Court File No. DC-24-00000007-00JR

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

B E T W E E N :

THE ONTARIO HEALTH COALITION and CATHERINE PARKES

Applicants

- and -

ONTARIO MINISTER OF LONG-TERM CARE

Respondent

APPLICATION UNDER Rules 14.05(2) and 68.01 of the *Rules of Civil Procedure*, RRO 1990, Reg 194 and Section 2(1) of the *Judicial Review Procedure Act*, RSO 1990, c J.1

FACTUM OF THE APPLICANT
~ JUDICIAL REVIEW ~

August 23, 2024

GOLDBLATT PARTNERS LLP
20 Dundas Street West, Suite 1039
Toronto, ON M5G 2C2

Steven Shrybman LSO# 20774B
Tel: 613-858-6842
sshybman@goldblattpartners.com

Lawyers for the Applicants

TO: **MINISTRY OF THE ATTORNEY GENERAL**
Crown Law Office - Civil
720 Bay Street, 8th Floor
Toronto, Ontario M7A 2S9

Michael J. Sims, LSO #52970R
Tel: 416-420-4983
Email: michael.sims@ontario.ca

Matthew Chung, LSO #74244K
Tel: 416-262-6770
Email: matthew.chung@ontario.ca

Lawyers for the Respondent

Table of Contents

Page

PART I - THE FACTS

A. Overview

1. This case is about decisions made by the Minister of Long-Term Care and the Director of the Capital Planning Branch (the "Director"), which culminated in an undertaking by the Director to issue a long-term care (LTC) home licence to CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) (hereinafter "Southbridge") for the development of 320 beds in a new LTC home, "Southbridge Pickering", to be built on the site of and replace the current Southbridge Orchard Villa LTC home.

2. Southbridge operations at Orchard Villa (the "Home") are among the most notorious in the province because of the catastrophic failure by Southbridge to provide necessary care to the Home's residents during the Covid-19 pandemic, when nearly all of its 230 residents contracted covid and 70 of these individuals died. Many of the regulatory failures and other problems that gave rise to that terrible tragedy had persisted at the Home since Southbridge acquired it in 2015, and they continue to this day.

3. Nevertheless, the Minister found that it was in the public interest to permit Southbridge to expand its operations on the Orchard Villa site, and the Director decided to issue the impugned undertaking on his opinion that, in spite of all the evidence to the contrary, the past conduct of Southbridge "affords reasonable grounds to believe" that Southbridge will operate the new home lawfully and with honesty and integrity, and will not harm the health, safety or welfare of its residents.

4. The evidence clearly shows that the Director failed to base his decision, as the *Act*[1] requires, on the objective record of Southbridge's past conduct of operations at Orchard Villa. That record shows a clear pattern of failure by Southbridge to comply with its regulatory obligations, and of causing risk of, and harm to residents, which is one of the worst of any LTC home in the province. The persistence of such failures throughout the years of the Company's operations at Orchard Villa, belie any notion that it is willing or able to operate the new LTC home at issue in a manner that will comply with its legal obligations, and provide for the proper care and safety of residents entrusted to its care.

5. The Applicants submit that both the Minister and Director's decisions are unreasonable and failed to be made in a manner that complied with the *Act*, and furthermore were not made in a manner that was "transparent, intelligible and justified" as the jurisprudence requires. They further contend that they have been denied natural justice and any fair opportunity to participate in the approvals process and to have their concerns taken into account.

6. On these grounds the Applicants seek orders quashing the Minister's decision, and the Director's undertaking to issue Southbridge a 30-year licence to build and operate a new 320 bed LTC home on the Orchard Villa site.

B. Southbridge Operations at Orchard Villa

(i) The Notoriety of Southbridge Operations at Orchard Villa

7. Southbridge acquired the licence to operate the current Orchard Villa home from its previous owner in 2015. As described below, since that time Southbridge operations at the Home

[1] *Fixing Long-Term Care Act,* 2021, S.O. 2021, c. 39, Sched. 1 (the "***Act***").

have persistently failed to comply with the *Act* and Regulations and to provide proper resident care. These failures came to a head during the Covid-19 pandemic and had such catastrophic consequences that they have since been the subject of scrutiny by the Long-Term Care Covid-19 Commission, the Auditor General and the Ombudsman.

8. As related by the Commission, because of the virtual collapse of resident care at Orchard Villa, on April 21, 2020, the Durham Region's Medical Officer of Health was compelled to take the unprecedented step of invoking s. 29.2 of the *Health Protection and Promotion Act,* to order that the local hospital, Lakeridge Health, assume management of Orchard Villa. When Lakeridge staff arrived, they found staffing levels at the home to be 20-25% of the normal complement, garbage "everywhere", "very shocking" personal protective equipment (PPE) practices, and the absence of even rudimentary infection control measures. Just to "stabilize the situation," Orchard Villa required a deep clean costing almost $500,000.[2]

9. The report of the Auditor General concerning preparedness for the pandemic identifies Orchard Villa as having the second highest number of Covid-19 cases of any LTC home in the Province[3] and being one of the six (6) worst homes in Ontario in respect of having acute respiratory outbreaks in the years 2016 – 2019, a key indication of poor inspection prevention and control (IPAC) practices.[4] It also found that 13 out of the 15 homes with the highest number of resident

---

[2] Affidavit of Dr. Pat Armstrong dated April 18, 2024 ("**Armstrong Affidavit**"), para 26, Application Record ("**AR**"), Tab 2, p 35 [A36], citing, Marrocco, F. N. A. Coke & J. Kitts (2021) Ontario's Long-Term Care COVID-19 Commission Final Report. Toronto: Queen's Printer of Ontario ("The Commission Final Report"), pp 38-39, pp 151-152.

[3] Dubé, P. (2023) *Lessons For The Long Term. Investigation Into The Ministry Of Long-Term Care's Oversight Of Long-Term Care Homes Through Inspection And Enforcement During The Covid-19 Pandemic,* September 7, 2023 https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports-on-Investigations/Ombudsman-Ontario-Lessons-for-the-Long-Term-Sept-2023-report-accessible.pdf . ("Ombudsman Report"), para 30, p 11.

[4] Auditor General Report, p 45.

deaths from Covid-19 were for-profit operations and of these, the home with the highest number, was Orchard Villa.[5]

10. The Ombudsman's report describes the loss of the lives of 70 Orchard Villa residents in the early months of the Covid-19 pandemic, when "other homes experienced no large outbreaks and few deaths." At 30 deaths per 100 beds, Orchard Villa had one of the highest mortality rates in any Ontario LTC home.[6] The report also singles out and includes several accounts of the horrific circumstances at Orchard Villa. As one example, the report states that: "In April 2020, according to a Ministry of Long-Term Care inspector, a staff person at the Orchard Villa home in Pickering called the Ministry to report that '…there is no staff to feed and care for residents, and that living conditions are like hell.' "[7]

11. In April 2020, Orchard Villa was among the five Ontario LTC homes where the Canadian Forces were brought in to provide "humanitarian relief and medical support." The observation report released by the Canadian Forces documented a range of disturbing conditions in the home.[8] The observation report described the conditions in the homes it visited as "deplorable."[9]

C. The Application and approval standards

(i) The Application

12. The Southbridge application for approval to develop a 320 LTC home on the Orchard Villa

---

[5] Armstrong Affidavit, para 17, AR, Tab 2, p 30 [A31], citing Ontario Auditor General Bonnie Lysyk (2021) COVID-19 Preparedness and Management Special Report on Pandemic Readiness and Response in Long-Term Care, ("Auditor General Report"), pp 27-28.
[6] Ombudsman Report, p 11, para 30.
[7] Armstrong Affidavit, paras 18, 30, 41, AR, Tab 2, pp 30 [A31], 37 [A40], 40 [A41]; and see Ombudsman's Report, para 34.
[8] The Commission Final Report, p. 186.
[9] *Idem*.

site in Pickering Ontario was acknowledged by the Ministry of Long-Term Care on January 19, 2021.[10] Because of a corporate restructuring by the Company,[11] a 'new' application for the same Project was made on March 21, 2023.[12] In consequence, various steps in the approval process have been repeated, including the public consultation conducted by the Ministry first in July, 2021, and then again in October, 2022.

(ii) The Approval Standards

13. The *Act* mandates a two-stage process for approving a new long-term care home. Under s. 103(1) of the *Act*, the Director may give an undertaking to issue a licence to operate a long-term care home to a person on the condition that the person agrees to satisfy the specified conditions set out in the undertaking. The Director is only authorized to give this undertaking where:

a. the Minister has determined that there should be a long-term care home in the area under s. 99;

b. the Minister has not imposed restrictions on who may be issued a license based on the public interest under s. 100, which would prohibit the undertaking at issue; and

c. the Director has determined that the person is eligible to be issued a license for a long-term care home, under s. 101 of the *Act*.

Section 101 of the *Act* provides, *inter alia*, that:

> A person is only eligible to be issued a licence for a long-term care home if in the Director's opinion certain eligibility criteria are met including the following:
>
> (a) the home and its operation would comply with this Act and the regulations and any other applicable Act, regulation or municipal by-law; ….

---

[10] Record of Decision ("**Record**"), Vol 1, Tab 6. p 229 [B301].
[11] Request to Approve a Licence Transfer under Section 108 of the Fixing Long-Term Care Act, 2021, dated August 22, 2022, Record, Vol 18, Tab 85 p 5580 [B5972].
[12] Record, Vol. 23, Tab 98G, p 7146 [B7566].

> (c) the past conduct relating to the operation of a long-term care home affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity …
>
> (d) it has been demonstrated by the person that the person or, where the person is a corporation, its officers and directors and the persons with a controlling interest in it, is competent to operate a long-term care home in a responsible manner in accordance with this Act and the regulations and is in a position to furnish or provide the required services;
>
> (e) the past conduct relating to the operation of a long-term care home, or any other matter or business affords reasonable grounds to believe that the home will not be operated in a manner that is prejudicial to the health, safety or welfare of its residents …
>
> [Emphasis Added]

(iii) The Public Consultations

14. As per s. 109 of the *Act* and the Public Consultation Policy and Guidelines, 2019, the Director determined that a public consultation was to be conducted in respect of the Southbridge application at issue.[13] Because of the Southbridge decision to restructure, the consultation that was held in 2021 was repeated the next year.

15. In neither consultation, were participants provided with more than perfunctory information about the Southbridge project other than that the Company was seeking a 30-year licence for a "320-bed development project" to be built on the site of the current Orchard Villa LTC home.[14]

(a) Consultation July 2021

16. The first of the consultations was conducted by teleconference on July 15, 2021, and as described more fully below, several dozen individuals, including the Applicants, participated on the call. During that consultation the participants were explicitly and repeatedly directed to limit

[13] Record, Vol 22, Tab 98D, p 7066 [B7482] and Vol 19, 89D, p 6135 [B6537].
[14] Record, Vol 22, Tab 98E, p 7069 [B7485] and Vol, 19 Tab 89E, p 6138 [B6540].

their comments to Southbridge's present plans, and to not speak about its past practices or performance. [15] In consequence, some participants were prevented from making such submissions. Others persisted in the face of the Ministry's efforts, and described the persistent failure of Southbridge before, during, and after the pandemic to provide necessary and proper care to residents.[16]

17. Many participants also provided written submissions including dozens of emails, and a petition signed by hundreds of individuals all of whom personally signed the petition giving their names and addresses. Several of those making submissions wrote about the circumstances surrounding the deaths of their loved ones at the Home.[17]

18. The record also [18] includes a summary prepared by Ministry staff of a handful of the emails submitted.[19] For example, the comments of the Applicant, Ms. Parkes, are summarized this way:

> "[she] stated that Her father passed away from acute respiratory failure and COVID-19, being denied oxygen, food and water, an opportunity to see his family and was in a state of confusion. "She is haunted by her father's death."[20]"
>
> The comments of another, Pamela Bendell, are summarized this way:
>
> "[Ms. Bendell's] mother passed away on May 8, 2020. She died from neglect from staff. A military report was conducted, and the report found that the residents were

[15] Affidavit of Catherine Parkes dated April 17, 2024 ("**Parkes Affidavit**"), paras 23-28, AR, Tab 3, pp 164-165 [A165-166] and Affidavit of Natalie Mehra dated April 18, 2024 ("**Mehra Affidavit**"), paras 11-19 pp 246-249 [A254].
[16] *Idem.*
[17] Record, Vol 23, Tab F, pp 7071-7145 [B7491], and see email submissions by Carol Lewis Record (Vol 18, Tab 88Y) [B6077], Carolin Flemming (Vol 18, Tab 88Z) [B6079], Carolin Flemming (Vol 18, Tab 88AA) [B6081], Cathy Parkes (Vol 18, Tab 88DD) [B6088], Fred Cramer (Vol 18, Tab 88III) [B6153]; June Morrision (Vol 18, Tab 88XXX) [B6190]; Liz Tobias (Vol 18, Tab 88ZZZZZ) [B6317], Pamela Bendell (Vol 18, Tab 88GGGGGGG) [B6409], Rob Cramer (Vol 19, Tab 88TTTTTTT) [B6440], Cathy Parkes (Vol 21, Tab 94C) [B7337] and Pamela Bendell (Vol 21, Tab 94N) [B7363].
[18] Record, Vol 23, Tab 98F, pp 7116–7127 [B7535], see also Email submissions following meeting Record, Vol 21, Tab 94A-R pp 6921-6962 [B7330], and Vol 22, Tab 94 S-U, pp 6963-7013 [B7379].
[19] Record, Vol 23, Tab 98F, pp 7071-7145 [B7491].
[20] Record, Vol 23, Tab 98F, p 7116 [B7535].

> dehydrated, malnourished, and were lying in feces and infested with bugs. Her mother had black eyes, skin tears, a broken toe, she was receiving treatment on her right knee in January prior to the pandemic and a patient lifter had dropped on her knee."[21]

19. Omitted from the Ministry's summary, but included in Ms. Bendell's email is this statement:

> The Military Report said one resident choked to death while being fed a liquid supplement lying down. That was our mother, she aspirated and went into cardiac arrest.[22]

(b) Consultation October 2022

20. As noted, due to a change in the Southbridge corporate structure, a further consultation by way of inviting written submissions, took place in October 2022. Over 210 individually composed submissions were received.[23] All opposed giving Southbridge the license it was seeking.[24]

D. The Approvals

(i) Minister's Decision

21. Under s. 99 and s. 100, the Minister determined there was a need for a LTC home in the Pickering area, and that no restrictions should be imposed concerning the particular corporate entity that could be authorized to develop it. Once again, because of the Southbridge restructuring, this decision was first made in 2020 and then again 2023.[25]

(ii) Director's Decision

22. On June 26, 2023, the Director formally approved the Project by providing an undertaking

---

[21] *Idem*, p 7117 [B7535].
[22] Record, Vol 21 Tab 94N, p 6951 [B7363].
[23] Record, Vol 18, Tab 88A -DDDDDDDDD, pp 5624 [B6018] to Vol 19, p 6119 [B6520].
[24] Record, Vol 22, Tab 98, p 7054 [B7469].
[25] November 20, 2020 and June 14, 2023; Record, Vol 22, Tabs B and C, pp 7062 – 7065 [B7478].

to issue a licence to Southbridge to develop 320 LTC beds at Southbridge Pickering.[26] No notice of that decision was made public at that time or provided to the Applicants, or to the Applicant's counsel notwithstanding his request to be so apprised.[27] The Directors decision only came to the Applicant's attention more than five months later when the following notice was posted to the Ministry's website in December 2023. The posting stated:

> "Decision
>
> The Director under the Fixing Long-Term Care Act, 2021 has reviewed the Southbridge Pickering proposal and has made a decision. The proposal related to Southbridge Pickering has been approved and as such the Director has provided an undertaking to issue a new 320-bed long-term care home licence for up to 30 years to CVH (No. 6) LP by its general partners, Southbridge Health Care LP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.) upon the completion of the redevelopment of the home."[28]

23. Because no commitment had been made to notify the participants or their counsel, the posting came to Applicant's attention only because the Ministry's public registry was monitored on a daily basis to see whether the Project had been approved.[29]

E. The Record of Decision

24. The Record contains hundreds of documents and is over 7200 pages long. Several of its 23 volumes are dedicated to providing a detailed description of the Project itself. Nearly 550 pages reproduce the written submissions of participants in the consultation processes.[30]

---

[26] Record, Vol 23, Tab 99, p 7183 [B7603].
[27] Record, Vol 21, Tab 94Q and Vol 22, Tab 94U, pp 6957 [B7369] and 7013 [B7429].
[28] Armstrong Affidavit, para 6, AR, Tab 2, p 26 [A27].
[29] Mehra Affidavit, paras 23-24, AR, Tab 4, p 250 [A258].
[30] Record, Vol 18, Tab 84, pp 5627-6118 [B6019] and Vol 19, Tab 84, pp 6921-7015 [B7333], and see notes of the call Vol 22, Tab 94V, p 7016 [B7432], and "Feedback", Vol 23, Tab 98F, pp 7071-7145 [B7491].

25. The Record also includes information about the failure of Southbridge operations at the Home to comply with the *Act* and Regulations, and to provide for the proper care and safety of residents, including an account of the Company's record of regulatory non-compliances between January 2018 and June 30, 2021 during which time Southbridge was given 121 notices of regulatory infractions, plans for correction and compliance orders.[31]

(i) Facts and Information Not Included in the Record

26. The record of decision does not include any account of the Company's failures to comply with the Act and the regulations from the time it acquired the Home in 2015 to 2017. During that time Southbridge was cited dozens of times for non-compliance and was given numerous Orders for failing to comply with written notifications and voluntary plans of compliance.[32]

27. The Record also fails to include the assessments of Southbridge operations at the Home provided by the Commission, the Auditor General and the Ombudsman, which, as described above, included critical commentary concerning Southbridge operations at Orchard Villa.

28. Similarly, the Record neither includes, nor refers to, the testimony of the families of Orchard Villa residents to the Commission[33] which echo the comments from Lakeridge hospital staff and the Canadian Forces. These comments include evidence that long before the pandemic, dire understaffing, poor management, and the absence of infection control procedures were

[31] Record, Vol 22, Tab 96, pp 7062-7047 [B7478].
[32] Mehra Affidavit, Exhibit D, and Exhibits E and H, AR, Tab 2D, 2E, 2H [A272], [A276], [A362].
[33] Parkes Affidavit, Exhibit A, AR, Tab 3A [A170].

common occurrences at the Home, and had resulted in cases of extreme weight loss, bed sores, infections and other harms.[34]

(a) The Southbridge Compliance Record at Orchard Villa from July 1 2021 to June 26, 2023

29. The most glaring omission from the Record is the absence of Southbridge's compliance record at Orchard Villa from July 1, 2021, to the date of the Director's decision in June 2023. During this period, Southbridge's record of failing to comply with its regulatory obligations and to provide for the proper care and safety of residents continued virtually unabated.

30. As Dr. Armstrong summarizes this publicly available information, during this two-year period beginning on July 1, 2021, Southbridge was cited numerous times for failing to comply with the *Act*, Regulations, and directives during this time. Several of these failures were so serious as to give rise to Compliance or Director's Orders for failing to take proper corrective action once the applicant was notified of the failure. [35]

31. While more than one of these failures created risk of, or harm to residents, several are particularly problematic. These are set out in the Inspection Reports dated, June 29, 2021, March 10, 2022, and January 16, 2023, and concern the failure of Southbridge to comply with IPAC protocols and health directives essential for safeguarding the lives, health and well-being of residents. It is this very failure that allowed the ravages of Covid-19 to spread so quickly through the Home during the pandemic. As described by the inspection report of January 2023, the failure

---

[34] Mehra Affidavit, para 23 and Exhibit E, AR, Tab 4, p 250, Tab 4A [A258], [A261].

[35] Armstrong Affidavit, paras 31-38, AR, Tab 2, pp 37-39 [A38-40]. See also, *Reports on Long-Term Care Homes,* https://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2693&tab=1 ("**Reports on LTC Homes**").

to comply with IPAC protocols and directives actually occurred during yet another outbreak of Covid-19 at the Home. Just as troubling is the fact that Southbridge was cited for "obstruction" by falsifying its records to cover up this failure.[36]

PART II - LAW AND ARGUMENT

A. The Minister's Decision

(i) Clear Predetermination

32. By the time the Minister exercised his authority under ss. 99 and 101 of the *Act*, the Project was already a *fait accompli*. Prior to the issuance of the Minister's decision on June 14, 2023, the Ministry had already provided commitments of funding support for the Project and the Company had issued a tender and retained a company to build it.[37]

33. In addition, in December 2022, Southbridge wrote the Ministry of Long-Term Care to advise that it was seeking a Municipal Zoning Order ("MZO") to build three 15 story high rise buildings on the Orchard Villa site, one of which would house the 230 bed LTC home at issue. Over the unanimous objections of the Council of the City of Pickering on June 9, 2023 the MZO was passed to override the local land use and zoning rules to permit the construction of three 15 story towers on site occupied now by the two-story Orchard Villa home which the new home would replace.[38] Only one of these towers would be used for the Project. By doing so, the Government expended significant political capital overriding local planning authority, clearly

---

[36] *Idem*.

[37] For example, see Letter from Minister, November 20, 2020 regarding approval of funding, Record, Vol 1, Tab 9, p 436 [B508]; Execution Development Agreement, June 17, 2021, Record, Vol 2, Tab 16, pp 537-608 [B630]; Total Capital Development Funding June 16, 2023, Record, Vol 2, Tab 28, p 895 [B988]; Signed Procurement and Bonding Attestation, August 10, 2023, Record, Vol 17, Tab 67, p 5378 [B5753]; and Letter from Assistant Deputy Minister, August 30, 2023, Record, Vol 18, Tab 73, p 5402 [B5794].

[38] Ontario Regulation 125/23, which was filed on June 9, 2023, https://ero.ontario.ca/index.php/notice/019-7206.

signalling its commitment to have the Project proceed. All that remained was the formality of issuing the requisite formal approvals.[39]

34. The test for apprehension of bias is whether, as a matter of fact, the standard of open-mindedness has been lost to a point where it can reasonably be said that the issue at large has been predetermined.[40] An apprehension of bias may rest on the actions of a Minister where a Minister makes statements, or, in this case – undertakes actions - that lead an outside observer to conclude that any effort to dislodge that opinion would be futile.[41]

35. The effect of the Government's actions to smooth the process for the development of the Southbridge Project *in advance* of the Minister's statutorily required exercise of discretion was a clear signal that the Government had already determined that the Project was needed, and that no restriction should preclude Southbridge from proceeding with it. These were precisely the determinations that the Minister was statutorily obliged to make, but he had yet to do so.

B. The Director's Decision Was Unreasonable

36. In *Vavilov*, the leading case on the subject of judicial review of administrative decision making, the Supreme Court described the respective obligation of the applicant, the Court, and the decision maker in the judicial review of administrative decisions. The applicant seeking judicial review of the exercise of a statutorily granted discretionary decision bears the onus of showing that the decision was unreasonable.[42] Whether this decision is reviewed as merely an exercise of

---

[39] Armstrong Affidavit, Exhibit C, AR, Tab 2C [A145].
[40] *Zündel v. Canada (Attorney General) (T.D.)*, 1999 CanLII 9357 (FC), [1999] 4 FC 289.
[41] *Newfoundland Telephone Co v Newfoundland (Board of Commissioners)*, 1992 CanLII 84 (SCC) at 638 ["***Newfoundland Telephone***"] and *Old St Boniface Residents Assn Inc v Winnipeg (City)*, 1990 CanLII 31 (SCC) at 1197.
[42] *Vavilov v. Canada (Citizenship and Immigration)*, 2019 SCC 65, ("***Vavilov***"), para 316.

statutory discretion, or an exercise of statutory discretion which engages *Charter* values, the standard of review is reasonableness.[43]

37. For its part, in conducting a reasonableness review, the court must consider "the outcome of the administrative decision in light of its underlying rationale." The authorities, here the Minister and the Director, are responsible for making decisions in a manner that is "transparent, intelligible and justified." In all of this, judicial review is concerned with both the outcome of the decision and the reasoning process that led to that outcome.[44]

38. The Applicants submit that the Director's decision was unreasonable for three reasons. First, the Director failed to adequately consider – or consider at all – statutorily required evidence in reaching their decision. Second, the Director's decision is directly at odds with both the purpose of the governing statute and the *Charter* values which animate the *Act*. Third the Director's decision is neither transparent, intelligible, nor justified in failing to indicate a chain of reasoning capable of establishing the requisite rational connection between outcome on the one hand, and the facts and law on the other.

39. Finally, the process by which public consultations were undertaken by the Ministry in relation to the Minister and Director's decisions was inadequate as the public was explicitly discouraged and, in some cases, prevented from raising concerns regarding Southridge operations at Orchard Villa, and the Record includes no indication that the substance of the extensive public input opposing the Project was considered by the Director.

---

[43] *Vavilov*, paras 16-32.
[44] *Vavilov*, paras 83-87.

40. Although each of these deficiencies would on their own support a finding of unreasonableness, together they paint a stark picture of a deeply problematic and undoubtedly unreasonable exercise of statutory discretion.

(i) The Director's decision is neither transparent, intelligible nor justified

(a) Memorandum to Director (June 23, 2023)

41. In cases where reasons are not given, as is true here, the reviewing court looks to the record before the decision maker, as well as to the relevant factual and legal constraints on the decision maker in order to determine whether the decision is reasonable.[45]

42. While the Record of Decision is voluminous, the only indication of the reasoning process behind the Director's decision is provided by the memorandum to the Director dated June 23, 2023, upon which his decision appears to have been based.[46] The memorandum includes a description of the project and the various steps taken to assess it. It includes an account of the consultation process, noting the unanimous opposition to the project registered by a 44-page petition and numerous separate responses. Because of their volume, these submissions are not attached to the memorandum but are offered to the Director upon his request. There is no record of such a request. There is also no reference to, or information about the extensive public response to the first consultation held in 2021.

43. There is also no reference in the memorandum to the detailed criticisms of Southbridge operations at Orchard Villa made by the Long -Term Care Commission, the Auditor General, the

---

[45] *Vavilov*, para 137.
[46] Record, Vols 22-23, Tab 98A – I, pp 7051- 7182 [B7467] – [B7491].

Canadian Armed Forces, or the Ombudsman.

44. There are several documents attached to the Memorandum, but these do not include evidence of past conduct of Southbridge at Orchard Villa or reference to its chronic failures to meet its regulatory obligations, or to the harm caused to residents at the home. Apart from the Company's own attestation that it is competent and able to meet its obligations under the law and to residents,[47] the only evidence presented to the Director concerning the past record of the company is a perfunctory response by Mr. Sikora, the Manager of the Ministry's East District Office.[48]

45. Mr. Sikora indicates "that based on [his] knowledge of the licensees past conduct" that he had no concerns with the ability of Southbridge to "operate the home in accordance with the law and with honesty and integrity"; to do so in a "manner that maintains the health, safety and welfare of its residents", "to furnish and provide the required services" and "to operate the Homes in a competent and responsible manner".

46. Mr. Sikora did not respond to the requests that he provide a rationale for his decision, or "any necessary evidence to support [his]the rationale". There is nothing in the Record to indicate what, if any knowledge Mr. Sikora had about the past record of Orchard Villa. Nevertheless, and without any analysis or further explanation, the memorandum concludes that the eligibility of the Proposed Licensee has been established and recommends that it be approved.[49] The Director did so three days later.

---

[47] Record, Vol 23, Tab 98G, p 7157 [B7576].
[48] Record, Vol 23, Tab 98H, p 7183 [B7603].
[49] Record, Vol 22, Tab 98, p 7056 [B7471].

(b) There is No Chain of Reasoning to Support the Director's Decision

47. The rule of law requires that a grant of statutory authority is not absolute.[50] The Director's discretion to determine LTC licence applications is not unfettered, but rather must be exercised in accordance with the very specific statutory criteria.

48. Section 101 of the *Act* concerns the eligibility of a person to be issued a licence for a LTC home and sets out six mandatory criteria, and the statute requires that the Director formulate the opinion that each of these distinct criteria has been met. Four of the criteria concern whether the applicant will comply with the requirements of the *Act* and Regulations, and two of these further require that the past conduct of Southbridge LTC home operations "affords reasonable grounds to believe" that Southbridge Pickering will be operated "in accordance with the law and with honesty and integrity" and not "in a manner that is prejudicial to the health, safety or welfare of its residents".

49. This double-barrelled test – to form an opinion, and to do so based on whether the past record of Southbridge "affords reasonable grounds" for his belief - serves to underscore that the Director's decision must not only be based on a subjective belief but must also be *objectively justifiable*.

50. It is clear on the Record before the Court that the Director failed to reach his decision in accordance with these statutory criteria, or that in the alternative, that he failed to do so in a manner

---

[50] *Roncarelli v. Duplessis*, 1959 CanLII 50 (SCC), [1959] SCR 121; *Bellemare v. Lisio*, 2010 QCCA 859 (CanLII), para 30 , leave to appeal refused 2010 CanLII 59795 (SCC); *Strom v Saskatchewan Registered Nurses' Association*, 2020 SKCA 112 (CanLII), para 105.

that was transparent, intelligible, and justified.

51. The Director's failure to take required account of the operational record of Southbridge at the Home is plainly evident. The Record discloses that the Director failed to consider the past conduct of Southbridge notwithstanding his mandate to do so, and while the most glaring gap in the Record concerning Southbridge's past conduct concerned operations at the Home for the two-year period preceding his decision, it is evident that none of the Southbridge record of regulatory non-compliance and inadequate resident care was considered by the Director.

52. While it is trite law that a decision maker may only assess and evaluate the evidence before it, the failure to diligently collect and consider evidence in relation to the mandatory statutory criteria on which a decision is to be based cannot insulate the decision maker from review.[51] This failure alone warrants granting the relief the Applicants seek.

53. However, even if this failure is not considered fatal to his decision, there are no reasonable grounds upon which the Director could formulate an opinion that Southbridge was eligible to be issued the impugned license. In particular:

a. Whereas Section 101 (a) requires the Director to determine whether, in his opinion, "the home and its operation would comply with this *Act* and the regulations and any other applicable Act, regulation or municipal by-law;" the facts show that Southbridge has a persistent record of regulatory non-compliance, and it has been cited hundreds of times for failing to meet its obligations under the *Act* and

[51] *Vavilov*, paras 106 and 125.

regulations. As described above,[52] that record of non-compliance has endured from the time that Southbridge acquired the home in 2015 to the present day.[53]

b. Whereas Section 101 (c) requires that "the past conduct relating to the operation of a long-term care home affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity …" the facts show that Southbridge has repeatedly failed to comply with its obligations to report critical incidents to the Ministry or the Police,[54] including of incidents that have resulted in risk of or harm to residents.[55] Furthermore, and as noted, in January 2023 the Inspections Branch cited Southbridge for "obstruction", in that it falsified records concerning its compliance with IPAC procedures and health department orders.[56]

c. Whereas s.101 (d) requires it has "been demonstrated by the person that the person or, where the person is a corporation, its officers and directors and the persons with a controlling interest in it, is competent to operate a long-term care home in a responsible manner in accordance with this *Act* and the regulations and is in a position to furnish or provide the required services"; the facts show that Southbridge has repeatedly failed to demonstrate such competence, even to the

---

[52] See paras 25-31.
[53] *Southbridge Homes Compliance History*, Record, Vol 22, Tab 96, pp 7034-7045 [B7450]; Record of Orchard Villa Inspection and Compliance Orders, Mehra Affidavit, Exhibit H.42-H.86, AR, Tab 4H, pp 930-1582 [A945]; Armstrong Affidavit, paras. 31-38 [A38], AR, Tab 2, pp 37-39, and Reports on LTC Homes.
[54] See Critical Incident Inspection Report dated March 16, 2022, Mehra Affidavit, Tab 4H.84, p 1570 [A1590].
[55] For recent examples, see Inspection Reports for March 16, 2022 (Mehra Affidavit, Tab 4H.84, p 1570) [A1590] and January 16, 2023; and also Inspection Reports published for July 17, August 2, August 17 and November 1, 2023 (Reports on LTC Homes).
[56] Armstrong Affidavit, paras 37-38, AR, Tab 2, p 39 [A40] and Inspection Report for January 16, 2023 (Reports on LTC Homes).

extent that required local health authorities to take over operations at the home.[57] Moreover, Southbridge has little experience providing front line care, and the Company's recent efforts to do so at Orchard Villa have done nothing to bring operations at the Home into an acceptable sphere or regulatory compliance and proper resident care.

d. Whereas s. 101 (e) requires that "the past conduct relating to the operation of a long-term care home or any other matter or business affords reasonable grounds to believe that the home will not be operated in a manner that is prejudicial to the health, safety or welfare of its residents", the facts show that Southbridge's operations at the Home have repeatedly put the health, safety and welfare of the residents at grave peril. These failures had extremely tragic consequences during the pandemic when 70 of its 230 residents died during the early months of 2020.[58] Moreover, since then, Ministry inspectors have repeatedly cited the home for putting residents at risk or causing them harm, including for failing to comply with the very IPAC procedures that are critical to controlling the spread of infectious diseases such as Covid-19.[59]

54. It is clear that none of these many failures are isolated incidents. Instead, they comprise a persistent pattern of non-compliance with the *Act* and its regulations that has repeatedly caused risk and harm to the lives, safety and well-being of Orchard Villa residents. Particularly troubling

---

[57] The Commission Final Report, pp 38-39, pp 151-152.
[58] Ombudsman Report p. 11, para. 30.
[59] See para 31, and as examples also see Inspection Reports dated April 30, and June 29, 2021, March 10, 2022, and January 16, 2023 (Reports on LTC Homes) see also, Mehra Affidavit, AR, Tabs 4H.79, 4H.80, 4H.83 [A1529], [A1550], [A1578].

is the Southbridge failure to correct the IPAC related problems that led to the horrific events at the Orchard Villa during the pandemic.

55. As stated by the Supreme Court in *Vavilov* a decision will be unreasonable "where the conclusion reached cannot follow from the analysis undertaken or if the reasons read in conjunction with the record do not make it possible to understand the decision maker's reasoning on a critical point."[60] These failures are patently evident in the present case. To take the Southbridge record at Orchard Villa as supporting the opinion that Southbridge is eligible for the licence it sought is entirely "untenable in light of the relevant factual and legal constraints that bear on it."[61]

56. In other words, the record fails to disclose a "chain of reasoning" or analysis to explain how, in light of its record, it was reasonable to determine that Orchard Villa was eligible for the licence at issue. If there is an intelligible rationale from formulating the opinion that the explicit requirements of s. 101 were met, it is entirely missing from the record. Utterly absent from the record is "internally coherent and rational chain of analysis and that is justified in relation to the facts and law that constrain the decision maker"[62] required to support a determination that the Director's decision was reasonable.

57. Finally, on this point, as noted, the only 'reasons' offered by Director for his decision was posted as a notice on the Ministry's website nearly six months after is decision was made. Reading this notice in conjunction with the record is of no assistance in revealing a "chain of reasoning" or

---

[60] *Vavilov*, para 103.
[61] *Vavilov*, para 101.
[62] *Vavilov*, paras 102 – 104.

analysis to explain how, in light of its record, it was reasonable for the Director to determine that Orchard Villa was eligible for the license at issue. If there is an intelligible rationale for formulating the opinion that the explicit requirements of s. 101 were met, it is not found in either these "reasons", or the Record. As such, the decision cannot be considered justified in light of the relevant factual and legal constraints that bear on it."[63]

58. For these reasons the Applicants submit that the Director failed to exercise his authority in a manner that was transparent, intelligible, and justified and his undertaking to issue the licence at issue should be quashed.

(ii) The Director's decision neither promotes the objects of the *Act*, nor accords with relevant *Charter* values

59. There is no longer any question in Canadian law that discretion flowing from a grant of statutory authority must not only be exercised in accordance with statutory requirements, but to be reasonable, the decision maker must give due consideration to and weigh *Charter* values engaged in their decision.[64]

60. When a decision engages the Charter, reasonableness and proportionality become synonymous.[65] In *Doré v. Barreau du Québec*, 2012 SCC 12, Justice Abella set out what has become known as the *Doré* framework – the approach for reviewing discretionary administrative decisions that limit *Charter* protections. The first step in a *Doré* analysis requires determining whether an administrative decision engages the *Charter*, either by limiting *Charter* protections *or*

---

[63] *Dunsmuir v. New Brunswick*, 2008 SCC 9 (CanLII), [2008] 1 SCR 190, paras 47 and 74, are referred to *Vavilov*, para 99.
[64] *Doré v. Barreau du Québec*, 2012 SCC 12 (CanLII), [2012] 1 SCR 395 ["***Doré***"], para 24.
[65] *Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32 ["***Trinity Western***"], para 80.

values.[66] This is a broader inquiry than simply inquiring about whether the *Charter* rights of the parties to the litigation are affected. The analysis must proceed regardless of whether the parties seeking review of the decision are representative of the rights holders or not.[67] Further, the *Doré* framework applies not only where an administrative decision directly infringes *Charter* rights but also in cases where it simply engages a value underlying one or more *Charter* rights, without limiting these rights.[68]

61. There can be little doubt that the impugned decisions here engage the *Charter* values of human dignity, and security. The accounts of the horrors suffered by the residents of Orchard Villa during the pandemic detail the suffering, the ill-health, the limit of freedom, and surely the deprivation of human dignity experienced by the residents of the Southbridge home.[69]

62. In addition, the *Charter* values that are engaged here are reflected in the stated purpose of the *Act* from which the Director's discretion flowed. The stated purpose of the *Fixing Long Term Care Act* is as follows:

> *Home: the fundamental principle:*
>
> *The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.* (Emphasis added).[70]

---

[66] *Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256 ["***Commission Scolaire***"], at para 61.
[67] *Commission Scolaire*, at para 63.
[68] *Doré*, paras 35 et seq.; *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12 (CanLII), [2015] 1 SCR 613, para 4; *Trinity Western*, para 57.
[69] See paragraphs 8-12.
[70] *Fixing Long-Term Care Act, 2021*, S.O. 2021, c. 39, Sched. 1, Article 1.

63. The stated purpose of the statute itself avers to the *Charter* value of human dignity. The *Act* explicitly requires that the exercise of discretion granted therein ought to be exercised in accordance with these values.

64. The Applicants concede that there is a clear need for long term care facilities, and that the Minister and Director are responsible for facilitating the development of facilities that will meet the needs of Ontarians. However, any discretionary decision must balance these aims with the *Charter* values engaged. Both the Minister and Director are obligated to balance the need for long term care facilities with the concurrent requirement that they must ensure that facilities deliver services in accordance with the values of human dignity, safety, and security.

65. The decision must also show that the decision maker "meaningfully"[71] addressed the *Charter* protections to "reflect" the impact that its decision may have on the concerned group or individual.[72] In light of the Director's failure to fully consider the Southbridge record of repeatedly causing harm to the lives and security of residents, it is clear he failed to consider how this decision engaged the values of human dignity at all, let alone afforded "meaningful" consideration to the issue. The record shows that neither the Minister, nor the Director, gave *Charter* values meaningful consideration, or on the Record, any thought at all. Their decisions must fail on this ground as well.

(iii) The consultations held in respect of the Southbridge application did not provide participants a fair opportunity be heard

66. In both 2021 and 2022, the Minister determined pursuant to Section 109 of the *Act* that

[71] *Vavilov*, para 128.
[72] *Vavilov*, para 133.

public consultation was warranted with respect to the Southbridge application.[73] In 2021, this included a public meeting by teleconference, and in 2022, the public was invited to submit written comments. Whether it would have been reasonable for the Director to determine that no consultation was warranted is moot. Once his decision was made, he was obliged to conduct the consultations in a manner that was concordant with the essential principles of fairness.

67. Yet in neither consultation were participants given more than a perfunctory description of the Project that would endure for 30 years with the benefit of more than $100 million in public funding. During the teleconference held in 2021, participants were repeatedly told to restrict their comments to the Project proposal, and that comments concerning the past or present record of Southbridge operations at Orchard Villa were not relevant or welcome. While participants were invited to submit further comments in writing, and then again in 2022, at no time did a representative from the Ministry disavow that position.[74]

68. Where a particular administrative decision-making context gives rise to a duty of procedural fairness, the specific procedural requirements that the duty imposes are determined with reference to all of the circumstances,[75] including: (1) the nature of the decision being made and the process followed in making it; (2) the nature of the statutory scheme; (3) the importance of the decision to the individual or individuals affected; (4) the legitimate expectations of the person challenging the decision; and, (5) the choices of procedure made by the administrative

---

[73] Record, Vol. 22, Tab 98D (no.1), p 7066 [B7482], and Vol. 19, Tab 89D (no. 2), p 6135 [B6537].
[74] Memorandum to Director, Capital Planning Branch, dated June 23, 2023, Record, Vol. 22, Tab 98, p 7056 [B7471]
[75] *Baker v. Canada (Minister of Citizenship and Immigration)*, 1999 CanLII 699 (SCC), [1999] 2 SCR 817 ["***Baker***"], paras 21-23

decision maker itself. [76] By virtually every one of these indicia, the families of current and past Orchard Villa residents were entitled to the basic rights of procedural fairness.

69. It is undeniable that the direct experience of these family residents, including many whose spouses or parents died at the Home were highly relevant to the Director's decision. Yet, other than for being advised of their unanimous opposition to the licence, there is no evidence that the Director made any inquiry to know their views. The Director's failure to consider the collected public feedback in reaching his decision constitutes a stark departure from the reasonable expectations of the individuals who participated in the public consultation meeting and the written consultation process.[77] As indicated by his apparent disinterest in the substance of the hundreds of submissions the consultations elicited,[78] it appears that consulting the community was regarded primarily as a public relations exercise to be forgotten as soon as it was completed.

70. There are two other indications that the Director and the Service Area Office regarded the problems arising from Company's failures at Orchard Villa as primarily a matter of public relations rather than of failing to provide for the proper care and safety of the Home's residents. Thus, presumably taking its guidance from the Director, the Service Area office consistently paid more attention to the extent of public and media interest in the Home, than to Southbridge's performance.[79] The conditions attached to the undertaking also express such a bias by placing considerable emphasis of the need for the Company to improve its communications strategy with

---

[76] *Baker*, paras 23-27; see also *Congrégation des témoins de Jéhovah de St-Jérôme-Lafontaine v. Lafontaine (Village)*, 2004 SCC 48, [2004] 2 S.C.R. 650, para 5.
[77] See especially *Qi v. Canada (Minister of Citizenship and Immigration)*, [1995] F.C.J. No. 1615 and *Mercier-Néron v. Canada (Minister of National Health and Welfare)*, [1995] F.C.J. No. 1024.
[78] *Infra*, para 36.
[79] Record, Vol. 23, Tab 98H [B7581], Vol. 21, Tab 89G, p 6826 [B7238] and Vol. 22, Tab 95, p 7031 [B7447].

respective stakeholders.[80]

71. Cases in which written reasons tend to be required include those in which the decision-making process gives the parties participatory rights and where an adverse decision would have a significant impact on an individual.[81] In *Vavilov*, the Supreme Court held:

> It is well established that individuals are entitled to greater procedural protection when the decision in question involves the potential for significant personal impact or harm: *Baker*, at para. 25. However, this principle also has implications for how a court conducts reasonableness review. Central to the necessity of adequate justification is the perspective of the individual or party over whom authority is being exercised. Where the impact of a decision on an individual's rights and interests is severe, the reasons provided to that individual must reflect the stakes. The principle of responsive justification means that if a decision has particularly harsh consequences for the affected individual, the decision maker must explain why its decision best reflects the legislature's intention. This includes decisions with consequences that threaten an individual's life, liberty, dignity or livelihood.

72. Therefore, in addition to the failure to give due consideration to the comments and submissions the public was invited to provide or provide proper and timely notice of his decision to them, the Director also failed to provide any explanation as to why, given the Southbridge record at Orchard Villa, it was reasonable to conclude that the Company was eligible for the licence he undertook to provide it.

73. Unlike the plain exercise of statutory discretion, any failure to afford a requisite level of procedural fairness in the exercise of ministerial discretion is an error reviewable on a standard of correctness.[82] However, whether on a standard of correctness or reasonableness, the Director failed to provide the fairness required to those with an interest in the Southbridge application and his

---

[80] Record, Vol. 22. Tab 98, p 7055 [B7470].
[81] *Baker*, para 43.
[82] *Baker*, para 21.

decision should therefore be set aside on this ground as well.

PART III -REMEDY

74. If this Court finds that either or both of the Minister's and Director's decisions were unreasonable and should be quashed, the present circumstances weigh against remittance for reconsideration. First, as the Supreme Court found in *Baker*, when a decision is quashed on grounds of procedural unfairness or bias, remitting it to the same decision-maker could perpetuate the unfairness, making it preferable for the court to set the decision aside without remittance.[83] Second, as the Supreme Court held in *Vavilov*, "Declining to remit a matter to the decision maker may be appropriate where it becomes evident to the court, in the course of its review, that a particular outcome is inevitable and that remitting the case would therefore serve no useful purpose."[84]

75. Finally, the extensive stakeholder input in this case shows strong support for more long-term care beds in homes that are capable of providing proper care for residents. Of the hundreds who spoke up or wrote to express opposition to the Project, none questioned the need for more long-term beds, but only opposition to licensing Southbridge to own or operate them. Some suggested that a home or homes be established by Lakeridge Health, the local municipality, or another non-profit provider, and this preference accords with the Commissions commentary on the public preference for not for profit LTC service providers. As the Commission pointed out, certain problems are endemic to the for-profit delivery of LTC, including:

- Staffing: For-profit homes tend to offer lower wages and benefits to their staff, have

[83] *Idem*.
[84] *Vavilov*, para 142.

higher staff turnover, and have lower staffing levels and staff-skill mix (i.e., the mix of medical and non-medical staff).

• Quality of care: Residents in for-profit homes tend to have a higher prevalence of pressure ulcers, more hospital admissions, and increased incidents of excessive and inappropriate use of psychoactive medications.

• Infrastructure: For-profit entities own more of the province's older homes; these homes were built according to the design standards in place at the time of construction, prior to the newer provincial structural and design standards; as a result, they have more three- and four-person rooms (and therefore crowding).

• Consumer preference: The long-term care waitlist is shorter for for-profit homes (32 per cent) compared to not-for-profit and municipal homes (68 per cent)." [85]

76. The Southbridge application has now been outstanding for years, including for reasons arising from Company's decision to restructure its corporate operations midstream. Given the Ministry's many signals that the application would be approved, others who could meet the community's need may have been discouraged from applying for their own project. Any further delay would only forestall Ministry efforts to encourage other providers with the competence and incentive to provide quality LTC care, and the record to prove it. As the principal funder of such projects, the Minister would have considerable influence if he chose to do so.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

August 22, 2024

Steven Shrybman

GOLDBLATT PARTNERS LLP
20 Dundas Street West, Suite 1039
Toronto, ON M5G 2C2

Lawyers for the Applicant

[85] The Commission Final Report, pp. 38-39.

SCHEDULE "A"

Case Law

1.	*Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] S.C.J. No. 39, [1999] 2 S.C.R. 817
2.	*Bellemare v. Lisio*, 2010 QCCA 859 (CanLII), leave to appeal refused 2010 CanLII 59795 (SCC)
3.	*Congrégation des témoins de Jéhovah de St-Jérôme-Lafontaine v. Lafontaine (Village)*, 2004 SCC 48, [2004] 2 S.C.R. 650
4.	*Doré v. Barreau du Québec*, 2012 SCC 12 (CanLII), [2012] 1 SCR 395
5.	*Dunsmuir v. New Brunswick*, 2008 SCC 9 (CanLII), [2008] 1 SCR 190
6.	*Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32
7.	*Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12 (CanLII), [2015] 1 SCR 613
8.	*Mercier-Néron v. Canada (Minister of National Health and Welfare)*, [1995] F.C.J. No. 1024
9.	*Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256
10.	*Newfoundland Telephone Co v Newfoundland (Board of Commissioners)*, 1992 CanLII 84 (SCC)
11.	*Old St Boniface Residents Assn Inc v Winnipeg (City)*, 1990 CanLII 31 (SCC)
12.	*Qi v. Canada* (Minister of Citizenship and Immigration), [1995] F.C.J. No. 1615
13.	*Roncarelli v. Duplessis*, 1959 CanLII 50 (SCC), [1959] SCR 121
14.	*Strom v Saskatchewan Registered Nurses' Association*, 2020 SKCA 112 (CanLII)
15.	*Vavilov v. Canada (Citizenship and Immigration)*, 2019 SCC 65
16.	*Zündel v. Canada (Attorney General) (T.D.)*, 1999 CanLII 9357 (FC), [1999] 4 FC 289

Secondary Sources

1.	Marrocco, F. N. A. Coke & J. Kitts (2021) *Ontario's Long-Term Care COVID-19 Commission Final Report.* Toronto: Queen's Printer of Ontario ("The Commission Final Report")
2.	Dubé, P. (2023) *Lessons For The Long Term. Investigation Into The Ministry Of Long-Term Care's Oversight Of Long-Term Care Homes Through Inspection And Enforcement During The Covid-19 Pandemic,* September 7 https://www.ombudsman.on.ca/Media/ombudsman/ombudsman/resources/Reports-on-Investigations/Ombudsman-Ontario-Lessons-for-the-Long-Term-Sept-2023-report-accessible.pdf . ("Ombudsman Report")
3.	Ontario Auditor General Bonnie Lysyk (2021), *COVID-19 Preparedness and Management Special Report on Pandemic Readiness and Response in Long-Term Care*, ("Auditor General Report")
4.	*Reports on Long-Term Care Homes,* https://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2693&tab=1 ("**Reports on LTC Homes**")

SCHEDULE "B"

Canadian Charter of Rights and Freedoms, being Part I of the *Constitution Act, 1982*, Schedule B, *Canada Act 1982*, 1982, c. 11 (U.K.) [R.S.C., 1985, Appendix II, No. 44], ss. 1, 2(*b*).

Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1

Home: the fundamental principle
1 The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

~~~~~~

Public interest — need
99 (1) Subject to subsection (2), the Minister shall determine whether or not there should be a long-term care home in an area, and how many long-term care home beds there should be in an area, by considering what is in the public interest, having taken into account,

(a) the long-term care home bed capacity that exists,

(i) in the area, or

(ii) in the area and any other area;

(b) the other facilities or services that are available,

(i) in the area, or

(ii) in the area and any other area;

(c) the current and predictable continuing demand for long-term care home beds,

(i) in the area, or

(ii) in the area and any other area;

(d) the funds available for long-term care homes in Ontario;

(e) any other matters that may be provided for in the regulations; and
~~~~~~

(f) any other matters that the Minister considers to be relevant.

Exception, Minister's policy
(2) The Minister is not required to make a determination under subsection (1) where,

(a) the Minister has made a policy respecting the matters described in subsection (1); and

(b) the Director has decided that an application for a licence is covered by the policy and that the Director is entitled to act under the policy.

Making policy available
(3) If the Minister makes a policy under subsection (2), the Minister shall ensure that the policy is made available to the public.

Non-application of Legislation Act, 2006
(4) Part III (Regulations) of the Legislation Act, 2006 does not apply to a policy made under subsection (2)
~~~~~~

Public interest — who can be issued a licence
100 (1) The Minister may restrict who may be issued a licence based on what the Minister considers to be in the public interest, having taken into account,

(a) the effect that issuing the licence would have on the concentration of ownership, control or management of long-term care homes,

(i) in the area,

(ii) in the area and any other area, or

(iii) in Ontario;

(b) the effect that issuing the licence would have on the balance between non-profit and for-profit long-term care homes,

(i) in the area,

(ii) in the area and any other area, or

(iii) in Ontario; and

(c) any other matters that may be provided for in the regulations.

How determined
(2) The Minister may make a restriction in a particular case of an application for a licence or, where the Minister has made a policy respecting the matters described in subsection (1), the
~~~~~~

Director may decide whether an application is covered by the policy and whether or not the restriction applies.

Making policy available
(3) If the Minister makes a policy under subsection (2), the Minister shall ensure that the policy is made available to the public.

Non-application of Legislation Act, 2006
(4) Part III (Regulations) of the Legislation Act, 2006 does not apply to a policy made by the Minister under subsection (2).

~~~~~~

Limitations on eligibility for licence
101 (1) A person is only eligible to be issued a licence for a long-term care home if, in the Director's opinion,

(a) the home and its operation would comply with this Act and the regulations and any other applicable Act, regulation or municipal by-law;

(b) where the home is subject to a development agreement, the home, or the beds that are subject to a development agreement, complies with, and will continue to comply with, the applicable design manual and any additional design requirements required under the development agreement;

(c) the past conduct relating to the operation of a long-term care home or any other matter or business of the following affords reasonable grounds to believe that the home will be operated in accordance with the law and with honesty and integrity:

(i) the person,

(ii) if the person is a corporation, the officers and directors of the corporation and any other person with a controlling interest in the corporation, and

(iii) if the person with a controlling interest referred to in subclause (ii) is a corporation, the officers and directors of that corporation;

(d) it has been demonstrated by the person that the person or, where the person is a corporation, its officers and directors and the persons with a controlling interest in it, is competent to operate a long-term care home in a responsible manner in accordance with this Act and the regulations and is in a position to furnish or provide the required services;

(e) the past conduct relating to the operation of a long-term care home or any other matter or business of the following affords reasonable grounds to believe that the home will not be operated in a manner that is prejudicial to the health, safety or welfare of its residents:

(i) the person,
~~~~~~

(ii) if the person is a corporation, the officers and directors of the corporation and any other person with a controlling interest in the corporation, and

(iii) if the person with a controlling interest referred to in subclause (ii) is a corporation, the officers and directors of the corporation; and

(f) the person is not ineligible because of any other reason that may be provided for in the regulations.

Service of ineligibility decision
(2) If the Director decides that a person is not eligible to be issued a licence under subsection (1), the Director shall serve the person with a copy of the Director's decision, including reasons.

Appeal of ineligibility decision
(3) A person who the Director decides is not eligible to be issued a licence may appeal the decision to the Appeal Board and, for that purpose, sections 171 to 176 apply as if references to the licensee were references to the person, and with such other modifications as are necessary.

~~~~~~

Undertaking to issue licence
103 (1) Following a determination by the Minister or a decision of the Director under section 99, the Director may, subject to any restrictions under section 100 and subject to section 101, give an undertaking to issue a licence to a person on condition that the person agrees to satisfy the specified conditions set out in the undertaking. 2021, c. 39, Sched. 1, s. 103 (1); 2022, c. 16, s. 4.

~~~~~~

Public consultation
109 (1) Subject to subsection (3), the Director shall consult the public before,

(a) issuing a licence for a new long-term care home under section 102;

(b) undertaking to issue a licence under section 103;

(c) transferring a licence, or beds under a licence, under section 108; or

(d) amending a licence to increase the number of beds or to extend the term of the licence under section 116.

Public consultation, format
(2) The Director may determine how public consultations under subsection (1) shall be conducted.

Exception

(3) The Director is not required to consult the public under subsection (1) or under any other provision of this Act where the Director,

(a) has determined that a public consultation is not warranted in the circumstances; or

(b) has made a policy governing types of circumstances in which public consultation is not warranted, and the policy applies to the circumstances, unless the Director makes an exception to the policy.

Making policy available
(4) If the Director makes a policy under clause (3) (b), the Director shall ensure that the policy is made available to the public.

Non-application of Legislation Act, 2006
(5) Part III (Regulations) of the Legislation Act, 2006 does not apply to a policy made by the Director under clause (3) (b).

==========

Health Protection and Promotion Act, R.S.O. 1990, c. H.7

Orders to deal with communicable disease outbreaks

29.2 (1) Subject to subsection (2), a medical officer of health may make an order requiring a public hospital or an institution to take any actions specified in the order for the purposes of monitoring, investigating and responding to an outbreak of communicable disease at the hospital or institution. 2007, c. 10, Sched. F, s. 6.

When order may be made
(2) A medical officer of health may make an order under subsection (1) if he or she is of the opinion, upon reasonable and probable grounds, that an outbreak of a communicable disease exists or may exist at the public hospital or institution, and that the communicable disease presents a risk to the health of persons in the public hospital or institution, and that the measures specified in the order are necessary in order to decrease or eliminate the risks to health associated with the outbreak. 2007, c. 10, Sched. F, s. 6.

Time
(3) In an order under this section, a medical officer of health may specify the time or times when or the period or periods of time within which the order must be complied with. 2007, c. 10, Sched. F, s. 6.

Person directed
(4) An order under this section may be directed to the administrator of the public hospital or the superintendent of the institution, and the administrator or superintendent shall ensure that the actions provided for in the order are taken. 2007, c. 10, Sched. F, s. 6.

Reasons for order
(5) An order under this section is not effective unless the reasons for the order are set out in the order. 2007, c. 10, Sched. F, s. 6.

Definitions
(6) In this section,

"institution" means an institution as defined in subsection 21 (1); ("établissement")

"public hospital" means a hospital to which the Public Hospitals Act applies. ("hôpital public") 2007, c. 10, Sched. F, s. 6.

I. Ontario Regulation 125/23, which was filed on June 9, 2023, https://ero.ontario.ca/index.php/notice/019-7206