AMENDED/MODIFIE JUNE 23rd, 20 20
PURSUANT TO/CONFORMEMENT A
Rule 26.02
Local Registrar/Greffier Local
Superior Court of Justice (Ontario)

Court File No. CV-20-00001409-00CP

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

SYLVIA LYON, as litigation administrator for THE ESTATE OF URSULA DREHLICH, deceased, and, SYLVIA LYON, personally

Plaintiffs

and

CVH (No. 6) LP, SOUTHBRIDGE HEALTH CARE GP INC. SOUTHBRIDGE CARE HOMES, SOUTHBRIDGE CARE HOMES INC. c.o.b. ORCHARD VILLA and EXTENDICARE (CANADA) INC.

Defendants

Proceeding Under the *Class Proceedings Act, 1992*

AMENDED STATEMENT OF CLAIM

TO THE DEFENDANT(S)

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

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

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

Instead of serving and filing a statement of defence, you may serve and file a notice of intent to defend in Form 18B prescribed by the Rules of Civil Procedure. This will entitle you to ten more days within which to serve and file your statement of defence.

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

TAKE NOTICE: THIS ACTION WILL AUTOMATICALLY BE DISMISSED if it has not been set down for trial or terminated by any means within five (5) years after the action was commenced unless otherwise ordered by the court.

Date 25-MAY-2020 Issued by E-Filing
Local Registrar

Address of court office: 491 Steeles Avenue East
Milton, ON L9T 1Y7

TO: **CVH (No. 6) LP**
766 Hespeler Road
No. 301
Cambridge, ON. N3H 5L8

SOUTHBRIDGE HEALTH CARE GP INC.
766 Hespeler Road
No. 301
Cambridge, ON N3H 5L8

SOUTHBRIDGE CARE HOMES
766 Hespeler Road
No. 301
Cambridge, ON N3H 5L8

SOUTHBRIDGE CARE HOMES INC
766 Hespeler Road
No. 301
Cambridge, ON N3H 5L8

ORCHARD VILLA
1955 Valley Farm Road
Pickering, ON L1V 3R6

EXTENDICARE (CANADA) INC.
3000 Steeles Avenue East
Suite 700
Markham, ON L3R 9W2

CLAIM

1. The Plaintiffs claim as against the Defendants:

   (a) Compensatory damages for negligence, breach of contract and wrongful death in the amount $30,000,000.00;

   (b) Punitive and exemplary or aggravated damages in the amount of $10,000,000.00, or such other amount as may be proven at trial;

   (c) Cost of insured health services provided by the Ontario Health Insurance Plan ("OHIP") – the particulars of which will be provided prior to trial;

   (d) Prejudgment interest in accordance with section 128 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, as amended;

   (e) Post-judgment interest in accordance with section 129 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, as amended;

   (f) The costs of this proceeding, plus applicable tax; and,

   (g) Such further and other relief as to this Honourable Court may seem just.

THE PARTIES

2. The Plaintiff, Ursula Drehlich ("Ursula"), is now the Estate of Ursula Drehlich as represented by its Litigation Administrator, Sylvia Lyon. At all material times, Ursula was a resident of the long-term care home at Orchard Villa, located at 1955 Valley Farm Road, in the City of Pickering, in the Province of Ontario, until her death on April 23, 2020, at age 80.

3. The Plaintiff, Sylvia Lyon, is an individual residing in the municipality of Pickering, in the Province of Ontario, and was the daughter of Ursula.

4. The Defendants, CVH (No. 6) LP, Southbridge Health Care GP Inc., Southbridge Care Homes, Southbridge Care Homes Inc., are partnerships and corporate entities, carrying on business as a long-term care home known as Orchard Villa, licenced by the Ministry of Long-Term Care and located at the premises known as 1955 Valley Farm Road, in the City of Pickering, in the Province of Ontario. At all material times, these Defendants were responsible for the acts and/or omissions of their staff, servants, employees and agents.

5. The Defendant, CVH (No. 6) LP is a partnership carrying on business as a retirement home known as Orchard Villa licenced by the Retirement Homes Regulatory Authority and located at the premises known as 1955 Valley Farm Road, in the City of Pickering, in the Province of Ontario. At all material times, this Defendant was responsible for the acts and/or omissions of its staff, servants, employees and agents.

6. The Defendant, Extendicare (Canada) Inc., is a corporate entity offering management and consulting services for long-term care homes and retirement homes. At all material times, this Defendant was engaged in the management of the long-term care home and retirement home known as Orchard Villa, located at the premises known as 1955 Valley Farm Road, in the City of Pickering, in the Province of Ontario.

7. Collectively herein the Defendants, CVH (No. 6) LP, Southbridge Health Care GP Inc., Southbridge Care Homes, Southbridge Care Homes Inc. and Extendicare (Canada) Inc., are referred to as "Orchard Villa".

THE CLASS

8. The Plaintiffs bring this action pursuant to the *Class Proceedings Act* on behalf of the following class:

(a) All persons who contracted the coronavirus ("COVID-19") at Orchard Villa;

(b) All persons who contracted COVID-19 from one of the residents or from another cross-infected person;

(c) All residents of Orchard Villa who paid for such residency in the period of the pandemic caused by COVID-19, as staff shortages precluded the care contracted and paid for; and,

(d) All living children, grandchildren, siblings and spouses within the meaning of section 61 of the *Family Law Act,* R.S.O. 1990, c.F-3, as amended, of the persons who contracted COVID-19 at Orchard Villa and Cross-Infected Persons ("the *Family Law Act* Claimants").

9. The Plaintiff, Sylvia Lyon, is an appropriate representative of the proposed class. She will be able to adequately and fairly represent the interests of the proposed class and does not have an interest that conflicts with the interests of the proposed class.

THE EVENTS AND NEGLIGENCE OF ORCHARD VILLA

Background

10. In 1968, the Defendant, Extendicare (Canada) Inc., ("Extendicare") commenced operation as a supplier of long-term care services in Canada. By 2019, it had developed a network of 118 owned and managed homes and had a reported revenue of $1.13 billion.

11. In 1976, Extendicare expanded into the United States of America and, by 2013, had developed a portfolio of more than 140 senior care communities.

12. In or about 2013, two separate *qui tam* actions were brought against Extendicare and a subsidiary under the *False Claims Act*. These actions alleged that, from January 1, 2007 to June 30, 2013, Extendicare had billed Medicare and Medicaid for materially substandard nursing services that were so deficient that they were effectively worthless and it had billed Medicare for medically unreasonable and unnecessary rehabilitation services.

13. The United States contended that such nursing services were materially substandard and/or worthless because Extendicare failed to provide care to residents that met federal standards of care and statutory and regulatory requirements. More particularly, the United States contended that Extendicare: (a) failed to have a sufficient number and skill-level of nursing staff to adequately care for the skilled nursing residents; (b) failed to provide adequate catheter care to some of the residents; (c) failed to follow appropriate pressure ulcer protocols; (d) failed to follow appropriate falls protocols at the skilled nursing facilities; (e) failed to appropriately provide for some of the residents' activities of daily living; and, (f) failed to

appropriately administer medications to some of the residents to avoid medication errors.

14. Furthermore, the United States contended that Extendicare submitted or caused to be submitted claims to Medicare for payment for the provision of medically unreasonable and unnecessary rehabilitation therapy services provided to Medicare Part A beneficiaries.

15. On October 10, 2014, the United States Department of Justice announced that the two actions had been resolved. In announcing this settlement, the acting Associate Attorney General declared, "It is critically important that we confront nursing home operators who put their own economic gain ahead of the needs of their residents." Extendicare agreed to pay the total of $38,000,000 and to enter into a Corporate Integrity Agreement for a period of five years.

16. On November 7, 2014, Extendicare announced the sale of its American portfolio of senior care communities for $870,000,000. It intended to grow and expand its business in Canada.

17. By letter dated January 13, 2015, the current Administrator advised residents of the newly named Orchard Villa that the long-term care home and retirement home had been sold. The new owners had chosen Extendicare, "a recognized leader in quality, clinically based services to work with the home management team to manage and support all aspect of [Orchard Villa.]"

18. Orchard Villa operates as a long-term care home as well as a retirement home. It has capacity for a total of 308 residents, who privately pay for their residence there. In the long-term care home, Orchard Villa has 233 beds and four dining rooms, including: a large dining room that serves the residents in the units known as Linden, Maple, Birch and Pine and three smaller dining rooms for the

units known as Pine, Cedar and Aspen. In the retirement home, Orchard Villa has capacity for 75 residents and two dining rooms, serving residents in the Victoria Wing and Ottawa Wing.

19. Effective January 29, 2015~~, In or about July 2015~~, the Defendants, CVH (No. 6) LP, Southbridge Health Care GP Inc., Southbridge Care Homes, Southbridge Care Homes Inc. purchased and assumed the operation of Orchard Villa, with Extendicare managing and supporting all aspects of Orchard Villa.

20. Subsequently, the Ministry of Long-Term Care received numerous complaints regarding inadequate care of the residents.

21. In 2017, based upon such complaints, the Ministry of Long-Term Care conducted an inspection of Orchard Villa over 20 days: August 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 31, and September 1, 5, 6, 7, and 8, 2017.

22. By report dated November 8, 2017, the Ministry of Long-Term Care reported that the inspections arose from complaints related to: insufficient staffing; alleged staff to resident neglect; skin and wound care; resident to resident abuse; medication incidents; end of life care and pain management; and, falls. Subsequently, the Ministry of Long-Term Care issued the following to Orchard Villa: 13 warnings, 7 voluntary plans of correction, 5 compliance orders, and 2 director referrals, citing amongst other things:

- a pronounced shortage of staff: "[Orchard Villa] failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents." Personal support staffing shortages were impacting the residents' care;

- there was no documented evidence to indicate that a physician or nurse practitioner had been notified when a resident's wounds displayed signs of infection, such as foul smelling. Such wounds resulted in the resident's hospitalization, including for a wound that

worsened over the course of approximately 5 weeks from a size of 4 cm by 3 cm to a size of 12 cm by 7.5 cm and exposed the Achilles tendon;

- an ongoing non-compliance with ensuring the policy to promote zero tolerance of abuse and neglect of residents, which includes investigations immediately completed and appropriate actions taken and such allegations and suspicions immediately reported to the Director. Such failures increase the severity of harm to the residents; and,

- a resident had sustained 11 falls before transfer to hospital, where there was no indication that a falls prevention program had been implemented until after the family expressed concerns.

23. By report dated December 3, 2018, following another complaint, the Ministry of Long-Term Care conducted an inspection of Orchard Villa and issued another warning and a voluntary plan of correction. The Ministry found that Orchard Villa had failed to ensure that there was at least one registered nurse who was an employee and a member of the regular nursing staff on duty and present at all times. The inspector reviewed the staffing schedule for a five month period in 2018 and identified 14 dates on which no registered nurse was present.

24. In 2019, the Ministry of Long-Term Care conducted inspections of Orchard Villa over 23 days: February 19, 20, 21, 22, 25, 26, 27 and 28 and March 1, 4, 5, 6, 7, 8 and 11, July 3, 4, and 5, and November 4, 5, 6, 7, and 8.

25. By report dated March 21, 2019, the Ministry of Long-Term Care issued the following to Orchard Villa: 2 warnings and 1 voluntary plan of correction. The Ministry found that Orchard Villa had failed to ensure that the care set out in the plan of care was provided to the resident as specified.

26. By report dated April 11, 2019, the Ministry of Long-Term Care issued the following to Orchard Villa: 3 warnings and 3 voluntary plans of correction.

27. Firstly, the Ministry found that Orchard Villa had failed to ensure that staff

and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with, and complement each other.

28. Secondly, the Ministry found that Orchard Villa failed to ensure that, as part of the organized program of laundry services, a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by residents. One personal support worker reported that "on most days they are short linens and continent supplies ... they report shortages to management but nothing seems to happen about it." Furthermore, it was noted that "[t]here is no emergency or pandemic supply of linens to draw from." It was further reported that there was "an ongoing problem with staff shortages."

29. By report dated July 24 and 25, 2019, the Ministry of Long-Term Care issued the following to Orchard Villa: 3 warnings and 3 voluntary plans of correction and 1 compliance order.

30. The Ministry of Long-Term Care found that Orchard Villa failed to:

- Ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other; and,

- Ensure that where required to have, institute or otherwise put in place a policy, that such policy was complied with and, specifically, in respect of a fall prevention and management program to reduce the incidence of falls and the risk of injury.

31. By report dated December 6, 2019, the Ministry of Long-Term Care issued the following to Orchard Villa: 4 warnings and 2 voluntary plans of correction and 1 compliance order.

32. The Ministry of Long-Term Care found that Orchard Villa failed to ensure

that:

- Residents have been protected from abuse by anyone;
- There was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident; and,
- where required to have, institute or otherwise put in place a policy, that such policy was complied with and, specifically, in respect of a fall prevention and management program to reduce the incidence of falls and the risk of injury.

33. By second report dated December 6, 2019, the Ministry of Long-Term Care issued the following to Orchard Villa: 2 warnings and 1 compliance order. Again, the Ministry found that Orchard Villa failed to ensure that care was provided as set out in the plan of care.

Pandemic – Outbreak of COVID-19

34. In December 2019, the first cases of patients suffering from COVID-19 were reported in China.

35. COVID-19 is a viral infection that can cause mild to severe disease that may be fatal. Commonly observed symptoms include fever, cough, shortness of breath, sore throat, and breathing difficulties. In more severe cases, infection can cause pneumonia or severe acute respiratory syndrome, particularly in those individuals with other chronic underlying health conditions. Seniors are a particularly vulnerable group as they are more likely to have chronic underlying health conditions and/or a compromised immune system.

36. On January 23, 2020, a patient suffering from the first presumptive case of COVID-19 in Canada was admitted to Sunnybrook Health Sciences Centre in Toronto.

37. By Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care Dated January 31, 2020, the Government of Ontario ("the Government") released guidance on the prevention and screening of COVID-19 specifically in long-term care homes. In this guidance, the Government noted the heightened vulnerability of residents in long-term care homes, stating:

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

38. Furthermore, the Government provided the following general advice to long-term care homes to prevent an outbreak of COVID-19 in their facility:

- Have procedural masks, tissues and alcohol-based hand rub available to residents and staff;
- Review infection prevention and control and occupational health and safety policies and procedures;
- Post signage on building entrances informing persons to self-identify if they are experiencing fever and/or acute respiratory illness, and have a travel history to Hubei province (including Wuhan), China in the last 14 days since onset of illness or contact with a person who has the above travel history and is ill; and
- Have ongoing surveillance programs in place throughput the year, including both passive and active surveillance to quickly detect respiratory infections.

39. By Novel Coronavirus (2019-nCoV) Fact Guidance for Long-Term Care dated February 11, 2020, the Government released updated guidance on the prevention and screening of COVID-19 in long-term homes.

40. By Memo dated March 9, 2020, the Government advised the long-term homes sector that "elderly individuals and those with underlying health conditions are at increased risk of severe outcomes [from COVID-19]." For the purposes of preventing an outbreak of COVD-19 in a long-term care home, it issued guidance to actively screen all visitors, residents, re-admissions and returning residents to long-term care homes. More fully, it advised:

- Posting signage and advising visitors who have travelled to affected areas or been exposed to a case of COVID-19 in the last 14 days to postpone their visit;
- Posting signage and advising all visitors who are ill to postpone their visit;
- Ensuring availability and accessibility of hand hygiene throughout the facility;
- Keeping staff and residents informed on COVID-19;
- Reminding staff to be monitoring themselves for illness and to stay at home when they are sick;
- Developing policies for managing staff who may have been exposed to a case of COVID-19;
- Assessing incoming residents for respiratory symptoms and potential exposures to COVID-19;
- Monitoring residents for new respiratory symptoms or fever;
- Quickly identifying and isolating any resident with acute respiratory illness or fever;
- Ensuring signage is clear and that personal protective equipment (gowns, gloves, masks and eye protection) for health care workers are available and accessible for care for patients with acute respiratory illness;
- Helping visitors with personal protective equipment if they are visiting residents under precautions; and,

- Reporting any suspected COVID-19 illness in residents or staff to the local public health unit.

41. As a further precaution to prevent the spread of COVID-19 amongst a vulnerable group, long-term care home respiratory tests were to be automatically screened for COVID-19.

42. On March 11, 2020, the World Health Organization officially declared a pandemic in respect of the outbreak of COVID-19.

43. On or about March 16, 2020, Orchard Villa began to refuse entry to visitors, with exceptions for such situations as end-of-life.

44. On March 17, 2020, the Government declared a state of emergency, issuing an order under the *Emergency Management and Civil Protection Act*. With this measure, the Government ordered the closure of all bars and restaurants as well as libraries, theatres, cinemas, schools and daycares and all public gatherings of more than 50 people.

45. These closures were premised on the practice of social distancing. COVID-19 spreads mainly among people within six feet of each other. Spread happens when an infected person coughs, sneezes, or talks, and droplets from their mouth or nose are launched into the air and land in the mouths or noses of people nearby. As well, spread may happen when a person touches a surface or object where such droplets have landed and then touch their own mouth, nose, or eyes.

46. On the same day, the Government enhanced its response to COVID-19 with up to $304 million in funding for 24/7 screening at long-term care homes as well as including building additional hospital capacity, supporting public health units with testing and screening, purchasing additional personal protective equipment for frontline workers and ventilators, and dedicated supports for rural, remote, Northern, and Indigenous communities.

47. March 18, 2020, upon the advice of the Chief Medical Officer of Health, the Government recommended that retirement homes only allow essential visitors.

48. On March 20, 2020, by an amendment to s.27(5) of Ont. Reg. 166/11 of the *Retirement Homes Act, 2010*, the Government required retirement homes to comply with the recommendations of the Chief Medical Office for long-term care homes in respect of COVID-19 and preventing the spread of it. To ensure the protection and safety of Ontario's seniors, retirement homes had to take all reasonable steps to follow: (i) any directive respecting COVID-19 issued to long-term care homes by the Chief Medical Officer of Health under section 77.7 of the *Health Protection and Promotion Act*, and, (ii) any guidance, advice or recommendations respecting COVID-19 given to long-term care homes by the Chief Medical Officer of Health and made available on the Government's website respecting COVID-19. This regulation took immediate effect.

49. On March 20, 2020, the Government amended regulations to allow for increased flexibility in staffing at long-term care homes, making it easier for qualified staff to be hired and for homes to prioritize skills where they are needed most. These measures allowed for homes to quickly bring in more and new staff, to prevent potential staffing shortages, and to allow staff to spend more time on direct care to residents.

50. On March 22, 2020, the Chief Medical Officer of Health issued a directive to long-term care homes to immediately implement further important measures. Firstly, the homes were to not permit residents to leave the home for short-stay absences to visit family and friends. Secondly, wherever possible, they were to limit the number of work locations that employees are working.

51. On March 23, 2020, the Government issued a temporary order for long-term

care homes to support increased staffing flexibility, enabling homes to be able to prevent and, if necessary, alleviate an outbreak of COVID-19. Additionally, it suspended short-stays in long-term care homes and provided guidance to homes on how to use short-stay beds to maximize capacity for applicants waiting for admission to a long-stay bed in a long-term care.

52. On March 24, 2020, the Government amended regulations to allow for streamlined long-term care admissions, discharge and re-admissions process, freeing up much-needed capacity in hospitals and ensuring residents who leave their long-term care home during the COVID-19 pandemic are prioritized for re-admission, giving them peace of mind.

53. On March 25, 2020, the Government launched "Ontario's Action Plan: Responding to COVID-19", which was a $17 billion emergency relief package to provide relief to families and certainty to businesses. This package included $3.3 billion in additional resources for the health care system and specifically $243 million for long-term care.

54. On March 27, 2020, the Government issued a second temporary order for long-term care homes to provide further flexibility in redirecting their staffing and financial resources to essential tasks during the COVID-19 crisis.

55. On March 28, 2020, based on the best advice of Ontario's Chief Medical Officer of Health, the Government issued an emergency order immediately prohibiting organized public events and social gatherings of more than five people, under the *Emergency Management and Civil Protection Act*.

56. At this time, Orchard Villa continued to permit residents to routinely sit together in the dining rooms for three meals per day. The six dining rooms have capacity hold 308 residents at tables measuring approximately 3.5 feet by 3.5 feet. Four residents sat at each table.

57. Orchard Villa permitted family members to deliver items, such as clean laundry, to residents in the Cedar Unit, Ottawa Wing, Victoria Wing, and other areas.

58. After a resident tested positive for COVID-19, Orchard Villa transferred that resident into the Pine Unit and such residents sat for their meals in the small dining room designated for the Pine Unit. However, the remaining residents continued to move freely through the facility and sit for their meals in the other five dining rooms.

59. By April 14, 2020, Orchard Villa finally confined all of the residents to their rooms and commenced serving meals in their rooms.

60. For staff attending to the confined residents, Orchard Villa failed to provide adequate or proper personal protective equipment in a timely manner. When provided, Orchard Villa directed staff to repeatedly use the same personal protective equipment – despite contamination.

61. Due to staff shortages, residents received inadequate care in respect of basic necessities, such as bathing and maintaining catheters. As a result, residents suffered from urinary tract infections, dehydration, and other related physical ailments, resulting in hospitalizations and/or deaths.

62. Throughout this period, Orchard Villa continued to contact families of residents with automated phone messages, re-assuring them that Orchard Villa had the situation under control, providing either inaccurate or incomplete information and/or information that no longer reflected the current situation. These messages failed to report that deaths had occurred as a result of COVID-19 at Orchard Villa.

63. On April 20, 2020, news reports indicated that 31 residents had died at

Orchard Villa from complications related to COVID-19 and another 115 residents and 30 staff that had tested positive for COVID-19. In its long-term care home, 98 residents and 24 staff had tested positive and, in its retirement home,17 residents and 6 staff had tested positive.

64. On April 21, 2020, the Durham Region Medical Officer of Health ordered Orchard Villa to address the immediate risk of COVID-19 to residents and staff, by Order issued pursuant to the *Ontario Health Protection and Promotion Act*.

65. The Order required Orchard Villa to enhance measures for the protection of residents and staff including:

- active screening of residents, staff and visitors;
- active and ongoing surveillance of all residents;
- active and ongoing oversight of the delivery of clinical care;
- screening for new admissions;
- managing essential visitors;
- specimen collection and testing for outbreak management; and,
- implementation of all of the above measures including the adoption and implementation of Infection Prevention and Control.

66. By newsletter dated April 23, 2020, Orchard Villa confirmed that 40 residents had died from complications related to COVID-19 and another 131 residents and 66 staff had tested positive for COVID-19. In its long-term care home, 104 residents and 59 staff had tested positive and, in its retirement home, 27 residents and 7 staff had tested positive.

67. On April 24, 2020, Lakeridge Health conducted a review of Orchard Villa's infection prevention and control and then implemented new protocols for the use of Personal Protective Equipment (PPE) as well as education and training for all

staff on assessing risk, barriers to transmission, and additional precautions and extended use of PPE. Additionally, Lakeridge Health transitioned clinical teams trained in infection prevention and control to assess the situation at the home and determine what additional care services are required to limit the risk of further transmission. Lakeridge Health supplemented the current staff at Orchard Villa with Registered Nurses, Registered Practical Nurses, Personal Support Workers, and Dietary professionals

68. On April 28, 2020, a medical unit from the Canadian Armed Forces arrived at Orchard Villa, enabling 20 to 25 soldiers to be onsite in two shifts for 24 hours per day, seven days per week.

69. As a result of the efforts of Lakeridge and the Canadian Armed Forces, the ratio of health professional and support staffing to resident met the standard ratios for long-term care at Orchard Villa.

70. With the assistance of Lakeridge Health and the Canadian Armed Forces, the risk of residents contracting COVID-19 began to reduce, with the implementation and adherence to proper protocols to prevent the spread of COVID-19.

71. The particulars of the allegations of negligence, gross negligence, breach of contract and wrongful death against the Defendants, CVH (No. 6) LP, Southbridge Health Care GP Inc., Southbridge Care Homes, Southbridge Care Homes Inc. and Extendicare (Canada) Inc., include but are not limited to the following:

    (a) They failed to ensure that the residents and staff of Orchard Villa were kept safe;

    (b) They failed to comply with directives issued by the Chief Medical Officer of Health and orders issued by the Government of Ontario

that related to preventing COVID-19 from infecting residents and staff of long-term care facilities, such as Orchard Villa;

(c) They failed to institute reasonable measures to prevent COVID-19 from infecting residents of Orchard Villa, such as undertaking proper screening of visitors and practicing social distancing;

(d) They failed to employ and properly train competent staff on proper, safe and adequate measures for preventing COVID-19 from infecting residents and staff of Orchard Villa;

(e) They failed to take proper care in the circumstances;

(f) They breached their duty as a caregiver and fiduciary to the residents and staff of Orchard Villa;

(g) They failed to meet the minimum standards of practice for preventing transmission of infectious diseases in the setting of a long-term care facility;

(h) They failed to warn the residents and staff of Orchard Villa of the potential exposure to COVID-19 in a timely fashion;

(i) They failed to adequately equip their employees with personal protective equipment in a timely manner;

(j) They failed to adequately supervise the work of their employees and staff regarding compliance with directives issued by the Chief Medical Officer of Health and orders issued by the Government of Ontario that related to preventing COVID-19 from infecting residents of long-term care facilities, such as Orchard Villa;

(k) They failed to take all reasonable, necessary and protective measures to ensure that the residents and staff of Orchard Villa were safe while on the premises of Orchard Villa; and,

(l) Such further and other particulars which may become known to the Plaintiff or the residents or staff of Orchard Villa or their family members that will be proven at the trial of this action and are within the knowledge of the Defendants.

72. The particulars of the further allegations of negligence, gross negligence, breach of contract, and wrongful death against the Defendants, CVH (No. 6) LP, Southbridge Health Care GP Inc., Southbridge Care Homes, Southbridge Care Homes Inc., include but are not limited to, the following:

(a) The failed to conduct any reasonable and/or due diligence before retaining the Defendant, Extendicare (Canada) Inc., to manage Orchard Villa; and,

(b) They failed to retain a reasonably competent corporate entity or otherwise, offering management and consulting services for long-term care homes and retirement homes, to manage Orchard Villa.

DAMAGES

73. The Plaintiffs claim general and special damages resulting from negligence, gross negligence, breach of contract and wrongful death. The full particulars of which the Plaintiffs undertake to provide to the Defendants prior to the trial of this action.

74. The Plaintiffs and the estates of the Plaintiffs claim for damages for pain and suffering arising from contracting COVID-19.

75. The *Family Law Act* Claimants claim for damages pursuant to s. 61 of the *Family Law Act*. The damages for these class members include pecuniary losses resulting from the injury or death of their family member, expenses incurred for the benefit of their family member, travel expenses incurred in

visiting their family member during his or her treatment and recovery, funeral expenses, a reasonable allowance for loss of income and the value of nursing, housekeeping and other services rendered to their family member, an amount to compensate for the loss of guidance, care and companionship reasonably expected to be received from their family member had the aforesaid negligence and misconduct not occurred.

Aggravated and Punitive Damages

76. The Plaintiff states that the Defendants failed to correct their behaviour, despite instructions, directions, and compliance Orders from the Ministry of Long-Term Care. The Defendants ignored such instructions, directions, and compliance Orders to the detriment of the residents of Orchard Villa. A persistent lack of resources, staffing, and protocols and/or adherence to such protocols rendered the infiltration of COVID-19 into Orchard Villa inevitable.

77. The Plaintiff states that the Defendants conducted their affairs leading to these subject occurrences in a high-handed, arrogant and capricious manner with a wanton disregard for the safety and well-being of the Plaintiffs and, as such, they are entitled to aggravated and punitive damages.

78. The Defendants' conduct was reprehensible and departed to a marked degree from ordinary standards of decent behaviour. The Defendants' reckless disregard for the Plaintiffs is deserving of punishment and condemnation by means of an award of punitive damages.

79. The Defendants' actions were callous and arrogant and offend the ordinary community standards of moral and decent conduct. The actions, omissions or both

of the Defendants involved such want of care as could only have resulted from actual conscious indifference to the rights, safety or welfare of the Plaintiffs.

THE PLAINTIFFS' INDIVIDUAL CIRCUMSTANCES

80. The Plaintiff, Ursula Drehlich, was a particularly vulnerable individual. In 1974, she suffered from a brain tumour that was successfully treated with surgery. However, the subsequent radiation treatment caused a severe palsy in her right hand and damaged her inner ears, rendering her deaf and affecting her sense of balance. Eventually, she was confined to a wheelchair.

81. In October 2013, the Plaintiff, Ursula Drehlich, became a resident of the long-term care home at Orchard Villa.

82. As a resident, the Plaintiff, Ursula Drehlich, was paying a monthly fee of approximately $2,474.40 to Orchard Villa, including basic room fee of $1,891.31 with an additional private room fee of $583.09. She had a private room in the Pine Unit, where meals were brought to her.

83. The Plaintiff, Sylvia Lyon, regularly visited the Plaintiff, Ursula Drehlich, while she was a resident at Orchard Villa.

84. After July 2015, when the Defendants purchased and assumed the operation of Orchard Villa, the Plaintiffs notice distinct changes in the level of care provided to the Plaintiff, Ursula Drehlich. For example, the Plaintiff, Sylvia Lyon, observed that staffing changed a much faster rate and noted inaccuracies and inadequacies in the Personal Care Plan for the Plaintiff, Ursula Drehlich.

85. On March 11, 2020, the World Health Organization officially declared a pandemic in respect of the outbreak of COVID-19.

86. From March 11, 2020 to April 11, 2020, the Plaintiff, Ursula Drelich, moved freely throughout Orchard Villa, before she was confined to her room, where she was attended by staff who had improper or inadequate personal protective equipment, which had been contaminated by repeated usage.

87. On April 16, 2020, the Plaintiff, Ursula Drehlich, was tested for COVID-19 and, on April 21, 2020, she was advised that she had tested positive.

88. On April 23, 2020, the Plaintiff, Ursula Drehlich, passed away due to contracting COVID-19.

89. The Plaintiffs claim general and special damages resulting from negligence, gross negligence, breach of contract and wrongful death. The full particulars of which the Plaintiffs undertake to provide to the Defendants prior to the trial of this action.

90. The Estate of the Plaintiff, Ursula Drehlich, claims for damages for pain and suffering arising from contracting COVID-19

91. The Plaintiff, Sylvia Lyon, is entitled to damages pursuant to s. 61 of the *Family Law Act*, including include pecuniary losses resulting from the death of the Plaintiff, Ursula Drehlich, expenses incurred for her benefit, travel expenses incurred in visiting her during her treatment, funeral expenses, a reasonable allowance for loss of income and the value of nursing, housekeeping and other services rendered to them, an amount to compensate for the loss of guidance, care and companionship reasonably expected to be received from her had the aforesaid negligence and misconduct not occurred.

92. The Plaintiffs plead and rely upon the following statues, as amended:

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

b) *Courts of Justice Act*, R.S.O. 1990, c. C.43;

c) *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

d) *Negligence Act*, R.S.O. 1990, c. N.1.l; and

e) *Retirement Homes Act*, 2010, c. 11.

93. The Plaintiffs propose that this action be tried in the Town of Milton in the Province of Ontario.

Dated:

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Lyon et al.
Plaintiffs

-and-

CVH (No. 6) LP et al.
Defendants

Court File No. CV-20-00001409-00CP

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT
MILTON

AMENDED STATEMENT OF CLAIM

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