

Long Term Care Covid-19 Commission Mtg.

Meeting with Maria Elias, CEO of Belmont House
on Tuesday, October 20, 2020

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1 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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6 --- Held via Zoom Videoconferencing, with all
7 participants attending remotely, on the 20th day
8 of October, 2020, 11:00 a.m. to 12:05 p.m.

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12 BEFORE:

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14 The Honourable Frank N. Marrocco, Lead Commissioner
15 Angela Coke, Commissioner

16 Dr. Jack Kitts, Commissioner

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19 PRESENTING:

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21 Maria Elias, CEO of Belmont House

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

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6 John Callaghan, Counsel, Long-Term Care

7 Commission Secretariat

8

9 Lynn Mahoney, Counsel, Long-Term Care

10 Commission Secretariat

11

12 Derek Lett, Policy Director, Long-Term Care

13 Commission Secretariat

14

15 Jessica Franklin, Ontario Long-Term Care

16 Commission Secretariat

17

18 Dawn Palin Rokosh, Director Of Operations,

19 Ontario Long-Term Care Commission Secretariat

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1 -- Upon commencing at 11:00 a.m.

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3 COMMISSIONER MARROCCO: So thank you
4 for agreeing to meet with us. We were very
5 interested in your response, Belmont House's
6 response, because it seemed to have been effective
7 from our perspective. And we thought it would be
8 beneficial, from our point of view, if we could
9 talk to people who had successfully navigated their
10 way through this. And so hence our request to
11 speak to you.

12 There's a transcript. We have a
13 reporter, so we do have a transcript and we put the
14 transcripts on our website eventually, within a few
15 days.

16 So we're ready when you are, unless
17 you're waiting for someone. We would like to get
18 your thoughts and impressions, this will be
19 extremely helpful to us.

20 MS. ELIAS: I want to start first by
21 thanking the Commission for this invitation. It's
22 an honour, but it's also a little nervous for me to
23 present our perspective and how we did things.
24 Because, you know, how we did things six months ago
25 is certainly different than how we're doing things

1 today. But there are some common themes. And the
2 common themes are to stay ahead and take this virus
3 seriously.

4 So what I did was, I took the
5 opportunity to do a brain dump actually. So
6 there's a number of slides here, I've got about 30,
7 I think, that almost are like notes. So certainly
8 you can interrupt me at any point in time, and if I
9 don't get through them all, at least you have them
10 for your reference.

11 COMMISSIONER MARROCCO: All right.

12 MS. ELIAS: So what I'm going to talk
13 about this morning is basically our perspective and
14 how we handle things.

15 And so are you able to see the "Belmont
16 House" on the screen?

17 COMMISSIONER MARROCCO: Yes, I have the
18 slide on my screen. I think everybody can see it.

19 We can.

20 MS. ELIAS: Great. Just to give you a
21 basic background.

22 Belmont House is located in what I
23 consider Downtown Toronto. We're a not-for-profit
24 charitable long-term care home and retirement home.
25 We have 140 long-term care beds and 81 retirement

1 department. It's important to note that one of our
2 nursing units is located in our east building that
3 houses all the retirement department.

4 So we do operate as one campus of care.
5 We've been around historically since 1852, where we
6 started off as a Magdalen Asylum and Industrial
7 Refuge for women that were in trouble and evolved
8 to this point today where we have long-term care
9 and retirements living.

10 So when I talked about our perspective
11 here at Belmont House, I'm going to basically cover
12 what we did before the pandemic -- well, before
13 COVID-19 was declared a pandemic by the WHO. When
14 the pandemic was declared, Wave 1 and Wave 2 of
15 preparedness and our thoughts on that.

16 And I'll bring you some perspective in
17 terms of Belmont House, but also from some of my
18 colleagues. I won't specifically identify them,
19 because I have not gotten permission to speak on
20 their behalf, but just the feeling of some of my
21 colleagues and other charitable not-for-profit
22 homes.

23 Before I get into the detail, I think
24 it's important to identify that long-term care
25 providers, and the whole system, the healthcare

1 system, people think of long-term care as operating
2 the same as hospitals, but we do have three
3 distinct providers that provide long-term care as
4 part of the healthcare system.

5 So, basically, the three providers are
6 municipal regional homes, like the City of Toronto
7 or the Region of Peel. Then you have
8 not-for-profit charitable homes like Belmont House,
9 or the Hellenic Home, the Copernicus Lodge,
10 Unionville Home Society, the Wexford, Sheppard
11 Village, to name a few. And they operate very
12 similar to the Belmont House campuses.

13 And then you have for-profit that
14 people generally hear of quite often, especially
15 through this pandemic. And these are the chains
16 like Chartwell and Extendicare.

17 So what did we do early on? I mean,
18 certainly in terms of Belmont House, and if I can
19 say that our success was related to these things,
20 nobody knows 100 percent for sure, but we feel that
21 what we did implement very early on, certainly led
22 to our success and certainly led to a delaying of
23 an outbreak at Belmont.

24 So we monitored the world and Canadian
25 situation, and we determined very early on, that

1 the signs were all there for a pandemic and that we
2 really needed to prepare.

3 We looked at what we did here at
4 Belmont during SARS. I've been here at Belmont for
5 20 years, a lot of members of my management team
6 have been here for many, many years, and we recall
7 what we went through during SARS, and we thought,
8 here we go again. We better start thinking.

9 And we looked at our pandemic plan, we
10 assessed our staffing, our food, infection control,
11 our PPE inventory, and we started looking at
12 preparing for what we felt was the inevitable.
13 Even though at that point in time at the federal
14 level, even at the provincial level, there didn't
15 seem to be that panic. It seemed to be something
16 that was far away on a different land and wasn't
17 going to hit us. But we felt that with the first
18 phase happening in Toronto in February, that we
19 really were in the situation of not whether it
20 would happen, but when it would happen.

21 So we determined very early on that we
22 needed more PPEs, and we started checking in with
23 our suppliers and we discovered --

24 COMMISSIONER MARROCCO: Can I stop you
25 there for a second?

1 When you say "very early on",
2 approximately when?

3 MS. ELIAS: So this part is like
4 February. So in February, because the World Health
5 Organization declared it as a pandemic in March,
6 the second week of March, I believe.

7 So in February, looking at the world
8 situation, we felt that it might come to, you know,
9 Canada, Toronto, we started looking at our pandemic
10 plan, and started looking at our supplies. And
11 generally, when we look at our PPE supply, we have
12 orders that we place.

13 And so what happened was, we started
14 calling our suppliers back in February -- sorry,
15 close to the end of February. And we soon
16 discovered that our suppliers, our regular
17 suppliers of PPE were indicating that they would
18 not be able to fulfill the orders for our PPEs.

19 And after calling a number of them, and
20 then we discovered, oh, those supplies, where are
21 they going? Well, they're going to be stockpiled
22 by government. Now we didn't know what level of
23 government that might be. Were the supplies that
24 we had ordered going to the federal stockpile, the
25 provincial stockpile? We didn't know. All we knew

1 is that our orders were not going to be completed.

2 So at that point in time, we started
3 hustling with a number of my colleagues, I belong
4 to an alliance, a group of homes in the GTA. And
5 we started sharing that information, and we soon
6 discovered that many of us were in the same boat.
7 And so we started looking at sourcing different
8 suppliers for PPE, because we wanted to be ready.
9 We didn't want to be in a reactive stage, because
10 we do remember what we went through during SARS.

11 So we started very early on placing
12 orders, looking at different suppliers throughout
13 the GTA, and even outside of the GTA. Even going
14 as far as ordering things through Amazon, Walmart,
15 wherever we could get our hands on it. And having
16 the network of homes of about 20 homes, all of us
17 were charged with the responsibility that if we
18 found a supplier, that we would share that
19 information amongst ourselves.

20 So within a couple of, two to
21 three weeks, we were sourcing out new suppliers.
22 So by mid-March, we were actually able to introduce
23 universal masking before the Government even
24 required it. So I do believe that that certainly
25 helped, where we were providing cloth masks to our

1 staff, because we were actually producing them
2 on-site through our laundry department. And
3 sourcing out the PPE very early through different
4 suppliers, that that made a huge difference in
5 minimizing or delaying COVID coming into our home.

6 And very early on we started having
7 regular meetings with our Occupational Health and
8 Safety Committee to prepare for a pandemic, and
9 having discussions at the Board level. Because we
10 could see that the prices of these PPEs were
11 climbing, and the difficulty of getting them, and
12 so having -- we have two boards here at Belmont.

13 We have our Operating Board, which is
14 the Board of Directors, and then we have a
15 Fund-Raising Board. And through the generosity of
16 the foundation, they did support and granted us a
17 quarter of a million dollars to ensure that we had
18 all that adequate PPE.

19 And so very early on we were faced with
20 the situation of finding the financial resources to
21 help support acquiring these PPEs, and we very
22 early on started looking at fund-raising.

23 COMMISSIONER MARROCCO: Ms. Elias, just
24 one second. Dr. Kitts.

25 COMMISSIONER KITTS: I'm interested in

1 the notion that your suppliers told you that the
2 Government was creating a central stockpile.

3 I don't know if you deal with from the,
4 I guess from the Ministry of Long-Term Care, did
5 you pursue that thought and whether it was
6 happening and whether you could rely on the
7 stockpile?

8 Was there something in between you
9 going out to Amazon and paying more, did you have
10 any dealings with the Ministry of Long-Term Care
11 before that?

12 MS. ELIAS: Well, when we were sourcing
13 out and trying to get supplies, at that point in
14 time, it was early days.

15 And, basically, the guidelines for
16 using personal protective equipment were similar to
17 what we have today, which is, if someone shows
18 symptoms, then you put on your PPEs.

19 So we actually didn't have
20 justification to go to government to argue our
21 point about being proactive in this. Keeping in
22 mind, that the World Health Organization hadn't
23 even declared it a pandemic at that point in time.

24 So we did not try and determine where
25 those supplies were going. Why the supply chain

1 was having issue delivering those items to us and
2 actually cancelling our orders.

3 So whether it was true or not, I don't
4 know, Dr. Kitts.

5 COMMISSIONER MARROCCO: So you figured
6 that even if you found -- correct me if I'm wrong.
7 You figured even if you found it, because you
8 didn't -- you would likely be kind of low on the
9 totem pole, because you didn't have people showing
10 symptoms?

11 MS. ELIAS: Right, absolutely. I mean
12 throughout the -- in those early days, basically,
13 similar to the SARS days, and when you see what was
14 happening around the world, truly the focus was on
15 preparing hospitals for a surge of patients.

16 And as I go on in the presentation,
17 I'll emphasize that again. But the thought
18 certainly was that we would maintain the current
19 guidelines in the sense of, if a resident showed a
20 symptom, like a typical cold symptom, then the
21 resident would be tested, then the employees have
22 to put on PPEs, and all that sort of stuff.

23 So even if a resident had showed
24 symptom, we would not be asked to shut down the
25 whole unit, right? And so pretty much in the early

1 days, we did feel that the focus was on hospital
2 and preparing the hospitals. And at the time, even
3 long-term care homes, early days, supported that
4 philosophy.

5 But as we saw as time moved on, we saw
6 that we weren't getting our supplies, outbreaks
7 started happening in long-term care homes, we
8 really felt at that point in time that we weren't
9 being given the proper focus to deal with this
10 pandemic.

11 COMMISSIONER MARROCCO: Can I just ask
12 you: From the time you figured out that you were
13 going to have to find this PPE yourself --

14 MS. ELIAS: Yes.

15 COMMISSIONER MARROCCO: -- to finding a
16 supplier who would supply it, how long would you
17 say that -- can you say how long that took?

18 MS. ELIAS: Until we felt comfortable.
19 I can say, well, we -- right from the get-go, so
20 end of February, like the third week of February,
21 we started working on that, and it was continuous.
22 It was continuous right up to the middle of April,
23 because unless the long-term care home was in
24 outbreak, we were not getting any PPE from any
25 government source. We still had to find our own

1 supply chain for PPEs. There wasn't -- you know,
2 the only way you that would get PPE is if you were
3 in an actual outbreak.

4 So there was no mechanism to be
5 proactive to protect our staff from bringing -- you
6 know, and the residents from COVID coming in. So
7 that's what we saw pretty much in those first few
8 months. Even when we went to universal masking in
9 April, still the issue was us finding our own
10 supplier. We did not have a stockpile that we
11 could tap into at a government level, unless you
12 were, you know, in a particular outbreak, and then
13 you'd have to order those supplies.

14 So it was very, very controlled. And
15 to be very honest with you, we felt that we had to
16 be proactive, and have the supplies here, when we
17 needed them, instead of trying to justify getting
18 those supplies and then waiting for a number of
19 days, you know. So we did test --

20 COMMISSIONER MARROCCO: The
21 justification for getting it is that you've got
22 people who are sick with the disease, it's a bit
23 late.

24 MS. ELIAS: Exactly. Exactly. And,
25 you know, that was the situation that all homes

1 were in during Wave 1. And I think that's
2 important to keep in mind, the whole setup, the
3 whole system was reactive instead of proactive in
4 Wave 1.

5 Certainly, the common words were
6 unprecedented, it took everybody by surprise. But
7 there are some things that I felt that different
8 levels of government weren't really treating it as
9 a potential pandemic, but were treating it as a
10 less serious situation.

11 And, also, I think that the big issue
12 was that there weren't enough supplies available
13 through supply chains, for PPEs. So a lot of work
14 was being done in the sense of, do you really need
15 it? Unless people are showing symptoms, you don't
16 really need it. At that point in time, it's late
17 in the game.

18 So I'll quickly go through some of the
19 other things that we did. Regular communication.
20 We would daily debrief on what's happening in the
21 world, in Canada and in our home. Regular
22 communication with families. And we continued to
23 order PPE, even when we felt that we had enough, we
24 were very, very concerned about not being able to
25 get PPE given we didn't know how long we'd be in

1 this situation. And given, again, our learning
2 from SARS, that it wasn't just a three-month
3 situation, that it could turn into a one-year
4 situation. So we wanted to continue to be
5 proactive.

6 Early days. We monitored residents for
7 any signs and symptoms, and staff, and got them
8 tested. We reorganized the work of the management
9 and administrative staff to support nursing and
10 dietary staff.

11 And very early on, when the Ministry
12 introduced the One Employer Rule, we looked at
13 hiring private caregivers from families to work as
14 nursing aides. So we created some new positions
15 that we were allowed to do, and also hired more
16 recreation staff to support family communication
17 and visits, and increased cleaning in the home. So
18 very early on we acted as if though we were in a
19 pandemic.

20 Some of the things that we did to keep
21 employee morale up, we had a hero board. We
22 displayed thank you letters from families. Weekly
23 meetings with the Occupational Healthy and Safety
24 Committee. As I mentioned, we did a lot of
25 fund-raising and purchased two-family interaction

1 Plexiglas screens. So it improved the family and
2 resident experience with indoor and outdoor visits.

3 And regular communication with both
4 boards on what was happening with COVID, and with
5 the continued need for financial resources to
6 support additional staff, additional screening, and
7 also purchasing more and more PPE. So we did get
8 approval from the boards to overspend.

9 So we certainly are in a deficit
10 situation, and we continue to be in a deficit
11 situation.

12 COMMISSIONER MARROCCO: Dr. Kitts.

13 COMMISSIONER KITTS: Yes, I just want
14 to go back to staffing.

15 You reorganized, you hired private pay.
16 Did you have a staffing shortage that concerned you
17 going into this pandemic?

18 MS. ELIAS: Oh, absolutely.
19 Absolutely. If I could just -- I'm not going to be
20 precise in my estimates, but long-term care has
21 always had issue with achieving full staffing. But
22 let me just say that -- let's just use as an
23 example, the Belmont House was at full staffing
24 before the pandemic. We covered all our shifts, we
25 had enough body to cover all our shifts.

1 Then we go into pandemic mode, and the
2 One Employer Rule, and then we go from 100 percent
3 down to about 70 percent. Because many of our
4 staff, and I'll refer to it later on again, many of
5 our staff had to choose: Where are they going to
6 work?

7 And Dr. Kitts, you would know this,
8 having run a hospital. You can't create full-time
9 jobs for every person that you employ; it's a 24-7
10 operation. So you need full-time people, you need
11 part-time people, and you need casual people.

12 And certainly what we found was our
13 full-time people were staying, but we did lose some
14 because of childcare issues, or health-related that
15 they were frightened to work because of their
16 immunity system.

17 But we lost some part-time and casual
18 people that were working in municipal homes. That
19 was predominantly municipal and hospitals.

20 So that One Employer Rule did have a
21 significant impact in lowering the number of
22 employees that we had available to work for us.
23 And then with some long-term care homes that had
24 significant outbreaks, you would see that staffing
25 reduced to below 50 percent.

1 So, you know, we have issues with not
2 enough staffing in long-term care to begin with.
3 You have a pandemic, and then you have legislation
4 that also constricts you from having a certain
5 number of bodies in the building.

6 COMMISSIONER KITTS: Thank you.

7 MS. ELIAS: So I hope that answers your
8 question.

9 So in terms of from the long-term care
10 sector, what we really felt that our -- in slide
11 ten, the primary focus was ensuring that hospitals
12 were prepared, right?

13 So we did feel ignored, but generally
14 the long-term care sector feels ignored compared to
15 the hospital sector. Let's be honest, we have an
16 inferiority complex in terms of where we fit in the
17 healthcare system.

18 Whenever you have a severe flu season,
19 or you have a situation like SARS or the pandemic,
20 the Government really pushes to move seniors out of
21 hospitals, to enable the hospitals to have the beds
22 to deal with the crisis, right? So we were finding
23 that, you know, I have a waitlist of 840 people and
24 I have a crisis list that generally runs from
25 8 to 12 people.

1 And early on, I saw that jump to 17.
2 And as of this Monday, my crisis list is 73 people.
3 And it's, you know, 95 percent made up of seniors
4 that are in hospital waiting for long-term care
5 placement.

6 So there's a huge demand for long-term
7 care beds with hospitals trying to move seniors out
8 of there. In the early days, long-term care homes
9 were basically told to take care of seniors who had
10 COVID and not to send them to hospital.

11 So very early on, we were told that if
12 a resident gets COVID in the home, you have to
13 manage it. Don't even think about sending to
14 hospital. Now did we actually, as long-term care
15 homes push that issue? We did as things got more
16 desperate. You saw the long-term care homes push
17 that issue of having COVID positive residents go to
18 hospital, but very early days, that's what
19 everybody was being told.

20 So we felt, well, if we got COVID, we
21 had to deal with it in our home, there was nowhere
22 else that we could move these residents to.

23 COMMISSIONER MARROCCO: Ms. Elias, just
24 one minute, please.

25 Dr. Kitts.

1 COMMISSIONER KITTS: Just in terms of
2 your home, do you have ward beds, three or four to
3 a room?

4 MS. ELIAS: No, no. Our shared
5 accommodation, when we say "basic" at Belmont is
6 two people in a room. So it does make it -- go
7 ahead.

8 COMMISSIONER KITTS: Do you feel you
9 have the ability to isolate positive patients and
10 cohort patients in your home?

11 MS. ELIAS: We have the ability to a
12 certain point. So when we looked at our pandemic
13 plan, and we looked at if we were to isolate
14 residents, we took an activity room, for example,
15 and we said, okay, each floor we can turn that
16 activity room into a long-term care room for
17 isolation purposes.

18 If we had a number of residents, we
19 could turn the auditorium into that. But not that
20 we had specifically dedicated rooms for isolation
21 purposes, we looked at rooms that could be
22 converted into isolation rooms. And so that's what
23 we did.

24 COMMISSIONER KITTS: Okay.

25 COMMISSIONER MARROCCO: Can I ask you,

1 your pandemic plan, was that as a result of SARS
2 and the recommendation --

3 MS. ELIAS: Yes.

4 COMMISSIONER MARROCCO: -- from Justice
5 Campbell?

6 So did you have an actual written or
7 actual plan? Was it in writing or --

8 MS. ELIAS: Yes.

9 COMMISSIONER MARROCCO: -- what was it?

10 MS. ELIAS: We do have an actual plan,
11 but of course you modify it over time, right?
12 Because there was some other outbreaks, I believe
13 in 2008 or something like that.

14 But we were required, with SARS, to
15 have a pandemic plan, we were required. And so
16 having gone through it before, we knew what we
17 needed to do.

18 So, basically, it was refreshing all of
19 our memories, what did we do before? How did we
20 deliver trays if people had to be isolated,
21 cohorting and not mixing staff between floors and
22 wearing full PPEs?

23 And so the issue for us was making sure
24 that we had the proper resources. We knew what
25 needed to be done, but we needed those particular

1 resources.

2 I think the challenge with COVID that
3 we didn't see with SARS was the testing issues.
4 And the staffing, it was more a prominence with
5 COVID than I recall during SARS.

6 So I just wanted to clarify that
7 sometimes people would say, "well, Belmont never
8 had an outbreak". Well, we did have an outbreak,
9 technically. We did show up on the Toronto Public
10 Health listing. At the end of April, we had a
11 private caregiver that tested positive, which then
12 spread that to a Belmont employee. But at that
13 point in time, what was great was, if there is a
14 positive, is that because we started universal
15 masking very early on in March, as soon as we had
16 supplies available that we could do that, we felt
17 that we were able to delay COVID coming into the
18 home to the point where we would have supports, you
19 know, from government, right? In the sense of, at
20 that point in time, the Government had brought
21 up -- sorry, had been able to bring up the testing
22 capacity, and had already implemented an initiative
23 to test all employees, and all residents in
24 long-term care homes. And they had started that in
25 mid-April. And so we found that the timing was

1 right, and we were able to test all our residents,
2 our retirement tenants and staff, and found that it
3 was only those two individuals that tested
4 positive.

5 So we had no residents or tenants who
6 tested positive. And, therefore, we got through
7 that without jeopardizing the life of our residents
8 and our staff. Having said that, we did go into
9 full outbreak mode, which meant a higher use of
10 PPE for the whole campus of care. Trade delivery
11 services, everything. And that's where you had our
12 own staff redeployed for management and
13 administrative function now to outbreak procedures.

14 So I wanted to touch on some of the
15 challenges we've found and break it down into
16 various themes, starting with HR. I did mention
17 the One Employer Rule and how, you know, it just
18 chips away at your ability to have the right number
19 of bodies in the homes, right?

20 And so the issue of constantly trying
21 to recruit people, but it's difficult to recruit
22 part-time, casual staff when they are only allowed
23 to work at one employer. And also, the fact that
24 we pay less than hospitals and municipal homes,
25 that also is a recruitment and retention issue.

1 So we did find, and we still continue
2 to find that our own full-time and part-time staff
3 that we converted to almost full-time, are picking
4 up a lot of overtime shifts and hours to ensure
5 that all of our schedule is completely booked.

6 The One Employer Rule is a significant
7 issue that we face. Because when you look at
8 hospitals, they are not restricted. So if someone
9 works in a hospital, they can work in three
10 hospitals. But in long-term care, you can only
11 work in one long-term care home. You can work in
12 retail and long-term care, but you can't work at
13 another long-term care home.

14 If you look at private pay caregivers
15 that are hired by the employees, they also don't
16 have that restriction. They can work at a number
17 of long-term care homes or, you know, in the
18 community, plus a long-term care home.

19 So we do find that certainly, you know,
20 a One Employer Rule would be the best practice;
21 there's no denying it. But in the reality of staff
22 shortages, sometimes you can't live to that best
23 practice. And we are finding that why are we being
24 held to this certain standard of a one employer;
25 when hospitals aren't, or private pay caregivers,

1 or healthcare agencies, you know, nursing agencies
2 aren't being held to that level.

3 So we certainly do need more work on
4 how we can increase the human resources, healthcare
5 professional so that we can have more individuals
6 that we can hire. It isn't just a matter of
7 throwing more money to it, we actually need the
8 bodies to fill these positions.

9 COMMISSIONER KITTS: Can I just ask a
10 question about the private aide caregivers?

11 So those would be caregivers who's
12 family of the resident were paying them to come in
13 and provide care.

14 MS. ELIAS: Right.

15 COMMISSIONER KITTS: So they were
16 exempt from the visitor policy?

17 MS. ELIAS: Sorry. They are exempt
18 now. Right, they can work in the community, they
19 can work.

20 In the early days, no. When in Wave 1,
21 we shut down and we did not allow private
22 caregivers to come in. But because we were
23 short-staffed, because of the One Employer Rule, we
24 went to those families and said: Can we actually
25 hire your private caregivers and consider them

1 Belmont House employee?

2 So they actually went on our payroll
3 system and because of that, they only worked at
4 Belmont.

5 So we then -- go ahead.

6 COMMISSIONER KITTS: So what about the
7 caregivers of families that weren't being paid?
8 Could they come in and --

9 MS. ELIAS: Yeah, the ones that we
10 didn't hire, they were not allowed to come in.

11 COMMISSIONER KITTS: Right. But the
12 thought is then, if you pay them, they can come in;
13 that's not true, is it?

14 MS. ELIAS: Well, the thought was that
15 we were going to hire them as employees. So once
16 you hire them as employees, then they're on your
17 payroll, you train them accordingly, and then we
18 hired them as nurse's aids.

19 So they weren't hired as PSWs, they
20 were hired to help the PSWs. And so they were also
21 non-regulated nursing staff, but they were there
22 under the supervision of the PSW to help our PSWs.

23 And so we did not hire every private
24 caregiver that was hired by a family. We only
25 hired an additional person per nursing unit, and

1 made them an employee and had them here for five
2 shifts a week, so that they had full-time hours.

3 At this point in time for Belmont, we
4 do not have those individuals working now as
5 employees any longer. Because now, during this
6 time period, families have been able to identify a
7 private pay caregiver as an essential caregiver.
8 And all residents are allowed to have two essential
9 caregivers for an unlimited number of hours or days
10 during the week.

11 So the visiting guidelines now enable a
12 private caregiver to come in as compared to, you
13 know, what was happening in March, April, May or
14 June, and July, tell you the truth.

15 I mean, the essential caregiver
16 provision was implemented in August. So for those
17 months from March to the end of August, we actually
18 were using those individuals as employees paid by
19 Belmont.

20 COMMISSIONER KITTS: And for the rest
21 of Wave 2, you foresee that these caregivers,
22 aide or family members, will still be allow to come
23 into the home?

24 MS. ELIAS: Yes. They will be allowed
25 to come into the home, and they're now being paid

1 by the families, so we don't that additional
2 expense.

3 Having said that, we may tap into
4 looking at how we can hire more people, if we're in
5 an outbreak and look at different strategies there.

6 COMMISSIONER KITTS: Thank you.

7 MS. ELIAS: Along with the other
8 HR challenges, pandemic pay, which was great. And
9 certainly was a huge retention, it wasn't great for
10 recruitment, because again, municipal homes and
11 hospitals pay more.

12 So when Belmont employees got \$4 an
13 hour more, so did the municipal home who already
14 pays us more got \$4 an hour more. So it didn't
15 help with recruitment, but it certainly did help
16 with retention. That ended in August, as you know.

17 And certainly with the introduction now
18 of the new PSW only special rate of \$3, it is
19 creating an imbalance and disruption to our
20 internal equity within the home, but there isn't
21 anything we can do about it. But it does not deal
22 with recruitment. You know, the difficulty that we
23 still have with recruitment. But it would be great
24 to see a pandemic pay reinstated until a vaccine is
25 available.

1 I touched on the recruitment and
2 retention issue that we were talking about a number
3 of things. But I think it is important to note
4 that, you know, if you work in a hospital, your
5 wages are pretty similar across the whole Province
6 of Ontario. But when you work in long-term care,
7 hospital and municipal homes pay higher hourly
8 rates, they have better benefits, they have better
9 pension.

10 Then you look at charitable homes,
11 which are sort of in the middle of the road with
12 wages and benefits. And then for-profit homes
13 generally have a lower wages and lower benefits.

14 So in terms of recruitment and
15 retention, I think it's important to ensure that we
16 do have those adequate PPE. If there was a way to
17 get rapid COVID-19 tests available in our home that
18 don't require lab work, I think that we'd have
19 better success of recruiting and retaining staff.

20 Other issues related to extra staff
21 workload. Early days, you know, physicians went on
22 Virtual Care, and we didn't get them back until the
23 summer. So there was significant extra workload on
24 the nursing staff.

25 And the physicians were told early on

1 that they should not send residents to hospitals.
2 So I think in terms of all the individuals or
3 associations that you speak to, you should also be
4 speaking to the Ontario Long-Term Care Clinicians
5 Association, as to how they handle things in Wave 1
6 and where they're going in Wave 2.

7 Additional workload was also with the
8 coroner. All of a sudden, funeral homes couldn't
9 come into the building to get resident's bodies.
10 So that was an additional workload on nursing
11 staff.

12 And keeping in mind that you have less
13 staff in the building, and now we're putting more
14 things on their shoulder, because others don't want
15 to come into the building, whether it's physicians,
16 or funeral home. And even staff testing -- and
17 I'll talk about the hospital partnerships -- we
18 have to do our own staff testing. So it's our own
19 employees our nursing staff that do that.

20 So it's additional workload on our
21 employees.

22 COMMISSIONER MARROCCO: So was it the
23 coroner that directed that they not come in, that's
24 how that happened?

25 MS. ELIAS: Right, yes. That's how

1 that happened, the coroner.

2 And again, early days, so everybody was
3 afraid to come into the building. Which didn't
4 give a comfort level to my employees, that
5 everybody is afraid to come into the building, but
6 I'm expecting my employees to come into the
7 building every day. So, you know, it certainly
8 doesn't help with staff or morale.

9 In terms of PPE, we talked a lot about
10 it. Still, I feel that there's issues related to
11 PPEs. You may know that the ONA requested and -- I
12 think it was an arbitration decision that enabled
13 ONA members to get N95 masks. And now there's been
14 a more recent decision, the Government has agreed
15 with all unions that employees can demand a N95
16 mask during an outbreak.

17 So the issue for us is, I'd love to
18 give all my employees an N95, but I just can't find
19 them. So again, we're in a situation where I have
20 to rely on a requisition system through government
21 to get those particular supplies. And whether I
22 will be given the full amount that I need is still
23 a work in progress.

24 There's been a recent announcement
25 about government giving homes eight weeks of

1 supply. And then we got a letter from Government
2 actually saying "up to eight weeks". So again,
3 some unclear messaging. We'll see what we end up
4 getting.

5 We have put in an order this week, and
6 we expect that order to be completed shortly. And
7 we'll have a better idea as to whether we've got
8 the full order or not.

9 So again, it goes back to PPEs should
10 really be used as a proactive measure in infection
11 control, and not reactive. And we need to have
12 everything that we need to have.

13 COVID testing continues to be a
14 challenge. I mean, it was pretty good during the
15 summer. We were able to get all staff tested in
16 mid-April, but the partnership with the hospital is
17 not always consistent.

18 And I'll talk about hospital
19 partnerships in a while. And when the hospital is
20 not available, then we have to look to a private
21 lab, like LifeLabs. And with hospitals we
22 generally get our results within 48 hours versus a
23 private lab, which can be anywhere from four or
24 five days as a turn around.

25 And ordering swab kits from Public

1 Health can also take three to five days.

2 So we're always having to be on top of
3 testing and ordering our supplies. So when we look
4 at Wave 2, it would be great if the hospital can
5 handle all of our capacity, so that we're not
6 trying to figure out every two weeks who's going to
7 do our analysis of our swab test.

8 With residents, the testing is going
9 well. But certainly we've gone back to a model of
10 only testing residents with symptoms. Essential
11 caregivers, testing availability, when we look at
12 what's available for essential caregivers, if
13 you've been -- I'm sure you have been listening to
14 the media -- we've gone from being able to handle
15 40, 50 thousand tests a day to now not being able
16 to handle them.

17 And then the testing centres have been
18 shut down for essential caregivers, they can't go
19 to the testing centres. And so the only thing
20 that's available to them now is the pharmacy for
21 non-symptomatic essential caregivers.

22 And we've had a lot of complaints from
23 family members that it's taking anywhere from, you
24 know, taking days for them to get an appointment,
25 then when they get an appointment it can take three

1 to four days, and then another four to six days to
2 get results. So certainly it's not an effective or
3 efficient process.

4 The Government introduces the ability
5 for essential caregivers, and in some cases, they
6 are family members, to be able to come into the
7 long-term care home, but now those individuals are
8 frustrated because they can't get their tests on a
9 timely basis.

10 So one of the things that we have
11 looked at here, is to do the testing at our own
12 long-term care home for our own essential
13 caregivers. So that they're not struggling with
14 getting the appointments at the pharmacies, and
15 waiting for those delays.

16 We just did it last week, so we'll see
17 how it progresses. But we still do continue to
18 have challenges as to who will analyze those test
19 results.

20 In terms of screening -- I mean, what
21 I'm giving you today is a perspective of the
22 operations in a home and things we had to deal
23 with. A lot of time taken away staff, we needed
24 staff to cover all three shifts to test. You know,
25 take temperatures and to check the paperwork on

1 everyone entering the building, our employees and
2 essential caregivers.

3 So it would be helpful if there was a
4 way, not only today but in the future, to use
5 technology that would take temperatures and take a
6 record of all those questions and keep that data in
7 a database, instead of boxes and boxes of thousands
8 of sheets of screening information for everybody
9 coming into the building.

10 Infection, prevention and control.
11 Certainly staff spend a lot of time with that. My
12 assistant director of care is, slash, you know, the
13 infection control and prevention nurse. But I've
14 had to now give her some assistance so that she can
15 more properly focus on the infection prevention and
16 control.

17 So it would be helpful to have
18 dedicated staff in our homes, in particular, during
19 this pandemic, that focus on infection control.
20 And not every home has that expertise and that
21 staffing.

22 In terms of financial challenges, I
23 mentioned earlier on how significant the cost of
24 PPE were, and the additional staffer screening and
25 the overtime cost. But just to give you a sense of

1 our home.

2 140 long-term care beds, and 81
3 apartments. We have spent -- keeping in mind that
4 the pandemic hit March. We have spend \$1.1 million
5 related to COVID so far this year. And we have
6 received approximately \$575,000 from the
7 Government. And if we do get another \$92,000 for
8 October, November, December, but we don't know
9 100 percent, we would be looking at receiving from
10 the Government, approximately, \$851,000 still
11 leaving us with a shortfall of a quarter of a
12 million dollars that the home has to cover.

13 So, certainly, Belmont is not unique in
14 this is that there's going to be significant debt
15 and deficits in long-term care homes to cover these
16 costs from COVID.

17 Visiting guidelines, I touched on that
18 a bit already. Wave 1, visiting guidelines were
19 extremely strict. No family members or private
20 caregivers were allowed in the building. So a lot
21 of time was spent on Skype visits, window visits,
22 so on.

23 We increased staff hours in order to
24 accommodate all these visiting guidelines. When we
25 went to the new guidelines in August with the

1 essential caregivers coming into the building and
2 the introduction of short accesses and temporary
3 overnight accesses for long-term care residents, we
4 did feel that it didn't make sense that if a family
5 member and essential caregiver came into the
6 building, they had to attest to a COVID negative
7 test. And yet our residents would be allowed to
8 leave the building, to go out with people that had
9 never been tested.

10 And so when those guidelines came out
11 in August, I have to tell you, all long-term care
12 homes went ballistic. How is that logical, or now
13 it's opening up, increasing the risk level of
14 having long-term care residents going out,
15 unsupervised absences with individuals that we
16 don't know whether they were tested or not.

17 So that coincided actually with weeks
18 later, the numbers increasing in Toronto. I can't
19 actually tell you that there's a correlation there,
20 you know, I don't know whether some of my residents
21 went to weddings, or indoor restaurants, or they
22 went to crowded beaches, I couldn't tell you that
23 because they go out during the day, with their
24 family members in a very uncontrolled, unsupervised
25 environment.

1 In September and October, we felt that
2 the Government was taking too long to react to the
3 increasing COVID positive cases in Toronto. And we
4 were pushing for them to revisit these guidelines
5 and high alert area, like Toronto. So just to give
6 you that example.

7 At the end of August, we're letting
8 people out of the building, we're letting residents
9 out of the building into uncontrolled environments.
10 And then in early October, the Government indicated
11 that only essential caregivers were allowed to come
12 into the building. Yet there was no mention of
13 cancelling short absences or overnight absences.

14 And we took the position, well, since
15 the Government was silent on it, rightly or
16 wrongly, I said here -- and I checked with all my
17 other colleagues. I said, well, I'm cancelling
18 absences, short absences, and temporary overnight.
19 I'm not letting the residents out of the building.
20 Because if only essential caregivers could come in,
21 it doesn't make sense to me that residents could
22 leave the building.

23 So I shut that down, effective
24 October 5th. And then just last week, we got
25 notice from the Government that they finally did

1 hear our advocacy efforts on that issue, and they
2 shut down short absences and temporary absences as
3 of October 16th.

4 So certainly it would have been helpful
5 if the Ministry of Long-Term Care had gotten more
6 advice from our association or individual homes as
7 to, you know, the messaging that they were going to
8 give out, or the guideline, the changes to those
9 guidelines and get our reaction in how to
10 operationalize that particular issue.

11 I touched briefly on the hospital
12 partnerships. It did take two emergency orders to
13 direct hospitals to help long-term care homes.
14 It's unfortunate, we feel that we have an
15 integrated system, and we talk about Ontario Health
16 Teams, and yet long-term care homes did feel they
17 just did not have the support that they needed.

18 But in the defence of hospitals, we are
19 expecting a lot from them. When you look at the
20 number of long-term care homes in Ontario, and you
21 compare it to the number of hospitals, it's not
22 possible for one hospital to help that many
23 long-term care homes, in terms of PPEs, testing and
24 redeployment of hospital staff.

25 So for Belmont House, in our

1 partnership with our hospital, we were only
2 entitled to testing, right, using their lab, and
3 having their infection control team come out and do
4 an assessment on our practices here. But we did
5 not have access to hospital staff.

6 With Wave 2, we have been specifically
7 told that we would not be having access to hospital
8 staff. But again, even in this Wave 2, we're
9 having issues because our hospital partners cannot
10 do our testing of our staff. They can't analyze it
11 in the labs.

12 So it's pretty hit and miss. We don't
13 know from week to week whether the hospitals there
14 could do the lab processing or not.

15 So again, looking at some things like
16 on-site rapid tests, it doesn't require lab
17 processing, but would certainly help our industry.
18 There's a lot going on, and we have to try to find
19 ways where we can be more self-sufficient in the
20 long-term care sector and not rely so much on the
21 hospital sector, because they have their own issues
22 and they can't shut down their surgeries and so
23 forth.

24 COMMISSIONER KITTS: Can I just ask:
25 Do you have a relationship with the hospital CEO?

1 Do you have an open lines of communication, should
2 you need them?

3 MS. ELIAS: Our partnership is with
4 UHN, so it's a very large and complex hospital.
5 And so we have relationship with staff in that, but
6 not a direct relationship with the CEO of UHN.

7 But the issue is that they just don't
8 have the capacity to support all these long-term
9 care homes that have been assigned to them. And
10 when we started seeing outbreaks in a number of
11 downtown Toronto homes, UHN said, well, they
12 couldn't do any more of our testing for this time
13 period, because they're focusing on these
14 particular homes that have outbreaks; which is
15 understandable.

16 But again, you know, we look at setting
17 up a system that sometimes realistically can't
18 work. So we always need to look at backups and how
19 to find ways where we're not always relying on
20 hospitals, you know, in terms of providing
21 staffing, which they could not provide.

22 And I was told very early on when I
23 asked about -- when we were looking for more PPEs,
24 I said to UHN, "Can you provide me with PPEs?" And
25 they said, "No".

1 We have this false impression that this
2 hospital partnership was going to solve all the
3 issues, without realizing that the hospitals
4 themselves don't have the capacity to deal with
5 their own operation and then a dozen long-term care
6 homes that have been assigned to them.

7 So I think we have to be more realistic
8 in the capabilities of our partners. With Public
9 Health we saw a lot of inconsistencies in the early
10 days. And what was shocking to me was that I
11 believe that one of the homes that had the first
12 outbreak, and had the most significant outbreak,
13 that Public Health unit had not even tested for
14 COVID-19. So there were symptoms in the home, and
15 it wasn't even identified as COVID-19, and then
16 that particular home then spread very quickly.

17 So we certainly could do a better job
18 in consistency across all Public Health units, how
19 they determine an outbreak, and how they work
20 together as a consistent force during a pandemic
21 instead of individual silos.

22 Government communication and policy
23 development -- I think I've run my time. So are
24 you okay for another five minutes or so?

25 COMMISSIONER MARROCCO: We are. For

1 another five, no problem.

2 MS. ELIAS: Okay. So for government
3 communication and policy development. I know that
4 things are fast and furious during a pandemic. But
5 what I think is important to note is that overall,
6 we need clearer messaging in the early days, but
7 even now it's very confusing.

8 Who's in charge? We have Ontario
9 Health, we have Toronto LHIN, Ministry of Health,
10 Ministry of Long-Term Care, they all have their own
11 communications and we get directives from different
12 bodies. We get the same documents coming from
13 these different branches of government, and it
14 becomes very confusing and overwhelming, all these
15 documents and communications from these various
16 sources within one government.

17 So one source of information, and clear
18 message, and identifying who does what would be
19 very helpful.

20 Employee view. I mean, certainly, you
21 know, we've covered this. You know, lots of expert
22 work for the employees. We feel that the
23 downloading to the sector has not been appreciated
24 in the sense of the additional work.

25 And long-term care homes continue to

1 feel anxious and would like to restrict the number
2 of people coming into the homes, and they're
3 anxiously looking at what rapid testing would do
4 for our homes.

5 In terms of being prepared, I feel that
6 we still haven't dealt with the key issues of PPE,
7 testing and human resources. There were issues in
8 Wave 1, and I believe that they continue to be
9 issues in Wave 2. And we still don't have a
10 comfort level on that.

11 How far have we come? We've made some
12 good strides with the PPE during July and August,
13 but now we're feeling that supplies might be
14 limited and prices are climbing, and we certainly
15 feel that there's a limit on N95 masks.

16 In terms of testing, it was very hit
17 and miss and wasn't really effective in the early
18 days. And then when you look at, you know, July
19 and August, everyone that wanted to be tested,
20 could be tested. And now we seem to be back in
21 October, it looks a little bit different, but it's
22 the same old thing, which basically is: Not
23 everyone is able to be tested. And it takes a long
24 time to get tested now that we're back on an
25 appointment system like we were in the early days.

1 And the test results are taking far too long.

2 So as a long-term care home, as a
3 healthcare professional, we are just confused as to
4 how we've ended up back in this state, when we've
5 been hearing all summer long that the Government
6 was able to, and is continuing to be able to
7 process 40 to 60 thousand tests per day, and yet we
8 can't seem to process it now, and we're controlling
9 it by the appointments.

10 We're still in this situation with
11 staff shortages. The pandemic pay certainly helped
12 with retention, but we need to look at different
13 ways of increasing our ability to have more people
14 enter education programs to become healthcare
15 professionals. And we're still losing staff to
16 hospital and municipal homes.

17 In conclusion, what worked well. I do
18 believe the Government is doing the best they can,
19 there's no doubt in my mind. But I do believe that
20 we should move faster. And not take so long to
21 analyze all the numbers, and then we're missing the
22 mark, we're too far behind.

23 I do believe that we need more
24 additional funding. We appreciate all the funding
25 that we've gotten from the Government, but we can

1 certainly use more to pay for those expenses of
2 PPEs, screening and overtime.

3 And so I did say that I still don't
4 feel that we've resolved the issues of PPE testing
5 and staffing shortages. And that the costs are not
6 fully covered by Government.

7 So thank you for taking the time to
8 listen from a perspective of a long-term care home.
9 I know I've covered a lot of material in the sense
10 of all the things that we've been having to do and
11 deal with. And it is challenging to, I think the
12 word for 2020 should be "pivot". It's every two
13 weeks we have to pivot, and we have to do something
14 new, or some new guidelines or deal with some new
15 situations. So it's an ongoing challenge, but
16 certainly we'll do the best we can to get through
17 it.

18 COMMISSIONER MARROCCO: Well, thank
19 you.

20 MS. ELIAS: Any questions?

21 COMMISSIONER MARROCCO: No, I don't
22 think so. I think we asked them as we went along.
23 Do either of the Commissioners...

24 MS. ELIAS: Great.

25 COMMISSIONER MARROCCO: I think we've

1 asked the questions. Thanks very much.

2 We were looking for this kind of
3 perspective, a home that is managing with whatever
4 the difficulties are. And we do appreciate you
5 taking the time. And in fairness of, and the
6 detail in the presentation.

7 Thank you very much.

8 MS. ELIAS: You're very welcome.

9 And certainly I'm available if you have
10 any other questions.

11 COMMISSIONER MARROCCO: Well, we'll
12 certainly bear that in mind.

13 MS. ELIAS: Thank you very much
14 everyone.

15 COMMISSIONER COKE: Thank you.

16 COMMISSIONER KITTS: Thank you, bye.

17

18 -- Hearing concluded at 12:05 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, JUDITH M. CAPUTO, RPR, CSR, CRR,
4 Certified Shorthand Reporter, certify;

5
6
7 That the foregoing proceedings were
8 taken before me at the time and place therein set
9 forth;

10
11 That all remarks made at the time
12 were recorded stenographically by me and were
13 thereafter transcribed;

14
15 That the foregoing is a true and
16 correct transcript of my shorthand notes so taken.

17
18
19 Dated this 21st day of October, 2020.

20
21
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: JUDITH M. CAPUTO, RPR, CSR, CRR
25

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