AMENDED THIS 11 JULY 23 PURSUANT TO
MODIFIÉ CE CONFORMÉMENT À

☐ RULE/LA RÈGLE 26.02 (_____)

☒ THE ORDER OF Justice Healey
L'ORDONNANCE DU
DATED / FAIT LE July 13, 2023

REGISTRAR SUPERIOR COURT OF JUSTICE
GREFFIER COUR SUPÉRIEURE DE JUSTICE



Court File No. CV-21-00000142-00CP

**ONTARIO**
**SUPERIOR COURT OF JUSTICE**

B E T W E E N:

GEORGE HEAD by his Litigation Guardian MARCELLA LAMBIE, MARCELLA LAMBIE, The Estate of JANET MARTIN, deceased, by her Estate Representative SCOTT MARTIN, and SCOTT MARTIN

Plaintiffs

- and -

859530 ONTARIO INC., BARRIE LONG TERM CARE CENTRE INC., JARLETTE HOLDINGS INC., JARLETTE LTD., and ROBERTA PLACE RETIREMENT LODGE INC.

Defendants

(Proceeding under the *Class Proceedings Act, 1992*, S.O. 1992, c. 6)

**AMENDED STATEMENT OF CLAIM**

TO THE DEFENDANTS:

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the plaintiff(s). The Claim made against you is set out in the Statement of Claim served with this Notice of Action.

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

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

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

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. If you wish to defend this proceeding but are unable to pay legal fees, legal aid may be available to you by contacting your local Legal Aid office.

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

Date: 1 Feb 2021 ~~January 29, 2021~~ Issued by 'efiled'
Registrar

Address of Court Office:
75 Mulcaster Street
Barrie, ON L4M 3P2

TO: 859530 ONTARIO INC.
o/a Jarlette Health Services
5 Beck Blvd
Penetanguishene, ON L9M 1C1
djarlette@jarlette.com

AND TO: BARRIE LONG TERM CARE CENTRE INC.
o/a Roberta Place
711 Yonge Street
Midland, ON L4R 2E1
djarlette@jarlette.com

AND TO: JARLETTE HOLDINGS INC.
711 Yonge Street
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AND TO: JARLETTE LTD.
711 Yonge Street
Midland, ON L4R 2E1
djarlette@jarlette.com

AND TO: ROBERTA PLACE RETIREMENT LODGE INC.
o/a Roberta Place Retirement Lodge
5 Beck Blvd
Penetanguishene, ON L9M 1C1
Phone: (705) 733-3231
Fax: (705) 733-2592
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## CLAIM

1. The Plaintiffs George Head by his Litigation Guardian Marcella Lambie, and the Estate of Janet Martin, deceased, by her Estate Representative Scott Martin claim on their own behalf and on behalf of the Class Members as defined below:

a. An Order pursuant to the *Class Proceedings Act*, 1992, S.O. 1992, c. 6, as amended, certifying this proceeding as a class proceeding and appointing Marcella Lambie and Scott Martin as the Representative Plaintiffs for the Class;

b. A declaration that 859530 Ontario Inc., Barrie Long Term Care Centre Inc., Jarlette Holdings Inc., Jarlette Ltd., and Roberta Place Retirement Lodge Inc. (collectively, the "Defendants") owed duties of care to the Plaintiffs George Head, Janet Martin, and the Class with respect to long-term care facilities that they own, operate, and manage during the COVID-19 pandemic;

c. A declaration that the Defendants breached their duties of care to the Plaintiffs George Head, Janet Martin, and to the Class by engaging in the conduct described below;

d. A declaration that the Defendants are liable to the Plaintiffs George Head, Janet Martin, and to the Class for damages caused or materially contributed to by the Defendants' breaches of their fiduciary and common law duties of care;

e. A declaration that the Defendants are vicariously liable for the acts and omissions of their officers, directors, agents, employees, and representatives;

f. Damages for the Defendants' breach of contract, gross negligence, breach of fiduciary duty, and the Defendants' failure to act, or make a good faith effort to act, in accordance with applicable public health guidance and any federal, provincial or municipal law relating to COVID-19, in the amount of $25,000,000.00 or such other amount as this Honourable Court may find appropriate;

g. Damages pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3, as amended, in the amount of $100,000.00 for each such Plaintiff;

h. Punitive, aggravated, exemplary, and mental distress damages in the amount of $25,000,000.00 or such other amount as this Honourable Court may find appropriate;

i. Damages in an amount to be fixed by this Honourable Court for the costs of providing notice of certification of this action as a class proceeding, and for administering the plan of distribution of the recovery of this action, plus applicable taxes;

j. Pre-judgment and post-judgment interest in accordance with the *Courts of Justice Act*, R.S.O. 1990, c. C. 43, as amended;

k. The costs of this Action on a substantial indemnity basis, plus applicable

goods and services and harmonized sales taxes; and

l. Such further and other relief as may be required and as this Honourable Court deems just.

**BACKGROUND**

2. COVID-19 is a disease of public health significance and has been designated as communicable under Ontario Regulation 135/18, as amended. COVID-19 is a disease caused by the SARS-CoV-2 virus. COVID-19 has been declared a pandemic by the World Health Organization. The Province of Ontario has enacted emergency orders under the *Emergency Management and Civil Protection Act* as a result of the pandemic. Those orders have been continued under the *Reopening Ontario (A Flexible Response to COVID-19) Act*, 2020.

3. COVID-19 is present in the County of Simcoe and therefore poses a risk to the health of the residents of Simcoe Muskoka through community transmission. The COVID-19 virus is spread from an infected person to an uninfected person by direct contact or from a close encounter where respiratory secretions, droplets, or aerosols from the infected person are transmitted to the uninfected person.

4. Institutional settings such as Roberta Place Long Term Care Home facilitate the spread of COVID-19 and other communicable diseases where infection prevention and control measures and guidelines are not implemented and strictly complied with.

5. The elderly are especially vulnerable to COVID-19 and are entitled to care from properly trained and equipped staff, in a proper environment with adequate testing and

response protocols to prevent the introduction or spread of COVID-19.

6. Residents of Roberta Place Long Term Care Home are on average older than the general population and are more vulnerable to COVID-19.

7. The Defendants failed to protect the residents living in the Roberta Place Long Term Care Home through their grossly inadequate general planning and preparation for a viral respiratory outbreak.

8. In the months after COVID-19 emerged on the world stage and before any outbreaks in Ontario, the Defendants again failed to protect the residents in the Roberta Place Long Term Care Home by relying on grossly inadequate measures to prepare for and respond to the COVID-19 outbreak.

9. After the COVID-19 virus took root in Canada, the Defendants again failed to protect the residents living in the Roberta Place Long Term Care Home by repeatedly failing to act in accordance with, or make a good faith effort to act in accordance with, the leadership of public health officials and comply with public health guidance and directives regarding:

a. outbreak planning;

b. supply, use, and access to PPE;

c. visitor, supplier, and service personnel screening;

d. resident isolation and testing;

e. employee testing and screening; and

f. proper sanitation.

10. As a result of the Defendants' failures to adequately and/or properly plan, prepare and respond to the COVID-19 virus, the virus has run rampant through the Roberta Place Long Term Care Home.

11. On January 8, 2021, the Simcoe Muskoka District Health Unit declared a COVID-19 outbreak at Roberta Place Long Term Care Home.

12. On January 16, 2021, the Simcoe Muskoka Health Unit issued an order that would allow the Orillia Soldiers' Memorial Hospital to temporarily lead Roberta Place Long Term Care Home in controlling the COVID-19 outbreak. Staff from the Royal Victoria Regional Health Centre and the Canadian Red Cross were also deployed to help care for the Home's residents.

13. On January 26, 2021, the health unit confirmed 127 of the facility's 129 residents had contracted the virus.

14. As of February 12, 2021, 67 residents living at the Roberta Place Long Term Care Home have died of COVID-19 related complications. In most cases, they died alone without their families and loved ones at their side. In addition, one essential caregiver has died of COVID-19 related complications.

**THE PARTIES**

15. The Plaintiff Marcella Lambie is a resident of the Township of Oro-Medonte, in the Province of Ontario, and is also the Litigation Guardian of her brother, George Head, a resident of Roberta Place Long Term Care Home, a long-term care facility based in

Barrie, Ontario.

16. The Plaintiff Scott Martin is a resident of the City of Burlington, in the Province of Ontario, and is the Estate Representative of his late mother, Janet Martin. Janet Martin was a resident of Roberta Place Long Term Care Home, a long-term care facility in Barrie, Ontario at the time of the outbreak.

17. The Defendant 859530 Ontario Inc. is a privately held owner-operator of nursing and health care centres in Ontario. 859530 Ontario Inc. is a body corporate duly incorporated pursuant to the laws of Ontario and was at all material times the operator of, or had ownership interests in, Jarlette Health Services, located at 5 Beck Blvd, in the Town of Penetanguishene, in the County of Simcoe, in the Province of Ontario. 859530 Ontario Inc. was at all material times an operator, owner, and/or administrator of the Roberta Place Long Term Care Home in which George Head is a resident, and where Janet Martin was a resident.

18. The Defendant Barrie Long Term Care Centre Inc. is a privately held owner-operator of retirement and long-term care facilities in Ontario. Barrie Long Term Care Centre Inc. is a body corporate duly incorporated pursuant to the laws of Ontario and was at all material times the operator of, or had ownership interests in, Roberta Place Long Term Care Home, located at 503 Essa Road, in the City of Barrie, in the County of Simcoe, in the Province of Ontario. Barrie Long Term Care Centre Inc. was at all material times an operator, owner, and/or administrator of the Roberta Place Long Term Care Home in which George Head is a resident, and where Janet Martin was a resident.

19. The Defendant Jarlette Holdings Inc. is a privately held owner-operator of

retirement and long-term care facilities in Ontario. Jarlette Holdings Inc. is a body corporate duly incorporated pursuant to the laws of Ontario and was at all material times the operator of, or had ownership interests in, Roberta Place Long Term Care Home, located at 503 Essa Road, in the City of Barrie, in the County of Simcoe, in the Province of Ontario. Jarlette Holdings Inc. was at all material times an operator and/or owner of the Roberta Place Long Term Care Home in which George Head is a resident, and where Janet Martin was a resident.

20. The Defendant Jarlette Ltd. Is a privately held owner-operator of retirement and long-term care facilities in Ontario. Jarlette Ltd. Is a body corporate duly incorporated pursuant to the laws of Ontario and was at all material times the operator of, or has ownership interests in, Roberta Place Long Term Care Home, located at 503 Essa Road, in the City of Barrie, in the County of Simcoe, in the Province of Ontario. Jarlette Ltd. Was at all material times an operator and/or owner of the Roberta Place Long Term Care Home in which George Head is a resident, and where Janet Martin was a resident.

21. Jarlette Ltd. owns, operates, manages and/or advises at least four other long-term care and retirement facilities, including the following:

a. **Temiskaming Lodge**
   100 Bruce Street,
   Haileybury, ON P0J 1K0

b. **The Villa Retirement Lodge**
   Left Side Entrance,
   689 Yonge Street,
   Midland, ON L4R 2E1

c. **The Villa Care Centre**
Left Side Entrance,
689 Yonge Street,
Midland, ON L4R 2E1

d. **The Villa Care Centre and Retirement Lodge**
Left Side Entrance,
689 Yonge Street,
Midland, ON L4R 2E1

22. The Defendant Roberta Place Retirement Lodge Inc. is a body corporate duly incorporated pursuant to the laws of Ontario and was at all material times the operator of, or had ownership interests in, Roberta Place Long Term Care Home, located at 503 Essa Road, in the City of Barrie, in the County of Simcoe, in the Province of Ontario. Roberta Place Retirement Lodge Inc. was at all material times an operator, owner, and/or administrator of the Roberta Place Long Term Care Home in which George Head is a resident, and where Janet Martin was a resident.

23. The Defendants are for-profit private corporations that are paid to house and look after some of the most vulnerable members of our society: the elderly and those individuals requiring assistance with various aspects of daily living due to mental or physical incapacity.

**THE CLASS**

24. Marcella Lambie and Scott Martin bring this Action on behalf of: (1) all individuals who tested positive for COVID-19 living in Roberta Place Long Term Care Home, from January 10, 2020 to February 18, 2021 (the "Pandemic Period"); (2) the estates of all individuals who died from a COVID-19 infection acquired during the Pandemic Period

while living in Roberta Place Long Term Care Home; and (3) all family members who, by virtue of a personal relationship to one or more such persons described in (1) or (2), have standing in this action pursuant to section 61 of the *Family Law Act*, R.S.O. 1990, c. F.3, (together the "Class Members" or the "Class").

**THE EVENTS LEADING TO THE INJURY OF GEORGE HEAD**

25. On September 1, 2016, the Plaintiff George Head moved into the Roberta Place Retirement Lodge.

26. In or around March 2018, George Head transferred to the Roberta Place Long Term Care Home where he resides today.

27. On January 16, 2021, the Plaintiff Marcella Lambie was informed by a Roberta Place Long Term Care Home staff member that her brother, the Plaintiff George Head, was afebrile, weak, fatigued, and needed a test to determine whether he had contracted COVID-19.

28. On January 18, 2021, Marcella Lambie was informed that her brother George Head had tested positive for COVID-19.

29. On January 23, 2021, George Head had a fever, chest congestion, his oxygen saturation fell to 90%, he had an increased heart rate, difficulty swallowing, and he developed aspiration pneumonia.

30. George Head's physical and cognitive condition deteriorated significantly, such that George could no longer walk, talk, or feed himself without assistance.

31. Since testing positive for COVID-19, George Head has been isolated to his room and now requires the use of a wheelchair. He requires 24-hour care for all his activities of daily living.

32. George Head's physical and cognitive condition continues to deteriorate.

**THE EVENTS LEADING TO THE DEATH OF JANET MARTIN**

33. On May 30, 2015, Janet Martin, age 83, moved into Roberta Place Long Term Care Home where she resided until her death at age 89.

34. On January 13, 2021, the Plaintiff Scott Martin received a call from a nurse at Roberta Place Long Term Care Home informing him that his mother was not well, had a fever, and that now might be a good time to come and see her.

35. In the morning of January 14, 2021, Scott Martin arrived at Roberta Place Long Term Care Home and observed that his mother, Janet Martin, was in poor condition. She had a fever and could not breathe. A nurse at Roberta Place advised Scott Martin that it was only a matter of time before his mother passed away.

36. Janet Martin passed away at approximately 12am on January 15, 2021. Her death certificate indicates her cause of death was COVID-19.

**THE GROSS NEGLIGENCE**

37. The Defendants knew, or ought to have known, that the COVID-19 crisis constituted a serious danger to the residents and staff of Roberta Place Long Term Care Home.

38. The Defendants knew, or ought to have known, that the residents of Roberta Place Long Term Care Home were among the most vulnerable in the population to contracting severe or fatal symptoms of COVID-19.

39. The Defendants knew, and it was reasonably foreseeable, that the Plaintiffs and Class Members would trust and rely on the Defendants both to plan for acute respiratory infection outbreaks and to execute an outbreak plan.

40. The Defendants owed a duty of care to the Plaintiffs and the Class with respect to the management of the Roberta Place Long Term Care Home during the COVID-19 pandemic. At all relevant times, the Defendants had an obligation to safeguard the life, health, and dignity of George Head, Janet Martin, and the Class Members and to ensure continued and adequate care.

41. At all material times the Defendants owed a duty of care to the Plaintiffs and Class Members to ensure that there were reasonable protocols and procedures in place, or to make a good faith effort to have protocols and procedures in place, to protect the residents and staff of Roberta Place Long Term Care Home and prevent the introduction or spread of COVID-19 in accordance with applicable public health guidance and any federal, provincial or municipal law relating to COVID-19.

42. At all material times, the Defendants had an obligation to take reasonable steps, and make a good faith effort, to ensure the safety, well-being, health, and dignity of residents and staff in Roberta Place Long Term Care Home. The Defendants knew, or ought to have known, that residents in Roberta Place Long Term Care Home were a vulnerable population requiring appropriate safeguards and measures to prevent them

from contracting, or be put at risk of contracting, COVID-19. In particular, the Defendants knew, or ought to have known, that the dangers arising from COVID-19 infection posed a serious and credible risk to residents of Roberta Place Long Term Care Home. Given their age, pre-existing health conditions, and close proximity to one another, residents of Roberta Place Long Term Care Home were and continue to be at an increased risk of suffering a severe reaction and/or death as a result of a COVID-19 infection.

43. The Defendants breached these duties of care to the Plaintiffs and the Class through their acts and omissions, alone or in combination, in a manner that reflects a marked departure from the standards of care applicable in the circumstances, by:

a. failing to properly and adequately plan for and respond to the COVID-19 pandemic;

b. failing to implement adequate sanitary measures to mitigate the risk of transmitting the disease within Roberta Place Long Term Care Home, when they knew, or ought to have known, that having adequate PPE and sanitary measures were required to protect the health, safety, well-being, and dignity of the residents and staff;

c. failing to have adequate measures within the Roberta Place Long Term Care Home to care for the residents in a safe and competent manner;

d. failing to communicate adequately with families of residents;

e. repeatedly failing to act in accordance with or make a good faith effort to act

in accordance with, public health guidance, directives, and any federal, provincial or municipal law relating to COVID-19; and

f. not taking appropriate, or any, action after being informed by the Ministry of Long-Term Care on two occasions that the infection prevention and control practices within the Roberta Place Long Term Care Home were insufficient and placed residents at risk of disease transmission.

44. The standard of care reasonably expected in the circumstances required the Defendants to properly and adequately plan for and respond to the COVID-19 pandemic, implement adequate sanitary measures to mitigate the risk of transmitting the disease within Roberta Place Long Term Care Home, to care for the residents in a safe and competent manner, communicate reasonably with families of residents, and to ensure compliance with, or make a good faith effort to ensure compliance with, public health guidance, and any federal, provincial or municipal law relating to COVID-19 with respect to acute respiratory infections generally and to the COVID-19 pandemic specifically. The grossly negligent failure of the Defendants to ensure compliance, or make a good faith effort to ensure compliance, with the minimum standards fell markedly below the reasonable standard of care and is the direct and proximate cause of damage to the Plaintiffs George Head, Janet Martin, and the Class.

45. At the time of the issuance of this Claim, Roberta Place Long Term Care Home has 53 resident deaths, one essential caregiver death, 128 active resident COVID-19 cases, and 84 active COVID-19 cases amongst staff/team members.

46. As set out below, the Defendants 859530 Ontario Inc., Barrie Long Term Care

Centre Inc., Jarlette Holdings Inc., Jarlette Ltd., and Roberta Place Retirement Lodge Inc. were each grossly negligent, for their acts and omissions, alone or in combination, in that they:

a. failed to properly and adequately plan for and respond to the COVID-19 pandemic, or make a good faith effort in this regard;

b. failed to implement, or make a good faith effort to implement, COVID-19 outbreak control measures as per the Ministry of Health's COVID-19 Outbreak Guidance for Long-Term Care Homes (April 15, 2020);

c. failed to ensure, or make a good faith effort to ensure, adequate staffing levels to implement the outbreak control measures required by the Province, and public health guidance and directives;

d. failed to monitor, or make a good faith effort to monitor, all residents and staff in the Home for new symptoms compatible with COVID-19 (including atypical symptoms);

e. failed to have adequate staff, or make a good faith effort to have adequate staff, within the Roberta Place Long Term Care Home to care for the residents in a safe and competent manner;

f. failed to quickly identify, or make a good faith effort to quickly identify, symptomatic residents and staff, and when symptoms of COVID-19 were identified, initiate, or make a good faith effort to initiate, Droplet and Contact Precautions (as described by Public Health Ontario), ensure, or

make a good faith effort to ensure, a test for COVID-19 for any resident and staff with symptoms compatible with COVID-19 (including atypical symptoms) was completed, and perform, or make a good faith effort to perform, an assessment for the expansion of any existing designated outbreak areas within the Home;

g. failed to institute, or make a good faith effort to institute, staff (including housekeeping, janitorial, maintenance, etc.) and resident cohorting to prevent the spread of COVID-19 within the Home, as required by the direction of the Chief Medical Officer of Health;

h. failed to institute, or make a good faith effort to institute, cohorting of the infected and uninfected residents and staff;

i. failed to institute, or make a good faith effort to institute, alternative resident accommodation to maintain spatial separation of two meters;

j. failed to utilize, or make a good faith effort to utilize, respite and palliative beds/rooms to provide additionally distanced or isolated resident accommodations;

k. failed to utilize, or make a good faith effort to utilize, other rooms within the Home as appropriate to help maintain isolation of affected residents and staff;

l. failed to ensure, or make a good faith effort to ensure, adequate staffing levels (immediately and in preparation for the remainder of the outbreak)

so as to sufficiently designate each staff person to provide care for either a cohort of infected residents or a cohort of uninfected residents during the outbreak, but not both;

m. failed to decline new resident admissions until the outbreak is declared over by the local district health unit;

n. failed to decline re-admission of residents who were not part of the outbreak line list into the outbreak areas until the outbreak is declared over by the local district health unit;

o. failed to provide, or make a good faith effort to provide, in-room tray service for food and beverages to residents to restrict communal dining and the potential exposure to COVID-19;

p. failed to increase, or make a good faith effort to increase, the frequency of environmental cleaning for frequently touched surfaces and provide terminal cleaning for resident rooms when fully vacated;

q. failed to ensure, or make a good faith effort to ensure, that the appropriate personal protective equipment (PPE) was available and accessible for use by those who require use of PPE based on the Ontario Chief Medical Office of Health's Directives and current recommendations;

r. failed to ensure, or make a good faith effort to ensure, physical distancing of staff, including during breaks and in staff areas;

s. failed to ensure, or make a good faith effort to ensure, availability and

accessibility of hand hygiene products throughout the Home for all persons;

t. failed to ensure, or make a good faith effort to ensure, clear infection prevention and control signage and education for staff, visitors, and families, including outsourced workers and companies;

u. failed to require, or make a good faith effort to require, that staff report any symptoms of COVID-19 to the Home and that they be required to immediately self-isolate at home and arrange for COVID-19 testing as soon as possible;

v. failed to ensure, or make a good faith effort to ensure, appropriate infection prevention and control measures were taken when performing aerosol generating medical procedures (AGMPs) in the Home;

w. failed to ensure, or make a good faith effort to ensure, that staff, visitors, residents, and families were current with information about the status of the outbreak at the Home;

x. failed to comply with, or make a good faith effort to comply with, the measures specified by the Simcoe Muskoka District Health Unit's Medical Officer of Health and/or by the Chief Medical Officer of Health;

y. failed to communicate, or make a good faith effort to communicate, adequately, or at all, with families of residents;

z. repeatedly failed to comply with, or make a good faith effort to comply with,

public health guidance and directives regarding: (1) outbreak planning; (2) supply, use, and access to PPE; (3) visitor, supplier, and service personnel screening; (4) resident isolation and testing, and; (5) employee testing and screening;

aa. failed to implement, or make a good faith effort to implement, an adequate pandemic response plan for residents and staff, or at all, when it was obligated to do so at common law and under contract and knew, or ought to have known, that such a plan was required to safeguard the health, safety, well-being, and dignity of the residents and staff;

bb. when faced with a proliferation in COVID-19 cases, they failed to conduct, or make a good faith effort to conduct, even basic acute respiratory infection surveillance or to take standard droplet/contact precautions, let alone ensure the adequacy of PPE supplies or their use;

cc. failed to communicate with, or make a good faith effort to communicate with, the families of residents living at Roberta Place Long Term Care Home or staff regarding "presumptive positive" cases of COVID-19, in contravention of public health guidance and directives;

dd. failed to conduct, or make a good faith effort to conduct, adequate visitor screening long after public guidance was in place requiring it;

ee. failed to adequately supply or use PPE, or make a good faith effort to supply or use PPE, including, but not limited to, gloves, gowns, and/or face shields, for visitors, residents, and staff in accordance with public health

guidance and directives, including the Routine Practices and the various public health directives introduced in connection with the COVID-19 pandemic;

ff. failed to equip, or make a good faith effort to equip, visitors with adequate PPE despite knowledge of acute respiratory infection outbreaks, in breach of Directives 1, 3, and 5 and the *Occupational Health and Safety Act*, R.S.O. 1990, c. O.1, as amended;

gg. failed to undertake, or make a good faith effort to undertake, adequate screening and testing measures for staff working in close contact with presumed, suspected, or confirmed cases of COVID-19;

hh. allowed staff, employees, or contractors working at other facilities owned and/or operated by the Defendants to enter and work at Roberta Place Long Term Care Home;

ii. failed to ensure, or make a good faith effort to ensure, that adequate staff were in the Roberta Place Long Term Care Home to provide the expected and proper standard of care to residents. Exacerbating the inadequate staffing, Roberta Place Long Term Care Home was locked down, preventing visitors who could check on the well-being of their loved ones. At the same time, Roberta Place Long Term Care Home failed to provide the expected and reasonable level of communication to families of residents; ~~and~~

jj. failed to take reasonable care to ensure that residents were reasonably

safe while on the premises, in breach of section 3(1) of the *Occupiers' Liability Act,* R.S.O. 1990, c. O .2, as amended;

kk. failed to ensure that residents identified as COVID-19 positive were receiving optimal fluids to drink and were staying hydrated;

ll. failed to ensure that residents identified as COVID-19 positive were receiving regular meals and/or the basic nutritional requirements for life;

mm. allowed residents identified as COVID-19 positive to urinate and defecate in other residents' rooms;

nn. allowed the staff delivering snacks to residents' rooms to enter the rooms without wearing proper PPE;

oo. refused to remove and clean linens containing urine and feces from residents' beds;

pp. failed to clean food stains on the floor, feces on the walls, and urine on the bathroom floors;

qq. provided COVID-19 positive residents with brooms, mops, and other cleaning accessories and instructed the residents to clean their rooms on their own;

rr. failed to notify mobile and/or immobile residents identified as COVID-19 positive that their meal trays were being left in the hallway outside their rooms;

ss. failed to remove soiled meal trays from outside residents' rooms in a timely manner;

tt. failed to ensure that residents identified as COVID-19 positive received essential hygiene care, including regular bathing and/or showering, grooming, dental care, and/or handwashing;

uu. placed unmasked, wheelchair-bound residents adjacent and close to the Home's screening desk, where members of the public entered the facility without masks or other PPE;

vv. allowed residents to reside in common areas within the Home, without wearing proper PPE;

ww. disconnected the phone lines in the rooms of residents identified as COVID-19 positive;

xx. failed to change the soiled diapers of residents identified as COVID-19 positive in a timely manner;

yy. allowed residents identified as COVID-19 negative to wear clothing belonging to residents identified as COVID-19 positive;

zz. failed to ensure that residents identified as COVID-19 positive had easy access to a call bell in their rooms to alert staff of their need for help;

aaa. placed residents identified as COVID-19 negative in the same beds as residents identified as COVID-19 positive without changing the sheets;

bbb. failed to ensure that appropriate isolation precautions were initiated and implemented for all residents;

ccc. failed to ensure that staff were utilizing appropriate PPE in resident rooms;

ddd. failed to initiate isolation precautions when residents returned from other facilities, placing other residents in the Home at risk of disease transmission;

eee. failed to ensure that staff separated and appropriately handled soiled items, increasing the risk of contact surfaces becoming contaminated;

fff. failed to separate soiled linens on carts in the hallways from clean supplies, including gloves, linens, and towels;

ggg. failed to disinfect linen carts when carts were removed from residents' rooms;

hhh. allowed staff with soiled items in their hands to assist residents to the dining room;

iii. failed to properly launder soiled clothing and linens and return clean laundry to the residents in a timely manner;

jjj. allowed staff to use reusable isolation gowns;

kkk. allowed staff to enter residents' rooms without applying any eye protection;

lll. allowed staff to enter residents' rooms without tying or securing their gowns while attending to residents;

mmm. allowed staff to enter residents' rooms and converse with residents wearing only a procedural mask and without applying any additional PPE;

nnn. advised staff that prescription eyeglasses were sufficient eye protection when entering residents' rooms;

ooo. failed to provide staff with a supply of procedural masks;

ppp. allowed staff to change residents' beds while the resident was in the room, without gloves or eye protection;

qqq. allowed staff to cross the hallway while not wearing a procedural mask, and while residents were within six feet of them;

rrr. failed to ensure that staff were following signage related to PPE usage for residents who were isolated with droplet and contact precautions;

sss. allowed staff to provide nourishment to infected residents' roommates without applying any PPE;

ttt. failed to ensure that all staff were trained and retrained on isolation precautions related to COVID-19 and the appropriate use of PPE, including the correct process for putting on and taking off PPE;

uuu. failed to ensure that staff in the Home maintained proper documentation and/or records of training on isolation precautions related to COVID-19;

vvv. failed to develop and implement an auditing process on isolation precautions to ensure that staff were utilizing the appropriate PPE when

providing care to residents;

www. failed to rectify, or make a good faith effort to rectify, a widespread pattern of non-compliance with public health guidance relating to COVID-19, including cohorting and isolation of affected and unaffected residents and staff;

xxx. allowed residents identified as COVID-19 positive to be in the lounge area;

yyy. failed to prevent a severe staffing shortage;

zzz. lost 36 of the 130 initial COVID-19 swabs taken of the residents;

aaaa. failed to maintain ongoing and frequent monitoring of residents' vital signs;

bbbb. failed to anticipate shortages in PPE and take corrective action to ensure that PPE was widely available to staff and residents during the outbreak;

cccc. failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) Program;

dddd. allowed staff to hang used and soiled isolation gowns over the handrails in the hallways outside patient rooms;

eeee. failed to ensure that residents' mobility aides were cleaned by night shift staff on a weekly basis;

ffff. failed to ensure that the surfaces of mobility aides were free of harmful viruses, bacteria, and/or fungi;

gggg. allowed residents who were confirmed COVID-19 positive to share rooms with residents who were not confirmed to have COVID-19;

hhhh. allowed residents who were confirmed COVID-19 positive to come into close contact with residents in shared rooms who were not confirmed to have COVID-19;

iiii. allowed staff to provide care to both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19;

jjjj. allowed residents identified as COVID-19 positive to touch high-touch surfaces out of isolation, and come into close contact with other residents;

kkkk. failed to transfer residents identified as COVID-19 positive to local hospital facilities for emergency treatment;

llll. failed to supervise visitors to the Home to ensure visitors were complying with COVID-19 safety and PPE protocols;

mmmm. failed to take immediate and comprehensive steps to inform Public Health Ontario, the Chief Medical Officer, or the public of the scope of the infection with COVID-19;

nnnn. failed to rectify a pattern of mismanagement, misallocation of resources and staffing, and repeated violations and cited deficiencies of infection control and prevention requirements;

oooo. usurped resources and monetary compensation into their own pockets as

opposed to putting in place PPE and preventative measures in anticipation of COVID-19;

pppp. were reckless, irresponsible, and neglectful of their responsibilities to provide standard quality and compassionate care to the residents of Roberta Place Long Term Care Home; and

qqqq. demonstrated an aggravated, flagrant, and careless pandemic response plan in response to the COVID-19 pandemic.

47. The Defendants were grossly negligent and failed in their duty to implement an appropriate standard of care as described by the above-pleaded failures. During the Pandemic Period, the Defendants continued to allow visitors to enter the premises of the Roberta Place Long Term Care Home, when such visitors had recently travelled outside of Canada to countries such as the United Kingdom where a new variant of the COVID-19 virus had just emerged. Failing to prevent visitors, or failing to make a good faith effort to prevent visitors, who had recently travelled outside of Canada to enter the premises of the Roberta Place Long Term Care Home was a gross violation of the duties owed to the Class Members.

48. For those Class Members who survive the outbreak of COVID-19 at the Roberta Place Long Term Care Home, they have endured harsh and intolerable treatment. They were locked down in their rooms, fearing for their safety and lives, not being provided with sufficient food and water, knowing other residents were dying around them and unable to visit with their loved ones and family members.

49. The Plaintiffs George Head, Janet Martin, and the Class Members would not have

sustained the injuries they did but for the above-pleaded failures of the Defendants. The above-pleaded failures of the Defendants, alone or in combination, caused or materially contributed to the resulting damages sustained by George Head, Janet Martin, and the Class Members.

50. By reason of the gross negligence of the Defendants, the Defendants are in breach of their duties of care to George Head, Janet Martin, and the Class Members.

**BREACH OF FIDUCIARY DUTY**

51. Given the circumstances of the relationship between the Defendants and the Class Members, including, but not limited to, the statutory obligations, authority, and responsibilities of the Defendants, the Defendants undertook to act in the best interests of Class Members above the interests of all others and to act in accordance with the duty of loyalty imposed on them.

52. The Defendants held a discretionary power over the quality of care provided to the residents of the Home. The physical and mental conditions of the Class Members residing at Roberta Place made them vulnerable to the Defendants. The discretionary power of the Defendants was increased during the Pandemic Period when they significantly limited the ability of family members to act as caregivers. During these periods, the Defendants had control over the care residents received. As a result, the Class Members were peculiarly vulnerable to, and at the mercy of, the Defendants regarding the care they received.

53. The Defendants and the Class Members were in an *ad hoc* fiduciary relationship.

54. The Defendants owed the Class, as beneficiaries, fiduciary duties that included:

a. to care for and protect the residents and act in their best interests at all times;

b. to operate the Home as a place where residents could live with dignity, security, safety, and comfort, while ensuring that residents have their physical, psychological, spiritual, and cultural needs adequately met; and

c. to demonstrate the loyalty expected of a fiduciary when acting in the interests of a beneficiary.

55. The Defendants breached their fiduciary duties to the Plaintiffs and the Class by failing to ensure compliance with minimum standards within the *Long Term Care Homes Act,* 2007, S.O. 2007, c. 8, and COVID-19 public health directives. The Plaintiffs and the Class Members were entitled to rely and did rely on the Defendants to their detriment to fulfill their fiduciary obligations.

56. The particulars of the Defendants' breach of their fiduciary duties include, but are not limited to:

a. they failed to keep residents safe when they failed to implement, or make a good faith effort to implement, COVID-19 outbreak control measures as per the Ministry of Health's COVID-19 Outbreak Guidance for Long-Term Care Homes (April 15, 2020);

b. they failed to keep residents safe when they repeatedly failed to comply, or make a good faith effort to comply with, public health guidance and directives regarding: (1) outbreak planning; (2) supply, use, and access

to PPE; (3) visitor, supplier, and service personnel screening; (4) resident isolation and testing; and (5) employee testing and screening;

c. they failed to provide residents with optimal fluids and the basic nutritional requirements for life after the declaration of the outbreak on January 8, 2021;

d. they failed to allow residents to live with dignity when they failed to provide residents with basic hygiene, including, but not limited to bathing, grooming, dental care, and handwashing, throughout the outbreak period;

e. they failed to allow residents to live with dignity when they failed to clean food stains on the floors, feces on the walls, and urine off of bathroom floors;

f. they failed to show residents the loyalty expected of a fiduciary when they failed to secure adequate PPE and failed to implement preventative measures in anticipation of COVID-19; and

g. they failed to show residents the loyalty expected of a fiduciary when they were reckless, irresponsible, and neglectful of their responsibilities to provide standard quality and compassionate care to residents.

**BREACH OF CONTRACT**

57. The Defendants entered into contracts with residents for the provision of care services at Roberta Place Long Term Care Home in which they agreed to provide:

a. adequate care and safety;

b. proper shelter, food, clothing, grooming, and care in a manner consistent with each resident's needs; and

c. a safe, clean, and secure environment.

The Defendants breached this contract by contravening the minimum standards for the provision of care during the COVID-19 pandemic.

58. The relevant contractual provisions are required to be included in any contract between a licensee and resident under section 3 of the *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8.

59. The particulars of the Defendants' breach of contract include, but are not limited to:

a. they failed to provide residents with proper shelter, food, clothing, grooming, and care in a manner consistent with each resident's needs;

b. they failed to ensure that residents identified as COVID-19 positive were receiving optimal fluids to drink and were staying hydrated;

c. they failed to ensure that residents identified as COVID-19 positive were receiving regular meals and/or the basic nutritional requirements for life;

d. they refused to remove and clean linens containing urine and feces from residents' beds;

e. they failed to clean food stains on the floor, feces on the walls, and urine

on the bathroom floors;

f. they failed to ensure that residents identified as COVID-19 positive received essential hygiene care, including regular bathing and/or showering, grooming, dental care, and/or handwashing;

g. they failed to ensure that residents lived in a safe and clean environment;

h. they failed to ensure that residents, or their representatives, had participation in decision-making;

i. they failed to ensure that every resident had a written plan of care setting out the planned care for the resident, the goals the care is intended to achieve, and clear directions to staff and others who provide care to the resident;

j. they disconnected the telephone lines in the rooms of residents identified as COVID-19 positive;

k. they failed to change the soiled diapers of residents identified as COVID-19 positive in a timely manner;

l. they failed to ensure that residents identified as COVID-19 positive had easy access to a call bell in their rooms to alert staff of their need for help;

m. they failed to properly launder soiled clothing and linens and return clean laundry to the residents in a timely manner;

n. they failed to ensure that residents' mobility aides were cleaned by night shift staff on a weekly basis;

o. they failed to ensure that the surfaces of mobility aides were free of harmful viruses, bacteria, and/or fungi;

p. they failed to ensure that the staff and others involved in the different aspects of care of the residents collaborated with each other;

q. they failed to ensure that there was an organized program of nursing services and personal support services for the Home to meet the assessed needs of the residents;

r. they failed to ensure that every resident had an organized program of nutrition care and dietary services to meet the daily nutrition needs of the residents, and an organized program of hydration to meet the hydration needs of the residents;

s. they failed to ensure that the Home, furnishings, and equipment were kept clean and sanitary; that each resident's linens and personal clothing were collected, sorted, cleaned and delivered; and that the Home, furnishings and equipment were maintained in a safe condition and in a good state of repair;

t. they failed to ensure that the Home met reasonable staffing and care standards;

u. they failed to prevent abuse and neglect of residents;

v. they failed to implement policies and/or procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

w. they failed to immediately investigate every alleged, suspected or witnessed incident of neglect of a resident by the staff, and ensure that appropriate action was taken in response to every such incident; and

x. they allowed improper or incompetent treatment or care of residents that resulted in harm to the residents.

60. As a result of the Defendants' breaches of the contract with the Class, members of the Class have suffered the following damages flowing from the breach:

a. mental anguish;

b. pain and suffering; and

c. loss of amenity.

**VICARIOUS LIABILITY**

61. The Plaintiffs and the Class plead that the Defendants can only act through their employees, directors, officers, and agents and are vicariously liable for their acts and omissions as hereinafter pleaded. The acts and omissions particularized and alleged in this claim to have been done by the Defendants were authorized, ordered, or done by the Defendants' employees, directors, officers, and agents while engaging in the management, direction, control, and transaction of the Defendants' businesses and are

therefore acts and omissions for which the Defendants are vicariously liable.

**DAMAGES**

62. As a result of the injuries sustained by George Head and the surviving Class Members, they suffer from and will continue to suffer from cognitive and physical impairments. George Head and the Class Members have suffered and will continue to suffer pain, disability, limitation of movement and emotional difficulties, which will permanently impair their enjoyment of life.

63. As a result of the deaths of Janet Martin and other deceased Class Members, their individual estates claim non-pecuniary and pecuniary damages.

64. As a result of the injuries sustained by George Head, Janet Martin, and the Class Members, both surviving and deceased, family members of the Plaintiffs and Class Members have suffered severe emotional trauma and a loss of guidance, care and companionship that they would have expected to receive from Class Members, and they claim damages pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3, as amended.

65. Family members of the Class have also incurred medical, hospital, pharmaceutical, therapeutic, travel, and other extraordinary expenses and will continue to incur such expenses for the rest of the Class Members' dependence upon them.

66. Family members of the Class have provided, and will continue to provide, extraordinary nursing care and other services for the Class Members, and they claim a reasonable allowance for their loss of income or for the services they have provided pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3, as amended.

67. As a result of the Defendants' gross negligence, breach of contract, breach of fiduciary duty, and failure to act, or make a good faith effort to act, in accordance with applicable public health guidance and any federal, provincial or municipal law relating to COVID-19, the Plaintiffs and Class Members are entitled to general damages, including damages pursuant to s. 61 of the *Family Law Act*, R.S.O. 1990, c. F.3, as amended for:

a. Loss of life;

b. Failure to provide contractually agreed-upon services;

c. Pain, suffering, anxiety, and psychological trauma endured by Class Members who had COVID-19 having gone without adequate care;

d. Emotional distress and psychological injuries suffered by family members as a reasonably foreseeable consequence of the Defendants' gross negligence, breach of contract, and breach of fiduciary duty;

e. Funeral expenses;

f. Loss of guidance, care, and companionship;

g. Hospital, medical, nursing, medication, and other out-of-pocket expenses; and

h. Costs and damage resulting to Class Members who had to remove residents from Roberta Place Long Term Care Home, including the resulting psychological stress and anxiety.

68. The Plaintiffs plead and rely upon the provisions of the *Class Proceedings Act*, 1992, S.O. 1992, c. 6, as amended; *Courts of Justice Act*, R.S.O. 1990, c. C.43, as amended; *Family Law Act*, R.S.O. 1990, c. F.3, as amended; *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, as amended; *Negligence Act*, R.S.O. 1990, c. N.1, as amended; *Nursing Act*, 1991, S.O. 1991, c. 32, as amended; *Occupational Health and Safety Act,* R.S.O. 1990, c. O.1, as amended; *Occupiers' Liability Act*, R.S.O. 1990, c. O .2, as amended; *Public Hospitals Act*, R.S.O. 1990, c. P.40, as amended; the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, as amended; the *Retirement Homes Act,* 2010, S.O. 2010, c. 11, as amended; the *Supporting Ontario's Recovery Act*, 2020, S.O. 2020, c. 26, Sch 1, as amended; and the *Trustee Act*, R.S.O. 1990, c. T.23, as amended.

69. The Plaintiffs George Head, Janet Martin, and the Class suffered losses or damages as a result of the Defendants' conduct. It is appropriate that these damages be assessed on an aggregate basis under section 24 of the *Class Proceedings Act*, 1992, S.O. 1992, c. 6, as amended.

**PUNITIVE DAMAGES**

70. Through their collective mismanagement of the COVID-19 pandemic, the Defendants have displayed wanton disregard for both residents and their families – some of the most vulnerable members of our society. The wanton failure to protect the lives and well-being of some of the most vulnerable members of our society and their families shown by the Defendants is a marked departure from the standards expected of Ontario long-term care facilities in response to an acute respiratory infection outbreak

and demonstrates callous and reprehensible behaviour deserving of an award of punitive damages.

71. The Defendants' wanton failure to protect the lives and well-being of its residents and by extension, their families, is a breach of its contractual obligations to the Home's residents and demonstrates callous and reprehensible behaviour deserving of an award of punitive damages.

**AGGRAVATED DAMAGES**

72. Through their collective mismanagement of the COVID-19 pandemic, the conduct of the Defendants has caused the Plaintiffs and the Class Members intangible injuries including pain, anguish, grief, humiliation, and loss of faith in friends, colleagues, and health care providers. The wanton failure to protect the lives and well-being of its staff, and by extension, their families, is a marked departure from the standards expected of Ontario retirement and long-term care facilities in response to an acute respiratory infection outbreak, aggravating the damages to the Plaintiffs and Class Members. The Defendants' culpable acts (or failures to act) support an award of aggravated damages.

**MENTAL DISTRESS DAMAGES FOR BREACH OF CONTRACT**

73. As a result of the aforementioned breaches, the Defendants caused the Plaintiffs and Class Members psychological, emotional, and physical harm, including anguish, humiliation, and serious and prolonged mental distress. As a result of the Defendants' wanton failure to protect the lives and well-being of its residents, and by extension, their

families, the Plaintiffs and Class Members felt embarrassed, utterly humiliated, and overwhelmed by a deep sense of personal guilt for not being able to intervene and help their loved ones residing at Roberta Place Long Term Care Home during the COVID-19 pandemic, deserving of an award of mental distress damages for breach of contract.

**DISGORGEMENT OF BENEFITS**

74. The Plaintiffs and the Class claim disgorgement of the benefits received by the Defendants on the grounds of breach of contract and gross negligence.

75. The Defendants committed multiple wrongs as described above. These wrongs conferred benefits on the Defendants, in the form of additional revenues, that they would not have acquired but for their wrongdoing.

76. The misconduct was motivated by the Defendants' desire to maximize the amount of profits they could reap from Class Members, who were vulnerable to the conduct of the Defendants.

77. There is no legitimate justification for allowing the Defendants to retain the profits derived from their wrongdoing. An award of compensatory damages against the Defendants would be an inadequate remedy and would fail to deter the type of misconduct exhibited by the Defendants.

78. It is appropriate that disgorgement of profits be assessed on an aggregate basis for the Class.

**PLACE OF TRIAL**

79. The Plaintiffs and the Class propose that this action be tried in the City of Barrie, in the Province of Ontario.

Date: January 29, 2021

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Court File No.: CV-21-00000142-00CP

GEORGE HEAD by his Litigation Guardian Marcella Lambie et al. - and - 859530 ONTARIO INC. et al.

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**SUPERIOR COURT OF JUSTICE**

Proceeding commenced at Barrie

**AMENDED STATEMENT OF CLAIM**
Proceeding under the
*Class Proceedings Act, 1992*, S.O. 1992, c. 6

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