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Milton

Court File No./N° du dossier du greffe: CV-21-00000344-00CP

COURT FILE NO.

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

CINDY SAMULSKI, as litigation administrator for THE ESTATE OF DOROTHY RAMSDEN, deceased, and CINDY SAMULSKI, personally

Plaintiffs

-and-

THE WEXFORD RESIDENCE INC.

Defendant

Proceeding Under the *Class Proceeding Act, 1992*

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 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: **THE WEXFORD RESIDENCE INC.**
1860 Lawrence Avenue East
Scarborough, ON M1R 5B1

CLAIM

1. The Plaintiffs claim against the Defendant:

   a) Compensatory damages for negligence, gross negligence, breach of the *Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of the *Human Rights Code* and wrongful death against the Defendant 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, Dorothy Ramsden ("Dorothy"), is now the Estate of Dorothy Ramsden, as represented by her litigation administrator, Cindy Samulski. At all material times, Dorothy was a resident of the long-term care home, The Wexford Residence,

located at 1860 Lawrence Avenue East, in the City of Scarborough, in the Province of Ontario, until her death on January 4, 2021.

3. The Plaintiff, Cindy Samulski ("Cindy"), is an individual residing in the City of Uxbridge, in the Province of Ontario, and was the daughter of Dorothy.

4. The Defendant, The Wexford Residence Inc., is a corporate entity, carrying on business as a long-term care home licenced by the Ministry of Long-Term Care known as The Wexford Residence, located at 1860 Lawrence Avenue East, in the City of Scarborough in the Province of Ontario ("The Wexford"). At all material times, The Wexford Residence Inc. was the occupier of The Wexford, located at 1860 Lawrence Avenue East, within the meaning of the *Occupiers' Liability Act*, R.S.O. 1990, c. O.2.

5. At all material times, The Wexford owed a duty of care to the Resident Claimants and were responsible for the health, safety, security and welfare of the residents of The Wexford, including Dorothy. At all material times, the Defendant was responsible for the acts and/or omissions of its staff, servants, employees and /or agents.

THE CLASS

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

i. The Resident Claimants:

a) All persons who contracted the coronavirus ("COVID-19") at The Wexford;

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

c) All residents of The Wexford 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,

ii. The *FLA* Claimants:

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 The Wexford and Cross-Infected Persons.

7. The Plaintiff, Cindy Samulski, 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, NEGLIGENCE, GROSS NEGLIGENCE, BREACH OF THE *OCCUPIERS' LIABILITY ACT*, BREACH OF CONTRACT/WARRANTY, BREACH OF FIDUCIARY DUTY, BREACH OF THE *HUMAN RIGHTS CODE* AND WRONGFUL DEATH, AS AGAINST THE DEFENDANT, THE WEXFORD:

Background

8. The Wexford operates as a long-term care home, licenced by the Ministry of Long-Term Care. It has capacity for a total of 166 residents, who privately pay for their care.

9. Throughout 2018, 2019 and 2020, the Ministry of Long-Term Care received numerous complaints regarding inadequate care of the residents at The Wexford. As a result of the Ministry of Long-Term Care's inspection reports, Ministry of Long-Term Care issued the following non-compliances with the *Long-Term Care Homes Act, 2007*: 26 Written Notifications, 18 Voluntary Plans of Correction, and 3 Compliance Orders between August 2, 2018 to February 4, 2020.

10. On August 2, 2018, the Ministry of Long-Term Care issued an inspection report where there was an incident of sexual abuse between residents. There was video camera footage that showed a resident being inappropriately touched by a tenant while waiting for the elevator. The Ministry found that the Home failed with their requirement to protect their residents from sexual abuse.

11. On November 14, 2018, the Ministry of Long-Term Care published a Critical Incident System Inspection Report. There was an incident of a PSW scaring and intimidating a resident and their family after raising their voice, pointing the finger at the family members, and telling them that they had already provided a specific type of care to the resident earlier in the shift and did not need to do it again. As a result of this 4-day inspection, the Ministry issued 2 Written Notifications of Non-compliances. This inspection revealed the following:

a) They failed to ensure that the residents' right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity was fully respected and promoted; and

b) They failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

12. On February 11, 2019, the Ministry of Long-Term Care published an Inspection Report based off complaints related to fall prevention and pain management. There was a complaint of a resident falling and complaining of pain, but did not get an x-ray for 7 days. The x-ray eventually revealed resident had a significant injury. The Home also failed to assess the resident after requesting a change in their pain management program. As a result of this 11-day inspection, the following non-compliances were issued: 3 Written Notifications of Non-compliances; 1 Voluntary Plan of Correction; and 1 Compliance Order. This inspection revealed the following:

a) They failed to ensure that residents were free from neglect by the Home;

b) They failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose; and

c) They failed to have, institute, or otherwise put in place policies and comply with them as required to under the *Long-Term Care Homes Act, 2007*.

13. On July 25, 2019, the Ministry of Long-Term Care published an Inspection Report based off complaints related to neglect, medication management, nutrition and hydration and personal support services. A resident had to be hospitalized due to nutrition and hydration issues, after having a total daily intake of fluids below the minimum requirement on 11 of the 12 days prior to admission to the hospital. This resident's dietary restrictions

and medication admission programs were also not followed. As a result of this 7-day inspection, the following non-compliances were issued: 3 Written Notifications of Non-compliances; and 3 Voluntary Plan of Correction. This inspection revealed the following:

a) They failed to ensure that staff and others involved in different aspects of care of the resident collaborate with each other with their assessments;

b) They failed to ensure that the care set out in the plan of care for residents were provided to the resident as specified in the plan;

c) They failed to have, institute, or otherwise put in place policies and comply with them as required to under the *Long-Term Care Homes Act, 2007*; and

d) They failed to ensure that a drug was administered to the residents in accordance with the directions for use specified by the prescriber.

14. On October 9, 2019, the Ministry of Long-Term Care published a Critical Incident System Inspection Report. There were incidents of residents being injured while assisted with transfers, and of residents who require assistance with the toilet and shower unassisted. There was another incident of a resident not being transferred to a hospital for 5 hours despite constant complaints of pain. This resident subsequently died in the hospital because the staff did not inform the registered nurse on duty about the pain complaints. As a result of this 8-day inspection, the following non-compliances were issued: 6 Written Notifications of Non-compliances; 5 Voluntary Plan of Correction; and 1 Compliance Order. This inspection revealed the following:

a) They failed to use safe transferring techniques when assisting residents, causing injury;

b) They failed to ensure that the residents were fully respected and their right to participate in decision making promoted;

c) They failed to ensure that the staff involved in the care of residents collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and consistent;

d) They failed to have, institute, or otherwise put in place policies and comply with them as required to under the *Long-Term Care Homes Act, 2007*; and

e) They failed to ensure that no medical directive or order for the administration of a drug to residents is used unless it is individualized to the resident's condition and needs.

15. February 4, 2020, the Ministry of Long-Term Care published a Critical Incident System Inspection Report. There were incidents relating to improper transfer techniques and use of assistive devices. As a result of this 7-day inspection, the following non-compliances were issued: 3 Written Notifications of Non-compliances; and 2 Voluntary Plan of Correction. This inspection revealed the following:

a) They failed to ensure the care set out in the plan of care was provided to the residents as specified in the plan;

b) They failed to ensure that staff were using safe transferring techniques when assisting residents; and

c) They failed to ensure that the written report to the Director included long-term actions to prevent recurrence.

16. In the years leading up to the outbreak of COVID-19, The Wexford was regularly in non-compliance with their obligations under the *Long-Term Care Homes Act, 2007*, including among other things: neglect; abuse; not providing the level of care required; not following protocol to reduce or prevent injury; and generally not observing the residents' rights to be treated with dignity and respect.

Pandemic – Outbreak of COVID-19

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

18. 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.

19. 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.

20. 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]

21. 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.

22. 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.

23. 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.

24. 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.

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

26. 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.

27. 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.

28. 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.

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

30. On March 19, 2020, the Chief Medical Officer of Health issued a memorandum regarding Managing Health Worker Illness and Return to Work. In this memo, the Chief Medical Officer of Health recommended, among other things, the following:

a) That health care workers should not attend work if they are sick;

b) That each workplace has a comprehensive strategy for screening and symptom monitoring where there are inpatients or residential or institutional settings and tailor their approach to screening to their unique setting. Screening should be focused on residents, volunteers, visitors and staff throughout the day, and should be done over the phone, upon arrival, at entrances and on a regular basis throughout the day. The goal of the screening is to ensure that no person with clinical symptoms consistent with COVID-19, whether they are visitors, caregivers, or staff, enter the building; and

c) That the health sector coordinate to arrange for staff to only work in one institution.

31. 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 Officer of Health respecting COVID-19. 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.

32. 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.

33. 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 locations that employees are working.

34. 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.

35. 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.

36. 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.

37. 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.

38. 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*.

39. On or around March 30, 2020, the Chief Medical Officer of health issued a Directive under the *Long-Term Care Homes Act, 2007*, requiring long-term care homes to immediately implement active screening of all staff, essential visitors and anyone else entering the home for COVID-19. In addition, the Directive requires that long-term care homes must conduct active screening of all residents, at least twice a day, to identify if any resident has fever, cough or other symptoms of COVID-19. Residents with symptoms must be isolated and tested for COVID-19.

40. On April 8, 2020, the Chief Medical Officer of Health issued an updated directive for long-term care homes to immediately implement that: long-term care homes were closed to visitors, except essential visitors, who must be screened; all staff and essential visitors to long-term care homes to wear surgical masks at all times for the duration of full

shifts or visits; the residents were not permitted to leave the property; to screen staff, visitors and residents at least twice a day for COVID-19; and the home inform residents and family members of any updates regarding COVID-19 in the home.

41. In this directive, the Chief Medical Officer of Health has directed instructions on an outbreak assessment for long-term care homes. If a single resident was tested positive, that resident must be isolated in a single room, with the home undertaking appropriate contact and droplet precautions. Once at least one resident or staff has presented with new symptoms compatible with COVID-19, the long-term care home should immediately trigger an outbreak assessment and take the following steps:

a) Place the symptomatic resident under contact/droplet precautions;

b) Test the symptomatic resident immediately;

c) Contact the local public health unit to notify them of the suspect outbreak;

d) Test those residents who were in close contact (i.e. shared room) with the symptomatic resident and anyone else deemed high risk by the local public health unit;

e) Prepare for cohorting practices to limit the potential spread of COVID-19; and

f) Enforce enhanced screening measures among residents and staff.

42. A guidance to screening was provided by the Ministry of Health on April 15, 2020. Long-term care homes must conduct active screening for COVID-19 symptoms of all staff, essential visitors, and anyone else entering the home. Screening must include twice daily symptom screening. They should screen new admissions and re-admissions for symptoms and potential exposure to COVID-19. All new residents must be placed in

isolation under contact and droplet precautions upon admission to the home and test within 14 days of admission.

43. On or around April 16, 2020, an Emergency Order titled “Limiting Work to a Single Long-Term Care Home” was passed under section 7.0.2(4) of the *Emergency Management and Civil Protection Act.* this Order limited employees of long-term care homes from working at more than one long-term care home as of April 22, 2020.

44. On or around April 21, 2020, the Ministry of Health recommended that a plan be immediately developed to test every resident and staff at each long-term care home for COVID-19.

45. On or around April 24, 2020, the Minister of Long-Term Care issued a directive requiring all long-term care homes in outbreak to cooperate with Ontario Health and to provide access for any resources being made available from the provincial or federal government. A COVID-19 “outbreak” at a long-term care home is defined by the Ministry of Health as one laboratory confirmed case of COVID-19 in a resident or staff member at the long-term care home.

46. On May 29, 2020, the Ministry of Health, Office of the Deputy Minister wrote a memorandum regarding an update on COVID-19 preparations and actions. It states that the key actions and preparations to respond to COVID-19 with continue to focus on deploying rapid supports, including testing in the homes and exploring visitor policies to reconnect residents while ensuring safety.

47. On or around June 10, 2020, Ontario's Chief Medical officer of Health issued a Directive prohibiting incoming residents at long-term care homes to be placed in a room with more than one other resident.

48. On July 30, 2020, the Ontario Long-Term Care COVID-19 Commission was formed, with Associate Chief Justice Frank Marrocco as commission chair, and Angela Coke and Dr. Jack Kitts as commissioners. Their goal was to investigate how and why COVID-19 has spread in long-term care homes, as the health care system prepares for a possible second wave of COVID-19 infection rates.

49. On October 8, 2020, the Chief Medical Officer of Health issued a directive for long-term care homes in Ontario to implement the following procedures: they must provide all regulated health professionals and other health care workers with information on the safe utilization of all personal protective equipment ("PPE") and all regulated health professionals and other health care workers must be trained to safely wear the PPE; they must assess their available supply of PPE on an ongoing basis; the employer will be responsible for PPE supply levels; a point-of-care risk assessment must be performed by every regulated health professional before every patient or resident interaction; droplet and contact precautions must be used for all interactions with suspected, probable or confirmed COVID-19 patients or residents; and staff at long-term care homes must wear surgical masks at all times for source control for the duration of full shifts, regardless of whether the home is in an outbreak or not.

50. On October 21, 2020, the Ontario Long-Term Care COVID-19 Commission released their first interim recommendations. They recommended the increased supply

of PSWs, ensuring that long-term care homes have the appropriate staff; permanent investment to develop and implement a human resources strategy to increase permanent nurses and support staff; to continue to facilitate calls from family members of residents; collaboration between long-term care homes and hospitals; and that the Ministry of Long-Term Care should work with the Ministry of Health to formalize a relationship between the services at local hospitals and the long-term care homes.

51. The Commission also recommended that every long-term care home has a dedicated Infection Prevention and Control lead who can monitor and ensure compliance with proper protocols, and provide basic training to all staff; to enhance the ministry resources to provide compliance support; to provide high priority access to testing and quick turnaround for results of residents and staff; and residents who are COVID-19 positive should be transferred to alternate settings to avoid further transmission of the virus and to help them recover.

52. On December 4, 2020, the Commission released their second interim recommendations. The report recommended that until the pandemic is over, to require a clear lead for the quality of care in each home; to include performance indicators of the home and post these performance metrics in their performance reports; that the Ministry of Long-Term Health reintroduce the annual resident quality inspections for all long-term care homes; and improve enforcement by prioritizing timely responses to non-compliance with Infection Prevention and Control and Plan of Care orders.

53. On December 7, 2020, the Chief Medical Officer of Health issued another directive to the Ministry of Long-Term Health. This directive requires active screening, including

temperature and symptom check of all staff, visitors, and residents, twice a day. It required a proper protocol for the return to the home from the hospital or the community, which included 14-day isolation. It also includes steps on how to react to a single case of COVID-19 in a resident. Under the circumstances, the resident must be in isolation under Droplet and Contract Precautions, in a single room.

54. In addition to the above, further directives, orders and recommendations have been issued, and continue to be issued, by the Ministry of Health, the Ministry of Long-Term Care, the Chief Medical Officer of Health, and the Province of Ontario.

55. Pursuant to the *Long-Term Care Homes Act, 2007*, the Minister of Health may issue operational or policy directives respecting long-term care homes, and that these directives are binding on all licencees under the Act, including The Wexford. Despite this, The Wexford did not provide an adequate PPE; infected residents were not isolated; the dining room and common areas were open; staff were going from one room to another without changing PPE; staff worked on multiple floors with the home; and staff did not properly wear PPE around both their mouth and nose.

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

57. As of January 19, 2021, there were 26 current confirmed COVID-19 cases in residents, and 17 current confirmed COVID-19 cases in staff at The Wexford. To date, 7 residents have died of COVID-19 at The Wexford.

58. The particulars of the allegations of negligence, gross negligence, breach of the *Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of the *Human Rights Code* and wrongful death against the Defendant, The Wexford Residence Inc., include but are not limited to the following:

i. Allegations of negligence, gross negligence, and breach of *Occupier's Liability Act*:

59. The Plaintiffs plead that the particulars of the Defendant's negligence, gross negligence, and breach of the *Occupiers' Liability Act*, including those of their agents, servants, employees and contractors for who they are in law responsible, include, but are not limited to, the following:

a) They failed to ensure that the residents and staff of The Wexford 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 The Wexford, as required under the *Long-Term Care Homes Act, 2007*;

c) They failed to institute effective measures to prevent COVID-19 from infecting residents of The Wexford, such as undertaking proper screening of visitors and practicing social distancing;

d) They failed to implement a proper infection prevention and control program at The Wexford, or at all, contrary to the *Long-Term Care Homes Act, 2007*;

e) They failed to follow acceptable practices regarding the prevention and containment of contagious respiratory illnesses, such as COVID-19;

f) They failed to practice at least 2 metres of social distancing;

g) They failed to take the necessary steps for ongoing screening, self-isolation and self-monitoring;

h) They failed to stop staff from working between multiple locations;

i) They failed to have an adequate number of staff during each shift;

j) They failed to have adequate staffing plans in place in the event of an outbreak;

k) They failed to implement adequate sanitary measures to mitigate the risk of spreading COVID-19 between the staff and the residents of The Wexford, when they knew or ought to have known that adequate sanitary measures were necessary to prevent the spread of COVID-19 at The Wexford;

l) 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 The Wexford;

m) They failed to ensure that all staff participated in the implementation of the infection prevention and control program at The Wexford, including their policies and guidelines, contrary to the *Long-Term Care Homes Act, 2007*, and its Regulations;

n) They failed to hire sufficient or adequate staff to ensure the proper supervision of the residents of The Wexford, and to prevent and/or control situations of danger, including the outbreak of COVID-19 at The Wexford;

o) They failed to adequately equip their employees, residents, and essential visitors to The Wexford with personal protective equipment in a timely manner, when they knew or ought to have known that proper PPE was necessary to prevent the spread of COVID-19 at The Wexford;

p) They failed to adequately train staff on the safe way to wear PPE;

q) They failed to warn the residents and staff of The Wexford of the potential exposure to COVID-19 in a timely fashion;

r) They failed to provide updates regarding COVID-19 in the home to the residents and family members in an effective and timely manner;

s) 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 The Wexford;

t) They permitted essential visitors and staff infected with COVID-19 to enter The Wexford, when they knew or ought to have known those essential visitors and staff could infect the residents of The Wexford;

u) They failed to implement proper COVID-19 testing measures at The Wexford for staff and residents, contrary to public health orders, guidance and directives;

v) They failed to identify that Resident Claimants were infected with COVID-19 within a reasonable time;

w) They failed to properly treat Resident Claimants once they became infected with COVID-19;

x) They failed to take proper care in the circumstances;

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

z) They failed to take all necessary and protective measures to ensure that the residents and staff of The Wexford were safe while on the premises of The Wexford;

aa) They failed to make safety upgrades to The Wexford building, which contributed to the spread of COVID-19 at The Wexford;

bb) They failed to ensure The Wexford building met the required design standards for long-term care homes contrary to the *Long-Term Care Home Design Manual, 2015*;

cc) They failed to communicate with families of residents at The Wexford, regarding presumptive positive cases of COVID-19 and the protocols implemented in response;

dd) They failed to communicate with families of residents at The Wexford, when their family member began showing symptoms of COVID-19 or has tested positive with COVID-19, and provide updates on their condition;

ee) They failed to operate The Wexford in a manner so that its residents could live there with dignity and in security, safety and comfort, contrary to the Resident Bill of Rights in the *Long-Term Care Homes Act, 2007*, its Regulations and the Ministry of Health and Long-Term Care;

ff) They failed to ensure the care plan was updated to accurately reflect changes in Resident Claimants' needs;

gg) They failed to perform regular assessments to ensure that any changes in Resident Claimants' conditions were observed, recorded and reported to other staff and/or the physician in charge of care;

hh) They failed to ensure that Resident Claimants received the care required, and the care as set out in their care plans;

ii) They failed to take reasonable care to properly monitor, supervise, and ensure the safety of the Resident Claimants;

jj) They failed to ensure that residents exhibiting skin integrity were properly assessed, or at all, and/or received immediate treatment and appropriate interventions;

kk) They failed to ensure a skin and wound care program was properly developed and/or implemented;

ll) They failed to ensure that The Wexford had adequate supplied for the proper treatment and care of the Resident Claimants;

mm) They failed to ensure that residents at The Wexford were properly bathed, fed, and hydrated, in accordance with the *Long-Term Care Homes Act, 2007*;

nn) They failed to ensure that medications and/or other treatment were properly administered, or at all, to the Resident Claimants;

oo) They failed to ensure a falls management and prevention program was properly developed and/or implemented;

pp) They failed to ensure a continence care and bowel management program was properly developed and/or implemented;

qq) They failed to employ, supervise, train and instruct their agents, servants and/or employees to ensure that Resident Claimants would not sustain injuries while at the home, and are reasonably safe;

rr) They failed to enforce a code of conduct at The Wexford to ensure their agents, servants and/or employees acted in full compliance with said code of conduct in the interactions and care of residents;

ss) They failed to ensure that their agents, servants and/or employees were duly qualified and accredited in accordance with the qualifications specified for their positions at The Wexford;

tt) They failed to promulgate suitable policies for the prevention of injuries at The Wexford;

uu) They failed to rectify the various deficiencies and infractions that have been previously identified by the Ministry of health and Long-Term Care;

vv) They fell below the reasonable standard of care required in the circumstances in their treatment, care and supervision of the Resident Claimants, including Dorothy; and

ww) Such further and other particulars which may become known to the Plaintiffs or the residents or staff of The Wexford or their family members that will be proven at the trial of this action and are within the knowledge of the Defendant.

60. The Plaintiffs plead that the Defendants had ample time prior to the outbreak to implement an adequate infection prevention and response plan at The Wexford. Despite having knowledge of COVID-19 outbreaks at long-term care homes in Ontario and the associated issues with staffing levels and access to PPE, the Defendant failed to make a good faith effort to properly, or at all, implement the public health orders, guidance and directives to prevent the spread of COVID-19 and/or other illness and death at The Wexford.

61. The Defendant failed to ensure there were adequate staffing levels and amounts of PPE at The Wexford, despite knowing this was necessary to prevent the mass spread of COVID-19. In addition, the Defendant knew, or ought to have known, that adequate staffing levels were necessary to ensure that the Resident Claimants received necessary care, assessments and treatment at The Wexford. As a result of staffing shortages, the Resident Claimants suffered injuries, illness, and/or death.

62. The Plaintiffs claim that the Defendant failed to upgrade and/or modify and/or renovate the building design of The Wexford, when they knew or ought to have known that these homes had a C-level bed design, which did not meet the current design standards as set out in the *Manual* effective April 1, 1998.

63. The Plaintiffs claim that the Defendant's failure to upgrade and/or modify and/or renovate the building design of the C-level home caused and/or contributed to the mass spread of COVID-19 at The Wexford and caused the Resident Claimants suffer serious and permanent personal injuries and damages, including death.

64. The Defendants failed to act or make a good faith and/or honest effort to act, in accordance with public guidance relating to COVID-19, including advice, recommendations, directives, guidance or instructions given or made in respect of public health and any federal, provincial or municipal law relating to COVID-19.

ii. Breach of Contract/warranty

65. The Resident Claimants pay for their residency, care and treatment from The Wexford. In exchange for payment, The Wexford contracted that they would and could provide and arrange for: competent, careful and skillful care and treatment; safe facilities; resources; and equipment necessary. Pursuant to the *Consumer Protection Act*, this consumer agreement has an implied warranty on the services contracted for.

66. The Wexford are in breach of contract, as they failed to provide the level of care contracted for by the Resident Class, including Dorothy.

iii. Breach of Fiduciary Duty

67. The Plaintiff, Dorothy, claims that her relationship with the Defendant and/or their servants, agents and/or employees was a relationship of utmost trust and confidence. The Resident Claimants are especially vulnerable persons, suffering from pre-existing physical, cognitive and/or psychological impairments and illnesses. Furthermore, their

status as elderly persons with pre-existing illnesses also made them especially vulnerable to contracting COVID-19 and/or other illness and suffering complications, including death.

68. The Resident Claimants, including Dorothy, were exclusively reliant on the Defendant and/or their servants, agents and/or employees to provide them with necessary care, treatment, assistance and other needs. For example, some Resident Claimants were immobile and dependent on the Defendant to transfer, bathe and change them. Other Resident Claimants were non-verbal and were unable to communicate their helplessness and their needs.

69. The Defendant had an obligation to ensure that the Resident Claimants, including Dorothy, received safe and competent care. They were dependent on the Defendant to determine the best options for their care and treatment of a day-to-day basis. The Resident Claimants, including Dorothy, were dependent on the Defendant to provide them with a safe and protected environment and keep them safe from infection, injury, and neglect.

70. The Defendant had a wide discretion in relation to the type of treatment given, if at all, to the Resident Claimants, including Dorothy. This discretion included what type of treatment to provide, and when/whether to transfer to a hospital. The Defendant held broad discretionary powers that could affect the residents' health, safety, mental state and other interests.

71. Following restrictions on who could enter The Wexford due to COVID-19, the Resident Claimants became even more dependent on the Defendant. Family members, friends and outside caregivers were limited in their ability to enter The Wexford to ensure

the Resident Claimants were receiving adequate care, treatment and protection from the Defendant. Further, the Resident Claimants were unable to leave The Wexford, and were unable to communicate with their family members or friends for long periods of time. The Resident Claimants were even more vulnerable and reliant than ever on the Defendant during this period.

72. The Wexford was in a position of power *vis-a-vis* the residents, who have entrusted The Wexford with their care. This creates an *ad hoc* fiduciary duty owed by The Wexford to their residents. The fiduciary duty owed to the Resident Claimants by The Wexford is also grounded in obligations under the Residents' Bill of Rights to promote and respect the rights of the residents, under the *Long-Term Care Homes Act, 2007*.

iv. Breach of the *Human Rights Code*:

73. The Resident Claimants, including Dorothy, have a right to equal treatment under the *Human Rights Code*, R.S.O. 1990, c. H.19 with respect to the provision of services, goods and facilities and to occupancy of accommodation, without discrimination because of age and/or disability.

74. The Plaintiffs claim that the Defendant did not provide the same level of services, goods, facilities and accommodation to the Resident Claimants because of their age and/or disability, thereby infringing their rights under Part 1 of the *Human Rights Code*.

75. Elderly and disabled persons have the right to the same level and quality of services as everyone else. By failing to ensure there were adequate resources, protocols and staffing, especially adequately trained staff, The Wexford did not treat the Resident

Claimants equally. The Defendant provided a sub-standard level of care and services to the Resident Claimants because they were elderly persons.

76. Furthermore, those Resident Claimants with physical and/or cognitive disabilities were not provided with an equal level of services at The Wexford, because of their disability. For example, physically and cognitively disabled Resident Claimants were not transferred, bathed or changed for weeks because of their disability and they were neglected by the Defendant and/or their servants, agents and/or employees. The Defendant and/or their servants, agents and/or employees did not treat the Resident Claimants with respect or dignity.

77. The Defendant and/or their servants, agents and/or employees violated the Resident Claimants' rights to be free from discrimination on the basis of age and/or disability in their occupancy of accommodation and their receipt of services.

DAMAGES

78. The Plaintiffs claim general and special damages resulting from negligence, gross negligence, breach of *Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of *Human Rights Code* and wrongful death.

i. Resident Claimants' Damages:

79. As a result of the Defendant's negligence, gross negligence, breach of *Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of *Human Rights Code* and wrongful death, the Resident Claimants, including Dorothy, suffered general damages including, but not limited to, the following:

a) Pain and suffering, loss of enjoyment of life, physical and emotional losses;

b) Permanent and disabling impairments of their health and capacity to function;

c) On-going health issues and the risk of further medical complications; and

d) Injury to dignity, feelings and self-respect.

80. As a further result of the Defendant's conduct, the Resident Claimants, including Dorothy, suffered special damages including, but not limited to, the following:

a) Extended hospitalization and past, on-going future care costs including the cost of on-going treatment and medical monitoring arising from the unknown long-term impacts of COVID-19;

b) Past and future attendant care costs;

c) Past and future housekeeping and home maintenance costs;

d) Out-of-pocket expenses; and

e) Funeral expenses.

81. The Resident Claimants further state that they are entitled to a full return of all monies paid to the Defendant from March 11, 2020 onwards, as a result of the breach of contract/warranty.

82. The damages set out above are claimed on an aggregate basis if and where deemed appropriate by this Honourable Court.

ii. *FLA* Claimants' Damages:

83. As a result of the Defendant's negligence, gross negligence, *breach of Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of *Human Rights Code* and wrongful death, the *FLA* Claimants, including Cindy, have been deprived of the benefits of the comfort, care, support, guidance and companionship normally provided by the Resident Claimants. The *FLA* Claimants claim general damages for their loss of past and future comfort, care, support, guidance and companionship that they reasonably expected to receive from the Resident Claimants, pursuant to the provisions of the *Family Law Act.*

84. As a further result of the Defendant's conduct, the *FLA* Claimants, including Cindy, have incurred special damages, including lost income and out-of-pocket expenses to, and for, the benefit of the Resident Claimants, including care and services provided to the Resident Claimants while they were in hospital and any funeral expenses. The *FLA* Claimants claim damages for these losses pursuant to the provisions of the *Family Law Act.*

85. The *FLA* Claimants further plead that they were deprived of the ability to properly say goodbye to the deceased Resident Claimants prior to their death and as a result have suffered mental anguish and a significant decrease in their enjoyment of life. The *FLA* Claimants claim damages for these losses.

86. The *FLA* Claimants further plead that the deceased Resident Claimants were integral members of the *FLA* claimants' close knit families and their untimely deaths have resulted in a significant decrease in their enjoyment of life, sense of happiness and

cohesiveness of family, and their loss has been deeply felt by these family members. The *FLA* Claimants claim damages for these losses, the full particulars of which will be provided prior to the trial of this action.

87. The damages as asset out above are claimed on an aggregate basis if and where deemed appropriate by this Honourable Court.

iii. OHIP's Subrogated Claim:

88. Some of the expenses related to the medical treatment and medical monitoring that the Resident Claimants have undergone, and will continue to undergo, have been borne by the provincial health insurer, the Ontario Health Insurance Plan ("OHIP"). As a result of the Defendant's negligence, gross negligence, *breach of Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of *Human Rights Code* and wrongful death, OHIP has suffered and will continue to suffer damages, which are claimed in this action pursuant to the *Health Insurance Act*, R.S.O. 1990, c. H.6.

iv. Punitive, Aggravated and/or Exemplary Damages:

89. The Plaintiffs state that the Defendant failed to correct their behaviour, despite findings of non-compliance by the Ministry of Long-Term Care. The Defendant ignored the Ministry's Inspection Reports to the detriment of the residents of The Wexford, even after the initial outbreak of the COVID-19 pandemic. A persistent lack of resources, staffing, and protocols and/or adherence to such protocols rendered the infiltration of COVID-19 into The Wexford inevitable.

90. The Plaintiffs plead that the Defendant behaved in a reprehensible and unconscionable manner by failing to implement an adequate COVID-19 response plan and failing to protect the health, safety, well-being and dignity of the Resident Claimants, which resulted in serious injury, illness and death to the Plaintiffs and the Class.

91. The Defendant was aware that the Resident Claimants, including Dorothy, were vulnerable individuals and especially vulnerable to serious and/or fatal complications arising from contracting COVID-19. Further, the Defendant was aware that the Resident Claimants were dependent on the Defendant for proper care, treatment and protection, especially from contracting COVID-19 when they were not able to have direct contact with outsiders.

92. The Plaintiffs state 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.

93. 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.

94. The punitive, aggravated and/or exemplary damages as set out above are claimed on an aggregate basis if and where deemed appropriate by this Honourable Court.

THE PLAINTIFFS' INDIVIDUAL CIRCUMSTANCES

95. The Plaintiff, Dorothy Ramsden, became a resident of the long-term care home at The Wexford, in October 2015. As a resident, Dorothy had her own room. She was paying approximately $2,400.00 per month for her residency.

96. Dorothy was a particularly vulnerable person, as she was blind and had mobility issues. She required the use of a stand-sit lift when transferring, and the use of a walker when ambulating. During Dorothy's time at The Wexford, Cindy or her sister visited Dorothy for dinner almost every single day.

97. In early March 2020, Dorothy's health declined, to the point where she needed assistance with transfers, eating, and toileting. She was now restricted to a wheelchair.

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

99. In the months following March 11, 2020, The Wexford was severely understaffed. They were so understaffed that Cindy was told by the Director of Care at The Wexford that they did not have the staff or the time to feed her mother. As a result of the understaffing of The Wexford, Dorothy was neglected.

100. In June 2020, Dorothy was no longer toileted, following a skin tear that occurred during a rough transfer by staff. Dorothy was now required to toilet in a diaper. The changing of her diaper was commonly neglected by the nurses at the home. Dorothy was no longer showered. When Cindy was finally allowed to visit her mother again in September 2020, Dorothy said in passing she had not been showered since June 2020.

As a result of this neglect, Dorothy suffered intense urinary tract infections during the summer of 2020, causing sepsis. She also suffered from a fungal infection and diaper rashes.

101. There was another incident during the summer of 2020, where one of the staff took Dorothy's dentures, and mixed them up with another resident's dentures. The staff then tried to force the other resident's dentures into Dorothy's mouth, despite the dentures not fitting.

102. Upon discovering these two incidents involving Dorothy, Cindy filed complaints against the Home. She wrote and called the Home so often that they cut Cindy off of the email list for updates on COVID-19 in The Wexford. Despite the requirement for The Wexford to advise the families of the residents of any COVID-19 updates in the Home, The Wexford went out of their way to deny updates to Cindy. They also stopped reporting the number of residents infected in the Home, despite direct instructions to do so by the Ministry of Health.

103. Cindy continued to visit Dorothy in the Home from September to December 2020. Cindy noticed that the Home only provided nurses and staff with one level-1 mask per shift. She saw that the nurses and staff did not change their PPE between seeing COVID-19 positive residents and COVID-19 negative residents. Nurses and staff often wore their masks underneath their nose, diminishing the PPE's effectiveness. Nurses and staff also worked at multiple floors at the home.

104. At no point did The Wexford restrict the movements of their residents, despite the advice to do so from the Chief Medical Officer of Health. The Wexford kept its dining room

and common room open, allowing possibly infected residents to sit closely to other, un-infected residents, until December 2020.

105. On December 17, 2020, when Cindy was visiting Dorothy, Cindy noticed that Dorothy looked severely dehydrated. Dorothy had not been given anything to drink since the previous day. No one at the Home noticed her symptoms. Due to the neglect of the Home, Dorothy was not provided water for over a day. Dorothy and other residents were regularly neglected by her care givers while COVID-19 ran through the Home.

106. On December 18, 2020, Dorothy tested positive for COVID-19. Despite just testing positive, and having very good vitals, The Wexford was recommending they not treat Dorothy and just keep her comfortable. This was unacceptable to Cindy, and she required they send Dorothy to the hospital. On December 19, 2020, she was transferred to Scarborough General Hospital. At the emergency room, she was provided with steroids and oxygen, and put on an IV. She remained under the care of Scarborough General Hospital until her death on January 4, 2021.

107. By December 18, 2020, 25 out of the 28 residents on Dorothy's floor were positive for COVID-19. It was not until December 18, 2020 that The Wexford started to separate COVID-19 positive residents from non-infected residents, despite the advice to do so from the Chief Medical Officer of Health.

108. The Plaintiffs claim general and special damages resulting from negligence, gross negligence, breach of *Occupiers' Liability Act*, breach of contract/warranty, breach of fiduciary duty, breach of the *Human Rights Code*, and wrongful death. The full particulars of which the Plaintiffs undertake to provide to the Defendant prior to the trial of this action.

109. The Estate of the Plaintiff, Dorothy Ramsden, claims for damages for pain and suffering arising from contracting COVID-19.

110. The Plaintiff, Cindy Samulski, is entitled to damages pursuant to s. 61 of the *Family Law Act*, including pecuniary losses resulting from the death of the Plaintiff, Dorothy Ramsden, 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 her, an amount to compensate for the loss of guidance, care and companionship reasonably expected to be received from her had the aforesaid negligence, gross negligence, and misconduct not occurred.

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

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

b) *Consumer Protection Act, 2002*, S.O. 2002, c. 30;

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

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

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

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

g) *Health Insurance Act,* R.S.O. 1990, c. H.6;

h) *Human Rights Code,* R.S.O. 1990, c. H.19;

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

j) *Occupiers' Liability Act*, R.S.O. 1990, c. O.2;

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

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

112. 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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Court File No.

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT
MILTON

STATEMENT OF CLAIM

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