Court File No./N° du dossier du greffe: CV-20-00003392-00CP

COURT FILE NO.

Electronically issued
Délivré par voie électronique : 07-Dec-2020
Milton

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

HENRY PIETAK, as litigation administrator for THE ESTATE OF ALEXANDER PIETAK, deceased, and HENRY PIETAK, personally

Plaintiffs

and

ROSSLYN RETIREMENT INC.

Defendant

Proceeding Under the *Class Proceeding Act, 1992*

STATEMENT OF CLAIM

TO THE DEFENDANT

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 years after the action was commenced unless otherwise ordered by the court.

Date _____ Issued by _____
Local Registrar

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

TO: **ROSSLYN RETIREMENT INC.**
307 King Street East, Suite B
Hamilton, ON L8N 1C1

CLAIM

1. The Plaintiffs claim against the Defendant:

   (a). Compensatory damages for negligence, breach of contract and wrongful death in the amount $20,000,000.00;

   (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 all applicable taxes; and

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

THE PARTIES

2. The Plaintiff, Alexander Pietak ("Alexander"), is now the Estate of Alexander Pietak, as represented by his executor of estate, Henry Pietak. At all material times, Alexander was a resident of the long-term care home, Rosslyn Retirement Residence,

located at 1322 King Street East, in the City of Hamilton, in the Province of Ontario, until his death on May 30, 2020, at age 95.

3. The Plaintiff, Henry Pietak ("Henry"), is an individual residing in the City of Hamilton, in the Province of Ontario, and was the son of Alexander.

4. The Defendant, Rosslyn Retirement Inc., carries on business as a long-term care home known as "Rosslyn Retirement Residence", licenced by the Ministry of Long-Term Care and located at the premises known as 1322 King Street East, in the City of Hamilton, in the Province of Ontario. At all material times, this Defendant was responsible for the acts and/or omissions of their staff, servants, employees and agents.

THE CLASS

5. The Plaintiffs bring this action pursuant to the *Class Proceedings Act, 1992*, S.O. 1992, c.6, on behalf of the following class:

(a). All persons who contracted the coronavirus ("COVID-19") at Rosslyn Retirement Residence;

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

(c). All residents of Rosslyn Retirement Residence 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 Rosslyn Retirement Residence and Cross-Infected Persons ("the *Family Law Act* Claimants").

6. The Plaintiff, Henry Pietak, is an appropriate representative of the proposed class. He 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 ROSSLYN RETIREMENT HOME:

Background

7. Rosslyn Retirement Residence operates as a retirement home, licenced by the Retirement Homes Regulatory Authority ("RHRA"). It has capacity for a total of 66 residents, who privately pay for their residence there.

8. On or about June 30, 2016, the Defendant, Rosslyn Retirement Inc., purchased and assumed the operation and control of Rosslyn Retirement Residence.

9. Subsequently, the RHRA received numerous complaints and reports of inadequate care of the residents at Rosslyn Retirement Residence. This prompted the RHRA to undertake inspections at Rosslyn Retirement Residence, which revealed that the home was regularly in non-compliance with the *Retirement Homes Act, 2010*, S.O. 2010, c.11.

10. On September 1, 2016, the RHRA inspection Rosslyn Retirement Residence based on a complaint. On October 3, 2016, the RHRA issued a report based on their inspection, in which they found Rosslyn Retirement Residence in non-compliance with 6 of their obligations under the *Retirement Homes Act, 2010*, citing, among other things:

(a). The staff of the home is providing continence care as a care service and the licensee did not establish a continence care program;

(b). They did not ensure there are procedures in place to keep the home free from bedbugs. The licensee did not document any procedures that the home did implement, and there was a lack of evidence to support that timely action was taken; and

(c). They did not ensure screening measures, including a police background check, on volunteers before accepting them to work in the home, and did not ensure that volunteers were trained according to legislative requirements.

11. In response to a report of theft of a resident's money at Rosslyn Retirement Residence, the RHRA inspected the home on October 18, 2016. On December 22, 2016, the RHRA issued their report in which they found that Rosslyn Retirement Residence received an allegation of theft of a resident's money and did not report the suspicion to the registrar. The home failed to ensure that the policy to promote zero tolerance of abuse was complied with in response to the allegation of theft, and failed to ensure that staff receive the required training to promote zero tolerance for abuse and neglect.

12. On January 9, 2017 the RHRA underwent a compliance inspection to ensure that Rosslyn Retirement Residence took corrective action based on the findings of the previous reports. On February 15, 2017, the RHRA issued a report based on their inspection, in which they found Rosslyn Retirement Residence in non-compliance with 7 of their obligations under the *Retirement Homes Act, 2010*, citing, among other things, that:

(a). They failed to consult with the local medical officer of health to address health care issues in order to reduce the incidence of infectious disease outbreaks in the home, and failed to keep a written record of such consultation and recommendations;

(b). They failed to ensure that, within two days after a new resident commences residency, an initial assessment of the resident's immediate care needs is conducted, in particular with respect to the presence of infectious diseases, risk of falling, and any known allergies;

(c). They failed to ensure all staff received adequate food training, and did not ensure that whenever food is prepared, at least one person involved holds a current food handling certificate;

(d). They failed to ensure that all staff who administers a drug to residents receives training in the procedures applicable to the administration of the drug; and

(e). They failed to ensure that an audit of the controlled substances in home is performed monthly.

13. Based on inspections that took place June 6, 2018, the RHRA issued two reports, the first dated June 21, 2018, and the second dated June 28, 2018. The first report found among other things, evidence that Rosslyn Retirement Residence failed to consult with the local medical officer of health to address health care issues in order to reduce the incidence of infectious disease outbreaks in the home, and failed to keep a written record of such consultation and recommendations. The second report revealed complaints about a bedbug outbreak that occurred in the home. The second report found that Rosslyn Retirement Residence had a bedbug outbreak, but failed to properly address any of the complaints of the bedbug outbreak.

14. In a report based on a routine inspection dated January 2, 2019, the RHRA found 4 instances of non-compliance with the *Retirement Homes Act, 2010*, citing among other things, that:

(a). They failed to ensure that the emergency plan provided for resources, supplies and equipment vital for the emergency response being set aside and readily available at the home and regularly test such resources, supplies and equipment;

(b). They failed to ensure that they consult on an ongoing basis and not less than once a year with the local medical officer of health about identifying and addressing health care issues in the retirement home in order to reduce the incidence of infectious disease outbreaks in the home; and

(c). They failed to ensure that staff who administer drugs or other substances prepare a written record noting the name and amount of the drug, the route of admission and date and time it was administered.

15. In the years leading up to the outbreak of COVID-19, Rosslyn Retirement Residence was regularly in non-compliance with their obligations under the *Retirement Homes Act, 2010*, including among other things: neglect; abuse; improper documentation; not providing the level of care required; not following protocol to reduce or prevent injury, the spread of infectious diseases, or pest infestation; and generally not observing the residents' rights to be treated with dignity and respect. Further, Rosslyn Retirement Residence consistently disregarded their obligations to consult with local medical officers of health to reduce incidences of infectious disease outbreaks in the home, or document any consultations or recommendations related to infection prevention and control.

Pandemic – Outbreak of COVID-19

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

17. 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.

18. 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.

19. 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]

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

(a). Have procedural masks, tissues and alcohol-based hand rub available to residents and staff;

(b). Review infection prevention and control and occupational health and safety policies and procedures;

(c). 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

(d). Have ongoing surveillance programs in place throughput the year, including both passive and active surveillance to quickly detect respiratory infections.

21. 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.

22. 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:

(a). 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;

(b). Posting signage and advising all visitors who are ill to postpone their visit;

(c). Ensuring availability and accessibility of hand hygiene throughout the facility;

(d). Keeping staff and residents informed on COVID-19;

(e). Reminding staff to be monitoring themselves for illness and to stay at home when they are sick;

(f). Developing policies for managing staff who may have been exposed to a case of COVID-19;

(g). Assessing incoming residents for respiratory symptoms and potential exposures to COVID-19;

(h). Monitoring residents for new respiratory symptoms or fever;

(i). Quickly identifying and isolating any resident with acute respiratory illness or fever;

(j). 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;

(k). Helping visitors with personal protective equipment if they are visiting residents under precautions; and,

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

23. 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.

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

25. On March 17, 2020, the Government declared a state of emergency, issuing an order under the *Emergency Management and Civil Protection Act,* R.S.O. 1990, c. E.9. 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.

26. 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.

27. 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.

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

29. On March 20, 2020, by an amendment to s.27(5) of Ont. Reg. 166/11 of the *Retirement Homes Act, 2010*, S.O. 2010, c.11, 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*, R.S.O. 1990, c. H7, 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

36. 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*.

37. Despite the emergency orders issued by the Government, and the directives from the Chief Medical Officer of Health, at no point did Rosslyn Retirement Residence restrict the movements of their residents. Rosslyn Retirement Residence permitted residents to enter the community and return to the home without undergoing a screening process to detect symptoms of COVID-19. Further, Rosslyn Retirement Residence did not have any restrictions on visitors visiting the home.

38. Up to the evacuation of the home, Rosslyn Retirement Residence on May 15, 2020, residents continued to have their meals in the dining room, with other potentially COVID-19 positive residents.

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

40. On May 15, 2020, Rosslyn Retirement Residence began evacuating its residents, with the majority of residents being transported to the hospital. On the same day, the Retirement Homes Regulatory Authority issued a compliance order under section 90 of the *Retirement Homes Act, 2010* to Rosslyn Retirement Residence. The Registrar found that they had contravened O. Reg 166/11 under the *Retirement Homes Act, 2010*, pertaining to infection prevention and control and failure to protect residents from neglect. Rosslyn Retirement Residence was ordered to take steps to rectify these contraventions and are not permitted to admit new residents to the home. Residents are also not permitted to return to the home. They were ordered to retain a regulated health

professional to manage the creation and implementation of policies, precautions and procedures to protect residents from exposure to COVID-19, as directed by the Chief Medical Officer of Health.

41. On June 15, 2020, the Registrar issued an order to revoke the licence for Rosslyn Retirement Residence effective immediately. This order was issued because Rosslyn Retirement Residence no longer demonstrated that it is competent to operate the home in a responsible manner in accordance with the *Retirement Homes Act, 2010* and its regulations; that their past conduct no longer affords the registrar that they will operate in accordance with the *Act* with honesty and integrity, in a manner not prejudicial to the health, safety and welfare of the residents; and they have contravened a requirement under the *Act*.

42. In the Final Inspection Report leading to the revocation order, the RHRA found that the staff lacked infection prevention and control training and not provided with adequate PPE. Staff were also required to supply their own PPE due to inadequate supplies at the home, and did not receive proper training on the use of PPE during the pandemic. A staff member at Rosslyn Retirement Residence was allowed to remain working during their shift, with close contact with residents, after exhibiting symptoms of COVID-19. This incident of the staff member working in the home while exhibiting symptoms of COVID-19 was not properly reported.

43. On June 15, 2020, news reports indicated that 14 residents had died at Rosslyn Retirement Residence from complications related to COVID-19. 64 out of the 66 residents

at Rosslyn Retirement Residence and 22 staff had tested positive for COVID-19. By June 22, 2020, it was confirmed that 15 of the residents have now died.

44. The particulars of the allegations of negligence, gross negligence, breach of contract and wrongful death against the Defendant, Rosslyn Retirement Inc., include but are not limited to the following:

(a). They failed to ensure that the residents and staff of Rosslyn Retirement Residence 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 Rosslyn Retirement Residence;

(c). They failed to institute reasonable measures to prevent COVID-19 from infecting residents of Rosslyn Retirement Residence, 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 Rosslyn Retirement Residence;

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

(f). They failed to have a clear lead for the quality of care amongst the leadership team of the Executive Director, Director of Nursing and Personal Care and Medical Director in the home;

(g). They breached their duty as a caregiver and fiduciary to the residents and staff of Rosslyn Retirement Residence;

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

(i). They failed to warn the residents and staff of Rosslyn Retirement Residence of the potential exposure to COVID-19 in a timely fashion;

(j). They failed to have appropriate training in infection prevention and control, including the proper use of PPE;

(k). They permitted staff members exhibiting symptoms of COVID-19 to continue to work in close proximity to residents;

(l). They failed to include performance metrics and supply of PPE in the Long-Term Care home performance reports;

(m). They failed to post their home performance reports in the home;

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

(o). 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 Rosslyn Retirement Residence;

(p). They failed to take all reasonable, necessary and protective measures to ensure that the residents and staff of Rosslyn Retirement Residence were safe while on the premises of Rosslyn Retirement Residence; and,

(q). Such further and other particulars which may become known to the Plaintiff or the residents or staff of Rosslyn Retirement Residence or their family members that will be proven at the trial of this action and are within the knowledge of the Defendant.

DAMAGES

45. 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 Defendant prior to the trial of this action.

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

47. 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, and 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

48. The Plaintiffs state that the Defendant failed to correct their behaviour, despite compliance orders from the RHRA. The Defendant ignored such compliance orders to the detriment of the residents of Rosslyn Retirement Home. A persistent lack of resources, staffing, and protocols and/or adherence to such protocols rendered the infiltration of COVID-19 into Rosslyn Retirement Home inevitable.

49. The Plaintiffs states that the Defendant 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.

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

51. The Defendant's actions were callous and arrogant and offend the ordinary community standards of moral and decent conduct. The actions and/or omissions of the

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

THE PLAINTIFFS' INDIVIDUAL CIRCUMSTANCES

52. The Plaintiff, Alexander Pietak, became a resident of the retirement home at Rosslyn Retirement Home in July 2017. As a resident, he was initially paying a monthly fee of approximately $2,200.00, which was increased to $2,300.00 in 2018, to Rosslyn Retirement Residence.

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

54. At no point did Rosslyn Retirement Residence have a policy on restricting visitors to the home, despite the advice to do so from the Chief Medical Officer of Health.

55. At no point did Rosslyn Retirement Residence restrict the movements of their residents, despite the advice to do so from the Chief Medical Officer of Health. Rosslyn Retirement Residence permitted residents to enter the community and return to the home without undergoing a screening process to detect symptoms of COVID-19.

56. During this period, Rosslyn Retirement Residence did not have any screening or testing when residents return to the residence. When Alexander's family expressed concern over the fact that there were no restrictions stopping residents from coming and going, potentially bringing COVID-19 into the home, they were advised by a manager at Rosslyn Retirement Residence that the management is not able to stop residents from leaving the premises.

57. Despite the directives of the Chief Medical Officer of Health and orders issued by the Government, Rosslyn Retirement Residence continued to have residents eat their meals in the dining room, as opposed to isolating the residents to prevent the spread of COVID-19.

58. On or around May 15, 2020, the Plaintiff, Alexander Pietak, discovered that he had tested positive for COVID-19. He was then evacuated from Rosslyn Retirement Residence to the hospital. On May 30, 2020, Alexander passed away in the hospital due to contracting COVID-19.

59. 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 Defendant prior to the trial of this action.

60. The Estate of the Plaintiff, Alexander Pietak, claims for damages for pain and suffering arising from contracting COVID-19.

61. The Plaintiff, Henry Pietak, is entitled to damages pursuant to s. 61 of the *Family Law Act*, including include pecuniary losses resulting from the death of the Plaintiff, Alexander Pietak, expenses incurred for his benefit, travel expenses incurred in visiting him during his 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 him had the aforesaid negligence and misconduct not occurred.

62. 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). *Emergency Management and Civil Protection Act,* R.S.O. 1990, c. E.9;

(d). *Family Law Act*, R.S.O. 1990, c. F.3;

(e). *Health Protection and Promotion Act*, R.S.O. 1990, c. H7;

(f). *Negligence Act*, R.S.O. 1990, c. N.1.I; and

(g). *Retirement Homes Act, 2010*, S.O. 2010, c. 11.

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

(Date of issue)

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PIETAK et al.
Plaintiffs

-and-

ROSSLYN RETIREMENT INC.
Defendant

Court File No.

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT
MILTON

STATEMENT OF CLAIM

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RCP-E 4C (May 1, 2016)