

# **COVID-19 and Long-Term Care Home Regulations in Canada**

## **Comparing Ontario and British Columbia**

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## **Abstract**

This paper will explore the role of regulatory standards in LTC to try and understand why the COVID-19 virus had such devastating effects within Canada. Specifically, Ontario and British Columbia will be used as two case studies to answer the following three-part research question: What, if any, are the long-term care (LTC) regulatory differences between Ontario and British Columbia? If there are differences, 1) do these regulatory differences help explain the differentiating COVID-19 outcomes in LTC facilities within each province? And 2) do they help explain the relationship between COVID-19 in LTC facilities and ownership status within Ontario and British Columbia? The paper will first explore LTC broadly in Canada, including an overview of COVID-19 within the country. Next, the paper will provide a brief history of LTC and current regulations and enforcement within Ontario and British Columbia. Third, the paper provides an overview of COVID-19 outcomes within LTC throughout the various waves of the pandemic. These sections also include a brief discussion on pre-pandemic emergency preparedness and personal protective equipment (PPE) shortages within each province. The analysis section will then compare the research gathered within each section and point to the differences seen when comparing the two jurisdictions. The paper concludes by using the analysis findings to answer the research question and introducing new avenues of exploration for future research.

## **Preamble**

*“To the world you may be one person; but to one person you may be the world”*

*Dr. Seuss*

I want to dedicate this paper to the lives lost throughout and affected by this pandemic. The last year and a half since the pandemic began has been a frenzy of ever-changing public health regulations, conflicting news articles, and confusion. Canadians are anxious, restless, and most of all exhausted by the effects of the COVID-19 pandemic. While we are finally reaching what hopefully seems to be the end of widespread cases in Canada, the journey to this point was anything but simple. Every day, we watched the news and waited for the number of new cases and deaths to go down – and when they increased, we would turn off the daily briefing update from our government and continue with our day-to-day, new-normal pandemic schedule. This static cycle was not, and is not, true for all Canadians. Many Canadians now go through the motions of their “new-normal” schedule while also mourning the loss of loved ones. This reality is also true for LTC residents who thankfully did not pass away from COVID-19; while the virus did not directly impact them, many patients' conditions deteriorated throughout the pandemic. The prolonged isolation from loved ones and confusion over current events had patients whose mental and physical health were already deteriorating worsen beyond initial expectations.

While the number of deaths in Canada is lower than in other countries, it does not change the fact that many Canadians have lost their lives to COVID-19. Unfortunately, many of those who died over the last year and a half due to the coronavirus were long-term care residents. The pre-existing holes latent in the long-term sector became

exasperated throughout the pandemic, and many people lost their lives due to this oversight across all jurisdictions. People prematurely lost loved ones because they fell victim to potentially avoidable COVID-19 outbreaks within their LTC facilities. Essential caregivers currently live in permanent anxiety over the care that their parents, grandparents, and/or partners are receiving behind closed doors, with little to no control over the situation. Many residents have dementia and other pathologies that affect memory, which has led to permanent confusion and fear regarding their situation.

LTC residents are first and foremost people. They are parents, grandparents, partners, brothers, sisters, friends and colleagues – but most of all, they are autonomous, dignified people. We have become desensitized to the number of deaths displayed on our daily COVID-19 case dashboard because we are fixated on seeing the numbers trend down. Unfortunately, people in LTC homes will eventually succumb to conditions or diseases that come with older age, a phenomenon we will all go through one day. People residing within LTC facilities continue to be defined by their status and the disease/condition that affects them, rather than the full lives they lived not too long ago and their impact on others. People who succumbed to the COVID-19 virus deserved more than a death behind closed doors with no loved ones around them. As we near what hopefully appears to be the end of this pandemic, I hope that we as a country can learn from our mistakes and treat people with the respect and dignity they have earned throughout their lifetime as cherished loved ones and productive members of society. Elderly people and their loved ones deserve more than to be put at excessive risk and marginalized while they are at their most vulnerable.

## **Introduction**

The COVID-19 pandemic, which began in early 2020, has had devastating effects on micro and macro levels across the globe. Canada, like other countries around the world, was impacted by the virus. However, the virus affected some sectors more than others. Specifically, in Canada, the Long-Term Care (LTC) sector was heavily impacted by COVID-19. The pandemic uncovered existing gaps within the Canadian LTC sector that now requires urgent attention. Now that Canada is cautiously approaching what appears to be the end of the pandemic, both federal and provincial/territorial governments are trying to prevent the same catastrophe from occurring again. While various reports and articles have been published throughout the pandemic on the topic, few have mentioned the regulatory standards of LTC within provinces and territories.

This paper will explore the role of regulatory standards in LTC to try and understand why the COVID-19 virus had such devastating effects within the country. Specifically, Ontario (ON) and British Columbia (BC) will be used as two case studies to answer the following three-part research question:

**Part 1:** What, if any, are the long-term care (LTC) regulatory differences between Ontario and British Columbia?

**Parts 2 and 3:** If there are differences, 1) do these regulatory differences help explain the differentiating COVID-19 outcomes in LTC facilities within each province? And 2) do they help explain the relationship between COVID-19 in LTC facilities and ownership status within Ontario and British Columbia?

The purpose of this research question is to explore how regulatory standards may (or may not) have played a role in the COVID-19 outcomes within LTC in Ontario and

British Columbia. The research question will also examine whether or not regulations and enforcement can also explain the link between COVID-19 outcomes and LTC facility ownership, a common variable discussed and researched throughout the pandemic.

The paper will first explore LTC broadly in Canada, including an overview of COVID-19 within the country. Next, the paper will provide a history of LTC and current regulations and enforcement within Ontario and British Columbia. The purpose of the history is to understand how historical governmental decisions gave rise to current regulations and enforcement within each jurisdiction and explore potential linkages between regulations and LTC ownership. Third, the paper provides an overview of COVID-19 outcomes within LTC throughout the various waves of the pandemic. These sections also include a brief discussion on pre-pandemic emergency preparedness and personal protective equipment (PPE) shortages within each province. Both factors provide insight into each jurisdictions' preparedness status before the onset of the pandemic. It is important to note that the data utilized within this paper to illustrate the current context of COVID-19 in Canada, Ontario and BC are all dated between late June and July 2021 (the tail end of the third wave). The analysis section will then compare the research gathered within each section and point to the differences seen when comparing the two jurisdictions. The paper concludes by using the analysis findings to answer the research question and introducing new avenues of exploration for future research.

## **Methods**

This paper is structured around a case study analysis to answer the above research question. Specifically, the paper utilizes a most-similar case study design to determine first, whether there are regulatory differences in the LTC sector between BC

and Ontario and second, whether these differences contribute to the differentiating COVID-19 outcomes seen in each jurisdiction. This approach is predicated on two cases that are similar in all respects except the variable of interest. The most-similar case study design then helps explore how two cases that seem similar demonstrate different outcomes for a given situation (Gerring, 2007). Since this research paper is exploratory, the most-similar case study will help reveal the regulatory (and other) factors that differ across the two jurisdictions that might be part of why there are differentiating COVID-19 outcomes between LTC facilities in Ontario and BC.

There have been numerous attempts to compare and contrast COVID-19 in BC and Ontario to understand why each jurisdiction had differentiated outcomes within LTC facilities (Kramer & Retnakaran, 2020; Liu et al., 2020; McGregor, 2020; Szklarski, 2020). While ON has a substantively larger population (14,734,014 as of July 2020) than BC (5,147,712 as of July 2020), they both represent the largest and third-largest jurisdictions in Canada (total population of 38,005,238) (Statistics Canada, 2020). While Quebec (8,574,571 as of July 2020) has a more significant population than BC, Quebec's COVID-19 outcomes were comparable to Ontario's (Canadian Institute for Health Information, 2021). Additionally, before the pandemic, the age, sex, and resident health and functioning characteristics of LTC residents within Ontario and BC were similar (Liu et al., 2020). While there have been several attempts to attribute COVID-19 LTC outcomes to ownership status, few studies investigate current regulations within each jurisdiction and their role in COVID-19 LTC outcomes. Therefore, this paper will use Ontario and BC as similar cases to investigate the potential regulatory factors (if any, and any other factors

i.e. ownership) that may have contributed to the differentiating COVID-19 LTC outcomes in each province.

Both the Government of Ontario and BC have published reports related to the Provinces' responses to COVID-19. In Ontario, a commission entitled *Ontario's Long-Term Care COVID-19 Commission* was launched in the summer of 2020 to investigate the cause and spread of the COVID-19 virus in ON's LTC facilities. The Commission's report, which focused on the first and second waves of the pandemic, was finalized and published in April 2021. Similarly, the Government of BC, in collaboration with Ernst & Young LLP (EY), published a report entitled *BC Ministry of Health Long-term care COVID-19 response review* to explore BC's response to COVID-19 in LTC homes within the first wave of the pandemic. While the reports specifically focus on COVID-19, the reports also provide background information into current LTC regulations and enforcement. Therefore, both reports are cited as references within the *Long-Term Care in Ontario* and *Long-Term Care in British Columbia* sections of the paper and the *COVID-19 in Ontario LTC Homes* and *COVID-19 in British Columbia LTC Homes* sections.

### **Long-Term Care in Canada**

As Dr. Albert Banerjee and others have noted, long-term care developed differently across various jurisdictions in Canada (Banerjee, 2007; Hirdes, 2013). Therefore, the term 'long-term care in Canada' is somewhat misleading. Different developmental histories across provinces and territories have led to a varied notion of 'long-term care' within each jurisdiction. Furthermore, long-term care is primarily under provincial/territorial jurisdiction, and therefore there is no national understanding or common language of terms across provinces and territories (Banerjee, 2007). With this in mind, what follows is

a high-level overview of long-term care in Canada followed by a more detailed review of long-term care in ON and BC, which explores facility ownership and types within each jurisdiction.

### *What is Long-Term Care?*

As used in this paper, long-term care refers to ongoing, indefinite care for individuals who cannot care for themselves. Long-term care sits at the intersection of health care -- nursing and medical care services available in LTC facilities, and social services -- the social and recreational programs available to residents of LTC facilities. Services can be either continuous or intermittent and are delivered over the long term (Banerjee, 2007). According to the CIHI report on COVID-19 in LTC settings in Canada, there are three different types of facilities encompassed by LTC: LTC homes, retirement homes and mixed setting facilities (Canadian Institute for Health Information, 2021).

LTC homes are also known as residential care homes, nursing homes and/or continuing care facilities. LTC homes provide 24-hour care seven days a week that includes professional health and personal care services. The majority of the patients in these facilities have complex health care needs. These homes are often funded or subsidized by provincial and territorial governments, although each jurisdiction has a different distribution of publicly and privately funded homes.

In contrast, retirement homes are also known as assisted living facilities, supportive living and/or seniors' villages. They do not necessarily provide 24-hour care, as residents generally do not have complex health care needs. Retirement homes often have individual suites within a general apartment complex that offers a combination of

housing, hospitality and primary health care support. Most retirement homes in Canada do not receive public funding, except for provinces that provide assisted-living services.

The final category, mixed services, refers to facilities that combine LTC and retirement home services. These facilities often receive public funding due to the health care services available to residents (Canadian Institute for Health Information, 2021).

In this paper, 'long-term care', 'long-term care homes', and 'long-term care facilities' are used interchangeably to refer to LTC facilities in ON and BC that provide various types of indefinite care (i.e., complex health needs or assisted living services) to its residents. This terminology reflects the fact that critical data on COVID-19 related positive cases and deaths group together long-term care facilities and mixed care settings. However, each jurisdiction has its breakdown of the various types of homes encompassed by long-term care and how they are regulated, which is explored in more detail in the sections *Long-Term Care in ON* and *Long-Term Care in BC*.

Long-term care is also often used to describe continuing forms of care, which have varying degrees of services available based on the patients' needs. For example, long-term care can reference hospital-based continuing care that generally involves a more intense, complex and shorter duration of care relative to long-term residential care. It can also reference home care and assisted living arrangements that provide essential support for residents who do not require 24-hour nursing care (Banerjee, 2007). In this paper, references to long-term care facilities refer to independent facilities, whether they are homes with 24-hour care or just basic support services, and not to individuals who receive care at home.

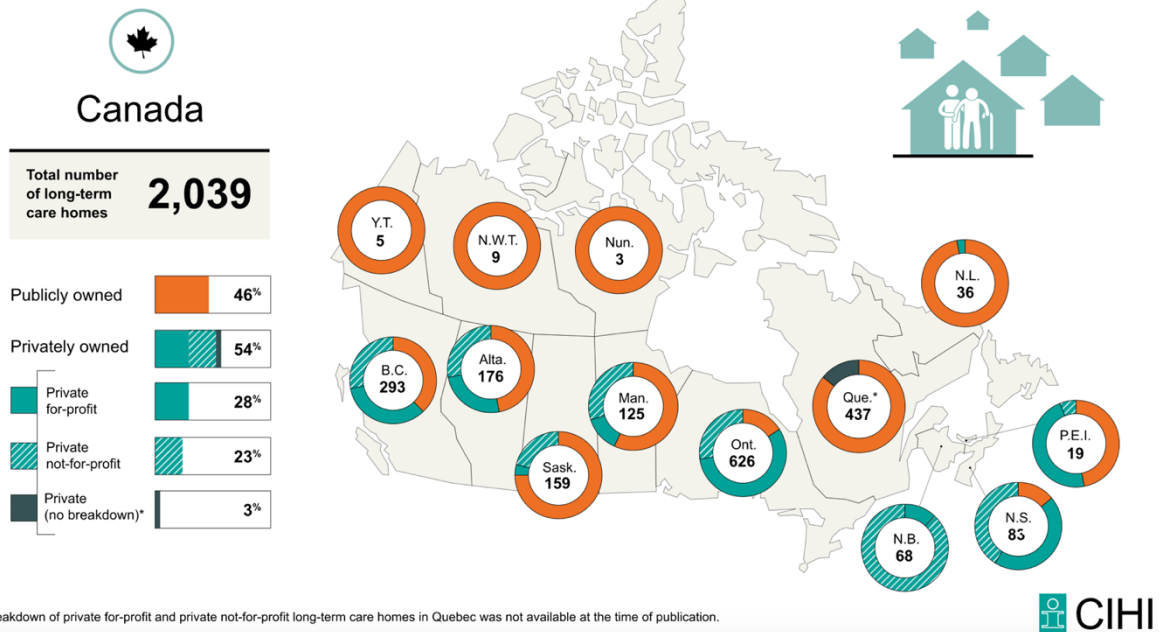
## Ownership

The terms ‘private’, ‘public’, ‘for-profit’ and ‘not-for-profit’ are often used to analyze COVID-19 outbreaks in LTC facilities. The provincial/territorial jurisdiction over long-term care and mixed legislation has given rise to different LTC facilities. Ownership of publicly funded LTC homes can be divided into publicly and privately-owned facilities. Privately owned LTC homes can be further divided into for-profit and not-for-profit organizations (Canadian Institute for Health Information, 2020b). These classifications, along with other terms, are defined in more detail below:

**Table I: Long-Term Care Facility Ownership Classifications**

<b><u>Public</u></b>	Publicly owned LTC facilities
<b><u>Private</u></b>	Privately owned LTC facilities that can be either for-profit or not-for-profit (Canadian Institute for Health Information, 2020b; Daly, 2015; Library of Parliament, 2020)
<b><u>Municipal</u></b>	Owned and operated by a municipality (public, not-for-profit)
<b><u>Regional</u></b>	Owned and operated by a regional health authority (public, not-for-profit)
<b><u>Provincial / Territorial</u></b>	Owned and operated by a division of the provincial/territorial government (public, not-for-profit)
<b><u>Federal</u></b>	Owned and operated by a department of the federal government (public, not-for-profit)
<b><u>Religious</u></b>	Owned and operated by a religious organization (private, not-for-profit)
<b><u>Lay/ Charitable</u></b>	Owned and operated by a voluntary, non-governmental and non-religious entity (private, not-for-profit)
<b><u>For-Profit</u></b>	Owned by an individual / corporation (for-profit) (Banerjee, 2007; Canadian Institute for Health Information, 2020b)

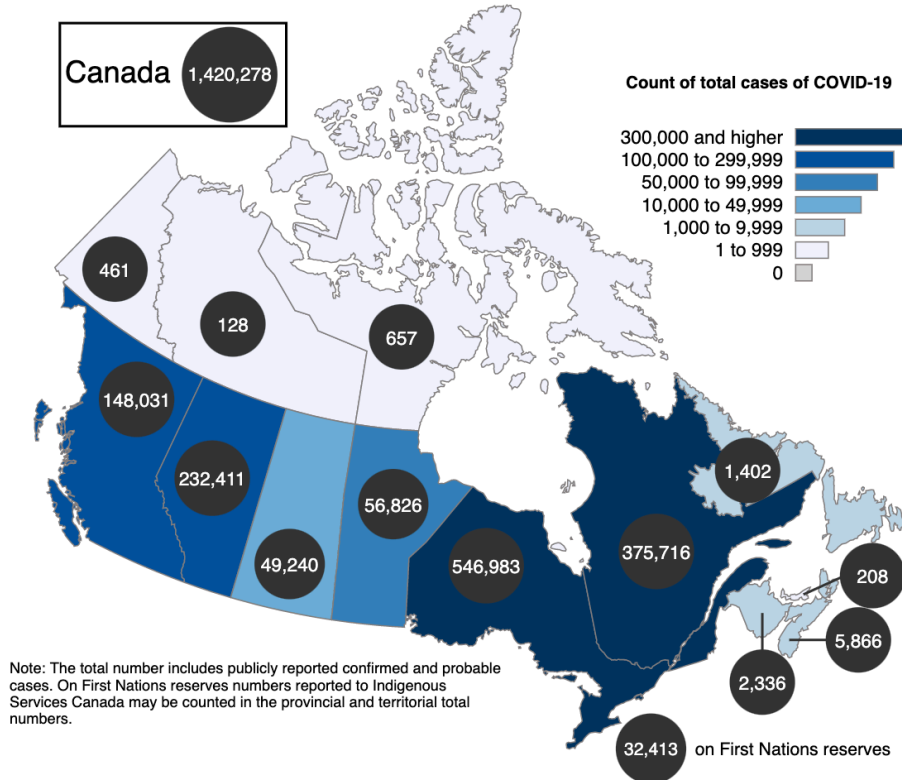
Provinces and territories are responsible for the system design, funding allocation, policy development and regulatory compliance for their LTC sector. Below is a breakdown of different long-term care facilities across each jurisdiction in Canada, by number and ownership status, as reported by the Canadian Institute for Health Information (CIHI) in September 2020. The infographic reproduced does not include information on congregate living facilities that do not provide 24-hour nursing care or receive public funding, i.e., retirement homes.



Reference: <https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them>

Currently, in Ontario, there are 626 long-term care homes. Of these facilities, 16% are publicly owned, 27% are private, not-for-profit and 57% are owned by private, for-profit organizations. BC has 308 long-term care homes, 35% of which are publicly owned, 28% are owned by private, not-for-profit organizations, and 37% are owned by private, for-profit organizations. ON has the largest number of privately owned, for-profit facilities amongst all jurisdictions across Canada (Canadian Institute for Health Information, 2020b).

## COVID-19 in Canada



Reference: <https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html>

As of July 10<sup>th</sup>, 2021, Canada has now seen a total of 1,420,278 cases of COVID-19 across the country. ON had a total of 546,983 cases, while BC had 148,031. The country has had 26,428 deaths – 9,245 in ON and 1,760 in BC (Government of Canada, 2021b). Unfortunately, Canada has had the worst LTC outcomes across all OECD countries during the first wave. As a percentage of all COVID-19 related deaths, the average percentage of LTC deaths amongst OECD countries was 38%. Despite having one of the lowest overall mortality rates of COVID-19, Canada saw 81% of deaths being attributed to LTC homes during the first wave (Canadian Institute for Health Information, 2020a).

There was also a considerable variation in COVID-19 LTC cases and deaths across the country. While the average LTC resident and staff cases as a percentage of

total COVID-19 cases during the first wave across the country was 20%, some provinces saw more (Nova Scotia, 35%; Quebec, 25%), and some saw significantly less (Newfoundland and Labrador, <1%, Prince Edward Island, 2%; Saskatchewan, <1%) (Canadian Institute for Health Information, 2021). The sections below explore long-term care in Ontario (ON) and British Columbia (BC) in more detail, as well as their specific COVID-19 responses and outcomes within LTC facilities.

## **Long-Term Care in Ontario**

### *Overview*

To live in a long-term care home, the applicant must be 18 years of age or older, have a valid ON Health Insurance Program (OHIP) card, and have care needs that require 24-hour nursing/ personal care, frequent assistance with day-to-day tasks, and on-site supervision to ensure safety and wellbeing of the applicant. The provincial government funds all personal and nursing care provided by long-term care homes in ON. At the same time, residents are required to pay for accommodation charges (i.e., room charges, meals). The current monthly accommodation costs for a long-stay basic room in a LTC facility in Ontario is \$1,891.31 per month, while a long-stay private room costs \$2,701.61 per month. A government subsidy is available for those who qualify for up to \$1,891.31 a month (or the cost of a long-stay basic room) (Government of Ontario, 2021c). Currently, the majority of homes in ON operate under private, for-profit ownership. It is important to note that retirement homes in ON are regulated separately from LTC homes under the *Retirement Homes Act (2010)* (Retirement Homes Regulatory Authority, 2011). Therefore, the total number of LTC facilities seen below and Ontario COVID-19 reporting

do not include retirement homes. The breakdown of ownership of LTC facilities in Ontario is provided in the chart below:

**Table II – LTC Facilities in ON**

<b>Total Number of Facilities:</b>	<b>626</b>
<b>Public:</b>	16%
<b>Private for-profit:</b>	57%
<b>Private not-for-profit:</b>	27%

Reference: <https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them>

*History of Long-Term Care*

From 1940-1966, ON saw the creation and expansion of long-term care facilities. The first public municipal home opened in 1949; however, by the early 1950s, long waitlists created pressure for action by the Government of Ontario. In the 1950s and 1960s, modern 'homes for the aged' were built and/or renovated, funded by municipal and provincial cost-sharing. As Ontario built more homes, more policies were required surrounding the regulation of these facilities. Many initial regulatory attempts were ineffective, with abhorrent conditions present in some private nursing homes. Two groups, the *Ontario Welfare Council (OWC)* and the *Associated Nursing Homes Incorporated of Ontario (ANHIO)*, were formed and lobbied the provincial government to fund, regulate and license private nursing homes to help mitigate ongoing health care concerns (Daly, 2015).

In 1966, the *Ontario Nursing Homes Act* was passed to regulate for-profit care providers after reports of private nursing home abuses. The Act provided regulation and inspection requirements for for-profit homes, and funding from the provincial government

was conditional on meeting these requirements. By the late 1960s, the system remained predominantly private and for-profit delivery with extensive public funding. The total number of beds went from 8,500 to 18,200 from 1966 to 1969. Health officials did find that private nursing homes lobbied for continual rate increases while investing as little funding as possible to improving patient care. In partial response, the *Rest Homes Act (1966)* allowed for 50 percent capital and 70 percent operating funding from the provincial government to municipalities to expand the number of public facilities. In 1972, the Province enacted the *Extended Care Plan*. This plan funded residents with care needs directly, and the funding formula required operators to provide at least one and a half hours of skilled nursing/ personal care a day per resident. This legislation was criticized for rewarding facilities for doing the “bare minimum” and it allowed for-profit nursing homes to grow from a baseline of 20 beds to over 100-200 beds per facility. In this period, LTC facilities increasingly became owned by corporate chains that viewed these homes as highly profitable for shareholders. In partial response, different pieces of legislation were enacted to help support not-for-profit/ public providers. The *Homes for the Aged Act (1990)* and the *Charitable Institutions Act (1990)* created a system where the Government of Ontario funded for-profit nursing homes differently than homes for the aged (municipal/ charitable public facilities), which continued until 1993 (Daly, 2015).

In 1993, the *Long-Term Care Statute Law Amendment Act (1993)* was passed to fund both nursing homes and homes for the aged under one formula that was tied to a classification system based on the complexity of patients’ needs in a given home. It eliminated extended care funding that the Province provided based on minimal staffing requirements and created a new envelope system that standardized funding of for-profit

nursing homes and non-profit, municipal homes for the aged. In 1994, the Ministry of Health and Long-term Care (MOHLTC) designed a new review system that involved specialty-trained nurses evaluating all 57,000 residents in the province. In 1996, the Government of Ontario eliminated all minimum staffing requirements. The Province also invested \$1.2B into the long-term sector to create 20,000 new LTC beds by 2006. This investment would balloon to \$1.5B by 2003, and the Government took the additional funding from municipal home funding privileges. Through the *Homes for the Aged Act (1990)* and the *Charitable Institutions Act (1990)*, municipal homes could access 50% funding grants. Now that the Province eliminated this grant option, two-third of the new beds created under this investment were within for-profit LTC homes. Furthermore, these newly built homes were much larger and had more beds than previous designs (Daly, 2015).

One paper published in 2004 by Berta et al. examined nursing homes (then operating under *the Nursing Homes Act (1990)*), municipal Homes for the Aged (operating under the *Homes for the Aged and Rest Homes Act (1990)*) and charitable homes for the aged (operating under the *Charitable Institutions Act (1990)*). This study found substantial performance variation across the three different types of facilities, explained by factors such as size, ownership, structure, etc. The two main factors that impacted performance were profit status and organizational size. Typically, non-profit operators re-invest their revenues in initiatives designed to improve facility performance while providing less profitable services. For-profit homes are theoretically responsible to their shareholders, so less revenue is used to improve service and the facility. Organizational structure referred to a facility's capacity for capital and human resources. In their paper, Berta et

al. utilized nurse staffing intensity as a measure/predictor of quality of care in LTC homes in ON. At the time, 62% of facilities were for-profit, 17.4% were government-owned, 14.1% were non-profit volunteer-owned, and 6.5% were non-profit religious-owned (Berta, Laporte, & Valdmanis, 2005).

Berta et al. found that stringent regulatory conditions brought on by the Government of Ontario between 1971-1996 favoured for-profit facilities due to their ability to achieve economies of scale, leading to the majority of LTC facilities in Ontario being for-profit. Second, the LTC sector went from being comprised of small, independently owned homes to larger homes with over 100 beds. Given the regulatory structure in place, large, for-profit homes were favoured and thrived financially at the expense of smaller, not-for-profit homes that relied on small subsidies to continue operations. The third observation by Berta et al. noted the increased homogeneity of type of care across homes, with most patients requiring "extended" care. This increased exclusivity of care, i.e., offering extended care services without chronic care services<sup>1</sup>. The facilities that tended to patients who required more chronic care services were either government-owned or not-for-profit/ religious homes, which reported higher nursing staffing intensity. In comparison, for-profit LTC facilities had significantly less nurse staffing power. The paper concluded by stating that no current empirical research shows the relationship between profit status and patient care. However, the trends outlined above regarding favouring for-profit homes at the expense of smaller, not-for-profit facilities and

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<sup>1</sup> Extended care is defined as the care given to a person with an established (physical or mental), unchanging chronic disease that requires personal care approximately two hours out of a 24-hour day and some medical supervision for psychological needs. Extended care does not include the diagnostic and therapeutic services offered in a hospital. Chronic care is more extensive than extended care. Chronic care is provided to an individual with a chronic illness or functional disability whose vital processes may or may not be stable and requires diagnostic and therapeutic care, medical management, and skilled nursing care within a 24-hour day (Berta et al., 2005).

homogeneity in care may lead to a discrepancy in patient care and, therefore, should be investigated further (Berta et al., 2005).

The *Long-Term Care Homes Act (2007)* was passed in 2010. This legislation amalgamated the *Nursing Homes Act (1990)*, *Homes for the Aged and Rest Homes Act (1990)*, and *Charitable Institutions Act (1990)* and returned the funding parity initially established in 1993. The *Long-Term Care Homes Act (2007)* created an extensive regulatory framework of over 300 regulations that shaped the delivery of long-term care across Ontario. There was a stricter compliance inspection process, and the Province now required publicly available reporting. These new regulations continued to favour for-profit companies in the sector. Smaller not-for-profit/ public LTC facilities complained about lacking the resources to keep up with the new regulatory requirements. The insufficient operating funding did not address staffing shortages that increased due to the creation of new beds, the requirement of new reporting and new compliance procedures. The *Long-Term Care Homes Act (2007)* was also criticized for lacking minimum care standardization (Daly, 2015). This Act, with revisions, is still in place today (Government of Ontario, 2020).

#### *Current Regulations and Enforcement*

The Government of Ontario regulates, inspects and sets out accommodation fees for all LTC homes. By law, LTC facilities are required to provide residents with safe, consistent, high-quality care as mandated by the *Long-Term Care Homes Act (2007)*. As mentioned above, the Act aimed to strengthen enforcement and improve care and accountability given unsatisfactory earlier evaluation frameworks. The legislation includes annual facility inspections that are made publicly available, whistle-blowing protections

for staff and relevant personnel to report on abuse and neglect, a detailed 'least restraint policy' that limits the use of restraints on patients, a more clearly defined *Residents' Bill of Rights*, and strengthened requirements related to the development of an integrated, interdisciplinary plan of care for residents. Additionally, the *Long-Term Care Homes Act (2007)* requires establishing a Residents' Council in each home. This provision encourages the creation of Family Councils to allow residents and their loved ones to advocate for themselves and others regarding their rights, facility operations, complaints, etc. (Banerjee, 2007; Government of Ontario, 2011).

There is little available literature that discusses the implementation and enforcement of the regulatory framework established by the *Long-Term Care Homes Act (2007)*. However, to develop recommendations to help the Government of ON navigate LTC homes during the second wave of the pandemic, ON's Long-Term Care Commission published a letter<sup>2</sup> that provided insight into the enforcement of the Act in LTC facilities. In 2013, the Government of Ontario recognized that comprehensive inspections would help identify systemic issues within LTC homes. To ensure compliance with the *Long-Term Care Homes Act (2007)*, the Province instituted annual Resident Quality Inspections (RQIs) by the end of 2014. Nearly all 626 LTC homes received RQIs in 2015, 2016 and 2017. These inspections changed in 2018 when, due to a backlog of almost 3000 complaints and critical incident inspections, the Government decided only to inspect LTC homes deemed 'high-risk'. In 2018, only 329 homes received inspections, which further dropped to 27 homes in 2019. After the COVID-19 pandemic hit, only 11 LTC homes

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<sup>2</sup> More information on this commission is provided within the *Methods* section.

received a proactive inspection from March 1<sup>st</sup> to October 15<sup>th</sup>, 2020 (Government of Ontario, 2021b).

The Commission also found that the Plan of Care was consistently identified as the top area of non-compliance from inspections made from 2018 to 2020 (Marrocco, Coke, & Kitts, 2020). As outlined in the *Long-Term Care Homes Act (2007)*, a Plan of Care refers to a written plan that sets out the planned care, the goals of the care, and the directions for the staff and other relevant personnel required to carry out care for the resident. The facility must document three items under this plan: the provision of the care set out in the plan, the outcomes of the care set out in the plan and the effectiveness of the plan of care. Every resident must be reassessed, along with the plan of care, every six months if goals outlined in the plan are met, if the care plan needs to be changed, or if the care plan has been ineffective in achieving the desired care outcomes. Regulatory requirements include a 24-hour admission care plan that facilities must develop for every resident admitted to the home. This plan must include criteria outlined in the Act, which includes: risk of the resident to themselves and others, types of care required, known health conditions, and more (Government of Ontario, 2011). The Commission found that weak enforcement of the Plan of Care was a systemic problem and recommended that the Province prioritize timely responses to non-compliance to Plan of Care orders (Government of Ontario, 2021b).

# Long-term Care in British Columbia

## Overview

To be eligible for LTC in BC, the applicant must be a Canadian citizen, a resident of BC for at least three months (with some exceptions), and 19 years of age or older. The applicant also must be unable to function independently due to chronic health issues or have health care conditions that require extensive care based on one (or more) of the following: a recent discharge from an acute care hospital, prevention of re-admission to the hospital, or a life-limiting health condition. Some public LTC facilities provide subsidized home and community care services free of charge, while others share the cost with the Ministry of Health and the resident. The monthly cost rate is determined by the after-tax income of the resident, with the minimum monthly rate being \$1,204.90 in 2021 (Government of British Columbia, n.d.-b). The majority of LTC facilities in BC are not-for-profit, with either public or private ownership. It is important to note that retirement homes in BC are regulated in combination with LTC homes under the *Community Care and Assisted Living Act (2007)* (British Columbia Housing, 2021). Therefore, the total number of LTC facilities seen below and BC COVID-19 reporting combines long-term care facilities and assisted living/retirement homes. The breakdown of ownership of LTC facilities (including assisted living and retirement homes) is provided in the chart below:

**Table III – LTC Facilities in BC**

<b>Total Number of Facilities:</b>	<b>308</b>
<b>Public:</b>	38%
<b>Private for-profit:</b>	25%
<b>Private not-for-profit:</b>	28%

Reference: <https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them>

## *History of Long-Term Care*

Originally, long-term care homes in BC were encompassed under the term 'residential elder care homes', which referred to old age homes and nursing homes where ageing single immigrant men with no family or impoverished elderly lived from the 1890s to the 1920s. Other elderly people who required more complex care were placed in hospitals with other patients. Economic limitations of World War I left BC with significantly fewer facilities when compared to provinces like Ontario or Quebec. The primary purpose of the facilities in the early to mid-20<sup>th</sup> century, either in the community or in the hospital, was to provide custodial care. This model of care came from the philosophy that residents were responsible for their situation, and therefore the facilities placed the fault and responsibility of care on the residents themselves. There was also limited government funding and fewer staff, as the consensus was that nursing home residents do not require as much care as acute hospital in-patients (Tung, Phinney, & Boschma, 2008).

Discussions around long-term care service delivery became more prominent after organized systems of continuing care were significantly boosted in 1977 due to federal/provincial cost-sharing. The federal government paid 50% of all insured health services developed by the Province through block grants based on population size. These block grants gave the provincial government more autonomy to extend their expenditures beyond insured services such as hospital and medical care and expand the home and long-term care sector<sup>3</sup>. In 1978, the Government of BC used this funding to begin the *Long-Term Care Program*, which integrated social and health services for disabled,

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<sup>3</sup> This explanatory factor also applies to Ontario, as federal-provincial cost-sharing of hospital care in the late 1950s applied to all provinces and territories. However, no literature suggested that policy decisions in Ontario were driven to the same extent by the advent of federal-provincial cost-sharing as they were in British Columbia, as cited above.

chronically ill and elderly citizens. In 1983, after amalgamating physiotherapy into the program, the program was renamed the *Continuing Care Division* to emphasize the continuity of care in the community and through facilities (Hollander & Pallan, 1995).

The *Continuing Care Division* delivered services through three programs: the *Long-Term Care Program*, the *Community Home Care Nursing Program*, and the *Community Rehabilitation Program*. This division provided long-term care assessments, case management, home nursing services, and rehabilitation services through provincial and/or municipal employees. In contrast, all other services were available on a fee-for-service basis. To determine a resource-allocation model for continuing care services, the Ministry of Health conducted a comprehensive international literature review on all possible continuing care models. They found that few jurisdictions funded community and residential long-term care under one division. Few reported on planning and utilization rates for community or home-based continuing care services. The Ministry of Health decided to blend various methodologies to fund their continuing care model – they used a population-based demand model for community services and integrated age and gender categories for further specification. They also utilized a needs-based approach for long-term care assessors/ case management to determine the proportion of patients who can be de-institutionalized or need to receive increased care within facilities. Finally, the Ministry of Health set a target of 55 beds per 1000 people aged 65 years of age or older, with 35 beds required in designated continuing care facilities and 20 beds for extended care units. They determined this proportion by analyzing the 65+ age population in BC, examining the international literature review, and projected data for demand (Hollander & Pallan, 1995).

However, there were longstanding issues regarding the policies and regulations of these facilities under these programs. The Social Planning and Research Council of BC (SPARC BC) identified the need for more research into the institutional elder care needs and services as early as 1972. Policies utilized at the time were not meeting the social and emotional needs of residents in these facility care settings. The provincial government developed guidelines for extended care facilities in 1971 entitled *Hospitals for Extended Care: Guide for Extended Care Programs*. These guidelines were intended to provide organizations with some direction in planning extended care facilities but were not meant to be used as enforceable regulations. In 1980, the BC Health Association (BCHA) issued a report to the LTC task force to review the quality of care and staffing within residential care facilities. The statement suggested that the Province lacked a clear provincial long-term care strategy, staffing formula for facilities, and clear government involvement in supporting nursing, recreation and general activity services beyond primary custodial care. Generally speaking, in this period, the Government did not prioritize supporting residential care facility activities. This lack of attention was further emphasized by discussions by the BC Legislative Assembly in 1987. Members of the Assembly indicated that Ontario needed a sustainable long-term care plan for eldercare. However, Tung et al. observed that care philosophy and psychosocial eldercare were rarely discussed in discussions held by the BC Legislative Assembly, despite these repeated calls for action (Tung et al., 2008).

By the late 1990s, three policies governed and regulated the operations of residential care facilities in BC: the *Hospital Act (1996)*, *Continuing Care Act (1996)* and the *Community Care Facility Act (1996)* (Tung et al., 2008). Today, residential care in BC

is licensed and registered under two different statutes, depending on where the care is administered. Care offered through residential community care facilities is regulated by the *Community Care and Assisted Living Act (2002)* (which replaced the *Continuing Care Act* and *Community Care Facility Act* of 1996) and the associated *Residential Care Regulation (2002)* (Banerjee, 2007). An extended care hospital or private hospital can also provide long-term care, regulated by the *Hospital Act (1996)* (British Columbia Office of the Ombudsperson, 2009; Library of Parliament, 2020). Both retirement homes/ assisted living facilities and long-term care homes are regulated under the *Community Care and Assisted Living Act (2002)* (British Columbia Housing, 2021; Government of British Columbia, 2002).

#### *Current Regulations and Enforcement*

In 2009 and 2012, the Ombudsperson for BC published two reports on LTC in BC. There was increasing public disapproval of the management of the LTC system, with complaints ranging from lack of access to information, delays in access to services, poor food quality, inadequate responses to concerns about care, etc. The investigation found three main areas that needed improvement: commitment to care and residents' rights, public information and reporting and use of resident and family councils. The 2009 report recommended that the Government of BC and the associated residential care and assisted living facilities set out the rights of seniors, provide timely access to accurate, consistent and comparable information on LTC facilities, and clarify and prove support for the role of resident and family councils (British Columbia Office of the Ombudsperson, 2009).

The Government accepted and implemented some of the recommendations outlined by the Ombudsperson. One example includes implementing the *Resident Bill of Rights*, which outlines residents' rights to health, safety and dignity. However, the Ombudsperson was disappointed overall in the Government's response and stated concern over the recommendations that the Province did not accept. For example, despite the recommendation for a single provincial website that can provide timely access to comparable information on long-term care and assisted living facilities, no commitment was made to achieve this goal (British Columbia Office of the Ombudsperson, 2009). Following the second report's release in 2012, the Province published the *Improving Care for BC Seniors Action Plan (2014)*. While the action plan did provide some positive small steps in the right direction, it did not commit to fully implementing the Ombudsperson's recommendations (Canadian Centre for Policy Alternatives, 2021; Government of British Columbia, 2014).

In October 2020, Ernst & Young LLP (EY), in collaboration with the BC Ministry of Health, published a report<sup>4</sup> that reviewed the response to COVID-19 in long-term care during the first wave. While COVID-19 outcomes in BC's LTC homes were better during the first wave when compared to other jurisdictions, there were still areas that required improvement. While the report mainly explicitly focused on the Province's response to COVID-19, some recommendations related to the enforcement of current regulations outlined through the *Residential Care Regulation*. For example, the Report recommended that regional health authorities and the Ministry of Health review their approach to audits and inspections of LTC facilities. The report suggested that there should be greater

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<sup>4</sup> More information on this collaboration and report is provided within the *Methods* section.

oversight and focus on infection, prevention and control protocols and outbreak preparedness (British Columbia Ministry of Health, 2020). This recommendation is directly applicable to Section 51 – emergency preparations of the *Residential Care Regulation*, which outlines the requirements that licensees must adhere to to be adequately prepared for emergencies within LTC facilities (Government of British Columbia, 2021d).

## **COVID-19 in Ontario LTC Homes**

### *Overview*

This section will explore the Government of Ontario's response to COVID-19 in LTC homes within the first (March 2020 – August 2020), second (September 2020 – February 2021) and third waves (March 2021 – present) of the pandemic. Currently, Ontario is at the tail end of the record-breaking third wave of the COVID-19 pandemic. In late April 2021, Ontario saw days where over 4000 new COVID-19 cases, with close to 3000 of those infected with the virus testing positive for one of the new variants (DeClerq, 2021). There is currently a total of 547,409 confirmed cases of the virus and 9,258 deaths in the province. There are three reported ongoing outbreaks amongst long-term care homes and one outbreak amongst retirement homes (Public Health Ontario, 2021a). However, this was not always the case. Below is a brief snapshot of ON's pandemic preparedness pre-COVID-19 and outbreaks during the first, second and third waves of the pandemic in the province.

### *Pandemic Preparedness and Personal Protective Equipment (PPE)*

Ontario, like other jurisdictions, was unprepared for the COVID-19 pandemic. However, specific decisions made by the current government left the province worse off

than necessary. For example, the Auditor General of Ontario warned in 2017 that Ontario was ill-equipped to handle a province- or country-wide emergency (Office of the Auditor General of Ontario, 2017). Despite the warning, the successive governments did not adequately prepare for any potential public health catastrophe (Government of Ontario, 2021b). For example, in 2017, the large stockpile of personal protective equipment for medical emergencies available for Ontario expired. By December 2019, three months before the pandemic, 90% of the expired stockpile was destroyed and not replaced (Howlett, 2021). In addition to not replenishing the supply of PPE, the government failed to keep track of PPE supplies in long-term care homes. The Ontario Long-Term Care COVID-19 Commission found afterwards that LTC homes lacked the necessary equipment to prepare for a public health emergency (Government of Ontario, 2021b).

Ontario's plan on pandemic preparedness was based on influenza-related scenarios in terms of an emergency preparedness plan. The *Ontario Health Plan for an Influenza Pandemic* (OHPIP) was adopted in 2013 and included various levels of government in the province, including indigenous groups. It outlined that if a pandemic should arise, the MOHLTC is in charge of pandemic responses within the province. Ontario's plan was, overall, relatively high-level and did not provide much detail about collaboration with federal and local governments, unlike the Toronto Public Health plan, which outlined detailed guidelines for services should a pandemic occur (Blouin Genest, Burlone, Champagne, Eastin, & Ogaranko, 2021). Another important note is that the OHPIP did not incorporate critical lessons learned from the SARS pandemic – various provincial commission reports warned about significant problems surrounding health

sector staffing and health facility infection prevention and control. (Government of Ontario, 2021b).

*The First Wave (March 2020 – August 2020)*

Initial discussions by the Government of Ontario about the coronavirus occurred during the first weeks of January 2020. The Government focused on making sure hospitals were prepared to handle any COVID-19 cases, based on the devastating effects SARS had on Ontario hospitals in 2003. In the early days of the 2020 pandemic, in an attempt to increase capacity for new patients, the Government transferred patients from hospitals to LTC homes. This decision resulted in reduced space within LTC homes, which contributed to the unfortunate spread of disease. The report published by the Ontario Long-Term Care Commission found that the Government's response to COVID-19 treated LTC separate from the rest of the healthcare system despite warnings that the virus can have devastating effects amongst LTC residents if not appropriately handled. By the end of February, public health experts in Ontario agreed that the spread of COVID-19 is inevitable and is cause for alarm. This claim was based on the fact that by March 11<sup>th</sup>, 2020, long-term care homes in Italy had suffered 827 deaths and 12,426 confirmed deaths. Community transmission in LTC homes in Washington State and BC was already associated with high mortality rates. However, the Province failed to act on these warnings due to various intergovernmental complexities. For example, the role of the Ministry of Health, Ministry of LTC, and Chief Medical Officer of Health (CMOH) was unclear during the first wave, resulting in various shifts of responsibility that amounted to limited proactive action against the virus (Government of Ontario, 2021b).

Because the Province destroyed most of its PPE stockpile (due to the PPE being expired) and many LTC homes had an insufficient supply, many staff and residents could not adequately protect themselves from the virus. Many LTC workers did not feel safe continuing to work in an environment where they were not well protected against the virus, especially since it also included putting their families at risk. This hesitancy resulted in massive staffing shortages in an already understaffed sector. Additionally, the Province did not adequately utilize the relevant provisions of the *Health Protection and Promotion Act (1990)*, whereby the CMOH has the power to issue mandatory directives backed by legislated sanctions. However, the CMOH was slow to act. Instead of utilizing the power to, for example, restrict LTC staff to only working at one site, the CMOH released a memo regarding actions that should be taken and that it may be possible to coordinate employees to a single site. This directive, known as Directive #3, was poorly worded and not universally followed. The CMOH stated that his powers did not allow him to issue a stronger directive and that a cabinet order was necessary (Government of Ontario, 2021b).

The first LTC outbreak was declared in Ontario on March 16<sup>th</sup>, 2020. During the peak period of the first wave, ON had 8,571 LTC resident deaths. This total is 28% greater than the five-year average number of LTC resident deaths of 6,688 patients. (Canadian Institute for Health Information, 2021). In total, LTC residents made up almost 69% of all deaths (1,937/2,812) reported during the first wave. There was a total of 390 LTC outbreaks across Ontario's 626 facilities by the end of the first wave. Between LTC residents, there was a total of 5,941 positive cases reported. There was a total of 2,533 positive cases among LTC staff, which resulted in eight deaths. The hardest-hit regions

in the province included Toronto, Peel, York Region, Durham and Ottawa (Public Health Ontario, 2020, 2021b).

The Government of Ontario stalled the release of positive test results in LTC homes due to the directive that allowed all citizens to receive a COVID-19 test, regardless of whether or not they were symptomatic. Due to limited lab capacity, test results often took over a week to be received, with a significant number of tests being backlogged by an increasing number of incoming tests. This backlog and slow turnaround time made it difficult for LTC staff to separate healthy residents from sick ones, especially if they were asymptomatic. Facilities were understaffed, with many staff members reporting severe mental health distress in caring for LTC residents. Family members could not visit their loved ones, leaving residents isolated, rapidly declining (both physically and cognitively), and depressed (Government of Ontario, 2021b).

#### *The Second Wave (September 2020 – February 2021)*

Despite the devastating outcome of the first wave, the Province did not adequately prepare for the second wave. The second wave saw a total of 9,019 new positive cases reported among long-term care residents, 1,006 of whom were hospitalized, and 70 admissions to the ICU. There were 1,934 additional deaths reported within LTC facilities. A total of 4,108 LTC staff tested positive for COVID-19 during the second wave, which included 47 additional hospitalizations and 10 ICU admissions. As well, two more LTC staff passed away from the virus. In contrast to the first wave, which saw 390 outbreaks, the second wave saw an increase of 899 outbreaks within ON's 626 LTC homes (for a total of 1,289 outbreaks), meaning that multiple outbreaks occurred within the same LTC facilities. The same regions affected in the first wave continued to report high case counts

within LTC facilities. However, the second wave saw other regions in ON reporting high numbers of confirmed cases within LTC facilities, including Eastern Ontario, Windsor-Essex County, Niagara Regional Area, Hamilton, and Halton Regional (Public Health Ontario, 2021b).

#### *Vaccine Distribution and the Third Wave (March 2021 – Present)*

Vaccines rollout began in December 2020 in Ontario. The Government created a COVID-19 vaccine distribution plan that outlined the populations, expected doses, vaccination sites and priority populations served within three distinct phases. The first phase, spanning from December 2020 to March 2021, targeted high-risk populations. The Government specifically targeted residents, staff, essential caregivers, and other LTC facilities, healthcare workers more broadly, adults in First Nations, Métis, and Inuit populations, and adult chronic home care recipients (Government of Ontario, 2021a). However, the rollout strategy did not go according to plan. Initially, the Government planned to vaccinate all LTC residents by February 15<sup>th</sup>, 2021. A study released by the Ontario Government's Science Table argued that if the Province prioritized vaccinating all of its LTC residents by January 31<sup>st</sup>, 2021, instead of February 15<sup>th</sup>, 2021, it would help prevent over 600 new COVID-19 infections and 115 deaths by the end of March. On January 25<sup>th</sup>, the Government of ON announced that it would change its target date from February 15<sup>th</sup> to January 31<sup>st</sup>, following the results of this study. However, due to internal miscommunication and delayed vaccine shipments, despite the official change in plan, LTC residents received their first shot of the vaccine and about half received both doses only by February 14<sup>th</sup>, 2021, one day before the original target date (Sinha, Feil, & Iciaszczyk, 2021).

Nevertheless, in general terms, the decision to focus on vaccinating LTC residents and staff by mid-February improved COVID-19 outcomes within these facilities. As mentioned above, there are currently three ongoing outbreaks in LTC homes and one outbreak amongst retirement homes across the province. Ontario has seen a total of 15,439 COVID-19 positive cases amongst LTC residents and 7,226 positive cases amongst LTC staff. Of these positive cases, 3,976 LTC residents and ten health care workers succumbed to the virus (Public Health Ontario, 2021a).

#### *COVID-19 Outcome Patterns Across LTC Facilities*

The Ontario COVID-19 Science Advisory Table published a report in January 2021 on the research published on COVID-19 within ON's LTC homes. This report found that private, for-profit facilities had almost twice as many residents infected and 78% more resident deaths when compared to not-for-profit homes (although the not-for-profit homes are disaggregated between private and public ownership). The Ontario COVID-19 Science Advisory Table found that the association between infections and ownership structure may be explained by the fact that for-profit homes had a higher proportion of older designs that fell below design standards established in 1972 (Stall et al., 2021). A separate CBC analysis corroborated these findings and found that three private, for-profit LTC home chains had the highest COVID-19 death rates across ON (Mancini, Pedersen, & Common, 2020). The Science Advisory Table report also found that the incidence of COVID-19 outbreaks and deaths was more significant in highly crowded homes. During the peak of the first wave, 90% of ON's LTC outbreaks involving more than 100 infected residents occurred in crowded homes (Stall et al., 2021).

## **COVID-19 in British Columbia LTC Homes**

### *Overview*

This section will explore the Government of BC's response to COVID-19 in LTC homes within the first (March 2020 – August 2020), the second wave (September 2020 – February 2021) and the third wave (March 2021 – present) of the pandemic. At the peak of the third wave, BC saw over 3000 new daily cases, although it is unclear how many cases were brought on by the variants due to data challenges (Weichel, 2021). BC has now reported 147,594 positive cases since the start of the pandemic in 1,754 deaths. Within long-term care homes, the province has reported a total of 329 outbreaks in 308 long-term care homes, with no new outbreaks currently reported. It is important to note that while Ontario reports specifically on long-term care homes, the BC reporting combines LTC and assisted living facilities within a single category for reporting purposes. In the sections below, both types of facilities are encompassed by the terms 'LTC homes' and 'LTC facilities' (Government of British Columbia, 2021a). Below is a snapshot of BC's pandemic preparedness pre-COVID-19 and outbreaks during the first, second and third waves of the pandemic in the province.

### *Pandemic Preparedness and Personal Protective Equipment (PPE)*

BC's pandemic preparedness plan was adopted in 2012 and adopted a different approach than in Ontario. The BC plan highlighted the importance of municipal governments working together with regional authorities to manage and create their procedures and required all regional health authorities to create their own Pandemic Influenza Contingency Plan. BC's plan stressed the importance of effectively delegating

responsibilities to appropriate actors and collaboration across various sectors. (Blouin Genest et al., 2021).

However, BC faced similar PPE shortages as Ontario in light of the first wave. In July 2013, BC had PPE inventory valued at \$5.7 million; however, by January 2020, the inventory value was halved to \$2 million. While many PPE were donated to the reserve by health authorities in 2014 in light of the Ebola outbreak, many PEE expired and was not replaced. For example, nearly 40% of Vancouver's supply was expired and therefore never used. Other health jurisdictions either dipped into the PPE reserve stockpile ahead of the pandemic or donated any extra supply, leaving them unprepared when the COVID-19 pandemic began (Woodward, 2020).

#### *The First Wave (March 2020 – August 2020)*

The first case of COVID-19 was reported in the province on January 28<sup>th</sup>, and a steady rise in positive cases among citizens began in February 2020. The first reported death of a LTC resident due to the virus in BC was on March 8<sup>th</sup>, 2020. Following the rise of cases and the first death in an LTC facility, the Provincial Health Officer, on March 17<sup>th</sup>, Dr. Bonnie Henry declared an emergency under the *Public Health Act*, which allowed her to make orders to manage the pandemic. This declaration of an emergency came with immediate policy changes that same day, including prioritization rules established for the admission of acute care patients to LTC facilities over the community and visitor restrictions to LTC facilities to allow essential visitors. On March 18<sup>th</sup>, there was a temporary suspension of interfacility transfers. TC facilities were required to notify the receiving facility if an outbreak was reported within 14 days of the transfer. Also, residents transferred to acute care for treatment of COVID-19 were allowed to return to the facility

only when medically stable. The in-facility respite was temporarily suspended, except for a few cases with a significant risk to the patient. The Government asked LTC homes to use respite, palliative and other beds/ rooms for COVID-19 patients (British Columbia Ministry of Health, 2020). On March 25<sup>th</sup>, the Province issued a single site order that limited workers within LTC and assisted-living facilities to working at only one site.

At the end of the first wave, BC saw only 90 outbreaks across LTC facilities. There was a total of 588 positive cases amongst LTC residents, with 157 deaths. Among staff and other relevant personnel, there were 692 confirmed positive cases and no deaths. While LTC facilities across Canada were hit hard by the COVID-19 pandemic, BC had lower infection and mortality rates overall when compared to Ontario and other larger provinces within the country. According to the BC Ministry of Health Long-Term Care COVID-19 Response Review, published in October 2020, these lower rates of positive cases and deaths across LTC facilities were due to governance and decision-making, policy, operations and workforce choices made throughout the first wave. The report found that due to a robust, coordinated approach between the provincial government and local health authorities, rapidly developed policy guidelines by the PHO at the very start of the first wave, and the early implementation of workforce-related policies such as the single site order all contributed to BC's mitigated outbreaks within LTC homes. However, the report also outlined lessons learned that the Government of BC should apply to future potential waves. For example, there were gaps in infection, prevention and overall pandemic preparedness within LTC facilities and varying interpretation and implementation of operational orders that differentiated practices across facilities within different health regions (British Columbia Ministry of Health, 2020).

### *The Second Wave (September 2020 – February 2021)*

Unfortunately, the second wave of the pandemic did not reflect the same relatively positive outcomes across LTC facilities (compared to other jurisdictions in Canada) as the first wave. By the end of the second wave, there was a total of 297 outbreaks across all LTC facilities (207 outbreaks reported during the second wave). There was a total of 2,682 new positive cases amongst LTC residents and an increase of 796 deaths. Amongst LTC staff, there was an increase of 1,495 total positive cases and no new deaths (Government of British Columbia, 2021b). A limited amount of information is available regarding what happened during the second wave, as the Ministry of Health Report cited above was published earlier in the second wave (October 2020). According to Dr. Samir Sinha, Director of Health Policy Research and Co-Chair of Ryerson University's National Institute on Ageing, BC did not adjust its approach or learn from gaps in the first wave, which the Ministry of Health reported on in October (British Columbia Ministry of Health, 2020; Hunter, 2021). Additionally, like Ontario, BC continued testing people who were asymptomatic, leading to backlogs in lab results that disclosed positive test results for LTC residents and staff later than necessary to manage COVID-19 positive residents properly. Overall, community spread was greater during the second wave than the first, leading to the inevitable outcome that the second wave would worsen in LTC facilities compared to the first. There are ongoing investigations into why COVID-19 had such devastating effects in BC's LTC homes during the second wave versus the first. Still, this information will likely not be available until Summer 2021 (Hunter, 2021).

### *Vaccine Distribution and the Third Wave (March 2021 – Present)*

According to BC's vaccine rollout strategy, all LTC residents and staff were scheduled to be the first vaccinated during Phase 1, which extended from December 2020 to February 2021 (Government of British Columbia, 2021c). While BC aimed to administer all 150,000 doses received by the end of January, delays in shipments of vaccines lengthened the time it took to vaccinate LTC facilities. On February 5<sup>th</sup>, 2021, 87% of LTC residents received their first dose, and on February 11<sup>th</sup>, all LTC residents and staff across the province received their first dose (Carrigg, 2021; Kotyk, 2021). The strategy helped reduce the number of new cases and outbreaks seen during the third wave. BC has now reported a total of 329 outbreaks with no current outbreaks reported in LTC facilities. A total of 3,584 positive COVID-19 cases and 1,032 deaths were reported across LTC residents, and a total of 2,278 cases and no deaths were reported amongst LTC staff (Government of British Columbia, 2021a).

### *COVID-19 Outcome Patterns Across LTC Facilities*

While less information is available on BC when compared to Ontario, similar patterns were also seen across BC facilities. A CBC investigation published in Feb 2021 found that COVID-19 outbreaks were more common in private, for-profit residences in British Columbia when compared to private, not-for-profit and publicly owned facilities. When comparing death rates, private for-profit facilities were slightly higher than private, not-for-profit facilities. However, both were found to have much higher death rates than facilities run by regional health authorities. Due to how information is presented via the Ministry of Health, there is no distinction between long-term care and assisted living/retirement homes. The differences seen can potentially be explained by many factors,

including the spending per resident (Carman, 2021). However, the COVID-19 response review report published by Ernst & Young in collaboration with the Government of BC suggests that privately owned facilities may have been at a disadvantage when compared to publicly owned facilities. Health authority-owned and operated facilities could procure personal protective equipment, manage staffing availability, and receive infection prevention and control training, while private facilities were left to manage independently. (British Columbia Ministry of Health, 2020).

## **Analysis**

### *Research Availability*

This paper provides an account of LTC, history of regulations, current regulations and enforcement of LTC in Ontario and BC. They are meant to help answer the three parts of the research question *What, if any, are the LTC regulatory differences between Ontario and British Columbia? If there are differences, 1) do these regulatory differences help explain the differentiating COVID-19 outcomes in LTC facilities within each province? And 2) do these regulatory differences help explain the relationship between COVID-19 in LTC facilities and ownership status within Ontario and British Columbia?* This section seeks to address these questions more directly. However, it is essential to note the limitations of the account provided within this paper. At the time of writing, there was limited information on the regulations and enforcement in LTC in Ontario and BC, especially pre-COVID-19 <sup>5</sup>.

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<sup>5</sup> For example, most of the history of long-term care in Ontario is drawn from three research papers. Information on current regulations and enforcement came from the LTC Commission report published in April 2021 and interim reports published throughout the first wave of the pandemic, rather than information provided and researched pre-pandemic.

Unlike Ontario, most of the research available for BC discusses the policy challenges surrounding the LTC sector in the province. However, similar to Ontario, some of this research was done and published in response to ongoing issues occurring within the sector, i.e., the two-part report from the Office of the Ombudsperson. Unlike Ontario, limited information was available on the current regulations and enforcement within BC. Unlike the Ontario LTC Commission report, the report published by Ernst and Young (in collaboration with the Government of British Columbia) focused entirely on the Province's COVID-19 response during the first wave. Minimal mention was made to existing challenges within the sector about regulations and enforcement. This lack of mention is interesting because the report on the Ombudsperson and the updated BC action plan were made available in 2012 and 2014. The Ernst and Young report did not mention these reports' findings and any subsequent policy changes. This lack of mention may be explained by the report on the response to COVID-19 focusing on the first wave only, where BC's response was overall positive compared to other jurisdictions in Canada, including Ontario. BC is undergoing another investigation exploring the second wave in more detail, but this report will not be made available until summer 2021 (Hunter, 2021).

The availability of research on LTC, regulations and enforcement within Ontario and BC speaks to a more significant issue. The majority of the research cited in this paper was done following complaints/issues within the sector or only after the outcomes of COVID-19 became more well known. Due to the accounts given in this paper and the information available for both Ontario and BC concerning regulations and enforcement, any linkages drawn in the subsequent sections of this analysis do not confirm a causal relationship between the variables. In sum, the limitations of the data mean

that it is difficult, if not impossible, to answer the research question posed definitively. However, the research and analysis conducted can help inform connections that may explain the differentiating outcomes within LTC sectors in Ontario and BC throughout the COVID-19 pandemic.

*COVID-19 Response*

**Table IV – First, Second and Third Wave Outbreaks, Cases and Deaths in Ontario and BC<sup>6</sup>**

<b>First Wave (Mar 2020 - Aug 2020)</b>	<b>Number of LTC Outbreaks</b>	<b>Number of Resident Cases</b>	<b>Number of Staff Cases</b>	<b>Number of Resident Deaths</b>	<b>Number of Staff Deaths</b>
<b>Ontario</b>	390	5,941	2,533	1,937	8
<b>British Columbia</b>	90	588	692	157	0

<b>Second Wave (Sept 2020 - Feb 2021)</b>	<b>Number of LTC Outbreaks</b>	<b>Number of Resident Cases</b>	<b>Number of Staff Cases</b>	<b>Number of Resident Deaths</b>	<b>Number of Staff Deaths</b>
<b>Ontario</b>	899	9,019	4,108	1,934	2
<b>British Columbia</b>	207	2,682	1,495	796	0

<b>Third Wave** (Mar 2021 - ongoing)</b>	<b>Number of LTC Outbreaks</b>	<b>Number of Resident Cases</b>	<b>Number of Staff Cases</b>	<b>Number of Resident Deaths</b>	<b>Number of Staff Deaths</b>
<b>Ontario</b>	200	479	585	105	0
<b>British Columbia</b>	32	314	91	79	0

\* BC data combines LTC and assisted living facilities

\*\* Based on available information at the time this paper was written - the third wave is still ongoing within both provinces

Based on the available information, both provinces had similar statistical patterns within the third wave of the pandemic. Overall case numbers and deaths amongst residents and staff significantly dropped compared to the first and second wave (see table above). Ontario and BC vaccinated all residents and staff by mid-February 2021, following the impacts of the second wave within both provinces' LTC sectors<sup>7</sup>.

<sup>6</sup> This table is a compilation of the statistics provided in the sections *COVID-19 in Ontario LTC Homes* and *COVID-19 in British Columbia LTC Homes* (British Columbia Ministry of Health, 2020; Canadian Institute for Health Information, 2020b; Government of British Columbia, 2021a, 2021b; Public Health Ontario, 2020, 2021b, 2021a).

<sup>7</sup> However, the information presented in the above table for the third wave is based on the information made available when the author wrote this paper. The actual third wave data is higher than the information presented in the table above since the third wave is still ongoing. Given high community vaccination rates, cases have continued to decline since February 2021. Therefore, although the numbers presented above are not complete, the significant decrease in widespread outbreaks, cases, and deaths compared to

Ontario and BC also had similar second-wave LTC outcomes. The second wave was the most devastating in both jurisdictions regarding LTC outbreaks, cases and deaths amongst residents and staff. In Ontario, the number of resident and staff cases nearly doubled and the number of resident deaths remaining consistent compared to the first wave. There are 899 outbreaks in 626 facilities because many of the same facilities had multiple outbreaks during the second wave. In BC, the number of outbreaks increased from 90 in the first wave to 207 outbreaks reported during the second wave. The number of resident cases and deaths increased nearly six-fold, and the number of staff cases double compared to the first wave. The second wave can be explained by both jurisdictions not learning from the mistakes made during the first wave of the pandemic. This point is especially true for BC, which had one of the best COVID-19 LTC outcomes during the first wave across Canada. Unfortunately, due to testing backlogs and not adjusting approaches based on lessons learned during the first wave, both the Ontario and BC LTC sector were strongly impacted by the second wave.

The primary difference between Ontario and BC regarding COVID-19 response is seen within the first wave. As described in the preceding sections, Ontario had multiple issues that resulted in very poor COVID-19 LTC outcomes within the first wave, including inadequate pandemic preparedness, slow government response/disorganized governance, PPE shortages and poor policy decisions (Government of Ontario, 2021b). In contrast, BC had a more robust pandemic preparedness strategy ahead of the first wave; the work of various government agencies at all levels was well coordinated and was quick to respond to challenges brought on by the virus (British Columbia Ministry of

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the first and second wave is likely to continue based on current vaccination and case trends seen in Ontario and BC, as described in the preceding sections.

Health, 2020). There is also a noticeable decrease in overall cases and deaths amongst BC LTC staff and residents compared to Ontario (see table IV). As well, some of the variance may be attributed to situational leadership, as seen through the detailed explanations above on the role of the Ontario CMOH in comparison to BC's PHO. However, this analysis is limited by the information available on BC. While Ontario reported specifically on LTC facilities within the province, BC combined LTC and assisted living/ retirement home data. Further analysis into the differences between LTC and retirement homes about COVID-19 outbreaks can be seen below under the *Ownership* section.

### *Regulations and Enforcement*

Both jurisdictions saw attempts over the last 10-20 years to improve regulations within the LTC sector due to ongoing compliance issues. These changes included stricter regulatory compliance and commitments to the care and rights of seniors residing within these facilities. In Ontario, this trend is evident when we consider the changes made within the *Long-Term Care Homes Act (2007)*. When originally introduced, the Act aimed to introduce stricter compliance to regulations and inspections. The Act provided a more clearly defined *Residents' Bill of Rights* and attempted to strengthen the requirement of an integrated, interdisciplinary care plan for LTC residents (Government of Ontario, 2011, 2020). In BC, following years of not prioritizing the LTC and assisted living sector and growing complaints from patients and families, the Ombudsperson published two reports with 176 recommendations on improving the sector (British Columbia Office of the Ombudsperson, 2009). These recommendations included stricter regulation enforcement and improving the associated *Resident Bill of Rights*. In response to these two reports,

the Government of British Columbia published the *Improving Care for BC Seniors Action Plan* in 2014, which aimed to build on the findings from the Office of the Ombudsperson. (Government of British Columbia, 2014).

In both jurisdictions, it is unclear how well these changes are enforced. Ontario has more information available on regulatory enforcement, as seen in reports published during the COVID-19 pandemic (Government of Ontario, 2021b; Marrocco et al., 2020). Enforcement appears to have been relatively weak. The LTC Commission's report found that the RQIs required by the *Long-Term Care Homes Act (2007)* fell drastically between 2018-2020, with only 11 homes receiving proactive inspection during the first wave of the pandemic. In contrast, from 2015-2017, nearly all 626 LTC facilities in Ontario received RQIs. There was poor enforcement of the Plan of Care, which requires updating every six months to properly reassess and meet the needs of patients within these homes. Both requirements are directly related to the care that LTC residents received (Marrocco et al., 2020). There is no evidence to suggest that changes have been made to the sector following the publication of these reports (at the time the author wrote this paper). In BC, there is little to no evidence or analysis of the enforcement of the *Improving Care for BC Seniors Action Plan* after 2014. Citizens can find Public information on inspections on each facility through their respective regional health authorities' websites. However, the information is hard to access and compare across different facilities. Each regional health authority publishes and reports on inspections independently of one another. No database compares all homes and differentiates between LTC and assisted living facilities (Government of British Columbia, n.d.-a).

The main difference between the two jurisdictions is how the historical changes to policies impacted the ownership of facilities within the respective province. As demonstrated earlier, the historical changes to LTC regulation in BC did not impact facilities' ownership and profit status to the degree seen in Ontario. While there is analysis available on the rise and impact of private, for-profit facilities in Ontario and BC, changes in policy and regulation in Ontario led to the province having the highest proportion of private, for-profit facilities in the country. This finding sets the stage for a discussion of the impact of ownership status.

### *Ownership*

It is crucial to address the role ownership status has on the COVID-19 outcomes within each jurisdiction. Much of the research and analysis released during the COVID-19 pandemic suggests that ownership status is one of the leading factors determining COVID-19 outcomes across LTC facilities (Carman, 2021; Liu et al., 2020; Szklarski, 2020). As discussed above, analyses conducted in both Ontario and BC show that private, for-profit facilities had worse COVID-19 outcomes when compared to public and private, not-for-profit facilities. There is a clear distinction in the number of cases and deaths seen within private, for-profit facilities compared to public and private, not-for-profit facilities in both jurisdictions. However, it is unclear if ownership is the primary factor for understanding the variances in COVID-19 LTC outcomes between Ontario and BC.

First, the legislation and associated regulations do not differentiate between private and public ownership, for-profit and not-for-profit LTC facilities in Ontario or BC. While the regulatory structure in Ontario gave rise to more private, for-profit facilities, the regulations themselves do not have different requirements for different facilities based on ownership

(Government of British Columbia, 2002; Government of Ontario, 2020). Second, although there were more outbreaks within for-profit, private facilities in both Ontario and BC, there were still outbreaks within public and private, not-for-profit facilities in both jurisdictions (Carman, 2021; Stall et al., 2021). As indicated earlier, in BC, the Ernst & Young report suggests that privately owned facilities may have been at a disadvantage compared to publicly owned facilities due to procurement of PPE, management of staff and infection prevention and control training (British Columbia Ministry of Health, 2020).

Third, there is a notable difference in overall cases and deaths between LTC facilities and retirement homes. Table V compares the number of cases and deaths in LTC and Retirement Home residents in Ontario and BC. This comparison is essential because while LTC facilities may vary in ownership, retirement homes are privately owned (with varying for-profit, not-for-profit statuses in BC) (British Columbia Seniors Living Association, n.d.; Ontario Retirement Communities Association, n.d.). As seen below, the total number and proportion of cases and deaths due to COVID-19 in retirement homes are much smaller than in LTC facilities. This comparison is also interesting because retirement homes are regulated differently in each province. While Ontario has its separate regulation for retirement homes, known as the *Retirement Homes Act*, BC retirement homes are regulated with LTC facilities under the *Community Care and Assisted Living Act* (British Columbia Seniors Living Association, n.d.; Ontario Retirement Communities Association, n.d.).

**Table V – First Wave Cases and Deaths: Retirement Homes and LTC facilities**

Retirement Homes	Cases	Deaths	Cases as a % of all COVID-19 cases	Deaths as a % of all COVID-19 deaths
Ontario	1,484	209	3.50%	7.40%
British Columbia	88	<5	1.50%	1.40%

Long-Term Care Facilities	Cases	Deaths	Cases as a % of all COVID-19 cases	Deaths as a % of all COVID-19 deaths
Ontario	8,580	1,823	20.30%	64.30%
British Columbia	573	118	9.90%	56.70%

Canadian Institute for Health Information. *Impact of COVID-19 on Long-Term Care in Canada: Focus on the First 6 Months — Data Tables*. Ottawa, Ontario: CIHI; 2021.

**Conclusion**

This paper sought to answer the following three-part research question: *What, if any, are the long-term care (LTC) regulatory differences between Ontario and British Columbia? If there are differences, 1) do these regulatory differences help explain the differentiating COVID-19 outcomes in LTC facilities within each province? And 2) do they help explain the relationship between COVID-19 in LTC facilities and ownership status within ON and BC?* In response to the first research question, there does not appear to be too many differences between Ontario and BC regarding regulations and enforcement. Both jurisdictions faced ongoing compliance issues within the sector and have attempted to introduce new regulatory structures over the last 10-20 years to remediate this problem. However, the findings from this paper suggest it is unclear within both jurisdictions how these new regulations are enforced in the present day. That being said, the history of regulations and enforcement for each jurisdiction has provided some information that can help answer the second and third research questions.

In response to the second research question, it is unclear how current regulations and enforcement played a role in the COVID-19 outcomes within LTC sectors in Ontario

and BC. While governmental reports within each province pointed out that both the Government of Ontario and BC need to improve inspection stringency and compliance, this paper can make little connection between current regulations and enforcements and the COVID-19 outcomes within LTC facilities. However, the historical account of regulations within Ontario and BC does help provide context to the relationship between COVID-19 outcomes within LTC facilities and ownership status to answer the last part of the research question. The historical governmental changes within the LTC sector in Ontario favoured private, for-profit ownership status facilities. The changes within the BC sector did not result in the same increase in the proportion of private, for-profit facilities in present-day British Columbia. This connection foreshadows the present-day argument that ownership is a key predictor of LTC home performance (Berta et al., 2005; Liu et al., 2020). It can also be related to uncovering why LTC in Ontario was so massively affected by the pandemic compared to BC and other jurisdictions in Canada, beyond just systematic failures related to PPE shortages, poor policy decisions, and overall disorganized governance.

While the findings in this paper cannot state whether or not regulations and enforcement played a role in COVID-19 outcomes within each jurisdiction, the research conducted and the analysis provided have unveiled important factors relevant to understanding LTC, regulations, enforcement, and COVID-19 in Ontario and BC. The analysis suggests that LTC outcomes are more complicated than just one responsible factor – the issue is more complex and heavily intertwined. For example, a potential avenue for further exploration includes analyzing the role of leadership throughout the pandemic (i.e., the CMOH of Ontario), as the decisions made before and during each

wave were critical to the COVID-19 LTC outcomes seen within each province. It would be necessary also to explore how the same leadership responsible for critical decisions throughout the pandemic within the LTC sector also play a role in future governmental considerations around long-term care. Another example of an important factor is ownership – while there is evidence to suggest that COVID-19 LTC outcomes and ownership status are linked, the analysis also shows that retirement homes (which are private, for-profit facilities) did not face the same case counts and deaths as LTC facilities. This finding may be due, in part, to the fact that LTC residents are sicker and require more medical care than residential home residents. Nonetheless, this finding suggests that more than just ownership status is responsible for the poor COVID-19 LTC home outcomes within each jurisdiction.

The findings in this paper also point to a lack of understanding of LTC regulations and enforcement within academia. While BC had better COVID-19 outcomes in LTC facilities when compared to ON in the first wave, the second and third waves between the two jurisdictions saw almost similar case and death incidence patterns. Overall, what happened in both provinces and Canada, more broadly, is entirely unacceptable. Researchers and government officials should emphasize understanding the current regulations and enforcement within each province and territory to try and uncover solutions to the ongoing issues present within the LTC sector. The federal government announced in Budget 2021 an investment of \$3B, starting in 2022-23, to support the development and permanent application of standards for long-term care within each province and territory (Government of Canada, 2021a). These standards should include some mention of the current regulatory and enforcement frameworks within each

jurisdiction and propose goals and require public reporting to publicize the enforcement of these new standards. Federal/provincial/territorial negotiations can also include discussions around ownership status – it may be possible that private, for-profit facilities are no longer necessary within the LTC sector. Governments can make a different arrangement between public and private enterprises that do not result in private, for-profit ownership of LTC facilities (i.e. private companies build and are responsible for the infrastructure of all LTC facilities, but they are all run on a public or private, not-for-profit bases).

It is unfortunately impossible to go back and change the disastrous LTC outcomes seen since March 2020. However, future research attempts and government action can help ensure that future LTC residents in Canada do not have to undergo the same horrifying, undignified treatment that was seen over the last year and a half. The author of this paper sincerely hopes that Canada has learned its lesson, as it has come at the expense of many Canadian lives unjustly lost too soon.

## Works Cited

- Banerjee, A. (2007). An Overview of Long-Term Care in Canada and Selected Provinces and Territories. *Women and Health Care Reform*, (October), 31. Retrieved from [http://www.womenandhealthcarereform.ca/publications/banerjee\\_overviewLTC.pdf](http://www.womenandhealthcarereform.ca/publications/banerjee_overviewLTC.pdf)
- Berta, W., Laporte, A., & Valdmanis, V. (2005). Observations on Institutional Long-Term Care in Ontario: 1996–2002. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, 24(1), 71–84. <https://doi.org/10.1353/cja.2005.0002>
- Blouin Genest, G., Burlone, N., Champagne, E., Eastin, C., & Ogaranko, C. (2021). Translating COVID-19 emergency plans into policy: A comparative analysis of three Canadian provinces. *Policy Design and Practice*, 4(1), 1–18. <https://doi.org/10.1080/25741292.2020.1868123>
- British Columbia Housing. (2021). Assisted Living Residences. Retrieved June 13, 2021, from British Columbia Housing website: <https://www.bchousing.org/housing-assistance/housing-with-support/assisted-living-residences>
- British Columbia Ministry of Health. (2020). *BC Ministry of Health Long-term care COVID-19 response review*.
- British Columbia Office of the Ombudsperson. (2009). *the Best of Care: Getting It Right for Seniors in British Columbia Part 1*.
- British Columbia Seniors Living Association. (n.d.). Frequently Asked Questions About Senior Living. Retrieved June 23, 2021, from British Columbia Seniors Living Association website: <https://www.bcscla.ca/senior-living-frequently-asked-questions/>
- Canadian Centre for Policy Alternatives. (2021). BC Ombudsperson Investigates

Problems in Seniors Care . Retrieved June 14, 2021, from Canadian Centre for Policy Alternatives website: <https://www.policyalternatives.ca/projects/seniors-care/ombudsperson>

Canadian Institute for Health Information. (2020a). *Pandemic experience in the long-term care sector: How does Canada compare with other countries?* (June), 1–9.

Canadian Institute for Health Information. (2020b, September 24). Long-term care homes in Canada: How many and who owns them? . Retrieved June 13, 2021, from Government of Canada website: <https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them>

Canadian Institute for Health Information. (2021). *The Impact of COVID-19 on Long-Term Care in Canada: Focus on the First 6 Months.*

Carman, T. (2021, February 4). COVID-19 outbreaks more common in for-profit senior residences in B.C. . Retrieved June 15, 2021, from CBC News website: <https://www.cbc.ca/news/canada/british-columbia/covid-19-outbreaks-seniors-care-homes-bc-1.5898338>

Carrigg, D. (2021, February 11). COVID-19: Long-term care home outbreaks in B.C. fall with vaccination complete . Retrieved May 22, 2021, from Vancouver Sun website: <https://vancouversun.com/news/local-news/covid-19-long-term-care-home-outbreaks-in-b-c-fall-with-vaccination-complete>

Daly, T. (2015). Dancing the Two-Step in Ontario's Long-term Care Sector: More Deterrence-oriented Regulation = Ownership and Management Consolidation. *Studies in Political Economy*, 95, 29–58.

DeClerq, K. (2021, April 24). COVID-19 Ontario: More than 4,000 new cases reported

as ICU admission continues to climb . Retrieved May 16, 2021, from CTV News website: <https://toronto.ctvnews.ca/ontario-logs-more-than-4-000-new-covid-19-cases-as-icu-admission-continues-to-climb-1.5400844>

Gerring, J. (2007). *Case study research: principles and practices*. Retrieved from <https://books-scholarsportal-info.proxy.bib.uottawa.ca/en/read?id=/ebooks/ebooks2/cambridge/2010-04-12/1/0511268092>

Government of British Columbia. (n.d.-a). Finding a Residential Care Facility. Retrieved June 23, 2021, from Government of British Columbia website:

<https://www2.gov.bc.ca/gov/content/health/accessing-health-care/finding-assisted-living-or-residential-care/residential-care-facilities/finding-a-residential-care-facility>

Government of British Columbia. (n.d.-b). Long-Term Care Services. Retrieved May 25, 2021, from Government of British Columbia website:

<https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/long-term-care-services>

Government of British Columbia. (2002). Community Care and Assisted Living Act 2002. Retrieved July 13, 2021, from Government of British Columbia website:

[https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/02075\\_01](https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/02075_01)

Government of British Columbia. (2014). *Improving Care for B.C. Seniors: An Action Plan*.

Government of British Columbia. (2021a). *British Columbia COVID-19 Situation Report Week 25: June 20-June 26, 2021*.

Government of British Columbia. (2021b). *British Columbia COVID-19 Situation Report*

*Week 9: February 28 - March 6, 2021.*

Government of British Columbia. (2021c, May 20). COVID-19 Immunization Plan .

Retrieved May 22, 2021, from Government of British Columbia website:

<https://www2.gov.bc.ca/gov/content/covid-19/vaccine/plan>

Government of British Columbia. (2021d, June 8). Residential Care Regulation.

Retrieved June 15, 2021, from Government of British Columbia website:

[https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96\\_2009#section51](https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96_2009#section51)

Government of Canada. (2021a, April 19). Budget 2021 Part 1 - Finishing the Fight

Against COVID-19 . Retrieved July 13, 2021, from Government of Canada website:

<https://www.budget.gc.ca/2021/report-rapport/p1-en.html>

Government of Canada. (2021b, June 13). Coronavirus disease (COVID-19): Outbreak

update . Retrieved June 13, 2021, from Government of Canada website:

<https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html>

Government of Ontario. (2011). *A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10*. Toronto, Ontario.

Government of Ontario. (2020). Long-Term Care Homes Act, 2007, S.O. 2007, c. 8.

Retrieved January 11, 2021, from Government of Ontario website:

<https://www.ontario.ca/laws/statute/07l08>

Government of Ontario. (2021a). *COVID-19 Vaccination Update - Technical Briefing*.

Toronto, ON.

Government of Ontario. (2021b). *Ontario's Long-Term Care COVID-19 Commission*

- Final Report* (p. 322). p. 322. Ontario Long-Term Care Commission.
- Government of Ontario. (2021c, April 1). Long-term care overview . Retrieved May 24, 2021, from Government of Ontario website: <https://www.ontario.ca/page/about-long-term-care>
- Hirdes, J. P. (2013). Long-term care funding in Canada: A policy mosaic. *Long-Term Care in the 21st Century: Perspectives from Around the Asia-Pacific Rim*, 9420, 69–81. <https://doi.org/10.1300/J031v13n02>
- Hollander, M. J., & Pallan, P. (1995). The British Columbia Continuing Care system: Service delivery and resource planning. *Aging Clinical and Experimental Research*, 7(2), 94–109. <https://doi.org/10.1007/BF03324298>
- Howlett, K. (2021, March 1). Doug Ford overrode Ontario’s top doctor on COVID-19 tests, overwhelming system . Retrieved April 25, 2021, from The Globe and Mail website: <https://www.theglobeandmail.com/canada/article-doug-ford-overrode-ontarios-top-doctor-on-covid-19-tests-overwhelming/>
- Hunter, J. (2021, March 21). How B.C.’s early success in protecting vulnerable seniors evaporated in COVID-19 second wave. Retrieved May 22, 2021, from The Globe and Mail website: <https://www.theglobeandmail.com/canada/british-columbia/article-how-bcs-early-success-in-protecting-vulnerable-seniors-evaporated-in/>
- Kotyk, A. (2021, February 5). COVID-19 vaccine: 87% of long-term care residents have received their 1st dose. Retrieved May 22, 2021, from CTV News website: <https://bc.ctvnews.ca/covid-19-vaccine-87-of-long-term-care-residents-have-received-their-1st-dose-1.5297821>

Kramer, C. K., & Retnakaran, R. (2020). Rates of COVID-19-associated hospitalization in British Columbia and Ontario: time course of flattening the relevant curve.

*Canadian Journal of Public Health*, Vol. 111, pp. 636–640.

<https://doi.org/10.17269/s41997-020-00405-3>

Library of Parliament. (2020, October 22). Long-Term Care Homes in Canada – How are They Funded and Regulated? . Retrieved May 24, 2021, from Library of Parliament website: <https://hillnotes.ca/2020/10/22/long-term-care-homes-in-canada-how-are-they-funded-and-regulated/>

Liu, M., Maxwell, C. J., Armstrong, P., Schwandt, M., Moser, A., McGregor, M. J., ...

Dhalla, I. A. (2020). COVID-19 in long-term care homes in Ontario and British

Columbia. *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, 192(47), E1540–E1546.

<https://doi.org/10.1503/cmaj.201860>

Mancini, M., Pedersen, K., & Common, D. (2020, December 18). These nursing home chains have the highest COVID-19 death rates in Ontario, data analysis finds |

CBC News. Retrieved June 15, 2021, from CBC News website:

<https://www.cbc.ca/news/canada/nursing-homes-covid-19-death-rates-ontario-1.5846080>

Marrocco, F., Coke, A., & Kitts, J. (2020). *Ontario's Long-Term Care COVID-19*

*Commission Second Interim Letter*. Toronto, Ontario.

McGregor, M. (2020, May 20). Time to heed the evidence on public funding for long-term care. Retrieved June 23, 2021, from Policy Options Politiques website:

<https://policyoptions.irpp.org/magazines/may-2020/time-to-heed-the-evidence-on->

public-funding-for-long-term-care/

Office of the Auditor General of Ontario. (2017). Office of the Auditor General - Annual Report 2017. In *Government of Ontario* (Vol. 1). Toronto, Ontario.

Ontario Retirement Communities Association. (n.d.). Retirement Living FAQs .

Retrieved June 23, 2021, from Ontario Retirement Communities Association website: <https://www.orcaretirement.com/retirement-living-faqs/>

Public Health Ontario. (2020). *Daily Epidemiologic Summary: COVID-19 in Ontario: January 15, 2020 to August 31st, 2020*.

Public Health Ontario. (2021a). *COVID-19 in Ontario: January 15, 2020 to July 10, 2021*. Toronto.

Public Health Ontario. (2021b). *Enhanced Epidemiological Summary COVID-19 in Long-Term Care Homes in Ontario: January 15, 2020 to February 28, 2021*.

2(Ccm), 1–14. Retrieved from <https://www.publichealthontario.ca/-/media/documents/ncov/epi/2020/06/covid-19-epi-ltch-residents.pdf?la=en>

Retirement Homes Regulatory Authority. (2011). Legislation and Regulations. Retrieved June 14, 2021, from Retirement Homes Regulatory Authority website: <https://www.rhra.ca/en/about-rhra/our-role/understanding-the-act/>

Sinha, S., Feil, C., & Iciaszczyk, N. (2021). The Rollout of COVID-19 Vaccines in Canadian Long-Term Care Homes, 15th March 2021 update . In *LTC Responses to COVID-19 - International Long-Term Care Policy Network*. Retrieved from <https://ltccovid.org/2021/03/19/the-rollout-of-covid-19-vaccines-in-canadian-long-term-care-homes-15th-march-2021-update/>

Stall, N. M., Brown, K. A., Maltsev, A., Jones, A., Costa, A. P., Allen, V., ... Hillmer, M.

(2021). *COVID-19 and Ontario's Long-Term Care Homes*.

Statistics Canada. (2020, July 1). Population estimates on July 1st 2020. Retrieved

June 23, 2021, from Government of Canada website:

<https://www150.statcan.gc.ca/t1/tbl1/en/cv.action?pid=1710000501>

Szklarski, C. (2020, September 30). Fewer COVID-19 deaths in B.C. than Ontario long-

term care credited to funding, policy . Retrieved June 23, 2021, from CBC News

website: [https://www.cbc.ca/news/health/long-term-care-covid-19-ontario-bc-](https://www.cbc.ca/news/health/long-term-care-covid-19-ontario-bc-1.5744857)

[1.5744857](https://www.cbc.ca/news/health/long-term-care-covid-19-ontario-bc-1.5744857)

Tung, S. M. W., Phinney, A., & Boschma, G. (2008). Residential Elder Care in British

Columbia : Policy Development and Culture. *Perspectives*, 34(4), 5–16.

Weichel, A. (2021, December 4). Third wave of COVID-19: B.C. adds 3,289 cases, 18

deaths over the weekend . Retrieved May 20, 2021, from CTV News website:

[https://bc.ctvnews.ca/third-wave-of-covid-19-b-c-adds-3-289-cases-18-deaths-over-](https://bc.ctvnews.ca/third-wave-of-covid-19-b-c-adds-3-289-cases-18-deaths-over-the-weekend-1.5383811)

[the-weekend-1.5383811](https://bc.ctvnews.ca/third-wave-of-covid-19-b-c-adds-3-289-cases-18-deaths-over-the-weekend-1.5383811)

Woodward, J. (2020, July 17). Depleted PPE supplies put B.C.'s readiness for

pandemic in jeopardy. Retrieved May 22, 2021, from CTV News website:

[https://bc.ctvnews.ca/depleted-ppe-supplies-put-b-c-s-readiness-for-pandemic-in-](https://bc.ctvnews.ca/depleted-ppe-supplies-put-b-c-s-readiness-for-pandemic-in-jeopardy-memo-1.5028955)

[jeopardy-memo-1.5028955](https://bc.ctvnews.ca/depleted-ppe-supplies-put-b-c-s-readiness-for-pandemic-in-jeopardy-memo-1.5028955)