent an interim supply, and were asked to monitor their use over the weekend. The same day, the Authority advised Parkside's Administrator (and two other long-term care facility managers) that a shipment of a week's supply of masks ordered by the Authority would be arriving that day and requested that they monitor the rate of use over the next few days so it could use the information for its supply chain.

By May 7, 2020, the proposed plan had been approved and the Authority had implemented a process for long-term care homes, including Parkside, to regularly order procedure masks through the Authority's supply chain. The process required Parkside to submit a spreadsheet every second Tuesday indicating the number of masks it had in inventory and how many it was using. It would then receive its order by Friday for the next two weeks. The Authority confirmed with us that it provided procedure masks to Parkside free-of-charge. Parkside ordered masks from the Authority under this system thereafter based on its staff's actual usage (one mask per shift unless it become soiled) not on the Authority's continuous masking principles and guidelines (four masks per shift).

Extendicare's *COVID-19 Universal PPE Strategy* required administrators to ensure each home's core supply of masks was secured in a locked location, to monitor the core supply and to contact corporate Extendicare or another designated supplier when additional

supplies were required. It also required administrators to ensure that there was a sufficient supply of PPE in each home area, including all appropriate sizes of fit-tested N95 or equivalent respirators, so they were readily available on all shifts. In addition, it required direct care staff to complete point-of-care risk assessments before providing care to a resident, and encouraged them to consider current science, evidence and directives regarding COVID-19 transmission, N95 or equivalent respirators and PPE, and the current COVID-19 status of the home.

On October 2, 2020, the Authority's Director of Continuing Care in Regina emailed all long-term care home administrators in Regina (including Parkside) suggesting that they have a least a weeks' supply of PPE (especially face masks), and, if they could not secure their own supply, asking them to advise the Authority of their needs. The email ended with: "**IF I do not have a response from you, I will assume that you have stocked at least a one weeks supply of the PPE required to go to contact droplet plus precautions.**" [emphasis in the original.]

On November 12, 2020, the Authority said, for the purposes of ordering sufficient procedure masks, it wanted Parkside to verify its staff numbers because, for the number of beds it has, it was reporting having less staff than other homes. The Authority thought this might be why it was not ordering what the Authority believed were enough masks and was almost out before getting new orders every two weeks. On November 16, 2020, Parkside's Director of Care was again asked to check its staffing numbers and number of masks per shift to determine if the numbers were correct. The spreadsheet indicated that Parkside was still using one or two masks per shift per person, and not the four masks per shift per person as required by the Authority.

According to senior Authority officials responsible for working with Parkside, its staff did not have proper immediate access to PPE (particularly face shields) notably after hours and on the weekend. In a November 22, 2020 email to Ministry officials, the Authority said: "What has become clear is that we have underestimated needs and utilization is higher and faster than anticipated in LTC."

After the outbreak was declared, Parkside was desperately looking for PPE and asked the Authority to help by supplying it with a very large order. On November 23, 2020, the Authority's Contracting, Procurement & Supply division emailed the Authority's Director of Continuing Care in Regina, stating that Parkside's request was "not reasonable, and it puts a huge draw on the stock we have, potentially shorting us for the rest of the Regina sites we serve." With the exception of N95 respirators, which were still in short supply, it suggested that Parkside should have no issue getting it through its own suppliers. As it happened, Parkside was able to secure the PPE it needed through Extendicare's supply chain.

FINDINGS

Based on the evidence we reviewed, by February 2020, the Ministry and the Authority were aware of the need to have a supply of PPE on hand in the province and took steps to ensure it had a secure supply chain not only to meet the Authority's needs, but for all long-term care homes as well. While there were initial concerns of a shortage, by the end of April, there was a continuous supply available. Parkside could order masks from the Authority on a bi-weekly basis, which were supplied to it free-of-charge. Therefore, we find

that the Authority ensured Parkside had access to a sufficient supply of procedure masks for staff to comply with the Authority's continuous masking principles and guidelines. Once the outbreak happened, Parkside did not have N95 masks on hand as was required by Extendicare's guidelines, and did not have enough procedure masks in stock locally to get it through the first several days of the outbreak. Extendicare's PPE supply chain was, however, able to provide Parkside with procedure masks in relatively short order thereafter.

Parkside's Compliance with the Authority's COVID-19 Masking Principles and Guidelines

On April 14, 2020, the Authority issued its *Continuous Masking Principles and Guidelines* and *Continuous and Extended PPE Use Guidelines – Continuing Care* requiring all long-term care home staff with direct or indirect contact with residents to wear a mask at all times. This rule was put in place on the basis that, coupled with physical distancing, point of care risk assessments, hand hygiene, and environmental cleaning and disinfection, it would help prevent the transmission of the virus to residents from staff who may be asymptomatic and vice versa. The *Guidelines* strongly encouraged the judicious use of masks but required them to be changed if they became wet, soiled with blood or bodily fluids or damaged. It stated that masks should be discarded when taking scheduled breaks and at the end of each shift, because of the risk of self-contamination if safe removal (doffing and donning) processes were not followed carefully. So, this meant, at a minimum, 4 masks per staff person per shift.

The next day, on April 15, 2020, at 10:05 AM, Extendicare's Regional Director emailed the Saskatchewan Union of Nurses and SEIU-West to advise that its Saskatchewan facilities would not be complying with the Authority's *Guidelines* because its supply chain would not be able to sustain it. He said, "to implement a directive that will use up all PPE without new ones, is a greater risk to our team members than maintaining our current practices, until such time we have sufficient PPE and a stable supply chain." In contrast, at 4:18 PM Parkside's Administrator emailed the Authority answering 'yes' to the question "are the screening and masking procedures implemented at your facility?"

In an April 16, 2020 staff briefing memo, Extendicare notified its staff across the country that it had created a new *COVID-19 Universal PPE Strategy*, which it stated was reflective of provincial directives. According to the official transmittal of the new policy, it was effective as of April 10, 2020. It instructed Directors of Care to (in part):

> 2. Provide all staff with a mask and a clean breathable storage container for the mask (such as a paper bag) at the beginning of each shift.
>
>   ***Note:*** The mask is for extended use throughout the staff's entire shift, unless the mask becomes damaged, soiled or contaminated with body fluids (i.e. blood, respiratory or nasal secretions from a resident).
>
> 3. Provide additional masks to ensure staff discard and reapply new mask after scheduled breaks in the provinces of Alberta and Saskatchewan.
>
> [Emphasis added.]

The Ministry's April 17, 2020 public health order required individuals providing direct patient care or working in patient care areas to wear a procedure mask continuously at all times and in all areas of the Facility, if they were involved in direct patient contact or could not maintain adequate physical distancing from patients or other individuals.

On April 20, 2020, in response to the Authority's request that long-term care administrators confirm the number of masks received and their daily burn rate, Extendicare's Senior Administrator replied, adding that Extendicare was only giving out one mask at a time with a paper bag to store the mask in between uses, that additional masks were available for staff if their mask became moist or soiled, and that Extendicare had not been burning through masks. The Authority replied that this was not the standard. Seemingly unaware that Extendicare's universal masking policy specifically required its Saskatchewan homes to comply with the Authority's *Guidelines*, the Senior Administrator responded that it was following Extendicare's standard which had been adopted in Ontario and Alberta. He said: "This way there is no wasting of masks."

That same day, Extendicare issued another transmittal notice to update its *COVID-19 Universal PPE Strategy* "to reflect new provincial directives pertaining to mask distribution amounts and usage." It added the following requirement:

> Homes will follow health authority or province-specific directives, as they become available, for minimum number of masks to be distributed per shift to each individual working in the home, including guidelines pertaining to their use.

It also instructed Directors of Care to:

1. Follow health authority or provincial-specific directives for minimum number of masks to be distributed per shift to each individual. Refer to COVID-19 Province-Specific Directives, Appendix 4.

   [Emphasis added.]
2. Refer to COVID-19 Universal PPE Guidelines, Appendix 1 for appropriate PPE use, storage, cleaning and disinfecting during COVID-19.
3. Provide all staff with a clean breathable storage container for the mask (such as a paper bag) at the beginning of each shift.

The updated version included links to the Authority's *Continuous Masking Principles and Guidelines*. It also required administrators to ensure its core supply of masks was secured in a locked location, monitor the core supply and contact corporate Extendicare or another designated supplier when additional supplies are required.

Despite Extendicare's official policy specifically stating otherwise, Parkside's Administrator confirmed with the Authority on April 21, 2020 that it was Extendicare's direction that it issue one mask per person per day and a brown paper bag, he stated: "in an effort to conserve PPE." The same day, Extendicare's Regional Director provided the Authority with a copy of Extendicare's April 10, 2020 version of its *COVID-19 Universal PPE Strategy*, confirming that staff are given one mask a day and if required, they can request additional masks if the one gets soiled or damaged. He stated that while its policy was not as prescriptive as the Authority's, Extendicare was committed to both PPE stewardship and keeping staff safe until such time there was a solid grasp on the supply chain. Again, he did not appear to realize that Extendicare's corporate policy required its Saskatchewan homes to comply with Saskatchewan's masking directive.

On April 22, 2020, the Authority's Director of Continuing Care in Regina told Parkside it was non-compliant with the Authority's PPE requirements because it was not providing its staff with four masks per shift. On April 24, 2020, an Authority Public Health Nurse emailed Parkside about its mask use:

> I have had a concern brought to me regarding the implementation of the extended/ continuous mask use at Parkside. It was reported that staff are provided with one mask per shift and a paper bag to hold the mask when removed for breaks. The concern is that this does not align with the guidelines/principles set out by the SHA and the reuse of a mask with storage in a paper bag could lead to contamination of both the inside and outside of the mask and subsequent exposure for the staff wearing it. I know we are in unusual times and there is a need to be judicious in our use of PPE but based on the information I was given, the described approach could be causing more harm than good. If you are facing challenges to provide the required PPE for staff, I urge you to contact your director of Continuing Care within the SHA for assistance in accessing PPE.

On April 28, 2020, Extendicare's Regional Director again reiterated that he was not going to follow Saskatchewan's masking rules, still seemingly unaware that Extendicare's masking rules specifically required him to comply with them:

> I wanted to reach out to clarify Extendicare's policy and choice to continue to follow our internal policy vs the SHA. We appreciate the support the SHA has and continues to provide PPE, mainly masks to our Homes. Our policy is based both on ICP practices and stewardship.
>
> Given the fact overall PPE remains in short supply across Canada and on-going outbreaks in the regions, whether C19 or otherwise, we do not feel comfortable moving to a standard, we feel cannot be maintained, at least in the short term. We also continue to work with our multiple vendors across Canada to purchase as much as we can buy to support all our homes. If another home requires additional PPE, we feel, we may be able to support them, when and if that happens.
>
> Our current practice is utilized in other jurisdictions, e.g. Manitoba with no concerns and as you can see, does allow for additional masks as needed based on a criteria.
>
> As for possible cross contamination, I would say if team members apply the correct hand hygiene practices linked to donning and doffing of PPE, there should be no concerns.
>
> Lastly, our policy allows ties into our willingness to remain stewards of PPE
>
> Lastly, if Public Health provides a mandate to provide a specific number of masks, we will be obligated to follow through.

That same day, when reminding all long-term care facilities by email to submit their mask requirements by the deadline, the Authority added "this is important for Extendicare who were unable to implement the 4 masks per day."

The Authority's Director of Continuing Care in Regina told us that Extendicare's Regional Director had been up front with the Continuing Care branch about his decision to not follow the Authority's masking directive. She noted that, earlier in the pandemic, the Ministry had included advice on how to keep masks safe in bags or wipeable containers, similar to Extendicare's masking rules. But she said she told Extendicare to "get rid of paper bags, [the Authority] will give you all the masks you need" – at no cost to Extendicare.

One direct care worker at Parkside told us that they actually called Public Health and reported the single mask use at Parkside, but nothing happened. The direct care worker said that the Director of Care "was aware that staff weren't happy with one mask per shift, but staff were told there wasn't enough masks and management were scared they would run out."

On September 1, 2020, Extendicare updated its *Infection Prevention and Control (IPAC) Manual* including its *Personal Protective Equipment Policy,* which referred to an updated *COVID-19 Universal PPE Strategy*. This version continued to require Parkside to follow health authority or province-specific directives for the minimum number of masks to be distributed per shift to each individual working in the home, including the Authority's guidelines pertaining to their use. As well, it provided a link to the Authority's PPE/Infection Prevention and Control webpage, which included links to its *Continuous Masking Principles and Guidelines*.

FINDINGS

There is no doubt that the pandemic and, therefore, advice on measures to be taken when providing care in the health care system was a fluid situation. However, by April 14, 2020, the Authority rolled out its *Continuous Masking Principles and Guidelines* and *Continuous and Extended PPE Use Guidelines – Continuing Care* requiring all staff who work in a long-term care home where they will have direct or indirect contact with residents to wear a mask at all times. The requirement for all direct care staff to wear masks at all times was also contained in the April 17, 2020 public health order. The Authority's *Guidelines* further directed that masks should be discarded when taking scheduled breaks and at the end of each shift, because of the risk of self-contamination by not removing and then putting it on again properly. This, of course, meant a minimum of 4 masks per person per shift.

However, it was clear from the onset of the pandemic that Extendicare's Regional Director felt that it did not have to follow the Saskatchewan rules and that it could follow Extendicare's one mask per shift and a paper bag – even though Extendicare's own *COVID-19 Universal PPE Strategy* actually recognized and directed its managers in Saskatchewan to follow the Saskatchewan directive.

In response to the draft report, Extendicare suggested that it was not clear if the Authority's masking principles and guidelines were recommendations, guidelines, or mandatory rules, and therefore, whether they had to be followed in Extendicare's Saskatchewan facilities. This is simply not true. We find that Extendicare clearly understood that the Authority was specifically and directly advocating for it to comply with the Authority's universal masking guidelines, including arranging to supply Parkside and its other homes with the necessary number of masks free-of-charge. Further, Extendicare itself had already decided and directed that its Saskatchewan homes were to follow the Authority's rules. Its own *COVID-19 Universal PPE Strategy* states it was to comply with the Authority's standards when it came to masking.

We find that Parkside was neither following the Authority's *Continuous Masking Principles and Guidelines* and *Continuous and Extended PPE Use Guidelines – Continuing Care* nor Extendicare's' *COVID-19 Universal PPE Strategy*, as it was required to do.

Relationship Between Extendicare and the Authority

This whole "one mask and a paper bag" versus "4 masks" per shift controversy is a good example of what we see as an issue with the relationship between the Authority and private operators like Extendicare who provide care under contract with the Authority.

While the Authority balked at Extendicare's defiance and made it clear to Extendicare's local and regional managers that that its facilities should be using four masks per day, the Authority did not take any steps to enforce its *Continuous Masking Principles and Guidelines* by, for example, directing Extendicare to follow them as it was entitled to do under the Principles and Services Agreement, or raising the issue to a higher level within Extendicare. In its submissions to us, the Authority noted, had it given Extendicare notice that it expected to comply with any specific pandemic-related standards or practices, and Extendicare refused, it would have had to invoke the dispute resolution provisions in the Agreement, which it said would not have been feasible. While we acknowledge that generally any time the parties to any contract disagree on the applicability or implementation of a specific provision (in this case, the provision requiring Extendicare to comply with the Authority's requests to implement necessary standards and practices as determined by the Authority) that it might become necessary to resort to dispute resolution mechanisms. However, this does not explain why neither the Authority's nor Extendicare's officials who were responsible for administering the services provided under the agreement at Parkside did not appear to realize that Extendicare was not free to ignore the Authority's standards and practices, or that the Authority could have raised this as an issue under the agreement.

As one Authority official told us: "Honestly, I don't think we ever did a final 'resolve of the issue' so [the Regional Director] indicated he would continue with single mask protocol until told differently." The official added: "I must say that as we were trying to address all [infection prevention and control and], PPE questions, somewhere in there [we] lost sight of the paper bag issue at Extendicare because direction had been provided that masks were to be made available and we were providing [them] so homes could order what was required." Based on the information we have reviewed, even during the outbreak and until the Authority took over, Parkside's staff were still using one mask and a paper bag per shift and were still not following the Authority's masking directive.

We acknowledge that the pandemic was (and is) an extremely stressful time for everyone involved in administering health care. There were decisions being made and reviewed daily. However, in our view, this issue demonstrates the relationship or perceived relationship between the Authority and Extendicare. The position of many officials we interviewed – in the Ministry, the Authority, and Extendicare – is that Extendicare is a private entity and entitled to follow its own policies and does not need to comply with the directions of the Authority. There is also a general sentiment among both Extendicare and Authority officials that because Extendicare is a large national company with operations in several provinces, it has as much, or more, expertise in long-term care than the Authority. Because of this, Authority officials did not insist that Extendicare to follow its universal masking directive. In their words, they could only encourage compliance. Equally, Extendicare's local and regional managers resisted following them – apparently, it seems, for no good reason. According to the Authority and Extendicare, there was, in fact, no shortage of procedure masks as of mid-April 2020. Further, Extendicare's own corporate masking policy required its local homes to implement the Authority's *Continuous Masking Principles and Guidelines*,

so its local and regional managers were defying its own corporate directions too. Lastly, the Authority supplied Parkside with masks free-of-charge.

Given this, we find that Extendicare's refusal to follow the Authority's *Guidelines* was unreasonable. It seems to have been motivated by Extendicare's local and regional managers' belief that they could chart their own course; that Extendicare did not have to comply with the Authority's masking rules, and that the Authority could not force them to - a belief shared by the Authority's local Continuing Care staff, and based on our interview with them, its Executive Director of Governance and Policy and Director, Corporate and Clinical Policy.

In our opinion, this is a misinterpretation of the relationship. While *The Provincial Health Authority Act* only requires operators to comply with relevant statutes, regulations and other laws, the Authority's Principles and Services Agreement with Extendicare requires it to take the Ministry's and the Authority's goals and directions into account and provides for the Authority to insist that Extendicare provide the services in accordance with the standards and practices the Authority requires its own long-term care homes to meet. Any additional costs associated with following the Authority's practices would no doubt be up for discussion, since the Agreement also requires the funding the Authority provides Extendicare to be fair and equitable, and set based on the specific services it provides.

As one Authority official told us, "the whole outsourcing of authority…has got to stop… they need to take direction within the province and be accountable for following up on the things we tell them to do."

LIMITING THE SPREAD OF COVID-19 FROM RESIDENT TO RESIDENT

As medical professionals have told us, one of the most basic measures for reducing the spread of COVID-19 is one with which all of us are now very familiar: Stay at least two meters apart from people who are not in your household or 'bubble' and when this is not possible, wear a mask. The difficulty, of course, is that to varying degrees, all long-term care homes are communal living spaces – even in the most prestigious and spacious homes where residents have private bedrooms, they generally have their meals and socialize together in common rooms and lounges. On top of this, they are provided personal and health care that by its nature requires them to be in close contact with staff. Long-term care residents largely do not have the option of avoiding contact with others.

To address this reality, the first public health order on March 17, 2020, restricted visitors to long-term care homes to family visiting for compassionate reasons, typically when a resident was near the end of their life. The intent was to limit residents from being exposed to the serious threat to their health posed by COVID-19. Other subsequent public health orders and rules focused on limiting residents' exposure to COVID-19 from the staff who care for them, who, like visitors, are also at risk of bringing COVID-19 into the homes from the community. Still other orders, rules and guidelines focused on keeping residents from spreading COVID-19 among themselves.

The task of maintaining social distancing among long-term care home residents is made still more difficult because of the wide range of their individual personal health conditions and characteristics. For example, as was reflected in the exemptions to the first November 5, 2020 masking public health order and continued in all subsequent ones, some residents have particular medical conditions that prevent them from wearing a mask. Others have

cognitive impairments, intellectual disabilities, or other mental health conditions that make them unable to understand the requirement to wear a mask or to maintain social distancing. At homes like Parkside, there are highly mobile residents with dementia who have no compunction about entering other residents' close personal spaces – many of whom are physically infirm and unable to then react and maintain social distancing.

Despite the challenges, it was the responsibility of the Ministry, the Authority and Extendicare to keep residents safe. This included taking measures aimed at keeping COVID-19 from entering the facility and if it got into the facility, measures to minimize the spread from resident to resident. Though there are a myriad of circumstances in which Parkside needed to take these steps, we considered two key requirements: (1) the steps taken to maintain social distancing during residents' meals; and (2) the steps taken to ensure residents did not spread COVID-19 during the outbreak.

Social Distancing During Meals

The March 20, 2020 public health order prohibited public gatherings of over 25 people in one room, except where two meter distancing could be maintained. Three days later, the Authority distributed a *Nutrition and Food Services COVID-19 Bulletin* to Parkside and other long-term care operators noting that dining rooms may need to be restructured to ensure social distancing practices are observed, including staggering mealtimes if necessary.

On March 26, 2020, the public health order was modified to prohibit indoor and outdoor public and private gatherings over 10 people, except in certain circumstances "where two meter distancing between people can be maintained." The order said that if a critical public service is unable to maintain two meter distancing, it had to use "other measures such as self-monitoring of personal health or supervision by Infection Prevention and Control Officers or Occupational Health and Safety." The same day, officials with the Authority's Environmental Public Health informed the head of the Authority's Public Health office in Regina that the Ministry needed all long-term care homes to move to serving residents in their rooms if they were able to do so. It said dining rooms could still be used as long as no more than 10 people (down from 25) were in a room at one time. It also said that floor-to-ceiling partitions could be used to divide the dining room into multiple rooms to accommodate more residents at one time. The Authority forwarded this information to Parkside's Administrator. Parkside's Administrator reacted to learning of the new dining rules in an email to the Authority's Executive Director of Continuing Care in Regina:

> This will be a *massive* and *horrible* task for Parkside. This would push us to at minimum 4 settings for each meal. I would need a ton of resources to pull this off.
>
> -This would totally disrupt resident life as meal times would blend together from Breakfast would not/or barley [sic] be finished before Lunch began and the same with lunch to supper.
>
> -We would have to start cooking at least two meal times (for each meal) as the food would be past food safety before all the resident [sic] would be given their meals. Clean and prep times in between would also be required for safe food handling.
>
> In a nutshell I think we would be running one meal into the next, any way we can keep this at 25 for now? If we get a positive case we would obviously go into outbreak mode.
>
> The other option would be to move residents out so we could meet the 10 rule?

In a follow up email, the Executive Director of Continuing Care in Regina offered the following feedback to Public Health:

> Some homes have large units (60-80+) with very large common dining/living spaces. They have adjusted to 25 and minimum of 2 metres separation with double meal sittings and some residents eating in their rooms or supported in other lounge space. A move to 10 is identified as almost functionally impossible, with 3+ sittings per meal, plus some being served in their rooms as no other common areas, and insufficient staff to assist across so many areas, including resident rooms. Even with extra staff on shift, it is not sufficient to provide safe supervision and assistance.
>
> ...
>
> Many homes do not have the infrastructure anymore to support tray services in rooms for all residents as we moved to the enhanced dining and cart service a number of years ago, so do not have the equipment on hand to provide this type of service.
>
> Homes have been supportive of initiatives and are very concerned about the safety of residents and of staff and are willing to take necessary steps, our older institutional style buildings are adding to the challenge.

On March 30, 2020 the Authority's Executive Director asked Public Health for help in addressing what she referred to as some specific challenges with dining spaces at Parkside:

> They have 3 care wings, that have between 62 and 84 residents living on each area. Each wing has 2 dining rooms [each of Parkside's three wings actually has just one dining room, though the north and south dining rooms are each adjacent to a separate resident lounge area] (no living rooms) and there is [sic] no large communal gathering spaces like some homes have. They have a hot food cart for service in each dining room, and some trays/covers, but a small number and insufficient to serve all residents in this manner. Doing this would not address the space issue in the 4-bed wards, as they cannot set it up to keep people 2 metres apart, there is insufficient space, but can provide 1-2, when seated in W/Cs.
>
> They have adjusted their dining spaces to 25, with 2 seatings, and a number of residents eating in their rooms. They have accommodated the 2 metre space requirement in doing so. Going to 10 means 3-4 sittings per meal, (1000-1400) and it is not possible to put more people in their rooms, as already have tried to maximize the shared space needs and overbed tables use for dining needs. Thorough cleaning between seatings, hand hygiene for residents, as well as staff at each meal period, direct service provided by staff, and maintaining the 2 metres [can't] be done. I have asked that they decrease as much as possible, advised they already had and were reviewing again, but indicated that they are struggling. We run the risk of food safety concerns and capacity to cook meals in the manner required to support fresh food for each service. Per the Nutrition and Food Services leaders, two meal services per mealtime can be supported and ensure food safety, following that the risk increases and the food quality also decreases. There is not enough kitchen capacity to cook two separate meals to have extended meal services.
>
> As noted below, building walls is not feasible, but creation of a temporary barrier of some sort may be if full height is not required, similar to a moveable office wall?

On March 30, 2020, the Authority's Executive Director of Continuing Care for Saskatoon provided all long-term care homes with copies of the Authority's visitor screening and restriction directive and related tools noting:

> All Public Health orders are applicable to special care homes, of note is the mass gatherings of less than 10 people. We are aware this impacts the dining experience and perhaps recreational activities at your homes but these are orders that apply to *all* in the province.

The next day, Extendicare's Long-Term Care Consultant for Saskatchewan emailed the Authority noting that there was an issue with it being able to maintain space between residents of 6 feet apart and having not more than 10 residents in the dining rooms in its older homes that have shared rooms and limited dining space, such as Parkside.

On April 3, 2020, the Provincial Affiliate Resource Group (of which Extendicare is member) that represents private long-term care homes' interests, wrote the Deputy Minister of Health expressing concerns about the ability to ensure physical distancing during residents' meals:

> Many homes do not have the infrastructure conducive to fully complying with the guidelines. Some have shared rooms and bathrooms that does not allow for 2 meters of separation between residents and all affiliates have insufficient staff to have all residents eat in their rooms. Many residents require supervision and/or assistance with eating and having them eat in their rooms would either increase their risk or require us to increase staff which is not easy to do without increased risk at this time. It is unlikely we could increase staff without access to a new labour pool, as we are finding difficulty replacing our current staffing compliment. Also delivering meals to rooms would place increased burden on staff. For example…a 100 bed facility in Saskatoon, built 60 years ago has 4 floors and one elevator. Delivering trays to residents under these circumstances would be a horrendous undertaking.

On April 3, 2020, Parkside's Administrator emailed the Authority about its efforts to comply with the Ministry's dining requirements:

> I thought I should send you what we are doing at parkside and the additional resources we have been using. I have given you some of the details verbally but now that we are mandated to 10 resident grouping for meal times this has stretched us past normal resources. When we were able to have 25 residents in the dining area we added a 4 hour dietary shift/each day and extended our other 4 hours shifts by an hour a day when we needed.
>
> So this is the deal. Now that we are 10 per dinning [sic] area I have added an additional 16 hours of dietary per day as we have moved to tray service in the residents rooms not to exceed 10 per dining area. For the weekend I have added 2 additional [recreation] staff to assist with feeding. As well going forward I have added a [continuing care aide] for Days and Evenings on all three wings, as we have no other choice but to serve the residents in their rooms, and by doing this now we have added the risk [of choking]?
>
> I would appreciate your approval on staffing increases for this, and there will be a small number of additional hours here and there as not every day is going as planned, and we will not shove the food down the residents throats to speed up meal service.
>
> We may need additional trays and carts, not a 100% sure as we are just running [trial] and error as we just started today.

The next day, the Authority's Director of Continuing Care in Regina approved Parkside's request for additional staffing for meal times and offered to find the food trays and carts it needed.

On April 8, 2020, the Ministry provided the Authority with its official updated guidance for food services in long-term care homes. It included the following social distancing requirements:

> No guests allowed in the dining room. Visitors are allowed in the facility if they meet the requirements related to compassionate reasons, and the checklist.
>
> - Social distancing of 2 meters shall be applied between residents.
>   - Diners sharing a residence may share a table.
> - No more than 10 people in a room.
>   - If a larger dining room is divided to provide more rooms, social distancing must still be practiced.
>   - If dividers are used consideration shall be given as to how they can be properly cleaned and disinfected after each meal sitting. Additional consideration should be given to ensure divider are not interfering with airflow or posing a hazard to residents and staff
> - Measures are to be implemented to ensure residents:
>   - Go directly to their table and don't congregate in the entrance area, and
>   - Return to their residences in a timely manner, no loitering.
> - Consider allowing healthy residents to have a "buddy" for meal times in dining room where applicable. This pair/group would be set for the duration of the mitigation measures and cannot be changed. It allows people to have a dining partner and some socialization.

On April 15, 2020, Parkside's Administrator gave the Authority a list of dining equipment (insulated bowls and mugs, trays, plate warmers and four food tray wagons) he said, "would make things go better."

On June 8, 2020, the Authority distributed an updated version of the Ministry's *Guidance for Food Service Long-Term Care and Seniors' Facilities on Mitigating Measures of COVID-19* to Parkside's Administrator (and others) noting that the persons per room rules were now aligned with current public health order indoor gathering limitations, which were 15 people at the time. When Phase 4 of the Re-Open plan started on June 22, 2020, the limit increased to 30 people. The public health orders still required homes to ensure two meter social distancing between residents.

Even before the Ministry's first dining guidance document was issued formally, Parkside's Administrator and the Authority's Executive Director of Continuing Care in Regina were clear that it was essentially impossible for Parkside to serve its residents three meals a day with 10 people in each of its dining rooms at a time given how many residents it had.

A Parkside staff member who was responsible for implementing the 10-person dining room limit (along with others) told us that it began serving about one third of its residents using tray service in their rooms. Hypothetically, if Parkside had 198 residents (which it

did when the outbreak was declared), this would mean it was serving 66 residents in their rooms. The other residents (132 people) would be served in its dining rooms, we were told, in two sittings. This same staff member said each dining room was staffed with two or three workers to help residents with their meals and to clean up after them. However, this meant that it could only have served seven or eight residents at a time if it was to comply with the 10-person order. Serving 7 residents at a time in each dining room (21 in total), would mean Parkside's cooks, cleaners and care aides would have had to seat, serve, and clean up not two, but six separate times for each meal in each dining room to serve all 132 people. Even assuming they gave residents just 20 minutes to get seated, eat and leave, and then gave themselves 10 minutes to disinfect the room, every meal service would have taken three hours. So, if lunch started at noon, some residents would be waiting until 2:30 pm before they could sit down to eat. This would have to happen every day at every meal in all three dining rooms. And, while the Ministry's maximum seating capacity increased to 15 and then 30 people, this was only relevant for facilities that, unlike Parkside, could accommodate this many residents for communal dining *and maintain proper social distancing*.

Because of this, Parkside staff told us that, despite trying, they did not consistently comply with the relevant public health order or the Ministry's dining guidance rules for residents:

- Parkside's Administrator told us he and his management team knew they could not maintain proper social distancing when there were 201 residents and 90 staff in the building every day. He said some small towns do not have that many people.
- Parkside's Assistant Director of Care told us she was involved in ensuring that the dining guidance rules were being followed. She said residents were very upset about the two different sittings. She said they want to eat when they want to eat. Residents at the second sittings said that they were 'second-class citizens' so they were getting the leftovers. The Assistant Director of Care told us residents lined up outside the dining room waiting to be seated. She said it was difficult to socially distance them, especially in the main wing, where the residents are a bit more mobile. She said residents would argue with staff "especially if you tried to social distance them." She also confirmed that it was common for residents from the second sitting to be seated early, right across from residents from the first sitting who had not left yet.
- A support worker acknowledged that they understood the 10-person maximum (later 15-person) was to include staff saying they were to have "let's say seven residents and three care aides or two care aides" in the dining room at a time. When we asked how the rule was implemented, this worker told us "they would put eight or nine residents in the dining room." However, this worker was not directly responsible for helping residents during meals.
- One direct care worker said, "I think very early on it was recognized that there could not be social distancing with the residents…just the nature of their patience and the environment." Comparing how Parkside managed resident dining before the outbreak with after (all residents dined in their rooms after the outbreak), the worker said, "maybe we should have gone to tray service a lot, lot sooner." "I don't think dining room service was feasible right from the get-go."
- A support worker told us that they tried to figure out which of their residents were early risers and to get them in to eat their breakfast right away. They said that the plan was to feed the residents in two sittings and clean up and disinfect between them but "a lot of times it did not happen." "It never seemed to carry out that way…just due to the

needs of the residents." "They often....would not want to wait, so they would just wheel themselves in." "Care aides would bring them in because...they were impatient in waiting."

- A support worker told us "it was always ten residents plus me...and two cleaners and two care aides, so there was, even when it was 10, it was more like 15."
- A direct care worker, said "it wasn't communicated really on how to do it...It was said, but...the one dining room on main wing is really small, and actually we should've only had six in there."
- One worker told us they initially served two residents at each table, but that this then changed to one resident per table, but they could not remember when the change was made. Another said: "The tables are only...I don't know if they're 30 inches, you know? And the people were sitting across from each other, so even in the wheelchair, that's not six feet." "And people would have their backs to each other."
- Like the Assistant Director of Care, direct care workers told us that the next sitting of residents waiting to eat would line up down the hallway outside the dining rooms. When we asked if they were social distancing, one said, "No. They were almost sitting on top of each other. It's a small fa[cility]. There is just not a lot of room."
- One worker told us "We were doing [cleaning], plus trying to get the second group in there, but not everyone eats at the same rate." "What they tried to achieve was completely clean out the dining room and bring all the new people back in but...it never worked." "Invariably, some people stayed in there."
- Another worker confirmed that residents at one sitting would not always have left the dining room before the next sitting would arrive, so "we actually did have quite a cluster at times, because staff just wanted to get stuff done."
- Another worker said, "We didn't have enough manpower. Some [residents] we lined up in the hallways to eat, if we had enough tables, which we usually didn't." "Some would eat with the tray on their bed, because we had no tables." "They tried, but there's no room to do [social distancing]...to get everyone fed in a timely manner and safely." "We are supposed to be around watching when the elderly are eating. It's kinda hard to do when you have people all over the place."

FINDINGS

The Ministry and the Authority's dining guidance requirements provided a few ideas for how long-term care homes were expected to implement the 10-person (and later 15-person) limit on indoor gatherings for residents written into the public health orders. But they were, in our view, inadequate because they were based on basic, incomplete assumptions about how long-term care homes are laid out and about what it takes to seat, feed and clean up after 200+ long-term care residents. They did not account for cramped facilities like Parkside. While the Ministry had the legal authority (and arguably the moral duty) to impose these restrictions on the long-term care sector to do its part to protect residents, as Ministry officials told us repeatedly during our interviews, it had no role and took no meaningful responsibility for how they needed to be implemented or for ensuring they were implemented. The Ministry set the expectation for maintaining social distancing among long-term care residents, but left it to the Authority and long-term care home operators to figure out how they were going to comply.

For Extendicare's part, Parkside's Administrator immediately understood that it was essentially physically impossible for it to comply. He immediately and clearly expressed his concerns to the Authority's Continuing Care branch who then relayed them to Public Health. In our view, once the Authority clearly understood how unachievable the guidance rules were for facilities like Parkside, it should have worked with Extendicare to take additional measures. As was alluded to by Parkside's Administrator in his initial criticisms of the rules, reducing Parkside's resident population, which is exactly what has happened since the outbreak, would have made it easier for it to serve meals and generally maintain social distancing among residents. And, although the Authority and Extendicare's discussions about reducing Parkside's resident population began in the context of trying to figure out how to respond to the Ministry's dining rules, as we have already discussed, they only did so after so many residents died during the outbreak.

Masking Residents

The November 5, 2020 public health order (effective November 6, 2020) required everyone, except in specific circumstances, to wear masks in special-care homes (and most public indoor spaces) in the cities of Regina, Saskatoon and Prince Albert. Among other circumstances, the order said masks were not required in the "private resident areas" of special-care homes. Neither the Ministry nor the Authority initially made it clear to Parkside, nor did Extendicare ask for clarification about how to apply the order to residents – specifically if it meant they had to wear masks when outside their private spaces (i.e., bedrooms.) The order was amended and extended multiple times throughout November, eventually becoming province-wide on November 18, 2020 and continued throughout December 2020. After it was further extended in a December 17, 2020 update, an Authority Director of Infection Prevention and Control clarified in a December 22, 2020 memo that it meant that residents had to be masked when outside their rooms, and that it superseded any Authority guidelines for resident masking.

An email with a copy of the memo attached, which was sent to Parkside by the Authority's Director of Continuing Care in Saskatoon on December 23, 2020, suggests the Director did not realize the public health order had required residents to be masked outside their bedrooms in certain areas of the province since November 6, 2020 and province-wide since November 18, 2020: "Please find attached a memo intended to clarify the direction regarding resident masking in LTC facilities with a recent revision to the Public Health Order on masking (Dec 17th)."

In reply, Extendicare's Regional Director comments to these 'new' directions also make it clear that he did not realize that all residents in Extendicare's Saskatchewan homes were to have been wearing masks when outside their bedrooms since November 6, 2020:

> I must say how disappointed I am with the email and direction below. Goes to show the SHA and PH is out of step with the rest of Canada.
>
> This adds a tremendous amount of work onto our team members, in all sites. Our ability to monitor such a directive, reinforces the practice to keep Elders in their suites as many cannot wear a mask due to their diagnoses, eg. Dementia, COPD.
>
> While I know this is not your decision, we believe this negatively impacts our residents.

FINDINGS

First, Extendicare does not appear to have complied with the Ministry's masking order at Parkside, which from November 6, 2020 onward, except in certain circumstances, required all its residents to wear masks when outside their bedrooms. For example, residents were lining up in the hallways to wait to be seated for their meals without wearing masks. Again, as well, the Authority's Continuing Care branch in Saskatoon does not appear to have realized until December 22, 2020, that it was the November 5, 2020 public health order and not a 'recent revision' that required residents to wear masks outside their rooms at least in Regina, Saskatoon and Prince Albert, and then province-wide as of November 18, 2020. As a result, other long-term care homes – including those run by the Authority – may also have not been complying with the masking public health order for most of November and December 2020.

Second, it is important to note that the Ministry's masking public health orders – beginning with the first one on November 5, 2020, exempted residents with dementia or other medical conditions such as chronic obstructive pulmonary disease from wearing them, so the Extendicare Regional Director's criticism of this aspect of the order seems misinformed.

Third, it is even more important to note that by the time the Regional Director sent his email, the Authority had taken over Parkside because Extendicare had not been able to effectively respond to the outbreak, almost all of Parkside's residents had contracted COVID-19, and many of them had already died. In hindsight, then, it seems to us that the additional effort of Extendicare's staff to ensure residents wore masks outside their rooms, and the additional hardship on those residents who could not wear them and had to remain in their rooms, would have been well worth making and dealing with if it meant more lives would have been spared.

Moving Residents and Their Belongings from Room to Room During the Outbreak

As we were advised by the Authority's Public Health division, grouping (i.e. cohorting) COVID-19-positive residents together separate and apart from residents who are not infected is an infection control best practice. In response to an earlier draft of this report, Extendicare submitted that this is not necessarily true with COVID-19. It submitted that, based on its experiences with its Ontario homes, depending on the layout of the home, moving COVID-19 positive residents from one part of the home to another could actually contribute to the spread of COVID-19 through hallway and staff contamination. However, there is no indication Extendicare considered this when establishing Parkside's facility-specific Pandemic Plan, which provided as follows:

> **Pandemic Plan**
>
> Pandemic Unit will be 600 hallway [17 semi-private rooms] on North wing, proceed as per instructions below:
>
> ...
>
> 4. Move residents from North wing (semi private hall) starting at 619 to transition this hall into Pandemic wing.
> 5. Move infected resident into room and place on isolation as per Public health guidelines. See pg 2 on how to transport infected resident

6. Move roommates from infected room into additional beds in rooms starting at 618. Roommates need to be in separate room from infected resident but on isolation to be monitored and tested.
7. Have vacated room from infected resident/residents deep cleaned/disinfected and then move clean residents from North into cleaned room
8. Close fire doors to 600 hallway and put up outbreak signage.

...

11. Instruct North wing staff to utilize Main service rooms for anyone working in 500 hall way [also on the north wing] so staff from clean area do not have to come into 600 hall.
12. Pandemic unit staff are to remain on wing until end of shift. These staff will be cohorted to this unit when at all possible.

Transporting infected resident to Pandemic wing

Don PPE per droplet precautions

Apply mask and gown to infected resident

Clear staff and residents from halls to transport resident to Pandemic wing

Transport resident in wheel chair to pandemic room

Have housekeeping clean/sterilize hall behind transport.

The reason the 600 hallway was chosen is because it can be closed off from the rest of the home. Staff assigned to care for positive residents could, therefore, also be cohorted to this unit to limit other residents and staff from exposure to COVID-19.

Into mid-November 2020, Parkside's resident population was 30 less than its maximum 228-person capacity. However, instead of pre-emptively emptying 600 hallway in case of an outbreak, Extendicare kept a few rooms in each of its wings empty, because, we were told, the Authority's Public Health division had advocated for keeping a few rooms open on each wing.

The first resident to be confirmed positive had been living in a private room in the main wing. Because of this, all residents on the main wing were the first to be tested. According to test reports we reviewed, 53 residents were swabbed on November 20, 2020, and the test results for the 12 residents who tested positive were reported by the lab on November 21, 2020, though Parkside did not get notice of the results until the following day. Of the 115 residents swabbed on November 21, 2020, three tested positive, but Parkside would not be notified of this until two days later.

As of 4:06 PM on November 22, 2020, when Extendicare's Senior Administrator provided an outbreak update to Extendicare and Authority officials, Parkside knew of the 12 positive residents on the main wing and one positive resident on the north wing (plus three positive staff). According to the update, Public Health had by then advised that all the positive residents should be cohorted together. Extendicare's Senior Administrator told us he disagreed with Public Health. He said: "We felt...and this is before I had any experience in it...that leaving people...in the room that they originally test positive was the best way to go." However, he also told us Public Health was adamant about cohorting positive residents together.

Because 12 of the 13 known positive residents were on the main wing already, instead of invoking Parkside's Pandemic Plan by emptying the 600 hallway of its residents and moving the known positive residents into it, Extendicare cohorted the positive residents on the main wing, where it already had two empty rooms with 8 beds. It should be noted that some Parkside staff told us that they believed it was Public Health who had told them to not invoke their Pandemic Plan and to instead cohort positive residents in the main wing. This is incorrect. When we asked the Senior Administrator why Parkside did not initially implement its pandemic plan and cohort positive residents in the 600 hallway, he said, "To say that we were going to uproot healthy people, to put sick people up there just because it's in a plan doesn't mean that's the best source. We had the biggest cluster on main wing. We wanted to try and maintain that cluster on main wing." As well, Public Health told us that while it recommended cohorting positive residents together, where Parkside did this was up to Parkside. While Public Health advocated for Parkside to cohort its positive residents as a matter of best practice, and knew Parkside intended to do this in the main wing, it did not direct Extendicare to not follow its Pandemic Plan. Based on all of the evidence we received from the Authority and Parkside, we find that Parkside's management team made this decision. Extendicare Parkside was not directed by Public Health to not follow its Pandemic Plan.

The following day, on November 23, 2020, another three known positive residents were cohorted to the main wing. By November 26, 2020, 19 of the 22 known positive residents were cohorted to the main wing, one was in the north wing, and two were sent to the hospital. As well, 54 staff (including 28 nurses and continuing care aides) were either COVID-19-positive or self-isolating.

On the one hand, it is difficult to fault Parkside's initial decision to try to cohort Parkside's positive residents in its main wing. When it made this decision, almost all the known positive residents were from the main wing. It is clear from our interviews with Parkside staff that they were hopeful that the outbreak was only present in the main wing and so they thought containing it there was the best option. On the other hand, as it turned out, their hopes were grounded in incomplete information. While they had only received a few confirmed test results from residents on the other two wings at the time, over the next few days, test results revealed that there were COVID-19 positive residents throughout the building. Further, at least one direct care worker had been coming to work for several shifts with symptoms and had not been social distancing or wearing a mask around other staff while on their breaks. Extendicare's Senior Administrator (who did not normally work at Parkside but came to manage the outbreak when some of its key management staff were put into self-isolation) did not become aware of this employee's (and several others) failure to comply with social distancing rules until learning of it through the Authority's contact tracing efforts.

Parkside then decided to convert its north wing into a COVID-19 unit and move all the positive residents from its main wing into it.

Several direct care workers who helped move residents during the conversion told us they thought the Authority had directed Extendicare to move all the positive residents a second time into the north wing. One worker told us her supervisor told her this. Again, while we found that the Authority knew that Extendicare intended to move the residents a second time and did not object to it, it was Extendicare who made this decision. The Senior Administrator told us:

> The problem with main wing is that to get…to south wing, you have to travel through those hallways [where the COVID-19 positive residents were] and then there's another 84 residents down there. So…it's not great, north wing, if you're going to cohort anybody[.]…And people walking back and forth to get out and in really created a concern.

One direct care worker made the point this way: "Main wing is right smack dab in the middle of the building."

The Senior Administrator told us "It was starting to get out of control." "I discussed it with my team. Do we move people from main wing to north wing knowing that we're seeing a cluster grow in north wing?" "…To try to protect the negatives on north wing, we [decided that we] would swap them for the positives on main wing." He said, "It was probably my biggest mistake." Parkside's Director of Care expressed similar regret. She said, "honestly we probably should have left everybody where they were and dealt with the isolation as it went, it probably wouldn't have spread as fast, I guess it is a guessing game. I think the more we moved them around the more we moved the virus around."

In our view, again, it is difficult to fault Parkside solely for its decision to convert its north wing into a COVID-19 unit. As the number of positive residents was mounting, it was no longer feasible to continue to cohort them in the main wing. First, the main wing is in-between the south wing and the central core, which includes the kitchen and the laundry room. This meant that, even with a temporary separate entrance for care staff to enter the south wing, meals, dishes and laundry still needed to be taken to and from the south wing through the main wing. This increased traffic meant indirectly exposing south wing residents to the COVID-19 positive residents in the main wing. Second, any COVID-19 positive residents with dementia who were prone to wandering could wander into the south wing or the central core, since these entrances needed to stay open for staff. The north wing has its own entrance and could be cordoned off from the rest of the facility.

By the time the decision was made, however, Parkside had more positive residents than the total number of beds in the north wing 600 hallway earmarked in its Pandemic Plan. This meant that it needed to empty the *entire* north wing of its healthy residents (and their belongings) and move all the positive residents (and their belongings) into it. Converting the whole north wing into a COVID-19 unit was a monumental task that took place over three days, from November 27 to 29, 2020, which was made massively more difficult because Parkside had lost so many staff to COVID-19 and self-isolation by then. As Extendicare's Senior Administrator told us: "The problem with the moves from the main to the north was too many moves at one time, and we were losing too many staff…People were exhausted already by that point." We agree.

While moving the COVID-19 positive residents to the north wing was not necessarily an unreasonable decision, several Parkside staff made it clear to us that they felt there were problems with the way it was done. For example, when we asked him, the Senior Administrator told us the residents were all wearing masks during the moves. However, every Parkside worker we talked to who was involved with moving the residents told us they were not always masked. One worker said for the most part they tried to have the residents' masks on, but some residents would not keep them on. While we acknowledge that its Pandemic Plan included ensuring residents were masked during the moves, given how many workers told us the moves did not go to plan, we find that Parkside moved positive and negative residents up and down the same hallways while at least some of them were not continuously wearing masks.

Another worker told us they were moving positive residents out and replacing them with a non-positive resident at the same time. She said when a positive resident was moved out, housekeeping would disinfect the resident's bed, dresser and other items, but did not disinfect the whole room. On this point, one Authority official told us when Parkside was moving people, its processes for environmental cleaning and infection control were not completed to proper standards: "A terminal clean normally takes you three hours… they weren't spending three hours in every room….Because of the tightness of space, the smallness of rooms, the amount of stuff in places…core cleaning these [rooms was not] being done [properly.]"

Another worker said: "Negative residents were sitting in the hallway as we were trying to get rooms cleaned." "It was a whole lot of chaos." "It was crazy."

A direct care worker assigned to the COVID-19 unit on the north wing told us that even after the unit was set up, Parkside continued to move residents around whom they assumed were negative, but who later tested positive. He said, in his opinion, this "was the worst thing they could have done…It was a comedy of errors." "In a 4-bed room, for example, one person would test positive, they'd move the other three to the other wing. They would then all test positive a week later." Another worker gave us similar information. She said they moved north wing negative residents to the south wing, who then turned out to be positive. She said, "It was…absolutely chaotic. Absolutely chaotic." An Authority Public Health official told us that the only real solution to this problem would have been private rooms, which was impossible for Parkside.

Lastly, two more direct care workers told us that because they were so short staffed, they would work on one side of the building and then get moved to the other side. One worker was moved from a non-COVID-19 wing to the COVID-19 unit, which she said happened with other staff as well. And, the other worker who had been cohorted to work on the COVID-19 unit was moved to another non-COVID-19 wing to work.

Days later, when Authority officials came for their site visit on December 2, 2020, and even still on the first day the Authority took over managing the outbreak under the co-management agreement on December 9, 2020, residents' belongings had not been put away and were still in the hallways.

FINDINGS

From everything we have been told about Parkside moving residents around, by the time the decision was made to establish the north wing as a COVID-19 unit, a few things are clear:

- Parkside's home-specific pandemic plan did not include detailed protocols to help staff safely and effectively move the *entire* population of its north wing out while simultaneously moving all COVID-positive residents into the wing in such a short period of time. It was clearly written to address outbreaks in which one or only a few positive residents needed to be moved at one time.
- Because Parkside is so cramped and was also so understaffed almost immediately upon the outbreak being declared, it did not fully comply with its pandemic plan during the moves in some key respects. It did not ensure residents were continuously masked (and gowned). It did not fully clean and disinfect every room after each movement of positive residents was made.

- Parkside did not cohort staff to the COVID-19 unit. While its pandemic plan only provided for this if "at all possible", and it was so understaffed at the time that may not have been at all possible, not cohorting staff coupled with staff not socially distancing during their breaks meant an increased risk of staff transmitting the virus from the COVID-19 wing to the non COVID-19 wings.

STAFF AND STAFFING

All long-term care homes are to operate according to the Ministry's *Program Guidelines for Special-care Homes.* The expectation is that residents are to be kept secure and cared for. Residents are to have access to health services, including medical care and treatment. Long-term care facilities are to provide nursing and personal care with a staff mix of regulated health professionals and continuing care aides/special care aides that meets the assessed care needs of its residents. When the Authority enters contracts with private operators to provide these services, the operator is required to meet these standards.

During our investigation, we reviewed several issues that arose at Parkside where, in our view, residents did not have access to sufficient staff to meet their care needs.

Access to Professional Health Care Services

THE MINISTRY'S WORKFORCE PLANNING AND POLICY

The Ministry's Director of Workforce Planning and Policy told us its role is to keep track of the numbers and types of workers in the health care system with a view to informing decisions about whether recruitment or other measures are needed. This includes, for example, forecasting how many registered nurses and licenced practical nurses are needed, how many are available, and whether mitigating measures are needed to ensure trained nurses are available when and where they are needed. As a result of the pandemic, he told us the Ministry worked with regulatory bodies to address the anticipated increase in demand for health care professionals precipitated by the pandemic. For example, regulatory bodies made changes to their bylaws to allow for emergency licensing. In addition, the unit facilitated weekly meetings among regulatory bodies and the Authority to address the Authority's workforce needs.

With respect to long-term care, the Director told us the Ministry did not provide any support directly to Extendicare or any other long-term care home operator, nor did it provide any support, direction or resources to the Authority to help it develop any long-term care staff-related policies, procedures or workforce strategies to address the pandemic.

For its part, Extendicare told us that it essentially struggled from the beginning of the pandemic to ensure it had enough staff for its homes in Saskatchewan (and elsewhere). Therefore, it seems, the Ministry's effort had no appreciable positive effect on Parkside's ability to have the staff it needed to care for its residents during the pandemic.

THE MINISTRY'S MEDICAL SERVICES BRANCH

Another branch of the Ministry – the Medical Services Branch - made changes to the way physicians working in long-term care homes could bill for their services.

As of April 1, 2020, following consultations with various stakeholders, including the Saskatchewan Medical Association, the Provincial Affiliate Resource Group, and physicians, changes were made to how physicians working in long-term care billed for their services. We were told this resulted in two new fee codes for the provision of routine (non-urgent) physician services in long-term care homes. One of the codes reduced billing for physicians providing care in long-term care homes – from one billable visit every 7 days to one billable visit every 14 days. Authority officials told us this meant that the doctors who care for long-term care residents effectively had their fees cut by 50%.

During the same time frame, in response to the pandemic, changes were made to allow fee-for-service physicians to provide patient care through telephone and virtual assessments. What happened, in practice, was that the weekly routine on-site physician visits to long-term care homes was eliminated and replaced with a minimum of one phone call every two weeks.

The Authority's Executive Director of Continuing Care in Regina told us that Continuing Care only realized in December 2020 that no doctors had been at Parkside in person during the pandemic, as everything had been done virtually, and that this was the case for most long-term care facilities in the province. However, in a March 20, 2020 memo to the Authority's Incident Command Centre in Regina, the Executive Director advised that, to support efforts to contain the spread of COVID-19, the Authority was asking long-term care physicians to provide services via phone consultations or other virtual options and only visit on an emergency basis. Given this, it should not have come as a surprise that no physicians went in person to Parkside, or other long-term care facilities during the pandemic. Further, Authority officials in Regina told us, anecdotally, that many of the doctors who routinely provide care to long-term care residents are themselves among those who are at greater risk of severe outcomes if they were to contract COVID-19.

Extendicare told us that these changes resulted in doctors not coming on-site to Parkside to care for residents from March 2020 onward, and that put added pressure on Parkside's care staff. Extendicare told us the changes created a major obstacle for it to overcome in working with physicians and the Authority to secure consistent, on-site medical support for Parkside residents. Both Extendicare and Authority officials told us that the Ministry's changes resulted in long-term care homes, including Parkside, having to rely more heavily on their nursing and other care staff. With no doctors on-site, nurses became solely responsible for assessing residents' symptoms in the first instance and then relaying any concerns to physicians over the phone.

Extendicare further told us, since physicians are paid by the Ministry, the shortfall in physician services could only be met by Extendicare hiring additional nurse practitioners at its own expense – costs not budgeted or accounted for in the funding it was provided for the year. As a result, Extendicare told us Parkside's residents had less access to physician services. In other words, because at the onset of the pandemic, the Ministry changed the way physicians provide care to long-term care residents and reduced their ability to bill for services in long-term care facilities, Parkside's residents (and likely residents at most other facilities) had less access to professional health care during the pandemic, because the Authority and Extendicare did not pay for additional nurse practitioner services to make up the shortfall.

FINDINGS

In our view, the timing of the changes made by the Ministry's Medical Services Branch created additional pressure for long-term home operators like Parkside, on top of other staffing challenges they faced because of the pandemic. These changes effectively eliminated on-site physician visits to Parkside for most of 2020. This created additional pressure on its nursing and other care staff when the pandemic was already placing once-in-a-lifetime pressures on them. While the Ministry eventually approved additional pandemic funding for long-term care homes, it did not do this until months after it reduced physician billing for long-term care, so Extendicare and others were left to consider whether to attempt to find and fund additional nursing staff on their own in the interim with no assurance that the shortfall in their budgeted funds would be made up.

Screening Staff for COVID-19 Symptoms

Parkside was aware of the importance of screening staff at long-term care homes for signs of COVID-19 before the Ministry or the Authority had imposed any orders or established any protocols about it. On March 11, 2020, Parkside's Manager of Infection Prevention and Control asked the Authority whether it intended to provide direction regarding the screening of visitors and staff, which she noted had been implemented in Ontario. The Authority replied that it expected to do so.

Two days later, on March 13, 2020, Extendicare issued a notice requiring its corporate office employees to complete a daily self-screening log for COVID-19 symptoms. The same day Extendicare's Regional Director for Saskatchewan and Manitoba sent the Authority (and others) copies of several Extendicare documents describing its approach to safeguarding its residents and staff, including, its employee daily self-screening log and guidelines. Parkside's Administrator told us that this was the first day it began requiring its staff to complete a daily COVID-19 screening log. The same day, Extendicare's Vice President of Long-Term Care Operations wrote all the administrators of its long-term care homes to advise that Extendicare would compensate employees who were directed to self-isolate by a public health official for the period of self-isolation. In other words, Extendicare's staff would continue to be paid if they had to self-isolate. In a March 20, 2020 memo to all its staff, Extendicare's Incident Management System team stated: "To limit the spread of this virus the best we can, staff members are not permitted to work while ill. We are relying on you to self monitor and self screen for symptoms. For Long-term Care… please use the in-person screening tools prior to entering any buildings."

On March 26, 2020, Extendicare's Incident Management System team sent a memo to all its staff stating that it incorporated the taking of temperatures into its screening process for its long-term care homes.

By April 2, 2020, the Authority had provided Parkside with copies of its screening policy and tool, stating it needed to be implemented the next day. It required Parkside's staff to be screened daily before the start of their shift. They had to complete a questionnaire and, if they passed, their temperature needed to be checked. At Extendicare's request, the Authority clarified that it should use the Authority's process, even though it had already been using its own process up until then. On April 16, 2020, the Authority provided Extendicare with its *COVID-19 Response Guidance for LTC Facilities* outlining the screening and testing process "which is leaning heavily on testing anyone with even mild symptoms as

the LTC setting is extremely high risk." It advised homes to exercise "high levels of vigilance with a low threshold for implementing additional precautions and pursuing testing."

The April 17, 2020 public health order required, as of April 28, 2020, or immediately where possible, all special-care home staff to undergo health screening that included a temperature check upon entering the home. Anyone disclosing or displaying signs or symptoms of COVID-19 was to be denied entry. All staff were required to undergo a temperature check prior to leaving the home. All long-term care home operators were required to log all temperatures.

On April 28, 2020, when the public health order came into force, the Authority informed Parkside that it was updating its staff screening protocols to align with recently released guidance from the federal government. The following day, it provided copies of its updated screening principles and guidelines and tools, along with its work standard for the use of infrared thermometers. The Authority had purchased thermometers for long-term care homes (including Parkside).

On May 3, 2020, the public health order was amended so only staff (and visitors') "exceedances temperatures" had to be logged by home operators.

Staff were to complete a screening tool. They were then to complete a sign-in sheet, confirming that they had completed the screening tool and had their temperature taken. According to the public health order, anyone disclosing or showing signs of COVID-19 would be denied entry.

When we asked them, both Parkside's Administrator and Extendicare's Senior Administrator told us that its staff screening process was consistent throughout 2020, including leading up to the outbreak in November 2020. However, based on all the information we gathered from Parkside staff, we find that this is not correct. When we asked them whether there was someone taking its employees' temperatures when they entered the building, one direct care worker told us that before the outbreak, "it was the honour system." They said at the beginning of the outbreak "We ended up having to get security because staff were not compliant with taking their temperatures." Another direct care worker told us that they just had to read a sheet and sign it, and someone took their temperatures. Another told us that you had to wait in line to get your temperature taken, and so some staff would just walk in without waiting.

During its December 2, 2020 site visit to Parkside, Authority officials noted that Parkside had a dedicated screener that ensured all individuals were screened with documentation (during working hours), but also that there were line-ups of staff in the morning outside the entrance and they were not practicing proper social distancing. The Authority reported not being clear on whether there was a screener during off-hours.

FINDINGS

The purpose of having staff complete a form when they arrive at work was to ensure they were getting their temperature taken and acknowledging that they completed the Screening Tool. We asked Extendicare for its completed screening forms from November 9 to 20, 2020 for the direct care worker who was the first known staff person to have worked while symptomatic. We wanted to confirm that the worker was consistently completing the screening process. For two weeks, Parkside told us they were looking for them, but could

not find them. Eventually, Parkside's Administrator told us the policy was that they only had to be kept for 30 days, so they had been destroyed. Given this was Parkside's policy (to destroy them after 30 days), we do find it curious it took two weeks for it to realize that. When we asked for a copy of the policy, Parkside provided us with an Authority Work Standard indicating that *visitor* screening forms, not staff forms, did not need to be retained after 30 days.

It is evident that close to the onset of the pandemic both the Authority and Extendicare had policies and tools in place to screen staff before entering a facility to help keep COVID-19 away from vulnerable residents. However, having the best policies and tools in place, does not help if they are not properly followed. We heard some conflicting information from Parkside's staff about whether the required entry screening protocols were being followed at Parkside to ensure no one came in with symptoms. Many of its staff members confirmed that the screening process was not consistent, was based on staff self-monitoring and was not audited or monitored to ensure it was effective. In any event, however, it is clear that staff entered Parkside to work when they had COVID-19 symptoms. So, whatever Parkside was doing, it did not work.

In its submissions to us, Extendicare noted that the mere fact that its screening protocol failed to capture every symptomatic employee does not mean that it was unreasonable. We agree. However, given that so many staff told us that the protocol was not consistently followed or monitored until after the outbreak occurred, we find, that Extendicare did not *effectively* implement and administer what were otherwise reasonable staff screening protocols at Parkside. It failed to consistently take reasonable steps to ensure it complied with the public health order requiring it to deny entry to anyone with COVID-19 symptoms.

Staff Testing for COVID-19

In a May 19, 2020 message to all staff, Extendicare's President said the company was advocating with provinces to adopt universal testing for COVID-19 for all long-term care staff. In a June 4, 2020 message, he told staff: "After a significant amount of advocacy, we have received support from the Ontario government to test all long-term care staff on a regular basis. This will begin at Ontario homes in the coming weeks." Extendicare's Vice President of Long-Term Care Operations wrote to Saskatchewan's Minister of Health on June 19, 2020 asking for the government's support to test its staff weekly throughout the province regardless if they show any symptoms, stating:

> It is now clear that screening for fever and other symptoms is insufficient to keep COVID-19 out of continuing care homes. On-going testing of staff on a regular basis is the only solution that will enable us to identify sources of the virus and remove them from the home before residents become infected. If we are to prevent further outbreaks, it is critical that we implement weekly testing of all staff to ensure that asymptomatic carriers do not bring COVID-19 into our homes.

In a June 30, 2020 follow up message to staff, Extendicare's President said this about its employee testing program:

> We have learned a great deal over the course of this pandemic. Key among those learnings is the prevalence of asymptomatic spread in high risk environments, like long-term care homes. In my last message (link to this), I referenced that Extendicare was launching an initiative to test all of our long-term care staff on a regular basis to help protect against team members unknowingly transmitting the virus.

...

> In the last four weeks, all new outbreaks in LTC have involved only staff. Our testing strategy has allowed us to identify and isolate a small number of positive staff before they bring the virus into our homes. I'm very hopeful that this will protect staff and residents until a vaccine becomes available. To-date, we have administered more than 10,000 tests at 71 homes across our Ontario LTC portfolio. Surveillance testing has identified positive staff at 25 homes who were asymptomatic at the time of testing. In each case, we avoided any spread to residents and work colleagues.
>
> We know that the novel coronavirus has a 4-5 day incubation period. As a result, we are trying to test staff on a weekly basis until this virus is no longer a threat to our communities. While Ontario was the first province to support regular testing, we continue to advocate for the same approach in other provinces.

Beginning on July 14, 2020, testing was available universally to anyone in Saskatchewan who requested it, whether they had symptoms or not. According to the Government of Saskatchewan's website, people who were symptomatic were to get tested for COVID-19 immediately as it limits the spread: "Getting tested and knowing your status is an important step to protecting yourself and others against COVID-19."

Extendicare's President updated its staff on its testing program in Ontario again on July 17, 2020:

> I am proud to report that we have administered more than 20,500 COVID-19 tests in homes across Ontario, which has helped us avert a possible 14 outbreaks since we launched the initiative, including three in the past week alone. Your actions have saved lives, made our homes safer and protected you and your families from COVID-19.

In an August 18, 2020 briefing note to the Minister of Health, the Ministry recommended against accepting Extendicare's request to routinely test its long-term care staff for COVID-19:

> Saskatchewan's universal testing approach, where residents attend testing sites, maximizes limited human resources.
>
> ...
>
> As of July 14, 2020, testing is available universally in Saskatchewan to anyone who requests it.
>
> Saskatchewan has implemented staff cohorting, health screening in LTC and PCHs and priority testing is available to staff.
>
> Testing of asymptomatic people is voluntary unless required by public health as a follow up to a contact.
>
> The network of LTC and PCHs is extensive; weekly/routine testing of all staff would be a considerable undertaking. Given existing demands on nursing staff in these facilities, it is not clear how further demands to conduct testing/be tested on a weekly basis, would be received.
>
> As of March 31, 2020, there were 159 facilities that provide LTC services[.]
>
> ...

Based on 2018-19 SHA data, the number of paid FTEs in LTC included:

- 5,038 Continuing Care Aids
- 898 Licensed Practical Nurses
- 1,235 Registered Nurses/Registered Practical Nurses

***Note**: the number of staff does not include other support staff such as dietary and housekeeping staff.

...

Current cohorting and screening measures have been effective in protecting vulnerable seniors living in [long-term care homes] and [personal care homes.]

The significant pressure on human resources and lab supplies for the SHA to implement weekly/routine on-site testing in all LTC and PCHs could be detrimental to the implementation of the overarching Saskatchewan testing strategy. The SHA human resource capacity to support testing is from the current nursing labor pool many of whom are also responsible for contact tracing and follow up.

Alternatively, if LTC and PCH nursing staff are trained to offer the testing in order to alleviate the demand on the current human resource testing capacity, the demands would shift to training, developing a supply distribution chain or providing funding to procure supplies, and implementing testing supply and specimen shipping to and from over 400 facilities, with well over 7,000 employees.

In an August 28, 2020 email to an Assistant Deputy Minister, Extendicare's Vice President of Long-Term Care Operations, again raised the proposal to routinely test its long-term care staff in Saskatchewan. He noted that as of August 27, 2020, Extendicare had identified 45 positive cases in 18 of its 34 Ontario locations, stopping a potential spread in those homes. He wrote:

> ...just wanted to send a quick note of appreciation for the discussion on Wednesday with yourself and the Minister. Prior to the redevelopment conversation, I was sharing some information with you regarding our staff testing program in [Ontario].
>
> ...
>
> We have advocated for a similar program in other provinces but understand there is not the interest in Saskatchewan given the ability for members of the public who are asymptomatic to receive tests throughout the province. We continue to advocate for these tests as a means to prevent the spread of covid-19 and as such, repeat our offer to provide them (we simply require the swabs and the routing through the provincial lab system and process, as our staff could provide the actual test). At a minimum, we believe the testing of staff working in other environments in addition to our care centres is especially critical.
>
> I hope this provides some further information regarding our testing program and rationale. To date, we have had 22 of our 58 LTC homes experience a covid-19 outbreak and the consequences it entails (19 in ON and 3 in AB) and believe this testing program has successfully stopped it from entering through asymptomatic staff carriers and ultimately saving lives.

In a November 27, 2020 letter to the Minister of Health, Extendicare's Vice President of Long-Term Care Operations again asked the Ministry to urgently reconsider supporting Extendicare's program of surveillance testing long-term care staff. Referencing the Parkside outbreak, he said:

> The number of resident and staff COVID-19 cases at Extendicare Parkside at this time is cause for deep concern and I ask for your urgent assistance on this matter. It is clear that symptom screening of staff is not enough to keep the virus out of homes given the well documented ability of this virus to spread through asymptomatic people. Given the current rate of community spread, it is essential that we begin testing all LTC staff weekly for COVID-19.

On December 2, 2020, the Authority's Physician Executive for Provincial Programs responded to Extendicare's November 27, 2020 letter to the Minister of Health. He agreed that as the community prevalence of COVID-19 increased, the Authority's screening measures were becoming less effective and that more formal implementation of testing measures at long-term care sites was required. He noted that the Authority had met on December 1, 2020, "to create a plan to…ensure affiliates are able to carry out resident and peer HCW testing for surveillance, in addition to initial testing of symptomatic individuals." He also noted that the Authority could provide Extendicare with sufficient swabs if it had the appropriate staff trained for acquisition. He also said that rapid point of care tests were available if desired at this time.

In January 2021, the Authority issued a Work Standard entitled "Abbott Panbio Assurance Testing in Long Term Care", which recommended the use of point of care testing of asymptomatic staff every 7 days.

FINDINGS

The Minister of Mental Health and Addictions, Seniors and Rural and Remote Health specifically requested that we investigate:

- Pre-outbreak infection prevention and control practices, pandemic planning and COVID-19 outbreak preparedness by Extendicare Parkside including the extent to which early learnings from other jurisdictions informed planning;

Extendicare had lobbied the Minister of Health - since June 2020 - to bring on-site rapid testing to its Saskatchewan homes – citing that this was successful in limiting the spread of COVID-19 in its Ontario long-term care facilities. The Ministry's position was initially that it was not necessary for the reasons outlined in the August 18, 2020 briefing note to the Minister of Health, including that testing was universally available at testing sites, Saskatchewan had implemented staff cohorting and screening in long-term care homes, which had been (to that point) effective. It also cited human resource limitations and lab supply pressures if the Authority were to implement weekly on-site testing for 7,000+ long-term care and personal care home employees. A Ministry official told us that, "the capacity of testing was limited, it was scarce." And that, "at the time, we could not accommodate any targeting testing."

It was not until after the outbreak started at Parkside, that the Authority acknowledged to Extendicare that its screening measures were becoming less effective and said it had started piloting on-site rapid testing in some facilities, including at Extendicare Moose Jaw. Rapid testing was implemented at Parkside beginning on December 8, 2020.

Based on Extendicare's experience in Ontario, it submitted that providing for weekly staff surveillance testing before the outbreak at Parkside began was, in its view the single biggest thing the Ministry and the Authority could have done to save lives. It submitted to us

that it was very likely that it would have prevented the first symptomatic staff member (who did not get tested) from spreading COVID-19 within the Parkside potentially saving dozens of lives.

Therefore, our answer to the Minister's question is yes. We found that there were early learnings from other jurisdictions (i.e., Ontario) that on-site testing of long-term care staff was helping to stop the spread of COVID-19. Ministry and Authority officials were aware of this, and rejected Extendicare's repeated requests to implement it. By the time the Ministry and the Authority introduced on-site rapid testing in Saskatchewan, it was, of course, too late for Parkside.

Staff Physically Distancing and Personal Behaviour

Since the pandemic started, we have all been advised to physically distance from anyone who is not from the same household or bubble in order to minimize and reduce the spread of COVID-19 and to wear a mask if physical distancing is not possible.

In an April 9, 2020 staff briefing, *Meeting the COVID-19 Challenge*, Extendicare advised its staff what to do so as to not bring COVID-19 into their homes (rather than focusing on what they should do to not bring COVID-19 into the facility):

> SCREENING
>
> Everyone plays a part in limiting the spread of the virus. Screening protects you, clients/patients, residents, family members, team members and your communities from exposure. If during the screening or self-screening process, you report any symptoms that could be related to COVID-19, contact your supervisor immediately.
>
> GETTING HOME PROTOCOL
>
> As we know, there is the possibility that our team members may come into contact with someone who is COVID-19 in the course of their duties. To ensure that you do not bring the virus home with you, we encourage team members to change before entering their home and put your uniform/work clothes in a plastic bag that can be discarded or a personal pillowcase that can be washed at the same time as your uniform/work clothes. Regular washing of your uniforms/work clothing is sufficient to keep them clean and get rid of the virus. For information on what team members should do when they get home to prevent the spread of COVID-19, click here.

The April 17, 2020 public health order required, as of April 28, 2020, all individuals providing direct resident care or working in resident care areas to wear a surgical/procedure mask continuously at all times and in all areas of the facility, if they were either involved in direct patient contact or could not maintain adequate physical distancing from patients and other individuals. Individuals who did not work in patient care areas or did not have direct patient contact were only required to mask if they entered patient care areas and physical distancing could not be maintained. This order continued in force across the province for the duration of 2020.

However, on November 5, 2020, the Ministry issued a masking public health order effective November 6, 2020 which required all individuals in special-care homes in Regina, Saskatoon and Prince Albert to wear masks continuously in all areas at all times. The requirement did not apply in certain locations and circumstances, including for example, in "private resident areas" of special-care homes, while a person eating or drinking "in any… location where food and beverages [were] being served," for people due to a cognitive

impairment are unable to understand the requirement, or for medical reasons, or as was necessary for a person to receive a health or personal service for the duration of the service only.

Once the social distancing and mask rules had been put in place, we were told that Parkside instituted limitations on the use of its staff break room. Specifically, it limited it to only 10 staff at a time and required its staff to maintain social distancing. We were told signs to this effect were posted at the door. Parkside's Administrator told us that he periodically monitored the staff break room and coached the staff on the requirement to maintain social distancing.

However, several Parkside employees told us that it was impossible to maintain proper social distancing in the break room, and that there were often more than 10 employees eating, drinking and socializing closer than two meters from each other without masks on. We also learned from many of our interviews with staff that co-workers socialized outside of work, and often carpooled together – so not social distancing and not wearing masks.

Here are some examples of what we were told:

- One direct care worker told us they were pretty sure they got COVID-19 from a co-worker in the break room, whom they said came to work with what were thought to be allergy-symptoms but turned out to be COVID-19 symptoms.
- Another direct care worker who tested positive told us that they were always watching for signs that residents were sick or had any signs of illness. They said in hindsight, they and their coworkers "should've been watching each other…that little change in the voice, or someone sounding stuffed up." They said, "Hindsight's 20/20. I know exactly where I got it. In the staffroom."
- Another direct care worker (who did not get COVID-19) told us that they would notice co-workers coughing and tell them "You shouldn't be here. You should go home." They said they would tell the nurse as well.
- When we asked another direct care worker whether they were aware of or observed any staff members attending work with COVID-19-related symptoms, they paused for several seconds and said: "Ya. I did. …I think a lotta staff just kinda chalked it up to not much of anything. I really believe that, and this is just my perception, that a lot of people really didn't believe that COVID-19 was really a thing." "I really believe that people did come to work with their symptoms just shrugging them off and if they don't say anything…because it was all honour system." They told us that six or seven employees posted about getting together outside of work to socialize at the beginning of the outbreak and that they were some of the ones who were off work.
- Another direct care worker told us they had carpooled, worked the same shifts and stayed at the same hotel as a co-worker. They did not wear masks when they carpooled. They both tested positive for COVID-19.
- A direct care worker told us that after the outbreak, Parkside management would come onto the floor to lecture staff about their PPE and distancing in the break room. Once they left, they said staff went back to what they were doing and not social distancing.
- A direct care worker told us the break room was too small to socially distance. After the outbreak, staff used the residents' dining room, but some staff still did not physically distance. This worker told us that this is where they felt they got the virus, from another worker who was coughing and sitting directly across the table from them.

- When asked whether there were any issues with staff and management following the Authority's infection prevention and control protocols regarding self-isolation, masking, social distancing, handwashing hygiene, etc., a direct care worker told us:

  > "We have a lot of staff who aren't compliant on a good day with their PPE."
  >
  > "They would…cluster in staff rooms or in the hallways."
  >
  > "We really only had one staff room."
  >
  > "We were told to try and keep as distant as we could from each other, which is not very feasible, especially in that little staff room."
  >
  > "There was times when they would be all huddled in the corner in the staff room."
  >
  > "And even after the outbreak they would be all cuddled into the corner in the dining rooms. You would have the ones that were overly paranoid. And you would have the ones that were 'eh'."
  >
  > "Staff…go out and sit in each other's cars and smoke…or hang out, or go for lunch together."

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Based on all of the information we received, it is clear that some of Parkside's staff were not following the Ministry's masking protocols and other public health measures at work or outside of work. While they may have been careful when attending to residents, once they were on their breaks, those precautions seemed to disappear, and they did not physically distance or wear masks. As one person put it, it was like they thought COVID-19 could not enter the break room.

As well, it is also clear that staff were coming to work with COVID-19 symptoms and socializing with each other outside of work while not physically distancing. By November 26, 2020, Public Health and the Authority's Infection Prevention and Control officials were aware that several Parkside staff had not been socially distancing from each other while unmasked on their breaks. We also heard from more than one Parkside employee that some staff continued to visit in close contact with each other without masks on in the resident dining rooms after the outbreak was declared and they had been converted for the staff's use as break rooms.

The Authority decided it had to make recommendations to Parkside to ensure its staff staggered their breaks and stayed apart, and felt the need to reiterate that these recommendations needed to be enforced. On November 27, 2020, a Public Health official laid out what he thought were a few key signals about the causes of the outbreak, which included:

1. Some staff come to work symptomatic, ignore signs or don't recognize them and work with the elderly.
2. Staff do the right things on the floor so to speak but not outside of that.
3. Spread occurs in lunchrooms, change rooms and driving to and from work, where no distancing is done, masks not worn and measures forgotten.
4. Staff socialize outside of work and have not kept smaller household bubbles.

However, part of the problem was the facility itself. As was noted following the Authority's December 2, 2020 site visit:

Staff breaks and interactions: Given Parkside's infrastructure limitations, staff were trying to maintain proper social distancing while on their breaks, but the layout of the break rooms made it difficult, and the break rooms were also being used for storage. Also, staff assigned to different wings were using the same breakrooms and there was no logging of 'ins and outs' into break rooms. Staff who smoked were not washing their hands before returning to work and possibly not socially distancing while in the smoking area. There was also some concern about whether staff were masking when carpooling to and from work.

Based on the information we have reviewed, it is clear that Parkside staff were not following physical distancing and other measures while at work, and based on the information they provided to contact tracers, this contributed to the spread of COVID-19 leading up to the outbreak and during the outbreak. While Parkside's management took some steps to enforce the public health orders and other infection prevention and control measures established by Extendicare and the Authority at work, it was obviously not enough.

Therefore, we find that Parkside failed to ensure its staff complied with the Ministry's public health orders regarding maintaining proper social distancing and wearing masks when social distancing was not possible while they were at work. We find that this continued even after the outbreak was declared. While each employee who did not comply with the orders is personally responsible for their behaviour, Extendicare was responsible for the safety of its residents, including ensuring its Parkside staff were compliant while at work.

On this point, it is important to note that Extendicare could not have dictated what its employees did in their private time away from work – though it is clear that it encouraged them to act responsibly while not at work. Any Parkside employees who socialized with each other outside of work, were entitled to do so as long as they were abiding by the public health orders in place at the time. To the extent individual employees failed to comply with the public health orders while not at work, then came to work while symptomatic and failed to comply with them while at a work, they contributed to the occurrence and severity of the outbreak.

Staff Cohorting

Cohorting means restricting the movement of staff so that they would only work in one facility to reduce the risk of staff transmitting COVID-19 among long-term care homes and other facilities.

On April 9, 2020, the Authority's Executive Director of Continuing Care in Regina, emailed Parkside's Administrator and others to advise that the province was working towards cohorting long-term care employees. Eight days later, the April 17, 2020 public health order required long-term care staff to be cohorted beginning on April 28, 2020. On April 18, 2020, the Authority issued a document called, *COVID-19 Response Framework: Cohorting within Long-Term Care, Affiliates and Personal Care Homes* noting that if any facility experienced inadequate staffing as a result of complying with the public health order, they would have to obtain the approval of a medical health officer to seek an exemption in order to permit staff to work in more than one long-term care home.

The challenge Extendicare faced in addressing the cohorting order at Parkside and its other Saskatchewan homes is better understood within the broader context of how collective bargaining in Saskatchewan's health care sector is governed. *The Health Labour Relations Reorganization (Commissioner) Regulations* prescribe appropriate employer units for the purposes of collective bargaining with the unions representing health care sector employees. The Authority and all long-term care home operators that are officially affiliates (i.e., almost all long-term care operators in Saskatchewan except Extendicare) make up one appropriate unit. The Saskatchewan Association of Health Organizations Inc. (SAHO) is prescribed as the exclusive authority to bargain collectively on behalf of this multi-employer unit. The *Regulations* prescribe three appropriate units for Extendicare, one for its Regina homes, and one each for its homes in Moose Jaw and Saskatoon. Extendicare has collective bargaining agreements with SUN and SEIU-West that govern its labour relations in all five of its Saskatchewan homes.

Practically, this means, for example, all the nurses represented by SUN that are employed by the Authority or any of its affiliates are governed by one collective bargaining agreement, and those that are employed by Extendicare are governed by Extendicare's collective bargaining agreement with SUN.

By April 16, 2020, SAHO had tentatively agreed with the unions representing the over 35,000 unionized staff employed by the Authority and its official affiliates to a Letter of Understanding regarding access to a labour pool during the pandemic. The LOU provided for employers to temporarily redeploy and reassign workers to address needs in other facilities during the pandemic, including for example, during an outbreak. This meant that the Authority and any of its long-term care affiliates (again, not Extendicare) could, if necessary, temporarily redeploy employees to another work area, unit, facility, department, community or bargaining unit. The LOU also authorized the Authority and its affiliates to mobilize and deploy a temporary COVID-19 supplemental workforce of contractors, management staff (i.e. out-of-scope employees), health system partners, students, volunteers or other personnel to meet temporary COVID-19 health care needs, and that doing this would not be a violation of the relevant collective bargaining agreements. This meant that, in addition to being able to move unionized staff from one facility to another to deal with an outbreak, the Authority and its official affiliates could have also established a non-unionized 'outbreak response team' to be at the ready to help any facility that needed it.

By the time the Authority's LOU had been agreed to, Extendicare had already recognized it was going to have staffing challenges in its homes. By March 27, 2020, Extendicare's Manager of Labour Relations had performed a staff shortage analysis that considered options for addressing potential staffing needs in light of the risk that COVID-19 could affect staff availability. Extendicare told us that, beginning in early April 2020, it started performing regular risk assessments of staffing levels at its Saskatchewan homes to help determine which were in greatest need of staffing support. Up to the outbreak, Parkside had generally normal staffing levels, but was occasionally running short. But other homes (for example Extendicare Preston in Saskatoon), were chronically understaffed – rated at or near, crisis levels.

In addition, having identified continuing care aide positions as critical, Extendicare told us it considered hiring uncertified individuals as provided for in a 2003 letter of understanding with SEIU-West, and hiring more support services, environmental services and food

services workers on the basis that these positions would be easier to fill. In other words, its strategy was to reduce the indirect care that continuing care aides usually do, so they could provide more direct care that only they can do.

On April 16, 2020, Extendicare's Senior Administrator asked the administrator of another private long-term care home operator (but which is an official Authority affiliate) whether the Authority's labour pool LOUs would apply to Extendicare, who equivocated and said they could talk later. It is not clear to us why Extendicare's Senior Administrator did not ask this question to Extendicare's Manager of Labour Relations.

The Ministry's cohorting order came into force on April 28, 2020. It required every long-term care home to restrict the movement of its staff (with some exceptions) between homes by ensuring they worked at only one facility. The order meant that any of Parkside's staff who also worked for other health sector employers covered by the order were required to work at just one location for the duration of the order, unless a medical health officer issued an exemption allowing them to work in more than one location, or to move from working at one location to another, whether permanently or temporarily.

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In our view, because it is a separate employer unit with separate collective bargaining agreements for its staff, Extendicare's pandemic-related staffing challenges were more difficult to overcome because it was only able to access its own smaller labour pool if, for example, an outbreak resulted in staff in one of its home's having to self-isolate. It did not have access to the Authority's and its official affiliates' larger labour pool under the Authority's LOU.

Access to Staff to Help During the Outbreak

Parkside's Administrator told us that quickly after the cohorting order came into effect 'human capital became scarce' for day-to-day operations. He said that Parkside lost 'over 100' part-time staff to other organizations. A spreadsheet prepared by Parkside's Director of Care indicated that as of November 28, 2020, 81 full-time and part-time registered nurses, licenced practical nurses and continuing care aides employed by Parkside were cohorted to other facilities. The Authority confirmed to us that some Parkside employees who had also worked at Authority facilities were cohorted to its facilities. The staff cohorting order, along with Extendicare's status as one of the only independent long-term care home operators in Saskatchewan without access to the Authority's labour pool, meant that Extendicare needed to develop its own unique plans to get access to qualified staff in the event of an outbreak in one of its Saskatchewan homes.

To this end, Extendicare told us that in May 2020, it launched a *Human Resources Consultant Project* under which it assigned a human resources consultant to its Manitoba and Saskatchewan region to, among other things, improve its capacity to manage staffing issues during the pandemic. It told us that the project "resulted in, among other things, changes to the homes' human resources operating models, a new staffing plan template and a process for managing workforce and recruitment, and new tools and processes to manage COVID-related leaves of absence among clinical staff."

Extendicare's Manager of Labour Relations for Saskatchewan told us because it did not have direct access to the Authority's labour pool, he approached SEIU-West and SUN about entering into its own LOUs based on the same terms of the Authority's LOU. On April 21, 2020, he emailed SUN and SEIU-West to ask whether they would be prepared to agree that the terms of the Authority's LOU applied to Extendicare and SUN and SEIU-West. Later that day, SEIU-West responded saying that it absolutely agreed. SUN replied on April 22, 2020, acknowledging that Extendicare would be following the Authority's cohorting framework as detailed in paragraph 11 of the Authority's LOU with SUN, which provided for SUN employees to be assigned to the labour pool and/or redeployed numerous times. SUN did not, however, express its agreement that all the provisions of the Authority's LOU would apply to it and Extendicare.

Despite these initial discussions, Extendicare never formally entered into separate labour pool LOUs with SEIU-West or SUN. Extendicare's Manager of Labour Relations told us that this did not mean it could not have temporarily reassigned employees from one home to another, because, in his opinion, its current collective agreements did not prohibit such transfers. The union representatives we spoke with confirmed this as well. Even though Extendicare could have transferred staff from other locations to Parkside without a formal LOU, it decided it would only do this on a voluntary basis partly because, the Manager of Labour Relations said, it was of the view that reassigning employees on a non-volunteer basis would lead to union grievances, but also, primarily, because the supply of staff was limited.

To address staff shortages, by late June 2020, Extendicare released what it called its formal *LTC Recruitment Strategy*, under which it, among other things, engaged an external hiring agency to assist with recruiting, established dedicated human resources support for its homes, told its homes to ensure they are staffed at above 100% levels, and to focus on offering and filling full-time positions.

On July 15, 2020, Extendicare's Senior Administrator emailed the Authority's Continuing Care branch in Saskatoon to follow up on what he called outstanding issues with the Authority's Annex R pandemic plan. Specifically, he asked if Extendicare Elmview or Extendicare Preston went into COVID-19 outbreak, "will Affiliate organizations have access to the [Authority's] labour pool?] The Authority, replied, "[A]ffiliate homes will have access to the labor pool." Based on this exchange, it appears that neither the Authority's Continuing Care branch in Saskatoon nor Extendicare's Senior Administrator (who was assigned to Parkside during the outbreak) realized that: 1) Extendicare is not an Authority affiliate, and 2) it therefore did not have access to the Authority's labour pool.

In an August 14, 2020 letter to all its staff about preparing for a second wave of COVID-19, Extendicare's President made the following observations about staffing during an outbreak:

> While we are still focused on fighting the initial wave of COVID-19, we have turned a significant amount of effort to preparing for a possible second wave. We are in a far better position today than we were when this virus first came to Canada, and we are applying what we've learned to protect our people in the event of a resurgence.
>
> ...
>
> Some of the hardest hit homes were those that experienced significant staff shortages caused by transmission of the virus or fear of being infected and bringing it home to family. It cannot be overstated how stressful a COVID-19 outbreak is on a team. We have added more long-term care staff and established

> partnerships with hospitals, health regions and health-care staffing agencies that are available to help if and when needed. In the event of an outbreak that impacts a home's leadership, we have an emergency leadership team at the ready to move in and help, keeping provision of care stable and consistent until recovering staff can return to work.

In an August 25, 2020 letter to the Authority's Executive Director of Continuing Care in Saskatoon, Extendicare's Vice President of Long-Term Care Operations asked for support for "Extendicare homes in your area with COVID-19 as attention turns to a possible second wave." He wrote (in part):

> While we are still focused on fighting the initial wave of COVID-19, we have turned a significant amount of effort to preparing for further episodes. We are all in a far better position today than we were when this virus first came to Canada, and we are applying what we learned in the event of a resurgence. A key pillar to our preparations at Extendicare is our relationships and partnerships with hospitals and health regions in all areas where we operate our homes. Keeping provision of care stable and consistent through an outbreak is our goal, and these partnerships are essential to that. In areas where there have been outbreaks, we have found that hospital and regulatory body partners were key to helping enhance infection prevention and control in homes. With that learning in mind, I would like to mention that our Regional Director [Manitoba and Saskatchewan] will reach out to you shortly to discuss:
>
> - a request for additional IPAC expertise, specifically assessments and PPE compliance audits, in the event of a future or suspect outbreak;
> - confirming the best point of contact within your organization for us to communicate with, in the event of a future or suspect outbreak; and
> - any existing group or structure leading or coordinating covid-19 preparations within your organization that our homes could participate in.

On September 8, 2020, Extendicare rolled out what it called its *Outbreak HRG Support Plan*. This plan included, among other things, proactively asking employees on leaves of absence to potentially return to help with an outbreak, including offering them a pay incentive called the "Outbreak Pandemic Pay Program," creating home-specific staff sourcing strategies to support more active recruitment, and leveraging provincial health authority staffing programs, if available.

In a September 16, 2020 presentation called *Ride the Wave*, Extendicare provided its long-term care home staff with detailed information about what it had learned from handling outbreaks regarding environmental services (laundry, cleaning, etc.). The presentation included directives for administrators about, for example, extra or redundant staffing, cross training staff and having relationships with other facilities with healthcare cleaning staff, as well as directives to ensure environmental services staff were prepared to address the challenges they would face during an outbreak, more and enhanced cleaning, more laundry, increased garbage disposal, and training, among several other things.

On September 17, 2020, Extendicare's Manager of Labour Relations provided its Regional Director for Manitoba and Saskatchewan, Parkside's Director of Care and several other Extendicare staff with a draft of a process for posting available jobs for both permanent and temporary vacancies, which specifically addressed how to fill a vacancy with an employee

who was cohorted to another location (whether with Extendicare or otherwise). He noted that if a cohorted employee who is offered a position refuses it, then Extendicare could use what he referred to as a "Escalation Procedures for Cohorting" – which was, in fact, a copy of the Authority's process for requiring employees to be cohorted to certain locations – but only "within the SHA and between the SHA & Affiliate organizations" – which specifically excluded Extendicare.

Despite all of this planning at the corporate level to address staff issues in general, Parkside did not take reasonable steps to develop an emergency staff replacement plan to deal with an outbreak that resulted in many staff having to self-isolate. On November 16, 2020, Parkside's Administrator asked the Authority's Executive Director of Continuing Care in Regina whether he could call in volunteers or family members 'when we were in a COVID outbreak. This suggests that he was just then (four days before the outbreak was declared and while some of its staff were coming to work with COVID-19 symptoms) trying to figure out how it could replace some of its staff.

On November 18, 2020, two days before the outbreak was declared and after the first positive resident had been sent to hospital with COVID-19 symptoms, Extendicare's Regional Director advised the Authority that it was still working on an outbreak staffing plan:

> We are working on a staffing plan in the event of a covid positive resident and our staffing becomes depleted.
>
> If a staff member, upon approval from the MHO, was able to work in another home, move from Elmview to work at parkside for a period of 2 weeks if staffing levels was low. Do they need to isolate for 14 days before returning to their original position?
>
> Currently, if a team member applies and is awarded a position in another home, they can start immediately.

Also on November 18, 2020, Extendicare's Manager of Labour Relations engaged in an email exchange with SEIU-West in which he stated, among other things: "Our understanding is that in emergency circumstances the assignment of personnel to another home is permissible within the cohorting regime provided that the employee only works in the assigned home for the duration of the assignment. It is also consistent with the Letter of Understanding signed between the SHA and unions."

In a November 20, 2020 memo, the Authority's Executive Director of Staff Services and the Executive Director of Continuing Care in Regina, clarified the Authority's Re-Cohorting rules and some recently approved exemptions. One limited exemption allowed an Authority facility or an affiliate to allow managers to come in to respond on-site to coordinate and support urgent required needs in the event of a COVID situation. The memo also noted:

> Staff may be re-cohorted to a site experiencing staff shortfalls in either COVID-positive or non-COVID situations. This process is a Human Resource (HR) function and will be managed through normal operational processes. It does not require an exemption, as the employee will only work in the cohorted site and will not work simultaneously at two sites. Re-cohorting is a management and HR driven process and is intended to meet ongoing staffing needs.

We understand this to mean that any of Parkside's staff who had been cohorted to other locations could have been brought back to work at Parkside, if Extendicare had formalized

its labour pool LOUs with SUN and SEIU-West. It is important to highlight, as the Executive Director noted in the memo, this was not a function of Public Health issuing an exemption to the cohorting order, but a function of how the Authority's LOUs were worded. In other words, Extendicare could have developed an outbreak staffing plan that included re-cohorting its existing staff back to Parkside.

Five days after the outbreak was declared and Parkside's staffing shortage was becoming critical, the Authority's Director of Continuing Care in Regina and Extendicare's Senior Administrator were discussing getting Parkside access to the Authority's and its affiliates' labour pool to replace workers, even though this was not possible under the Authority's LOUs. On this point, in hindsight, Parkside's Administrator told us it was asking for access to the labour pool but when it came down to it, 'there was no such thing.' During our interview with him, he acknowledged that Extendicare's lack of access to the Authority and its affiliates' labour pool was 'always an issue.' He told us this was why the Authority had to take over managing Parkside – so it could get staff to come to Parkside.

As late as November 27, 2020, Extendicare was still engaged in negotiations over a draft letter of understanding regarding the circumstances in which its 'COVID-19 premium' pay scheme would apply – employees were entitled to 1.5 times their normal wage for each hour they worked on Parkside's COVID-19 wing.

Based on a November 30, 2020 email from the Authority's Director of Continuing Care in Regina to Extendicare's Senior Administrator and Parkside's Administrator, it was only then that the Authority had identified some Parkside staff who had been cohorted at other locations who could be re-cohorted back to Parkside to help with the outbreak.

In a November 30, 2020 memo from its Emergency Operations Centre to all "Affiliate Organizations" (including Extendicare), the Authority advised that its ability to create or maintain a labour pool or supplemental workforce for reassignment to long-term care homes was limited, because among other things "the staffing situation in all long term care sites remains tenuous as our human resource capacity diminishes." It reported that it was instead focusing on recruiting staff to fill high demand positions. In other words, because of the same human resource scarcity Extendicare was experiencing, the Authority decided to focus on hiring more staff into various positions to ensure it could maintain regular operations instead of recruiting them to a supplemental workforce that could have helped during a serious outbreak.

Even as late as December 8, 2020, weeks after the outbreak had been declared, and after it was decided that the Authority would take over Parkside to deal with the outbreak, Extendicare's Chief Medical Officer was emailing asking for the Ministry to consider allowing Parkside's asymptomatic COVID-19-positive staff to immediately return to work to care for positive residents given "the critical staffing situation." It took just one day for the Ministry and the Authority to respond, by providing an interim waiver of the public health order to allow Parkside staff to return to work after 10 days of self-isolation instead of 14 days, a decision which was grounded in what other jurisdictions in Canada were doing at the time. However, Extendicare's request appears to have been made in desperation (as it had lost so many staff) and, in part, precipitated by its lack of planning before the outbreak about how it would replace its staff that were put into self-isolation as a result of an outbreak.

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Extendicare did not have access to the labour pool under the Authority's LOU. Not because of anything the Authority or Extendicare failed to do, but because Extendicare is not an Authority affiliate and has separate collective bargaining agreements with the unions representing its staff.

Its Senior Administrator in Saskatchewan and Parkside's Administrator, along with the Authority's Continuing Care officials in both Regina and Saskatchewan, did not appear to realize this until after the Parkside outbreak started and it was scrambling to find people to replace the staff it lost to COVID-19 and self-isolation. Even Extendicare's Manager of Labour Relations who, we were told, was responsible for ensuring Parkside COVID-19 staffing issues were addressed, told us: "...it was my understanding and belief that the SHA would send in staffing support in emergency circumstances."

However, we find there is no reasonable basis for Extendicare's understanding that the Authority would be able to provide it with staffing support in the event of an emergency. We find that this was a significant misunderstanding that contributed both to Parkside's failure to have an adequate outbreak staffing contingency plan, and to the time it took for the Authority and Extendicare to agree that the Authority needed to step in under the co-management agreement.

Extendicare submitted to us that the April 21, 2020 emails from its Manager of Labour Relations to each of the unions and their respective responses "are the evidence of the agreements between the parties." However, when we asked SUN and SEIU-West, they both told us Extendicare never followed up with either of them after these April 21, 2020 emails. Both unions told us that they do not have separate COVID-19 labour pool LOUs with Extendicare at all. Extendicare submitted that this is false. It said, "It is established in law that a formal signature is not required to indicate assent to, and to be bound by, contractual terms." It is not our role to adjudicate the existence of binding contractual terms. It suffices to say, though, that Extendicare did not have *signed* COVID-19 labour pool LOUs with either SUN or SEIU-West, and so, based on the unions' response to our inquiries about it, it is not clear what, if any, of the labour pool LOU provisions were truly agreed to and binding. Further, there does not appear to be a good reason why Extendicare did not arrange to have formal LOUs formally signed to avoid any doubt.

Despite it not being clear whether it had its own labour pool LOUs, Extendicare told us it could have required its employees to redeploy to Parkside, but it decided not to. First, it said mandatory redeployment created the risk that employees would quit or take unauthorized leaves of absence, which would have only exacerbated existing staffing shortages. Second, it said it wanted to avoid labour disputes that might take attention and resources away from the immediate task of protecting against COVID-19. Third, it said since it was experiencing province-wide labour shortages at the time, as well as an outbreak at Extendicare Moose Jaw, there was no surplus of employees who it could order to leave other homes for Parkside without creating labour shortages and health risks at the donor homes.

First, we acknowledge that it was possible that some employees might resist being re-cohorted to a home in outbreak. However, the Authority's LOUs specifically provide for employers to seek volunteers and then to assign employees if there were not enough qualified volunteers. In our view, it would have been reasonable for Extendicare to have worked with unions to manage the risks associated with redeployment in the context

of negotiating formal, signed labour pool LOUs. Second, we agree that avoiding labour disputes related to mandatory redeployments was reasonable. However, again, engaging the unions in discussions over its own labour pool LOUs would have been a reasonable way to address and hopefully avoid any misunderstandings resulting in grievances and other disputes. Third, while we acknowledge that the existence of specific labour shortages would have limited its ability to re-cohort its staff to Parkside, it is not clear how having staff volunteer instead of requiring them to relocate ameliorated any shortages. If, for example, Extendicare Preston did not have any nurses to spare, then it would not have mattered that they volunteered or were directed to go to Parkside – Preston would still have been short-staffed. We note that some continuing care aides who ordinarily worked at Extendicare Preston came to Parkside to help during the outbreak.

We accept, however, that because Extendicare's labour pool LOUs only applied (or would have only applied) to its own Saskatchewan staff, they would not have appreciably improved its access to needed labour, since at best, they (would have) allowed it to move its own Saskatchewan staff around temporarily. With far fewer staff than the Authority and all of its affiliates, Extendicare's labour pool was much smaller and therefore much less flexible, particularly given the demand for health care services generally.

The Authority's labour pool LOUs allowed it to create a temporary COVID-19 Supplemental Workforce to engage contractors, management staff, health system partners, students and volunteers to deal with COVID-19 related issues that would typically be done by unionized staff– such as the loss of staff during an outbreak. Unlike the labour pools who could not be deployed to Parkside, a COVID-19 supplemental workforce – an outbreak emergency team – could have been deployed to Extendicare. The Authority and Extendicare could have collaborated on the development of a COVID-19 supplemental workforce to be deployed to any long-term care home to deal with an outbreak, including Parkside. Unfortunately, neither of them appears to have realized this, or if they did, there is no indication either of them took any steps towards it.

We acknowledge that once the outbreak occurred, Parkside arranged to supplement its staff with personnel from staffing agencies and the City of Regina's Fire & Protective Services, but this was clearly too little too late.

Importantly, none of the challenges Extendicare faced with staffing and labour relations explain why Parkside did not take steps well before the outbreak was declared to have an outbreak staffing contingency plan, which Extendicare's corporate pandemic plan required because:

> Up to 20-50% absenteeism from work…within our sector may occur. Absenteeism will be the result of staff becoming ill, staying home to care for others, or refusal to go to work. Ill staff will be directed by Public Health as to the length of time they need to remain off work.

By mid-August 2020 Extendicare had learned a great deal from its experiences in other jurisdictions about the stresses long-term care facilities face during a serious COVID-19 outbreak. Its President stressed the importance of dealing with the risk of significant staff shortages by partnering with other health care providers and noted the creation of an emergency leadership team that could be at the ready. Its Vice President of Long-Term Care Operations reached out to the Authority for support in getting ready for a potential surge in the fall of 2020, again stressing the importance of its relationship with the Authority being

essential in the event of outbreaks, for example in providing enhanced infection prevention and control expertise.

While Extendicare developed thoughtful policies and its corporate leaders provided sound advice to its staff and made appropriate overtures to the Authority for its help, none of this ensured Parkside was actually prepared with a staff contingency plan. Based on what actually happened during the outbreak, Parkside was clearly not prepared for what it would do in case of a serious outbreak and significant numbers of its staff got sick or needed to self-isolate – which is exactly what happened.

Staffing Crisis

In the first few days after November 20, 2020 when the outbreak was declared and testing revealed that its staff had COVID-19, Parkside began losing staff who had to self-isolate. On November 23, 2020, the Authority's Director of Continuing Care in Regina sent an email to Public Health:

> I just left a call with Parkside Extendicare where they were advising us that all of their [care managers] have been advised or will be advised that they will have to isolate for 14 days leaving them with one [non care manager]. This may leave them in a position of not being able to safely care for their 200 residents, 16 of whom are COVID positive. Is there any way that all of us can touch base today to understand the decision making and problem solve the management of this situation?

An Authority Medical Health Officer replied (in part):

> The exclusion of staff is based on clear criteria of exposure and symptoms and risk of infection.
>
> This will impact in this facility, from what I have heard.
>
> So it needs escalation, but not sure how that gets done.

The Authority's Director of Continuing Care in Regina said she would set up a call with Parkside's outbreak administrators as: "It is important to understand and problem solve this as soon as this is possible."

The next day, Extendicare's Senior Administrator, who had taken over management of Parkside during the outbreak, expressed concerns to both Extendicare and Authority officials about what he felt was a change of rules in the middle of the pandemic. He felt that Public Health changed the definition of 'close contact' without warning. This, he believed, left Parkside desperately short of staff at a time when it had several known cases of positive residents. In his update for the previous day, he said:

> - Meeting was arranged with Public Health about changing the rules of the pandemic towards staff. 2 major changes- staff who have **not worn** a face shield are considered to be in close contact and if you have had contact with a positive person for an accumulative 15 minutes per 24 hours with masks on, you are considered close contact.
> - I informed both Public Health and SHA that by these definitions of close contact I am anticipating to lose 75- 100% of staff at Parkside.
>
> [Emphasis in the original.]

Extendicare's Vice President of Long-Term Care Operations replied that he would reach out to officials about the public health directive. The Senior Administrator said, "Yes please, they shut us and the SHA down. If the deciding [factor] on close contact is face shields why weren't we told this so we could have implemented it[?]"

Extendicare said this was the major reason it lost so many staff and could not replace them. Its Director of Labour and Employee Relations told us with respect to the risk of losing significant numbers of staff as a result of self-isolation, Extendicare was not informed of Public Health's self-isolation rule for close contacts until after the outbreak at Parkside began in November 2020. He said this rule was unexpected and was more stringent than self-isolation rules in other provinces. And, because Extendicare was not aware of this rule or its scope in advance, it was not able to make preparations for it.

For example, Extendicare told us that two of Parkside's managers were both required to self-isolate because they were deemed to be close contacts of another management employee, who had the onset of very mild COVID-19 symptoms as of November 16, 2020 and continued working until November 22, 2020. One of the managers told us they wore their mask constantly – and was very vigilant about wearing a mask at work. They said the management employee who contracted COVID-19 and another employee came into their office for just "five minutes." The other manager told us they did not think they should have been considered a close contact either, because they also wore a mask the whole time when they were in the vicinity of any other person at work and was never within two meters of the management employee who contracted COVID-19 when either of them was not wearing a mask.

What "close contact" meant became important to clearly define as of April 4, 2020, when the Ministry issued a public health order requiring all persons with COVID-19 and all persons identified by a medical health officer as a close contact of a person with COVID-19 to go into mandatory self-isolation.

On May 19, 2020, the Authority's Director of Continuing Care in Regina emailed all the long-term care home administrators in Regina, including Parkside's Administrator with a copy of a memo about an incident at the Pasqua Hospital. The memo said masked health care workers had possibly been exposed to an asymptomatic COVID-19-positive patient because they were not wearing eye protection. Because the patient displayed no respiratory symptoms, the workers had not breached PPE protocols, but they were ordered to self-isolate based on a risk matrix in section 2 of the province's *Communicable Disease Control Manual*, a copy of which the Authority attached to the email.

The version of the Manual provided to Parkside defined a "close contact" as a person who:

> Provided direct care for the patient, including health care workers, family members and caregivers or who had other similar close physical contact (e.g., intimate partner) without consistent and appropriate use of recommended Personal Protective Equipment (PPE);
>
> OR
>
> Lived with or had otherwise close prolonged contact (within two metres) with a probable or confirmed case up to 48 hours prior to symptom onset while the case was symptomatic and not self-isolating;
>
> OR
>
> Had direct contact with infectious body fluids of a case (e.g., was coughed or sneezed on or shared personal items such as eating utensils or drinking cups) without the appropriate use of recommended personal protective equipment
>
> [emphasis added.]

The risk matrix in the Manual (called: *Interim Guidance: Risk Classification for Asymptomatic HCWs with Potential Exposure to COVID-19 Patients/Resident/Clients in Healthcare Settings*) required health care workers interacting with a resident "with respiratory symptoms that is not wearing a mask or face covering consistently during interactions with [the health care worker] (beginning 48 hours prior to symptom onset)" to be excluded from work and self-isolate for 14 days after their last exposure if among other circumstances "they are wearing a procedural mask but not eye protection." It is this specific scenario that Public Health appears to have decided the two Parkside managers fell into based on their interactions with the management employee who worked while having COVID-19 symptoms.

The following week, on May 25, 2020, the Authority's Director of Continuing Care in Regina forwarded the Authority's self-isolation protocol for health care workers to long-term care administrators, including Parkside's Administrator. The protocol indicated that if a health care worker experiences a breach in PPE while working in a COVID-19 outbreak worksite, they would be considered a close contact and would have to self-isolate for 14 days. If they used proper PPE they would not be a close contact and would only have to self-monitor. It also said that if there was an exposure, Public Health would assess the type of exposure and provide direction specific to the situation.

It is these rules, then, that had been incorporated into the provincial *Communicable Disease Control Manual* and were communicated to Parkside's Administrator and the Senior Administrator who would be assigned responsibility for the outbreak, approximately six months before the outbreak.

FINDINGS

Based on our review of the documents submitted to us and our inquiries into Extendicare's submissions on this issue, we find that the definitions of "close contact" which appear to have been applied to most of Parkside's staff, were not novel changes to existing rules that Public Health made up and decided to apply after the outbreak was declared. We also find that the Authority provided Extendicare with detailed information about the rules and the circumstances in which they would be applied at least six months before the outbreak. We find, however, that Public Health's decision to require the two Parkside managers to self-isolate was not clearly the result of them being found to have met any existing definition of close contact.

Extendicare's criticism of Public Health's decision to require the two Parkside managers to self-isolate is based on the both of them, and the management employee that had COVID-19, stating that they all consistently and continuously wore procedure masks while at work. In their email to Public Health about who they were in contact with at Parkside, the management employee who contracted COVID-19 said they were within three or four feet of one of the managers during meetings while both of them had masks on at all times. And, they said they had meetings with the other manager in their office, but again they were at least two feet away and had masks on at all times. The Ministry's risk matrix does not appear to include this scenario as a close contact.

Public Health's COVID-19 Investigation & Report, however, summarized the information it received in a more general way, without specifically differentiating between each individual the management employee reported being in contact with: "[management employee] reports when in [their] office area with co-workers, [they do] not always wear a mask

and held staff huddles at the doorway to [their] office." We acknowledge that this is a reasonable summary of some of what the management employee reported. For example, they reported that another management employee came into their office a couple of times to help with their computer and that they were in and out of another management employee's office throughout the week – and that they could not be certain if they had masks on at all times. We find though that it is not an accurate summary of what the management employee reported about their interactions with the two Parkside managers.

Based on our review, it appears that Public Health ordered these two Parkside managers to self-isolate, not because contact tracing information clearly showed they were close contacts within the definitions in the Manual, but because Public Health was not confident they were not close contacts. Despite only having information indicating that they were never within two meters of each other without procedure masks on and never for more than 15 minutes in a 24-hour period, we find that Public Health ordered them into self-isolation out of lack of confidence and an abundance of caution. This is exemplified by one Authority official's view, who told us 'they were all crammed together in cubby holes', did not always wear masks and did not always physically distance. In their view, there was no choice.

Nothing we reviewed, however, revealed that Public Health applied a novel, never-before-disclosed close contact rule, which resulted in so many of Parkside's staff being required to self-isolate as Extendicare has claimed. For example, three other Parkside staff were required to self-isolate because the management employee reported that they were within close contact with them when they or all of them were not wearing masks – which is a close contact scenario in the *Communicable Disease Control Manual*.

Extendicare's claim appears to be premised on an assumption that its staff consistently and correctly used appropriate PPE when dealing with COVID-19-positive individuals. While this may have been true for its staff's interactions with residents, we have reviewed considerable and detailed evidence indicating that this was not true for its staff's interactions with each other. While the close contact and self-isolation rules in the *Communicable Disease Control Manual* only describe scenarios between health care workers and COVID-19 positive residents, it is logical and reasonable to interpret them as applying equally to interactions among health care workers.

Officials from Public Health told us, which is also reflected in communications between the Authority's Continuing Care branch and Parkside's management, that Public Health was concerned about the several reported breaches in the proper use of PPE by Parkside's staff. Several of Parkside's direct care staff were ordered to self-isolate based on the application of long-standing rules, not because they were in close contact with positive residents, but because they were in close contact with other positive staff members when they were not wearing any PPE, let alone masks and face shields.

For example, the eight Parkside staff who reported having the onset of COVID-19 symptoms before November 20, 2020, named a total of 22 Parkside staff as close contacts. At least two of the eight employees also said they were in close contact with other unnamed staff in the Parkside break room when none of them were wearing masks. One worker said they carpooled with a co-worker within 48 hours of the onset of their symptoms and neither of them wore masks. This same worker socialized with several other co-workers within days of having symptoms. Another said they shared their breaks with a co-worker, again when neither of them wore masks and within 48 hours of the onset of their symptoms.

While we acknowledge how difficult, and frankly, as it turned out, impossible, it was for Parkside to find replacement staff for those who had to self-isolate, it was not because Public Health changed the self-isolation rules at the last minute. Instead, we find it was because of a number of interrelated factors:

- Because Extendicare is not an affiliate of the Authority and, therefore, not part of the prescribed multi-employer bargaining unit of which the Authority and its affiliates are a part, it was not a party to the Authority's and its affiliates' labour pool LOUs. Therefore, it had no general ability to access any affiliate or Authority staff to work at Parkside during the outbreak.
- Despite being concerned any attempts to unilaterally transfer (re-cohort) staff from its other Saskatchewan homes to Parkside to help during the outbreak would result in grievances and staff shortages at other homes, Extendicare did not take reasonable steps before the outbreak to manage this risk. For example, though it took preliminary steps towards concluding its own formal labour pool LOUs with SEIU-West and SUN, it did not have formal signed labour pool LOUs with SEIU-West or SUN to provide it with the clear specific authority or a pre-negotiated process for temporarily transferring unionized staff from its other Saskatchewan homes to Parkside to address its outbreak-related staff shortages.
- Extendicare's limited labour pool in Saskatchewan meant that, even if with its own LOUs with SEIU-West or SUN, it was not in a position to be able to transfer enough of its unionized staff from its other homes to replace the 30+ Parkside staff who were placed into self-isolation. However, the LOUs for the Authority and its affiliates allowed it to deploy a temporary COVID-19 supplemental workforce of contractors, management staff and others to meet temporary needs. Extendicare did not – prior to the start of the outbreak – approach the Authority regarding the development of, and its potential access to a COVID-19 supplemental workforce.
- Extendicare failed to develop and implement a reasonable staff contingency plan for Parkside in the event an outbreak resulted in its staff contacting COVID-19 or having to self-isolate because they were a close contact of a positive resident or co-worker.

Recommendations

There are no recommendations an Ombudsman can make that could ever adequately address the tragedy that happened at Parkside or provide the basis for a public policy debate over how long-term care should be structured or funded. We do believe, however, that apologizing to its residents and their families is the least Extendicare could do. Further, in keeping with our mandate under *The Ombudsman Act, 2012*, our recommendations are made with a view to, hopefully, encouraging those responsible for governing, supporting, overseeing, and providing long-term care to fully and honestly review all the circumstances of Parkside's response to the pandemic and the outbreak, to work together to fully understand what went wrong and what could have been done better, and then to make improvements to the way long-term care is provided, managed, and accounted for in Saskatchewan. We expect Extendicare and the Authority to report publicly on whether they accept our recommendations and on the timelines for their implementation.

EXTENDICARE (CANADA) INC.

There is no doubt that Extendicare (Canada) Inc. has experts and officials to ensure policies are developed and communicated to its long-term care home managers and staff. However, having the best policies in the world is useless if they are not put into practice. We heard many good things from family members, who felt that, for the most part, Parkside's front-line staff provided good care to their loved ones. However, we found that Parkside was lax in enforcing the public health orders and implementing effective infection prevention and control measures with its staff to ensure that COVID-19 stayed out of the facility or was at least better contained. Nearly all its residents got infected. Parkside was woefully unprepared for the COVID-19 outbreak despite all the corporate-level planning Extendicare did, and all the support offered and provided to it by the Authority.

We recommend that:

1. Extendicare (Canada) Inc. issue a formal, written apology to each of the families of the Extendicare Parkside residents who passed away as a result of the COVID-19 outbreak, and to all other Extendicare Parkside residents whose lives were disrupted because they got COVID-19, because they were displaced from their home to other facilities, and because they had to live through the outbreak.

2. Extendicare (Canada) Inc. conduct, in collaboration with the Saskatchewan Health Authority, a comprehensive critical incident review of the COVID-19 outbreak at Extendicare Parkside as required by *The Provincial Health Authority Act* and *The Critical Incident Regulations, 2016.*

3. Extendicare (Canada) Inc. develop and implement effective administrative and management processes to ensure its Saskatchewan special-care home administrators and staff comply with its own corporate policies, procedures, plans and standards, and any Saskatchewan Ministry of Health or Saskatchewan Health Authority policies, procedures, plans, practices and standards that it either has agreed to comply with, or is required to comply with under any Act or regulation.

4. Extendicare (Canada) Inc. ensure that Extendicare Parkside has on-site, sustainable resources to effectively support its staff's compliance with all relevant infection prevention and control management processes, standards and practices, including good quality education, auditing and managerial oversight.

SASKATCHEWAN HEALTH AUTHORITY

The Authority is the operational arm of the provincial health system. Whether it provides health services itself or contracts with health care organizations to provide them, it is responsible to ensure health services in Saskatchewan meet reasonable standards. It cannot allow private long-term care operators to run their facilities without ensuring they at least meet and follow the standards and practices it has for its own facilities.

From the perspective of administering long-term care across the province in an integrated and consistent way, there cannot be fractured and inconsistent practices and standards from one home to the next. Residents should be able to expect the same quality of care no matter which long-term care home they live in, whether an Authority-run home or a privately-operated home.

Based on our investigation, the Authority generally gave Parkside reasonable support during the pandemic and outbreak. However, there were some areas where effective oversight was lacking, and where the Authority should have taken a greater, leadership role.

We recommend that:

1. The Saskatchewan Health Authority immediately stop the practice of having four special-care home residents share a bedroom.

2. The Saskatchewan Health Authority update its standard written agreement (Principles and Services Agreement) for special-care home operators without delay, and ensure all operators it enters into agreements with to provide services are required to comply with care-related policies, standards and practices, including infection prevention and control measures, that are acceptable to the Authority.

3. The Saskatchewan Health Authority establish and implement a detailed annual review and reporting process to ensure that all special-care homes in Saskatchewan are following all required care-related policies, standards and practices, including infection prevention and control measures, and that it publicize information about each home's level of compliance at least annually.

4. The Saskatchewan Health Authority ensure its communicable disease prevention and control management standards and practices are consistently applied in all special-care homes in Saskatchewan, including completing comprehensive infection prevention and control inspections of all special-care homes at least annually.

MINISTRY OF HEALTH

Although the Ministry was directly involved in communicating with the public on pandemic-related initiatives and issues, it provided no direct oversight or support to Parkside during the pandemic or outbreak. The Ministry's main contributions to the long-term care sector's response to the pandemic were: issuing public health orders directed at keeping long-term care residents from contracting COVID-19; and approving additional COVID-19 funding for the Authority to distribute to all long-term care operators to ease pandemic-related pressures. It was the Authority and long-term care home operators who were left to take operational steps to implement the measures necessary to comply with the public health orders and to care for their residents during the pandemic.

Because of this, and because our investigation focused on a tragedy that was precipitated by what we all hope is a once-in-a-lifetime (if not much less frequent) global calamity, we did not make any recommendations to the Ministry.

However, the Ministry's lack of direct operational responsibility for the administration of the long-term care system does not mean its role is not critical. It is responsible for establishing the governing framework for the long-term care system and for deciding how much, and on what initiatives, public money will be spent. This means it has a great deal of control over how and how well the sector functions. These sorts of decisions and responsibilities are not administrative in nature; they are matters of public policy. We strongly encourage it to play a positive role in helping the Authority and all other long-term care operators to ensure that something like the Parkside outbreak never happens again – to make meaningful and lasting systemic and structural improvements to Saskatchewan's long-term care system.

Ombudsman Saskatchewan
Promoting Fairness

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