Long-Term Care COVID-19 Commission Meeting

Bilingual Group Meeting with Commissioner and Families/Loved Ones
on Tuesday, February 9, 2021

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MEETING OF THE LONG-TERM CARE
COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all participants attending remotely, on the 9th day of February, 2021, 4:00 p.m. to 6:00 p.m.

BEFORE:
Frank N. Marrocco, Lead Commissioner
Dr. Jack Kitts, Commissioner
Angela Coke, Commissioner

MEETING WITH THE LONG-TERM CARE COVID-19 COMMISSIONERS, FAMILY MEMBERS AND LOVED ONES OF LONG-TERM CARE RESIDENTS.

PARTICIPANTS:
Dawn Palin Rokosh, Director, Operations
Long-Term Care Commission Secretariat
Alain Daoust, Team Lead Long-Term Care Commission Secretariat
Adriana Diaz Choconta, Senior Policy Analyst
Long-Term Care Commission
Angeline Hawthorn, Senior Policy Analyst

ALSO PRESENT:
Tiffany Fearon, Family Councils Ontario
Helen Martineau, Stenographer/Transcriptionist
NB Interpreter
L. Cote Interpreter

--- Upon commencing at 4:17 p.m.

DAWN PALIN ROKOSH: Good afternoon everyone. I believe we are ready to start. And I apologize for joining slightly late, I was having my own set of technical difficulties.

Has everyone had an opportunity to select the interpretation that they would like?

At the bottom of your screen there is a button for interpretation and you can select the interpretation that you like. And once you click the button then there's English and French there and you can select the language that you would like.

If you are comfortable -- there will be discussion in both English and in French today and everything will be happening simultaneously. So if you're completely comfortable operating in both languages then you can leave the interpretation off.

PARTICIPANT 3: So if someone is speaking French and my French isn't that great I should hit the "French" button?

DAWN PALIN ROKOSH: You should hit the "English" button.

PARTICIPANT 3: The "English", okay.

DAWN PALIN ROKOSH: If you hit the "English" button then everything you will hear throughout the meeting will be in English; and if you hit the "French" button everything you will hear throughout the meeting will be in French.

Alain, could you please repeat that in French, just very quickly? The instructions for interpretation.

ALAIN DAOUST: Yes, absolutely. So for those who wish to receive simultaneous interpretation services in French you will find an "Interpretation" button at the bottom of your Zoom screen. If you wish to hear simultaneous interpretation in French just select "French". That's it.

If you're comfortable in both languages and you wish to hear the participants directly, either in French or English, without simultaneous interpretation you don't need to click on anything at all, you'll get the original. But if you want French translation just click "Interpretation" and "French".

DAWN PALIN ROKOSH: Is everyone feeling okay with the -- any further questions

on the interpretation buttons? Okay. Wonderful.

Well, then let's begin our proceedings. And let me start by saying hello and good afternoon, and welcome to this bilingual group meeting with the Long-Term Care COVID-19 Commission, and family members and loved ones of long-term care residents from different areas across Ontario.

My name is Dawn Palin Rokosh and I'm a Director with the Secretariat that supports the Commission; and I'm joined this afternoon by my co-facilitator, Alain Daoust, who is a Team Lead with the Commission; as well as the following team members, Angeline Hawthorn, who you would have heard her voice a little bit earlier; and Adriana Diaz Choconta, who you would have met when you were entering the session today. Both Adriana and Angeline are Senior Policy Advisors for the Commission.

ALAIN DAOUST: So this is a bilingual meeting where both French and English-speaking participants can express themselves in either language. Simultaneous interpretation is provided and participants have the option, at

the bottom of the Zoom screen, to participate in either French or English.

Dawn will speak primarily in English, I will speak primarily in French and participants can hear us in the language of their choice.

As you perhaps know, the Commission is led by three Commissioners, who are with us this afternoon. Dr. Jack Kitts, who is the Chief Commissioner for today's meeting, and he is with Chief Commissioner Mr. Frank Marrocco and Commissioner Mrs. Angela Coke.

I would like to acknowledge and thank Tiffany Fearon, from the Family Councils Ontario who assisted in sharing and identifying participants for this meeting today.

So today's session is being held over Zoom. And as we said earlier, if you have any connection problems throughout the meeting you can simply join back into the meeting at any time. And if anyone has technical issues during the meeting please communicate with Angeline Hawthorn by email, and you chatted with her just ahead of the meeting.

Moreover, if you are comfortable

turning your camera on please feel free to do so. This session will not be video recorded. If you would prefer to stay off camera then that is fine as well.

DAWN PALIN ROKOSH: This session is being taken by our court reporter who is present on the call. The transcripts will be posted to our website but your names will not appear in the transcript. When you are speaking you will be recorded in the transcript as "Participant 1", for instance.

If you wish to refer to another person during the course of the session please refer to them by their anonymized participant number, which is displayed on the screen.

So although we have ensured that you are anonymous, both in our outreach as well as with your participation here today, the information you choose to share will be posted to the website. So please be aware of any identifiable stories that could reveal your identity, if that's a concern for you.

We'll begin the session with some introductory remarks in a moment from Commissioner Dr. Jack Kitts and then we'll

proceed to question 1. We'll hear responses from participants in numerical order asking Participant 1 to respond first and working our way through the list of participants. We will repeat the same process for question 2. And once we finish hearing from all participants today we will have some concluding remarks and then we'll wrap up our session.

In order to hear from all of you on both questions we've asked you each to speak for up to four minutes, about four minutes in response to each of the two questions.

We've also acknowledged, and we've discussed in our introductory conversations with you, that we acknowledge that you've been through a great deal and four minutes may feel insufficient to share your experiences and considerations related to recommendations for improving things in the future.

So we encourage you to focus first on conveying to the Commissioners the most important things you want them to know about your experience.

If there's something you weren't able to cover in your first speaking time you'll have

an opportunity to cover it in the second question.

So right now I'd like to invite Commissioner Dr. Kitts to address the group.

Dr. Kitts.

COMMISSIONER JACK KITTS: Thank you, Dawn and good afternoon everyone.

[Small portion in French not translated.]

Thank you all for meeting with us today. As you've heard my name is Jack Kitts and I'm one of three Commissioners appointed by the provincial government. My colleagues, which you've been introduced to, Commissioner Frank Marrocco and Commissioner Angela Coke, are with us today.

As you are no not doubt aware, this Commission was set up to investigate the spread of COVID-19 in long-term care homes and the impact it has had on families, residents and staff.

But before we begin I want to provide a bit on context about Commissions in general and our Commission specifically. Governments

will often set up Commissions of Inquiry after a tragic event has occurred. The purpose of a Commission is to investigate why the tragedy occurred and to make recommendations on how to prevent it from happening again.

Most Commissions begin their investigation after the tragedy is over. In our case we are conducting our investigation as the crisis continues to unfold.

Our final report and recommendations will be submitted to government at the end of April this year. However, we have already submitted two interim letters of recommendations to government because we believe they will help manage this second wave as it continues to unfold.

Our Commission is independent of government. Our role is to report our findings and recommendations. The decision, however, to accept and implement the recommendations is that of government.

As I stated earlier, an important part of our investigation is to learn how residents, staff and family members have been impacted by the spread of COVID-19 in long-term care homes.

So today we are asking you, as family members, to help us understand the impact COVID-19 has had on you personally and tell us what you would recommend to prevent this tragedy in the future.

We understand that many of you may be a little nervous about participating in this meeting but we want you to know that we truly appreciate your courage in taking time to help us with this very important task.

Our hope is that the work of our Commission will help ensure that such a tragedy is never repeated. And we believe that by sharing your stories you will help the public and government understand why it is so important that this never, ever happens again.

Now, before we begin I'd like to ask you to join me in observing a moment of silence in memory of those residents and staff of long-term care homes who have lost their lives to COVID-19.

[Moment of silence observed.]

COMMISSIONER JACK KITTS: Thank you. I will turn it back to your facilitators, Dawn

and Alain, to continue the meeting.

DAWN PALIN ROKOSH: Thank you very much, Commissioner Kitts.

So we'll start now with the first question. And the first question is:

Please tell us about your experience caring for a loved one in a long-term care home during the pandemic. How has the pandemic impacted you and your loved one or family member? Is there anything in particular that concerns you?

And I would like to call on Participant 1 please to start us off.

PARTICIPANT 1: Okay. First, my husband is sitting here with me, Carl, and we'd like to thank you for hosting this meeting and allowing us to voice our concerns.

It is mostly about emotion. It's been very taxing having mom in a home during the COVID time and at the same time we had to move; and again, the move was caused from COVID. The sale of our home during COVID and the closing of our bed and breakfast. So everything was happening at once.

And we felt that it was not in her

best interest to move homes, for her to -- to bring her down here with us. She didn't adjust well in going from one section of the home to the lockdown section so a whole home move would have been worse. Plus Bancroft has almost zero incidents -- has zero incidents actually and bringing her down here, even though there were just fewer, it just didn't make sense.

But we committed to regular visits to the home but they were so restrictive. Only certain hours, only certain days and only for 45 minutes. Well, one hour but by the time you got gowned and signed in and then said your goodbyes it was only 45 minutes. And we had to drive three hours each way for this 45-minute visit. And you couldn't go day after day. Like, it was like, okay, this is your time this week.

And so we had hoped that we could go up for several days and have several visits but you couldn't because they didn't visit -- you couldn't go in on Thursdays and you couldn't go in on Saturdays. So, I mean, it was just so frustrating.

And often in asking for these times they would say, No, we don't have -- we don't

have any time. Well, I'm a fairly strong individual so I would stand my ground and say, I am coming on Thursday and you'd better find a time for us.

So at this time we were just doing -- we were doing the visits and we were not aware of being able to be essential caregivers.

But I have to say that it was exhausting going through the process each and every time. We did try to combine it with other tasks that we had in the area so that it made the three-hour drive sort of one day we would do our tasks and the other day we would visit mom. But it was exhausting trying to get a meeting.

And when -- I would always say, like, you've got to open it up. You've got to allow us in. And they would say, Well, we're lack of staff. They would say, Call your MP. Which I did but nothing happened.

But then we were made aware of being able to become an essential caregiver, but this brought on more limitations. Only one person at a time, and this was even worse.

So I am a good communicator. My late husband was deaf and I learned to communicate

through sign -- not signing but, you know, through -- he could lip read me and I would -- I learned how to give distinct words for certain things and how to repeat. So getting through to mom was very good for me. But Carl has a very deep, low voice and mom can't understand him. So together I could keep a conversation going and I would repeat things, and she would start to get the gist of what he was talking about.

We had hearing aids but she keeps losing them and the home didn't care for them so we basically had to give up on that.

But with all the gowning -- so you put on a gown, you put on a mask, you put on a shield. We'd come in with these Haz-mat suits and she'd -- who are you? There was nothing to recognize.

And this week when I went in I immediately took her hands, and the head of nursing was there and she just about had a fit and said I had to go through all this getting degowned and getting into something else because I was touching her. Well, I call her my mom. She's my mom of course I'm going to touch her. I'm not going to sit on the other side of the

room.

But -- so now we have to have one day is for me to visit and I look after her hair and nails and pretty her up and tell her she's beautiful. The next day Carl goes in and there's no communication. She doesn't recognize him because he's so gowned. And she doesn't -- she can't understand him and I'm not there to interpret.

I don't understand why two people can't be there. So I asked, Can one day I go in to the home and do all the things and the next day we have a visit in one of those other rooms for Carl and I so that it's more family? No, you can't do that.

You can only have two essential caregivers. And because we don't live there we wanted to assign -- we wanted to assign a local person who knew her well, actually lived with us, and have her go in and visit and then Carl and I come in. No, you have to give up.

Well, I'm the one she can communicate with but Carl's her son and she loves him. And one day when I went in it's -- it was all about Carl, all about Carl, all about Carl. The next

day he goes in and she doesn't even recognize him.

The isolation has been terrible. And we've watched mom go from a participant to just about a vegetable. She just sits and stares. We used to be able to get her engaged in talking about when she worked at Heinz. And she'd always go on with lots and lots of stories but we can't do it now.

We can't get a local caregiver. I'm the one who looks after things but Carl's all that she has. And having to go in with all this garb and be so isolated, and there are so many rules. It's all regimented.

We take -- we take precautions. We have our COVID test. And now they're going to come in with this 15-minute test? I don't understand how -- and why we can't just wear a mask so they can see our lips? Most seniors are hearing impaired. I mean, why can't we just wear a face shield? The hospitals gave them to us. The hospital accepted it. But there are so many rules and regulations.

And I just say that we have to open this up. We're constantly tested. We are safe.

We would never, ever put our loved ones in danger. It's -- we just can't handle the isolation, it's the isolation. That's all I have to say.

DAWN PALIN ROKOSH: Thank you so much, Participant 1, for sharing that experience.

I'll now move to Participant 2 to respond to question 1. Participant 2.

PARTICIPANT 2: All right. So in answering your questions I'm not answering just for myself but as well as for others, as I'm a co-chair for a Family Council. And I'm going to represent my family's experience as well as theirs.

With the abrupt closure to access in long-term care in March there was mass confusion, anger and panic, and then there was the guilt, the overwhelming sense that we had abandoned those who needed us most.

During the first wave my facility was COVID free but getting updates and information was really difficult. Opportunities for Facetime and window visits were distressing as many of the residents didn't understand what was happening, and for many these communication

options were a source of upset and tears on both sides, even though we conducted support rallies, ribbon tieing, pizza lunches, gift cards and more to support the staff.

In June when the government allowed essential caregivers access our home remained shut. They kept saying Public Health told them it was necessary, but there was no COVID or outbreak in the facility at the time. We reached out to the Inspector of Public Health for our facility, who was really displeased because it wasn't true. They hadn't said they weren't allowed to be open. Interestingly, within 24 hours we had access with guidelines.

Once access was provided we noted, with concern, the lack of mask wearing from the staff, and very few other protocols.

For many the change that had taken place with their loved ones was a very bitter pill to swallow. Declining physical and cognitive functions were vastly apparent, the feelings of relief were tainted with guilt and despair.

During the summer and fall months we had constant questions about COVID-19

preparedness in the second wave and what the back-up plans were. We were reassured during Family Council meetings that everything was under control and that should COVID ever occur we were prepared. That didn't happen.

When the December announcement came that COVID was in our facility the staff and agency staff didn't want to work; back-up agency staff were not COVID tested; and, therefore, units were critically short staffed for days. Most staff were completely untrained on droplet precaution protocols. Some were resistant to shields and donning and doffing protocols. There was panic, disorganization and distress from staff and residents and families.

Communication to families of COVID-positive residents was critically slow and families were frantic for updates on their loved ones. Communication to the entire facility was also slow and our Council pushed for better and faster communications; town halls were conducted. And after a huge outcry based on format and attitude changes had to be made.

The residents were confined to their room and there was neglect in regards to

feeding, toiletry and medication distribution. Diaper changes were slow to happen, sometimes over 12 hours between changes and very poorly done.

Staffing members did not take into account -- staffing numbers did not take into account the additional time required for donning and doffing PPE, which results in much slower response times. Residents are getting far less care, some are not provided with a bed or sponge bath for over a month.

When these issues were brought forward they seemed to be addressed, but why should Family Council have to address basic care needs? Where were the audits? No one seemed to know what was being done or not done in the home.

Everything was thrown out the window when COVID actually happened. They weren't prepared. All of our management was deployed to home unit areas to provide additional support, which left their own areas understaffed and underutilized.

Let it be said that many of our regular staff tried their best. They worked long hours without adequate support from their

head offices. Physiotherapy all but stopped, meaning residents who were mobile were no longer so. Recreational programs were suspended and there was little for residents to participant in, and cognitive decline has been significant. All of these shortcomings were arguably to save the lives of the residents. But it leaves one asking, if this new existence is not living then what is it? It's torture.

The residents are virtual prisoners in their rooms, and once they are dressed and toileted are left alone. We've been told that staffing is currently at 125 percent, but the agency staff are not trained, they have no commitment to the facility or the residents and the residents are suffering. Many are rough with the residents because they don't know how to manage them. As long as there is bodies in the building the care doesn't matter so much.

Staff who do try are exhausted, they're injured and they're in despair. Essential caregivers were considered a problem if they complained; they were treated as if they were the cause of the COVID outbreak, but it was actually the staff.

Our presence was problematic as we were the eyes and ears of what was happening in the facility, and there lies the problem. When you see a day ratio of 1 to 28 because of short staffing it's only a point because we saw it. Kind of like that old question, if a tree falls in the forest and there is no one there does it make a sound? There were sounds. Cries of distress.

In closing -- this part gets me. I reached out to our Chairman. In my letter I asked for a different perspective of long-term care moving forward, I did not even discuss a pandemic response. And I was thanked. I was told that all care standards are set by the government and long-term care companies can't do more. I was advised that management would get back to me, and they did. Our CEO actually said they were really pleased that they didn't require third-party intervention, even though thirteen people die, and that they didn't need the military or Red Cross.

And I said -- I'm thinking, if a CEO is comparing death toll and catastrophic failures as a standard to be measured against

I'm terrified there's no hope.

That's all I have to say.

DAWN PALIN ROKOSH: Thank you very much, Participant 2, for that. Thank you.

Participant 3, I would like to call on you now to answer question 1 please.

Can you make sure you're off mute? Wonderful, thank you.

PARTICIPANT 3: Thank you. I do that all the time.

Thank you, Commissioners, for allowing me to speak on behalf of my wife and I.

And I want to speak to how our family's been impacted. And -- but I just don't want to focus on the idea of the pandemic, I want to really remind everyone that this started decades ago, years ago. And your work and your recommendations will carry weight.

Today I'm here as an essential family caregiver, and you'll notice I use the word "family" and there's a reason why and I'll explain it. Essential family caregivers and/or chosen family caregivers support long-term care by providing direct healthcare, emotional care, essential oversight for their loved ones.

Many in the medical profession will say openly, and quietly, that caregivers are indeed experts. And one example is the Ottawa Hospital, which now recognizes families and others who are trusted by a patient, i.e. a chosen family caregiver, as essential care partners. It just makes sense.

It took the military just to remind everyone to speak for residents. But not one single family caregiver, not one with lived experience was shocked. We went, Oh yeah, what's new? In other words, COVID-19 had nothing to do with the abuse that went on for decades, and it was abuse.

At the start I didn't understand why federal and provincial governments, and some in the LTC, or long-term care industry, refused to acknowledge the essential role of family and chosen family caregivers. Now I understand why. Simple. It's because they provide the much-needed oversight that has been lacking in long-term care. Period. They are far from just being a visitor.

Caregivers in fact ensure medications are properly dispensed, ensure that proper

hygiene and disinfection protocols are adhered to. They provide much-needed emotional, physical and spiritual support and beyond. I ask the Commissioners and everyone, does that sound like just a visitor?

The most conservative estimate today by the National Institute on Aging is that there's well over 8.1 million caregivers in Canada, more startling, 7.8 million caregivers have been doing it for more than a year. They contribute well over 25 billion a year. Caregivers are the largest unpaid, unrecognized un -- I guess less thankful force in Canada, period, work force. And yet rather than the industry welcoming them, and government, they are viewed as troublesome. The troublesome family. That's because -- again it goes back that they're the overseers. They report on what they see even when they're often afraid to do so.

I recall coming into the -- in the evenings after work, taking off my suit jacket to help change my mother-in-law while she was in bed. I would have thought that this would have made her feel or me feel uncomfortable, and at

first it did. But very soon after, later I realized she needed help. Don't we all?

What we do, each morning I go in to support my mom-in-law to help her with her nutritional needs. My bonus mom, I call her. She needs our help. We all do at some point in our lives, don't we?

It's a privilege to change her. It changed my life to care for her, I should say. It changed my life and it taught me more about myself than I would have ever known in all the work I've ever done.

My wife and I -- my wife then goes in for lunch and suppers staying there until she goes to bed. So she has some quality time with her mother and vice versa.

We spend collectively over 50 hours a week in direct care of my mother-in-law, and an additional 20 or so advocating, dealing with the Ministry, dealing with the administration, trying to work with them. Far from a visitor.

Impacts. So, yes, my wife and I have been impacted tremendously. I never thought it would be -- I would be an advocate for long-term care. I became one after witnessing first-hand

what my mother-in-law experienced when entering an LTC home. I was naive but my wife wasn't as she had cared for her father for many years.

I will say that in our particular case we have seen some improvements, but I speak for ourselves only.

Impact again. It costs us financially hundreds of thousands of dollars over the years easily. Careers lost, opportunities lost, my wife basically stopped her profession. And more importantly, I think we now suffer from a form of PTSD, believe it or not. I don't sleep at night. I wake up grinding my teeth to the point of my jaw locking and my shoulders aching. My wife as well grinding her teeth to the point that now she needs significant dental treatment.

So if you wonder if I see myself as a victim? No. If you're asking me if I'm angry? No. And that's because there was one thing one person taught me a long time ago, you can't be angry and smart at the same time.

So I want to get things done. I want to contribute to LTC and I want to see it as a welcome place to go and not a place to fear.

So retaliation? Yes. My wife and I

experienced intimidation and harassment in the past. All we can be accused of though is trying to do the best for my mother-in-law.

If it were not for my wife, for the most part, and the medical communities, some of which co-operated tremendously, my mom-in-law would have been dead, or in such horrific condition that the suffering would have been unbearable.

To answer part 2 of your question, my biggest concern is that Canadians want to go back to some sort of normal. But if normal means we go back to preCOVID normal then nothing's going to change. Caregivers will keep being harassed. And as a fellow caregiver I know, and others, now they are currently experiencing harassment, intimidation because they recently spoke to the media. That means residents will keep being mistreated and that is what keeps me up at night and wakes me up at 3:00 every morning. I thought we lived in Canada not what we were witnessing south of the border.

DAWN PALIN ROKOSH: Participant 3, thank you so much for sharing that experience.

I'd now like to call on participant 4 to respond to the first question. Participant 4.

PARTICIPANT 4: Hello, first of all I'm going to talk about my experience with my family and my father.

My family is in a residence. In October and November and December there was an outbreak of COVID and there were 95 residents that were affected. And of the 95, 15 died and about 70 employees were also affected; but everything went well for the employees.

My father is 91 years old. He's blind. He cannot eat by himself. He has problems with his hands. He has arthritis. And if you want to add something further, icing on the cake, during the first week my father had to have an eye removed, because in the residence the frequency of him receiving medication required in order to be able to maintain his eyesight was not met.

In order for my father not to have any pain he had to have drops every hour. And sometimes he had to wait 15 minutes between each application of these drops. The family all of a

sudden had to be made aware that it was impossible for the staff -- in order for the staff to be able to provide these drops. So we decided to go ahead with the surgery because this was very painful. He was in extreme pain for a year.

So my father was supposed to have his eye removed on April 5th and he was not able to have the surgery. We were stuck in the COVID no-man's-land. The hospitals didn't know what to do. The residence didn't know what to do in April either so everything was delayed. So my father went from April, May, June, July alone and he had -- he was subjected to this pain in his eye. Then in August he was able to have the surgery.

I am on the Family Council and I haven't been very pro-active, or active in this council because the people on the council with me are people who are aged 80 years or older, usually it's the spouses of the people who are residents.

And at that time people weren't doing Zoom or Skype or anything. It's my view that currently the spouses are more able to have

electronic meetings but many of those people saw their spouses die.

And there is a trend within these councils, when there's a family member who has died then you abandon the council. You want to be able to move on, to think about other things.

My only contribution with respect to my role in the Family Council is that I learned that priests were not able to enter residences; and this began in March. And even during the COVID crisis priests were not allowed to go into the residences.

So I wrote to Minister Fullerton and I asked her to explain that; and to allow the priest to be on the same wave length as pharmacy, specialists, et cetera. But we were told that priests could not enter into these residences. So basically we were going around in circles.

During the pandemic my father had COVID. He's extremely healthy, apart from the fact that he's blind and that he cannot walk and he is in a wheelchair almost all day.

But during the pandemic I didn't like the communication with the residents. One nurse

that was not part of the regular staff, she was hired specifically for this purpose to communicate with families. And she would read, from her home, something that would say, Your father's medical condition hasn't changed since the beginning. That was one person who was not part of the residence's staff. She was hired. She was sitting in her home. She didn't know my father. All she could see was a picture on the screen. This person was giving me bad information. Because when I saw that my father was unable then I started to call his room, because he had access to the phone fifteen minutes a day.

What I was led -- what I was able to understand is that at 4:15 every day he had his diaper changed. So he spent eight weeks, eight weeks in his bed; bedridden for eight weeks. And when I wanted to call him he was bedridden. He was not able to answer the phone. So there was a person who would give him the phone and then I would be able to talk to him at 4:15 when this was happening. And that's how I was able to keep the channels of communication open.

Myself and the other members of the

family we called every day at 4:15, and at one point when it was time to change his diaper we were able to talk to him. And what he was saying to us is that, The conditions here are unliveable. Well, COVID ended on December 8th but we weren't able to have the status as a caregiver until January, because the person who was responsible for training caregivers had COVID and she had a bad case of it.

So we allowed her to get well again and currently we are seeing my father. He has a good morale, he's lucid. This is someone who doesn't have any signs of dementia. So I think personally that he's doing quite well, but the situation was very difficult for a long period of time. And the visit protocols are too strict. Something really was not done properly.

But really what I wanted to say is that communication, when my father was sick they did it. They said that they weren't -- they didn't have to communicate with us. Okay, fine, but this person was a stranger. They didn't know my father. This person was reading off the screen a message and that person couldn't tell us anything. They couldn't tell us anything.

She didn't make us feel that she understood or she knew my father.

So Participant 3 said something, and this is what I say to people who are in the Family Councils, go visit your loved ones and never go the same time of the day, because in a residence you are the eyes and ears for the other families. That's all.

DAWN PALIN ROKOSH: Thank you very much, Participant number 4. We very much appreciate that you were able to share your experience with us. Thank you.

So now I'd like to call on Participant 5, please, to share your experiences in response to question 1.

PARTICIPANT 5: Okay, thank you.

First of all, I'd like to just say that a lot of the emotions and observations that Participant 2 had spoken about is something that was certainly felt in my sphere of contact, and equally so as participant 4 just said something as well that was quite relatable.

But my story is actually -- I guess when I hear the others I feel as though my story is quite a fortunate one in that my mother lives

in long-term care that is owned and operated by a large, for-profit organization, and I'll call it "head office".

I've been -- have six years experience with this particular home. My father was there and my mother is now. My father passed away a few years ago. And I am the chairperson of the Family Council and I have been for the past two years.

From March to July of 2020 the Executive Director of this home was forthcoming and pro-active and communicative. She received guidance from support services at head office regularly; and before the province instituted any LTC directives the home was screening on entry, turning away anyone who had traveled out of the country or was showing symptoms.

And the employer had also encouraged people to stay home, and had provided sick pay so that anyone who had travelled abroad could be at home until they were clearly not showing any symptoms and then come to work.

They also ensured employment at one site very early on, and additional hours were provided to staff so that they could make up any

lost hours that they may have experienced because they had to commit to one home. The morale at the home is good and the majority of the staff chose to work at our home.

Head office provided -- sorry, also the staff were encouraged to change from their street clothes into work clothes when they arrived and then back out of their work clothes into their street clothes when they left. And there was ample PPE and the home was encouraged to allow to -- to tell support services of head office of any requirements that they needed, whether it was resources or PPE.

So as a result of the guidance and the prompt and pro-active action of this particular Executive Director heeding all of the support that was offered to them, and providing that guidance to the leadership team, I think was one of the reasons why this home was actually quite fortunate in that they only had two asymptomatic resident cases and three staff cases from the period of March to July 2020.

And I have all of this knowledge because I was in touch with the Executive Director, and we realized that families needed

to have information. So I started hosting on-line Family Council meetings in April and these would be every week. And as the chairperson of Family Council I reached out to the email addresses I had, as I'm not privy to getting email addresses from the actual home. I have to sort of -- it has to be a reach-out and through newsletters that are sent out by the home.

But nonetheless, I hosted weekly meetings. And at each of these meetings the -- a member of the leadership team, or two, attended and provided regular updates with regards to what they were doing in the home as preventative measures, how the staff morale was, what the staffing situation was and provided a lot of very valuable information. And as time went on more and more families joined on as this was the only source of real communication they were getting from the home.

And I took notes of all of these meetings and distributed them to families as well, so those who could not attend the Zoom meeting at least had some form of information so that they could be sure or they would know what

was going on. They were posted to our website as well.

As time went on our Family Council grew. And I actually found out that there were some family members whose loved ones had just moved into the home before it had been locked down so they did not have an opportunity to get to know the care teams, nor did the care teams have an opportunity to get to know their loved ones. And so this was -- this was a huge gap that was felt.

And so despite all of the good things that the home was able to do they did not have enough support staff to keep on that communication front and provide that guidance to families, especially the new families who did not know their way around the home. They didn't know what was happening so they truly were left in a void. And you know, it was through the Family Council meetings that we were able to provide them guidance.

So what I would do is I would have a Part 1 with the leadership team and then a Part 2 with families only where we could talk about concerns and we could share experiences. And

once we were able to get in as essential caregivers we also could be made aware of, you know, if there were certain cleanliness issues or if staff weren't following IPAC protocols, and so forth.

However, December -- September to December COVID cases increased. Our Executive Director was promoted and there was -- there were interim directors. Outbreaks were lengthy and the families' questions and concerns were not being addressed directly as they once were.

But continuing to proceed and having this information and contact with the home, a new Executive Director being brought on board has now improved a lot of that.

But -- so lengthy outbreaks and no in-person visits after -- like when they were in outbreaks, had a negative impact on my mom, who has dementia. She has started a lot of weight loss and it was something I wasn't able to see until I could be an essential caregiver. Although gratefully, the nurses and the care team did inform me that she was losing weight, she wasn't eating properly and her condition, her cognitive condition had declined. And

family members, during council meeting, had also noted that their loves ones' conditions had significantly declined.

And actually this was also seen when we would go for virtual visits or for window visits, when they were permitted. Because there were outbreaks for such a long time nobody could actually see any of their loved ones unless they were essential visitors.

But -- so, you know, the concern here is that despite the fact that they did so many things right at the front end there still was not enough staff to keep the -- to engage with the residents and to keep them active and to help keep their minds active. So you know, residents -- I don't think that they would have declined in such a way if there had been that type of support provided to them.

New residents fell through the cracks. And this was, you know, partly because this particular home has very few office and support staff. They are mostly -- they are DOCs or ADOCs and one social worker and, you know, and an administrative officer. Anyway, there is not very many of them. So they really didn't have

the people in place to be able to communicate effectively with families, and I'm happy that I was able to act as that conduit for them.

But that definitely needs to be improved and families do need to become more active, I think, in their loved one's care. I mean, we grew from only eight people to now I have over forty people on the email list. And we're all actively engaging with the new Executive Director and getting responses from them so it's been very good that way.

Anyway, even though it's somewhat of a better story it's -- I think still something to learn from that the leadership really can make a difference.

DAWN PALIN ROKOSH: Absolutely it is, Participant 5. And I thank you very much for sharing that. And with Participant 5 we've come to -- we've now heard from all of our participants today in respect of question 1.

And I'd like to, at this juncture, thank all the participants for their very thoughtful statements that you've shared about your experiences and the experiences of your loved ones; which will absolutely be helpful for

ensuring the Commission's understanding, and also the public's understanding of what has happened in long-term care homes throughout the pandemic.

So now I would like to hand things over to my colleague, Alain Daoust, who is going to lead us through question 2.

Alain.

ALAIN DAOUST: Thank you very much, Dawn. Thank you.

So question number 2 is as following: Reflecting on your experience, is there anything that could have been done that would have made the situation better? What is the most important thing that the Commissioners need to know as they consider recommendations?

So I would like to invite Participant number 1 to take the mic please. So Participant number 1, over to you.

PARTICIPANT 1: Well, isolation has been the main issue. And even at the dinner table they are all sitting at their own table. And there was a certain form of community before but I just feel that the precautions, especially when there's no outbreak, and especially between

the residents, that they need to lighten up. There's no reason, when there's no outbreak, for residents to be sitting at their own table with nobody there. They need to bring a sense of community back with activities and with essential caregivers. With it being restricted to only one person again that sense of family is lost.

And we saw a huge decline in cognitive with mom, a huge decline. Just can't get through to her. And the way to get through to her is touching. And you just get through with, you know, massaging her hands, et cetera, maybe giving her a bit of a back rub after brushing her hair and, boom, your time is up. You have to go.

The gowning. I just feel like when we are going through the regular COVID testing, if we're going through -- I'm not sure what this is called, the 15-minute test. When we're being so, so careful, when we're not travelling, when we're not out and about socially in our own area, that we need to be allowed to come in as a couple and to be able -- to at least be able to get our masks down. I see wearing a shield, but

our masks off so that they can hear us so that there is a form of communication. Because otherwise there's just this Haz-mat person coming in and doing something.

So I don't know exactly what to recommend except it has to open up, with precautions. I'm not saying just open the doors, but they have to open it up to family and to essential caregivers. It's got to be opened up because mom's not eating, all she wants to do is sleep. They've got her on supplements all the time now. It's no fun to eat because she's sitting at a table all by herself.

And she sits in the hallway with her head down like this. And she says, I love my bed. Yes, because it's an escape from the horror she's living in. That's all I have to say. Open it up.

ALAIN DAOUST: Thank you very much Participant 1 for sharing your comments with the Commission.

I would now like to call on Participant number 2. You have the floor.

PARTICIPANT 2: Thank you. I'm not going to cry this time. I'm not going to cry

this time.

So first, what could have been done better? Staffing. When staff are limited to one location permanent staff should have been offered full-time positions with benefits. Many left for better paying jobs, and who can blame them? There was no urgency in locking in our very best resources, rather staff were considered expendable because the care standards are not a priority.

Detailed study on what an outbreak would mean and what kind of staffing levels would be required, not just to meet basic care but to support residents during the lockdown. Current staffing ratios are already unacceptable outside of the pandemic; it should be similar to our daycare system. During the pandemic our situation was awful. So little basic care was actually done.

Auditing. There should have been ongoing auditing of basic care in the homes. So many lapses and poor standards resulted in the neglect of our residents. It's unacceptable.

Training and education. Staff were completely unprepared for COVID. They didn't

know any PPE protocols and thought the residents were their source of danger, but the infection was coming in from the staff. They didn't understand if they had sick people at home that they were putting themselves, their colleagues and residents at risk. And that's how COVID came into our facilities, because they had contact with loved ones at home who were COVID positive and still came to work. There was no understanding that their outside behaviour and risk to self and the residents. This should have been an ongoing discussion when COVID started. It never was.

Staff who didn't follow the PPE protocols were rarely reprimanded because people are so grateful that they show up it's easier to say nothing and let them breach protocol.

At the outset of the pandemic ongoing training and practicing to prepare for an outbreak should have happened. Training requirements already so minimal for PSWs and it has to be really increased.

The agency staff don't know how to train -- are not trained for seniors; they don't understand cognitive impairment; they don't know

how to toilet people; they don't know how to provide dental hygiene such as brushing their teeth; and often they don't care. They call in sick and are not committed to the home, resulting in massive shortages in staffing.

COVID testing. Standardized rules for testing. As an essential caregiver I can't go in without a COVID result that's within seven days but the staff can. When there's a gap in a results and their shift the staff went in and went to work, and only after they were in the home and working did the results come in and they were positive; which meant they had exposed the residents and multiple staff members.

Dietary needs. There is little done to improve the quality of the diets for those who did become ill. Families were vocal and demanding more soups and Jello, and other more proper options for people who are ill, that had positive outcomes. However, our long-term care currently gets half the funding that prisons do in terms of food preparations. There has to be better resources for fresh, wholesome food for our seniors.

Planning. Preparing and operating in

a pandemic requires strategic planning. There were no plan B options. When things fell apart the scrambling was crazy to watch. The residents were dirty and hungry, garbages were overflowing and on-site staff were completely distraught.

IPAC protocols. They are poor protocols outside of COVID anyway. And staff don't understand infection control and this is how the spread took over in so many homes.

IPAC inspections should be separate and not limited to outbreak but conducted regularly to ensure the best practices are the standard not the exception.

Home inspections. Homes that are not in compliance with inspections rarely face any significant repercussions. Poor inspection results are posted and that's that. Follow-up to enforce compliance doesn't happen. Again, our system should be like a daycare where when they have infractions they are penalize and penalized swiftly and harshly.

Importance of services recognized for mental and physical well-being. Programming for physiotherapy and recreational departments are

critical to overall wellness of residents. There is little commitment to ensure the quality of life during a pandemic. Residents are left to sit in their rooms lonely and distressed and lost cognitive and physical capability. There is no accountability for no standard of care.

The changes during a pandemic can only be sued -- the changes in law that long-term care can only be sued for gross negligence meant that there was less initiative from long-term corporations to do what was needed during the second wave. They don't have to any more because proving gross negligence is almost impossible. This should be reversed immediately. It's only the threat of litigation that seems to get any notice from the long-term care corporations.

Profits over residents. During a pandemic all shareholder profit shares should be suspended immediately to ensure the funds are allocated to resident care and resident care and staffing only.

Re-funding and reorganization of long-term care allocations. Staff ratios, fresh food ratios and spending. Care standards have

to be reset to provide the same attention as do daycare and prisons. As it is there are very few supports for those with cognitive impairment, and less for those who are only physically impaired but not cognitively impaired in long-term care. There are no standards to acceptable programming, supports, or day-to-day care or staff ratios. When infractions are noted nothing is done. There has to be a way to address noncompliance.

Thank you.

ALAIN DAOUST: Thank you very much for your comments, Participant number 2.

We will now go to Participant number 3. Participant number 3, you have the floor for the second question please.

PARTICIPANT 3: Thank you again. As I mentioned earlier, families and Powers of Attorney need to be recognized in legislation as essential. They need to be recognized for who they are and the value they bring to healthcare. This never should have been a debate in the first place.

I ask you, the Commissioners, is there anyone here on the Commission that does not

believe that families are essential in the care of their loved ones?

I also ask you to consider this point, it's a tough one, ageism. It exist. And it's -- and that needs to become an open and authentic conversation in Canada, let alone just Ontario.

A friend of mine, and I'm going to try and keep this light, who some of you may have heard of him, his name is Mike McCurry. He was the former press secretary to President Bill Clinton. Him and I became friends, former -- through mutual interests, and we speak often about many subjects. Just recently one day I said to Mike that ageism is a big problem and no one really wants to talk about it.

I said, it's like when you turn the magic 60 or 65 and you're supposed to retire, go play some golf and get ready to pass on or die. Mike paused and said, very quietly he said, Well, I like the golfing part but not so much the other. And I laughed but he said it better than what I could have ever said.

The reality of ageism is why this tragedy occurred, in my view. If not imagine if

this was happening in daycares across the country. It would be -- there would be a revolt.

Before I go further, here are four points I want you to consider and keep in mind if you can.

Point 1: Without the support of essential family caregivers many loved ones would have not survived.

Point 2: Caregivers are the largest, unpaid work force in Canada saving us, the taxpayers, billions.

Essential caregivers care for the physical, emotional and spiritual needs of their loves ones unconditionally. There is no vested interest. It could be the right arm to support PSWs, nurses, and doctors. It just makes sense. Nobody is taking a position. It just makes sense to support.

The demographic -- the demography is changing. There will be an explosion and the need is compelling to fix long-term care once and for all.

Here are some recommendations, that while some will be outside of your mandate I

bring them forward as the issue on aging has no boundaries. After all, these are unprecedented times.

Recommendation one: Bring long-term care under the umbrella of the Canada Health Act. The rationale is that while it's true that the delivery of healthcare is a provincial jurisdiction, it is also equally true that equitable access be provided to all Canadians notwithstanding their age, as described in the Canada Health Act.

Point 2, sub point: Short of bringing long-term care under the legislative authorities of the Canada Health Act, set a separate, national, stand-alone Act be created perhaps called the "Long-Term Care Act" the "Elder Care Act" or "Protecting Our Seniors Act", just recommendations.

Point 2: The governments explicitly define and acknowledge that the role of families is essential to the care of their loved ones and, therefore, be defined as essential family caregivers and chosen family caregivers in legislation.

Who are chosen family caregivers?

They are trusted friends outside of the typical family unit and are trusted by the resident.

Three: Encourage investment in smaller, group-type home settings under the Canada Infrastructure Program and the National Housing Program, in collaboration with provincial and territorial partnerships. Those programs already exist. After all, they are -- a residence home is classed as a "home".

Four: Create a national essential family caregivers or essential caregivers working table; bring them to the table as full partners, again unpaid caregivers contribute, at a minimum, 25 billion.

Five: Increase training and salaries for PSWs in recognition of their critical role. Note that PSWs need to be truly recognize as professionals and have a career path forward.

Six: Strengthen enforcement, implement rigorous inspection protocols and give long-term care inspection officers greater authority to sanction licensees for repeated noncompliance.

Seven: Prosecute those who violate

existing laws related to abuse, neglect, mental, verbal or emotional harassment and/or retaliation. You don't need new laws, they currently exist under the current Criminal Code.

I want to end with these points: Today a marvelous book written by Moira Welsh was released entitled "Happily Ever after". I suggest you get it. It is a book of solutions, of hope and practicality, and evidence-based success stories.

Also, reach out to the true advocates and organizations making significant impacts with little gain for themselves, if any; i.e. Family Council Ontario, a group of four people who have done more in communications than anyone I know.

Two: Those within the bureaucracy, they are brilliant people making solid recommendations and often not heard from, or even their solutions are not implemented because they're not maybe politically palatable.

Three: Medical professionals, doctors, nurses, PSWs, people like Samir Sinha, Nathan Stall and too many others to mention, they need to be supported. I don't

think they're making a dime on this. It's costing them.

And stay away -- I'm going to really point this out, and stay away from what I call the "professional advocates", respectfully. Many of them never, in my view, have been in long-term care but now have magically somehow appeared.

This generation is our collective parents or friends and who made Canada what it is today; and they paid for it. We owe it to them to put the care back into healthcare. Right now we have a lucrative sick care industry not healthcare. That's what keeps us going. That's what keeps me up at night and millions of other caregivers.

Thank you.

ALAIN DAOUST: Thank you very much for sharing those comments and for your recommendations.

I would now like to move to Participant number 4 please.

PARTICIPANT 4: Okay. I would like to start by staying that what needs to happen in long-term healthcare is not to come back to the

situation that existed before March 2020.

Because, I mean, there's several things in the system which, in my opinion, gave the impression that everything was well and that everything was perfect in the healthcare system for long-term care before the start of the pandemic.

The first thing that I would like to highlight is that the department, or the Ministry, during a two to four year plan would like each residence to assess quality indicators, quality indicators, performance and I forget the rest of it in English.

So the Ministry in 2012 selected ten indicators of quality. Under the present-day government the Ministry has only selected four quality indicators. So we went from ten indicators to four.

I prepared a document for you, Mr. and Mrs. Commissioners, and I expect you to read it because if I have to go through it all I won't -- I'll be short of time.

One of the indicators, indicator number 2 says, from the annual resident survey, what number would you use -- sorry, indicator 3,

so based on the annual resident survey, what are you prepared to give a positive answer to? I can state my opinion without fearing reprisals. That's indicator number 3 for the annual survey.

Indicator 4 talks about, and listen well, how clear was the noting of palliative care needs? All I can tell you about indicators is that they weren't chosen by families.

Indicators of quality in the system should, in part, be chosen by family. I'll give you a percentage for indicator number 3 at the residence where my father lives. Here is the question: Can your parent express his or her opinion without fearing reprisals? The residents of my father's residence responded, 76 percent, Yes, I can express my opinion. Families responded 58 percent, Yes, I can express my opinion. I don't agree that we use surveys by using residents' opinions and not also families' opinions.

The indicators of quality should -- there should be questions on indicators of quality and families should be allowed to express their opinion.

I would also like to say that I'd like

to see a question like this one in the indicators of quality, the question could be the following: What is the percentage of absenteeism of your staff on Fridays, Saturday, and Sunday nights? And what is that percentage of absenteeism that is not filled? Not backfilled? Not replaced?

We are in a PSW crisis. It's not just a crisis of workers, it is a crisis of absenteeism sometimes and shortage of. But as a Family Council member when I travel through all -- when I go to all the groups, Ottawa and others, I realize that we can't get -- and when we talk to people and say we need to change things they think we're inventing data. I would like to have some data, hard data.

I also think that we need to change the surveys that are used in residences. Surveys are prepared by two large firms and I don't approve of the questions.

I think there should be a question such as this one, When you arrived in the residence did you wear a diaper? When did they put a diaper on you?

My father did not wear a diaper when

he came in; three weeks later he started wearing a diaper. They put him in a diaper and that had such an impact on his psyche. It was horrible.

I think that surveys should look into that. When you arrived in the residence did you wear a diaper? Do you wear one now? When did you start wearing a diaper? Why are you wearing a diaper? Do you wish to wear a diaper? Why do you wear a diaper? Well, it's probably because there aren't enough workers on the floor.

We have some of the best scores in health apparently in the world, our nurses RNs, assistant nurses. You know, they provide four hours of care, but they want to reduce the care time but we don't have any data. What's the impact with the shortage of workers? In my residence we're 3.2 hours and residents have to wear diapers.

And when we tell the workers, Change my father's diaper, they don't want to do it because apparently the blue section in the residents is not blue enough. So they won't go and change the diaper until the diaper is saturated and they know that when something happens with the blue line.

So all that to say I'd like the surveys to be changed because the caregivers know what questions should be asked; because the family caregivers know all of the weak points from the system, all of the weak points in the care of our loved ones. Because the personal support workers are tired, there's too much of a shortage, et cetera.

Another thing, personal workers. There's a professionalization, that comes from a word that someone in Quebec used in front of you on September 22nd, it's at page 19, line 19 of the report of that session.

The PSSPs or PSWs are not invited when drafting the annual plan. PSWs are never there. When I go through my father's plan it's a group of people that they -- they're not valued. PSWs should be on that planning committee where we talk about how care is going to line up for the year to come.

I'm a nutritionist. Well -- I'm sorry, the nutritionist at the residence sees my father once a year. She's not the one who feeds my father and my father is blind. It's the PSW, the personal support worker that feeds my father

so she's the one who can say how he is, not others.

Participant 3 told you to stay away from people with lots of diplomas, I have the same advice.

I'd like us to review Collective Agreements. I know that's impossible. Collective Agreements of personal support workers, they don't promote work-life balance in my residence. The older PSWs take the best weeks of holidays, for instance. They take their leave all of July, and what happens with the young PSW that's been working for a year and a half with two young children and can't take her holidays with her children in the summer? Well, she leaves that line of work. So Collective Agreements of PSWs, there is no attempt to provide for work-life balance and that's one of the reasons why PSWs leave their job so quickly. It's impossible to find any kind of balance between their family life and their work life.

I gave you, in my document, an overview of absences in terms of days. There are more absences on Fridays and Saturdays so

that means that there's a problem with work-life balance, once again.

I would like us to have access to -- think about Family Council. Samantha Peck lines 1, 2, 3 it was saying that the Family Councils are an organization that is provided for in the legislation but most members don't know what to do. Where do their responsibilities start? Where do they end?

Let me explain why. There are a lot of caregivers in a home. In my home there are 104 residents, but the 104 residents, well, there is -- the Ministry didn't allow caregivers going into the homes thinking that in a residence of 104 residents there were 50 families that could provide caregiving services? It's a Ministry that doesn't understand the reality. Caregivers the -- well there are four of us. There are four families that are acting as caregivers, the other residents are alone. So we need data on the number of caregivers. We need metrics. The Ministry doesn't have this information.

Another thing I want to say, in my home there is a new person who arrived on

September 28th. She got COVID in October and she died at the end of October.

Let me tell you this, I've just said that I don't have any figures on a whole series of things that are happening in the home. I spoke to you about the number of caregivers. This should be known, it should have been known before the pandemic. And given that there are so few caregivers the risk of accepting is very low.

What I want to say, I have read a lot because I've had time to do it. I want to say that we know more things on the medical side of things of how to treat people than what we know that actually happens on the ground with respect to people eating, walking, people who are doing this or that.

In a document that I read it says that there are five principal factors that can lead to death in a home. First of all, the insufficiency of liquids. Secondly, weight loss, and I'm thinking of participant number 1. The third factor, respiratory problems. Fourth one, fever. And the fifth one, to be a new admission.

When I read the study, and when you see my document you'll understand what I'm referring to, but the fifth cause of death in the residence in a home is to be -- the incapacity to adapt to life in a home when you're a new person being admitted. And yet we continue to admit people into homes during the pandemic. There is a woman who died during the pandemic without having seen her family.

New residents will always ask their families to act as interpreters with PSWs and others. They're shy. They want us to act on their behalf. It takes about a month for residents to understand the system. And during the pandemic there was basically, you know what? Find your own way. But there were a number of people who died, including this new resident, and that was a scandal in the local media. And currently there is a case before the courts.

Why do we admit new residents during a pandemic? These people have no support. And it's written in a brief report of examining factors associated with death within 31 days after assessment in long-term care homes.

So the fifth factor is to be a new

resident. Why are we admitting new residents? If I can, I simply want to provide time for other people -- actually I'll stop there. I had a lot to say.

ALAIN DAOUST: Thank you very much. Thank you for your comments and the suggestions that you've put forward to the Commission. It's very much appreciated.

And now I'd like to move to Participant number 5.

PARTICIPANT 5: Okay. What could have been done differently to make the situation better? Having more staff. Having more full-time staff, not only PSWs but also activation staff, nursing staff and support staff within the home.

Having the province increase salaries is probably very nice, but having that permanent increase for full-time staff, they would have benefits as well, is something that if we had that perhaps we would have been in a better situation.

Working in a long-term care home also requires specialized training, communicating with residents who have dementia, being aware of

the pressure sores, proper placement in wheelchairs, toileting, dental hygiene, and hygiene particularly, and just how to be able to relate to them.

It's a specialized skill and it's something that needs to be promoted in terms of something that is a positive thing that people can be proud of having that type of a job.

Perhaps we need to make the job a little more -- just promote it in such a way so that people actually can see the benefits of being a PSW, or an activation staff person, or having some form of role in long-term care.

But in fact leadership in the home, as I mentioned previously, is probably most important. So going forward whoever is responsible for hiring an executive leader or other leadership team members, whether it is in a for-profit, not-for-profit, municipal home, they must be hired effectively.

Leadership in long-term care requires an interactive leader who will provide guidance and support to their staff, helping them provide meaningful information to families and to their fellow staff. They should be willing to be

transparent and collaborative, they care about the home and its residents. They set standards and they hold their team accountable for adhering to those standards.

Pro-active, innovative, empathetic, strategic and forward-thinking, I think those are some of the qualities that are required if you're going to be working effectively in a long-term care home.

The collaboration between Family Council and leadership at the home is important and Family Councils play an important role. And perhaps that means the general population needs to be more aware of what Family Councils are and the role that they play.

However, it is not up to the Family Councils alone to be holding the homes accountable for adhering to a specific standard. It is a collaborative relationship but ultimately it is the home's responsibility to ensure that those standards are being met.

And where are the standards coming from? Well there should be higher standards that need to be set by governments at all levels perhaps. For that -- that I'm not sure federal,

provincial, municipal, everybody may have a role in it. But communication and training to the standard should be adhered to, and regular IPAC audits. Ministry of Health inspections need to take place. And the repercussions of those who are not compliant need to be much more serious and perhaps more public so they are adhered to.

And finally, just a recommendation in terms of where do we go from here? How do we know what to do? Let's not be in our own cocoon, right? Let's not just be looking at ourselves. Let's look at best practices in elder care in other provinces, in other countries. What has worked well? What have people been able to do? And how much did it actually cost to implement some of these things?

Those are my comments. So thank you very much for the opportunity.

ALAIN DAOUST: Thank you very much.

Thank you very much, everyone. This concludes the segment for this evening. Everyone has had a chance to answer both questions, and I would like to thank everyone, all of you, the participants, for taking the time to share your experiences and having the

courage to do so and share your experiences with the Commission.

And I would like now, if I may, to hand it back to Commissioner Kitts for the closing remarks for this evening.

COMMISSIONER JACK KITTS: Thank you, Alain. And thank you all again for your courage in recounting your experiences with us today.

You know, seeing this tragedy through your eyes and listening to your heart-felt messages has been very helpful in making the impact of this pandemic very real for me, and I know I speak for the other members of the Commission.

We will do our very best to submit a report that reflects your experiences, and your recommendations that you've given us today, to government so that they and the public at large can understand why this tragedy must never happen again.

Your presence today has been a big help in helping us shape the report that we will submit on behalf of you, your families and the public at large.

So I think one of you said we should

create an environment where we look forward to aging in a long-term care home as opposed to fearing that day. So we've heard you, we've listened and we will do our best.

Thank you very much and have a good evening. Bye bye.

COMMISSIONER ANGELA COKE: Thank you.

-- Meeting ended at 5:51 p.m.

REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified Shorthand Reporter, certify;

That the foregoing meeting was taken before me at the time and date therein set forth;

All discussions had by the participants were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and accurate transcript of my shorthand notes so taken. Dated this 9th day of February, 2021.

PER: HELEN MARTINEAU
CERTIFIED SHORTHAND REPORTER.

C L A R I F I C A T I O N S

Page 56, line 7: "Happily Ever Older" not "Happily Ever after"

WORD INDEX

< 1 >
1 7:*11* 8:*1*, *3* 12:*13*, *14* 18:*6*, *8* 23:*4* 24:*6* 35:*15* 39:*23* 42:*20* 43:*18*, *19*, *20* 45:*20* 53:*7* 64:*5* 65:*22*
104 64:*12*, *15*
12 21:*3*
125 22:*13*
15 30:*10*, *24*
15-minute 17:*17* 44:*20*
19 62:*12*

< 2 >
2 8:*5* 18:*7*, *8*, *9* 24:*4* 29:*10* 35:*19* 39:*24* 43:*7*, *11* 45:*23*, *24* 51:*13* 53:*10* 54:*12*, *19* 58:*24* 64:*5*
20 27:*19*
2012 58:*14*
2020 36:*10* 37:*22* 58:*1*
2021 1:*17* 73:*13*
22nd 62:*12*
24 19:*14*
25 26:*11* 55:*14*
28 23:*4*
28th 65:*1*

< 3 >
3 3:*20*, *25* 24:*5*, *9* 29:*24* 35:*3* 51:*15*, *17* 58:*25* 59:*4*, *11* 63:*3* 64:*5*
3.2 61:*17*
3:00 29:*21*
31 66:*23*

< 4 >
4 30:*1*, *3*, *4* 35:*10*, *21* 57:*22*, *23* 59:*5*
4:00 1:*17*
4:15 33:*16*, *22* 34:*1*
4:17 3:*1*
45 13:*11*, *14*
45-minute 13:*15*

< 5 >
5 35:*14*, *16* 42:*17*, *18* 67:*10*, *11*
5:51 72:*8*
50 27:*17* 64:*15*
56 74:*3*
58 59:*17*
5th 31:*8*

< 6 >
6:00 1:*17*
60 52:*18*
65 52:*18*

< 7 >
7 74:*3*
7.8 26:*9*
70 30:*11*
76 59:*16*

< 8 >
8.1 26:*8*
80 31:*20*
8th 34:*5*

< 9 >
91 30:*13*
95 30:*9*, *10*
9th 1:*16* 73:*13*

< A >
abandon 32:*5*
abandoned 18:*19*
abroad 36:*20*
abrupt 18:*15*
absences 63:*24*, *25*
absenteeism 60:*4*, *6*, *10*
absolutely 4:*10* 42:*16*, *25*
abuse 25:*13*, *14* 56:*1*
accept 10:*20*
acceptable 51:*7*
accepted 17:*22*
accepting 65:*9*
access 18:*15* 19:*6*, *14*, *15* 33:*13* 54:*9* 64:*3*
account 21:*6*, *7*
accountability 50:*6*
accountable 69:*3*, *18*
accurate 73:*12*
accused 29:*2*
aching 28:*14*
acknowledge 6:*13* 8:*15* 25:*18* 54:*20*
acknowledged 8:*13*
act 42:*3* 54:*6*, *11*, *14*, *15*, *16*, *17* 66:*11*, *12*
acting 64:*19*
action 37:*15*
activation 67:*15* 68:*12*
active 31:*18* 41:*14*, *15* 42:*6*
actively 42:*9*
activities 44:*5*
actual 38:*6*
adapt 66:*5*
add 30:*16*
additional 21:*7*, *20* 27:*19* 36:*24*
address 9:*4* 21:*14* 51:*10*
addressed 21:*13* 40:*11*
addresses 38:*5*, *6*
adequate 21:*25*
adhered 26:*1* 70:*3*, *7*
adhering 69:*4*, *18*
adjust 13:*2*
administration 27:*20*
administrative 41:*24*
admission 65:*25*
admit 66:*7*, *20*
admitted 66:*6*
admitting 67:*1*
ADOCs 41:*23*
Adriana 2:*16* 5:*17*, *19*
advice 63:*5*
advised 23:*17*
Advisors 5:*19*
advocate 27:*24*
advocates 56:*11* 57:*5*
advocating 27:*19*
afraid 26:*19*
after 10:*1*, *7* 13:*16* 16:*3* 17:*11* 20:*22* 26:*22* 27:*1*, *25* 40:*17* 44:*14* 48:*11* 54:*2* 55:*8* 56:*7* 66:*24* 74:*4*
afternoon 3:*2* 5:*5*, *12* 6:*9* 9:*7*
age 54:*10*
aged 31:*20*
ageism 52:*4*, *15*, *24*
agency 20:*8* 22:*14* 47:*23*
Aging 26:*7* 54:*1* 72:*2*
ago 24:*17* 28:*20* 36:*7*
agree 59:*18*
Agreements 63:*7*, *8*, *17*
ahead 6:*24* 31:*4*
aids 15:*10*
Alain 2:*14* 4:*7*, *10* 5:*13*, *21* 12:*1* 43:*6*, *8*, *9* 45:*19* 51:*12* 57:*18* 67:*5* 70:*19* 71:*7*
allocated 50:*21*
allocations 50:*24*
allow 14:*16* 32:*14* 37:*11* 64:*13*
allowed 19:*5*, *13* 32:*11* 34:*10* 44:*23* 59:*23*
allowing 12:*17* 24:*11*
ample 37:*10*
Analyst 2:*16*, *18*
and/or 24:*22* 56:*2*
Angela 2:*4* 6:*12* 9:*16* 72:*7*
Angeline 2:*18* 5:*15*, *19* 6:*22*
anger 18:*17*
angry 28:*18*, *21*
announcement 20:*6*
annual 58:*24* 59:*1*, *4* 62:*15*
anonymized 7:*14*
anonymous 7:*17*
answering 18:*10*
Anyway 41:*24* 42:*12* 49:*8*
apart 32:*21* 49:*2*
apologize 3:*4*
apparent 19:*21*
apparently 61:*12*, *21*
appear 7:*8*
appeared 57:*8*
application 30:*25*
appointed 9:*13*
appreciate 11:*8* 35:*11*
appreciated 67:*8*
approve 60:*20*
April 10:*12* 31:*8*, *12*, *13* 38:*2*
area 14:*11* 44:*23*
areas 5:*9* 21:*20*, *21*
arguably 22:*6*
arm 53:*16*
arrived 37:*8* 60:*22* 61:*5* 64:*25*
arthritis 30:*15*
asked 8:*10* 16:*11* 23:*12* 32:*14* 62:*3*
asking 8:*2* 11:*1* 13:*24* 22:*8* 28:*18*
assess 58:*11*

assessment 66:*24*
assign 16:*18*
assistant 61:*13*
assisted 6:*15*
associated 66:*23*
asymptomatic 37:*20*
attempt 63:*18*
attend 38:*23*
attended 38:*13*
attending 1:*16*
attention 51:*1*
attitude 20:*23*
Attorney 51:*19*
Auditing 46:*20*, *21*
audits 21:*15* 70:*4*
August 31:*15*
authentic 52:*6*
authorities 54:*13*
authority 55:*23*
aware 7:*20* 9:*18* 14:*6*, *20* 31:*1* 40:*2* 67:*25* 69:*14*
awful 46:*18*

< B >
back 6:*20* 11:*25* 23:*18* 26:*17* 29:*12*, *13* 37:*8* 44:*5*, *14* 57:*12*, *25* 71:*4*
backfilled 60:*7*
back-up 20:*2*, *8*
bad 33:*10* 34:*9*
balance 63:*9*, *18*, *21* 64:*2*
Bancroft 13:*5*
based 20:*22* 59:*1*
basic 21:*14* 46:*13*, *18*, *21*
basically 15:*12* 28:*10* 32:*18* 66:*15*
bath 21:*11*
beautiful 16:*5*
bed 12:*23* 21:*10* 26:*24* 27:*15* 33:*18* 45:*16*
bedridden 33:*18*, *19*
began 32:*10*
beginning 33:*6*
behalf 24:*12* 66:*13* 71:*23*
behaviour 47:*10*
believe 3:*3* 10:*14* 11:*12* 28:*12* 52:*1*
benefits 46:*5* 67:*20* 68:*11*
best 13:*1* 21:*24* 29:*3* 46:*8* 49:*13* 61:*11* 63:*10* 70:*12* 71:*15* 72:*4*
better 14:*3* 20:*20* 42:*13* 43:*14* 46:*3*, *6* 48:*23* 52:*22* 67:*13*, *21*
big 52:*15* 71:*21*
biggest 29:*11*
bilingual 5:*6*, *21*
Bill 52:*11*
billion 26:*11* 55:*14*
billions 53:*12*
bit 5:*16* 9:*24* 44:*14*
bitter 19:*19*
blame 46:*6*
blind 30:*14* 32:*22* 62:*24*
blue 61:*21*, *22*, *25*
board 40:*14*
bodies 22:*18*
bonus 27:*5*
book 56:*6*, *8*
boom 44:*15*
border 29:*23*
bottom 3:*8* 4:*13* 6:*1*
boundaries 54:*2*
breach 47:*17*
breakfast 12:*23*
brief 66:*22*
brilliant 56:*18*
bring 13:*2* 44:*4* 51:*21* 54:*1*, *4* 55:*12*
bringing 13:*7* 54:*12*
brought 14:*22* 21:*12* 40:*14*
brushing 44:*14* 48:*2*
building 22:*19*
bureaucracy 56:*17*
button 3:*9*, *11*, *22*, *24* 4:*2*, *4*, *13*
buttons 5:*1*
Bye 72:*6*

< C >
cake 30:*17*
call 7:*7* 12:*12* 14:*18* 15:*23* 24:*5* 27:*5* 30:*1* 33:*12*, *19* 35:*13* 36:*2* 45:*22* 48:*3* 57:*4*
called 34:*1* 44:*20* 54:*16*
camera 7:*1*, *3*
Canada 26:*9*, *13* 29:*22* 52:*6* 53:*11* 54:*5*, *11*, *14* 55:*5* 57:*10*
Canadians 29:*11* 54:*9*
capability 50:*5*
cards 19:*3*
CARE 1:*6* 2:*6*, *8*, *13*, *14*, *17* 5:*6*, *8* 9:*20* 10:*25* 11:*19* 12:*7* 15:*11* 18:*16* 21:*10*, *14* 22:*19* 23:*13*, *15*, *16* 24:*23*, *24* 25:*6*, *17*, *22* 27:*9*, *18*, *25* 36:*1* 39:*8* 40:*22* 42:*6* 43:*3* 46:*9*, *13*, *18*, *21* 48:*3*, *20* 50:*6*, *9*, *17*, *21*, *24*, *25* 51:*6*, *8* 52:*1* 53:*13*, *22* 54:*5*, *13*, *16*, *21* 55:*22* 57:*7*, *12*, *13* 58:*6* 59:*7* 61:*14*, *15* 62:*6*, *19* 66:*24* 67:*23* 68:*13*, *21* 69:*1*, *9* 70:*13* 72:*2*
cared 28:*3*
career 55:*18*
Careers 28:*9*
careful 44:*21*
caregiver 14:*21* 17:*10* 24:*20* 25:*6*, *10* 29:*15* 34:*7* 40:*21* 48:*7*
caregivers 14:*7* 16:*17* 19:*6* 22:*22* 24:*22*, *23* 25:*2*, *19*, *24* 26:*8*, *9*, *12* 29:*14* 34:*8* 40:*2* 44:*6* 45:*9* 53:*8*, *10*, *13* 54:*23*, *25* 55:*11*, *13* 57:*16* 62:*2*, *4* 64:*11*, *13*, *18*, *20*, *21* 65:*6*, *9*
caregiving 64:*16*
caring 12:*7*
Carl 12:*15* 15:*5* 16:*5*, *14*, *20*, *25*
Carl's 16:*23* 17:*11*
carry 24:*18*
case 10:*8* 28:*4* 34:*9* 66:*19*
cases 37:*21* 40:*7*
catastrophic 23:*24*
caused 12:*21*
CEO 23:*18*, *23*
certain 13:*11* 15:*3* 40:*3* 43:*23*
certainly 35:*20*
CERTIFICATE 73:*1*
Certified 73:*3*, *18*
certify 73:*4*
cetera 32:*16* 44:*13* 62:*8*
Chairman 23:*11*
chairperson 36:*7* 38:*4*
chance 70:*22*
change 19:*18* 26:*23* 27:*8* 29:*14* 34:*2* 37:*6* 60:*14*, *17* 61:*19*, *23*
changed 27:*9*, *10* 33:*5*, *17* 62:*2*
changes 20:*23* 21:*2*, *3* 50:*7*, *8*
changing 53:*21*
channels 33:*24*
chatted 6:*23*
Chief 6:*9*, *11*
children 63:*14*, *15*
Choconta 2:*16* 5:*17*
choice 6:*6*
choose 7:*19*
chose 37:*4*
chosen 24:*23* 25:*6*, *19* 54:*23*, *25* 59:*8*, *10*
circles 32:*19*
classed 55:*9*
cleanliness 40:*3*
clear 59:*6*
clearly 36:*21*
click 3:*11* 4:*21*, *23*
Clinton 52:*12*
closing 12:*22* 23:*10* 71:*5*
closure 18:*15*
clothes 37:*7*, *8*, *9*
co-chair 18:*12*
cocoon 70:*11*
Code 56:*4*
co-facilitator 5:*13*
cognitive 19:*21* 22:*5* 40:*25* 44:*9* 47:*25* 50:*5* 51:*3*
cognitively 51:*5*
Coke 2:*4* 6:*12* 9:*16* 72:*7*
collaboration 55:*6* 69:*10*
collaborative 69:*1*, *19*
colleague 43:*6*
colleagues 9:*14* 47:*5*
collective 57:*9* 63:*6*, *8*, *17*

collectively 27:*17*
combine 14:*10*
come 15:*15* 16:*21* 17:*17* 36:*22* 42:*18* 44:*23* 48:*12* 57:*25* 62:*20*
comes 62:*10*
comfortable 3:*14*, *18* 4:*17* 6:*25*
coming 14:*3* 26:*21* 45:*4* 47:*3* 69:*22*
commencing 3:*1*
comments 45:*20* 51:*13* 57:*19* 67:*6* 70:*17*
COMMISSION 1:*7* 2:*13*, *15*, *17* 5:*7*, *12*, *14*, *20* 6:*7* 9:*19*, *25* 10:*3*, *17* 11:*11* 45:*21* 51:*25* 67:*7* 71:*2*, *14*
Commissioner 2:*2*, *3*, *4* 6:*10*, *11*, *12* 7:*25* 9:*4*, *6*, *15*, *16* 11:*24* 12:*3* 71:*4*, *6* 72:*7*
COMMISSIONERS 2:*7* 6:*8* 8:*21* 9:*13* 24:*11* 26:*4* 43:*15* 51:*24* 58:*20*
Commissions 9:*24* 10:*1*, *6*
Commission's 43:*1*
commit 37:*2*
commitment 22:*15* 50:*2*
committed 13:*9* 48:*4*
committee 62:*19*
communicate 6:*22* 14:*25* 16:*22* 33:*3* 34:*21* 42:*1*
communicating 67:*24*
communication 16:*6* 18:*25* 20:*16*, *19* 32:*25* 33:*24* 34:*19* 38:*19* 39:*15* 45:*2* 70:*2*
communications 20:*21* 56:*15*
communicative 36:*12*
communicator 14:*24*
communities 29:*5*
community 43:*23* 44:*5*
companies 23:*16*
comparing 23:*24*
compelling 53:*22*
complained 22:*23*
completely 3:*17* 20:*11* 46:*25* 49:*5*
compliance 49:*16*, *19*
compliant 70:*6*
concern 7:*22* 19:*16* 29:*11* 41:*10*
concerns 12:*11*, *17* 39:*25* 40:*10*
concludes 70:*21*
concluding 8:*7*
condition 29:*8* 33:*5* 40:*24*, *25*
conditions 34:*4* 41:*2*
conducted 19:*2* 20:*22* 49:*12*
conducting 10:*8*
conduit 42:*3*
confined 20:*24*
confusion 18:*17*
connection 6:*19*
conservative 26:*6*
consider 43:*16* 52:*3* 53:*5*
considerations 8:*18*
considered 22:*22* 46:*9*
constant 19:*25*
constantly 17:*25*
contact 35:*20* 40:*13* 47:*8*
context 9:*24*
continue 12:*1* 66:*7*
continues 10:*9*, *15*
continuing 40:*12*
contribute 26:*11* 28:*23* 55:*13*
contribution 32:*7*
control 20:*4* 49:*9*
conversation 15:*7* 52:*6*
conversations 8:*14*
conveying 8:*21*
co-operated 29:*6*
corporations 50:*11*, *17*
cost 70:*16*
costing 57:*2*
costs 28:*7*
Cote 2:*24*
Council 18:*12* 20:*3*, *20* 21:*14* 31:*17*, *19* 32:*5*, *8* 36:*8* 38:*2*, *4* 39:*3*, *20* 41:*1* 56:*14* 60:*11* 64:*4* 69:*11*
Councils 2:*21* 6:*14* 32:*4* 35:*5* 64:*5* 69:*12*, *14*, *17*
countries 70:*14*
country 36:*17* 53:*2*
couple 44:*24*
courage 11:*8* 71:*1*, *7*
course 7:*13* 15:*24*
court 7:*6*
courts 66:*19*
cover 8:*25* 9:*1*
COVID 12:*20*, *21*, *22* 17:*16* 18:*21* 19:*8* 20:*4*, *7*, *9* 21:*18* 22:*24* 30:*9* 31:*9* 32:*11*, *21* 34:*5*, *9* 40:*7* 44:*18* 46:*25* 47:*6*, *8*, *12* 48:*6*, *8* 49:*8* 65:*1*
COVID-19 1:*7* 2:*6* 5:*7* 9:*20* 10:*25* 11:*2*, *20* 19:*25* 25:*12*
COVID-positive 20:*17*
cracks 41:*19*
crazy 49:*3*
Create 55:*10* 72:*1*
created 54:*15*
Cries 23:*8*
Criminal 56:*4*
crisis 10:*9* 32:*11* 60:*8*, *9*
critical 50:*1* 55:*16*
critically 20:*10*, *17*
Cross 23:*22*
cry 45:*25*
CSR 73:*3*
Current 46:*15* 56:*4*
currently 22:*13* 29:*16* 31:*25* 34:*11* 48:*21* 56:*4* 66:*19*

< D >
danger 18:*2* 47:*2*
Daoust 2:*14* 4:*10* 5:*13*, *21* 43:*6*, *9* 45:*19* 51:*12* 57:*18* 67:*5* 70:*19*
data 60:*15*, *16* 61:*15* 64:*21*
date 73:*6*
Dated 73:*13*
Dawn 2:*12* 3:*2*, *23* 4:*1*, *24* 5:*10* 6:*3* 7:*5* 9:*7* 11:*25* 12:*2* 18:*5* 24:*3* 29:*24* 35:*9* 42:*16* 43:*10*
day 1:*16* 13:*16* 14:*12*, *13* 16:*2*, *5*, *11*, *13*, *24* 17:*1* 23:*4* 32:*23* 33:*14*, *16* 34:*1* 35:*6* 52:*14* 72:*3* 73:*13*
daycare 46:*17* 49:*20* 51:*2*
daycares 53:*1*
days 13:*11*, *19* 20:*10* 48:*9* 63:*24* 66:*23*
day-to-day 51:*7*
dead 29:*7*
deaf 14:*25*
deal 8:*16*
dealing 27:*19*, *20*
death 23:*24* 65:*20* 66:*3*, *23*
debate 51:*22*
decades 24:*17* 25:*14*
December 20:*6* 30:*8* 34:*5* 40:*6*, *7*
decided 31:*4*
decision 10:*19*
decline 22:*5* 44:*9*, *10*
declined 40:*25* 41:*3*, *17*
Declining 19:*20*
deep 15:*6*
define 54:*20*
defined 54:*22*
definitely 42:*4*
degowned 15:*22*
delayed 31:*12*
delivery 54:*7*
demanding 48:*18*
dementia 34:*13* 40:*19* 67:*25*
demographic 53:*20*
demography 53:*20*
dental 28:*16*

48:2 68:2
department 58:9
departments 49:25
deployed 21:19
described 54:10
despair 19:23 22:21
despite 39:12 41:11
Detailed 46:11
Diaper 21:2 33:17 34:2 60:23, 24, 25 61:2, 6, 7, 8, 9, 20, 23
diapers 61:18
Diaz 2:16 5:17
die 23:21 32:2 52:19
died 30:10 32:5 65:2 66:8, 17
Dietary 48:15
diets 48:16
difference 42:15
different 5:9 23:12
differently 67:12
difficult 18:22 34:15
difficulties 3:5
dime 57:1
dinner 43:21
diplomas 63:4
direct 24:24 27:18
directives 36:15
directly 4:19 40:11
Director 2:12 5:11 36:11 37:16, 25 40:8, 14 42:10
directors 40:9
dirty 49:4
discuss 23:13
discussed 8:14
discussion 3:15 47:12
discussions 73:8
disinfection 26:1
disorganization 20:14
dispensed 25:25
displayed 7:15
displeased 19:11
distinct 15:3
distraught 49:6
distress 20:14 23:9
distressed 50:4
distressing 18:23
distributed 38:22
distribution 21:1
DOCs 41:22
doctors 53:17 56:23
document 58:19 63:23 65:18 66:2
doffing 20:13 21:8
doing 14:5, 6 26:10 31:23 34:14 38:14 45:4 65:16
dollars 28:8
donning 20:13 21:7
doors 45:8
doubt 9:18
drafting 62:15
dressed 22:11
drive 13:14 14:12
droplet 20:11
drops 30:23, 25 31:3

< E >
earlier 5:16 6:18 10:22 51:18
early 36:24
ears 23:2 35:7
easier 47:16
easily 28:9
eat 30:14 45:12
eating 40:24 45:10 65:16
education 46:24
effectively 42:2 68:20 69:8
Elder 54:16 70:13
electronic 32:1
email 6:23 38:5, 6 42:8
emotion 12:18
emotional 24:24 26:2 53:14 56:2
emotions 35:18
empathetic 69:5
employees 30:11, 12
employer 36:18
employment 36:23
encourage 8:20 55:3
encouraged 36:18 37:6, 10
ended 34:5 72:8
enforce 49:19
enforcement 55:20
engage 41:13
engaged 17:6
engaging 42:9
English 3:11, 15, 24, 25 4:2, 3, 19 6:2, 3 58:13
English-speaking 5:22
ensure 11:11 25:24, 25 49:13 50:2, 20 69:21
ensured 7:16 36:23
ensuring 43:1
enter 32:9, 17
entering 5:18 28:1
entire 20:19
entitled 56:7
entry 36:16
environment 72:1
equally 35:21 54:8
equitable 54:9
escape 45:16
especially 39:16 43:24, 25
essential 14:7, 21 16:16 19:6 22:22 24:19, 22, 25 25:6, 18 40:1, 21 41:9 44:6 45:9 48:7 51:20 52:1 53:8, 13 54:21, 22 55:10, 11
estimate 26:6
evening 70:21 71:5 72:6
evenings 26:22
event 10:2
everybody 70:1
evidence-based 56:9
exactly 45:5
examining 66:22
example 25:3
exception 49:14
Executive 36:11 37:16, 24 40:7, 14 42:10 68:17
exhausted 22:20
exhausting 14:9, 14
exist 52:4 55:8 56:4
existed 58:1
existence 22:8
existing 56:1
expect 58:20
expendable 46:9
experience 8:23 12:6 18:6, 13 25:11 29:25 30:5 35:12 36:4 43:12
experienced 28:1 29:1 37:1
experiences 8:17 35:14 39:25 42:24 70:25 71:1, 8, 16
experiencing 29:17
experts 25:3
explain 24:22 32:14 64:10
explicitly 54:19
explosion 53:21
exposed 48:13
express 5:23 59:13, 16, 18, 24
extreme 31:5
extremely 32:21
eye 30:18 31:8, 15
eyes 23:2 35:7 71:10
eyesight 30:21

< F >
face 17:21 49:16
Facetime 18:23
facilitators 11:25
facilities 47:7
facility 18:20 19:9, 11 20:7, 19 22:15 23:3
fact 25:24 32:22 41:11 68:14
factor 65:23 66:25
factors 65:19 66:23
failures 23:25
fairly 14:1
fall 19:24
falls 23:6
families 9:21 20:15, 16, 18 25:4 33:3 35:8 37:25 38:18, 22 39:16, 24 40:10 42:2, 5 48:17 51:18 52:1 54:20 59:8, 17, 20, 23 64:16, 19 66:11 68:24 71:23
FAMILY 2:7, 21 5:7 6:14 10:24 11:1 12:9 16:14 18:12 20:3 21:14 24:19, 21, 22, 23 25:6, 10, 18, 19 26:17 30:6, 7, 25 31:17 32:4, 8 34:1 35:5 36:8 38:2, 4 39:3, 5, 20 41:1 44:7 45:8 53:8 54:22, 23, 25 55:2, 11 56:14 59:10 60:11 62:4 63:21

64:*4*, *5* 66:*9* 69:*10*, *12*, *14*, *16*
family's 18:*13* 24:*14*
faster 20:*21*
father 28:*3* 30:*6*, *13*, *17*, *22* 31:*7*, *13* 32:*20* 33:*9*, *11* 34:*11*, *19*, *23* 35:*2* 36:*5*, *6* 59:*12* 60:*25* 62:*23*, *24*, *25*
father's 33:*5* 59:*15* 61:*20* 62:*16*
fear 28:*24*
fearing 59:*3*, *14* 72:*3*
Fearon 2:*21* 6:*14*
February 1:*17* 73:*13*
federal 25:*16* 69:*25*
feeding 21:*1*
feeds 62:*23*, *25*
feel 7:*1* 8:*16* 26:*25* 35:*1*, *24* 43:*24* 44:*17*
feeling 4:*25*
feelings 19:*22*
fell 41:*19* 49:*2*
fellow 29:*15* 68:*25*
felt 12:*25* 35:*20* 39:*11*
fever 65:*24*
fewer 13:*8*
fifteen 33:*13*
fifth 65:*24* 66:*3*, *25*
figures 65:*4*
filled 60:*6*
final 10:*10*
finally 70:*8*
financially 28:*7*
find 4:*12* 14:*3* 63:*20* 66:*16*
findings 10:*18*
fine 7:*4* 34:*21*
finish 8:*6*
firms 60:*19*
first-hand 27:*25*
fit 15:*20*
fix 53:*22*
floor 45:*23* 51:*16* 61:*10*
focus 8:*20* 24:*15*
follow 47:*14*
following 5:*14* 40:*4* 43:*11* 60:*3*
Follow-up 49:*18*
food 48:*22*, *23* 50:*25*
force 26:*13*, *14* 53:*11*
foregoing 73:*5*, *11*
forest 23:*7*
forget 58:*13*
form 28:*11* 38:*24* 43:*23* 45:*2* 68:*13*
format 20:*23*
former 52:*11*, *12*
for-profit 36:*2* 68:*19*
forth 40:*5* 73:*7*
forthcoming 36:*11*
fortunate 35:*25* 37:*20*
forty 42:*8*
forward 21:*12* 23:*13* 54:*1* 55:*19* 67:*7* 68:*16* 72:*1*
forward-thinking 69:*6*
found 39:*4*
Fourth 65:*23*
Frank 2:*2* 6:*11* 9:*15*
frantic 20:*18*
free 7:*1* 18:*21*
French 3:*11*, *15*, *21*, *22* 4:*4*, *6*, *8*, *12*, *15*, *19*, *22*, *23* 5:*22* 6:*2*, *4* 9:*9*
frequency 30:*19*
fresh 48:*23* 50:*24*
Fridays 60:*4* 63:*25*
friend 52:*8*
friends 52:*12* 55:*1* 57:*10*
front 39:*15* 41:*12* 62:*11*
frustrating 13:*23*
full 55:*12*
Fullerton 32:*13*
full-time 46:*5* 67:*14*, *19*
fun 45:*12*
functions 19:*21*
funding 48:*21*
funds 50:*20*
future 8:*19* 11:*4*

< G >
gain 56:*13*
gap 39:*10* 48:*9*
garb 17:*13*
garbages 49:*4*
general 9:*24* 69:*13*
generation 57:*9*
gift 19:*3*
gist 15:*9*
give 15:*3*, *12* 16:*21* 33:*21* 55:*21* 59:*2*, *10*
given 65:*8* 71:*17*
giving 33:*10* 44:*14*
golf 52:*19*
golfing 52:*21*
Good 3:*2* 5:*5* 9:*7* 14:*24* 15:*5* 34:*12* 37:*3* 39:*12* 42:*11* 72:*5*
goodbyes 13:*13*
government 9:*14* 10:*11*, *14*, *18*, *21* 11:*14* 19:*5* 23:*16* 26:*15* 58:*16* 71:*18*
Governments 9:*25* 25:*16* 54:*19* 69:*24*
gown 15:*14*
gowned 13:*13* 16:*7*
gowning 15:*13* 44:*17*
grateful 47:*16*
gratefully 40:*22*
great 3:*21* 8:*16*
greater 55:*22*
grew 39:*4* 42:*7*
grinding 28:*13*, *15*
gross 50:*9*, *13*
ground 14:*2* 65:*15*
group 5:*6* 9:*4* 56:*14* 62:*17*
groups 60:*12*
group-type 55:*4*
guess 26:*13* 35:*23*
guidance 36:*13* 37:*14*, *18* 39:*15*, *21* 68:*22*
guidelines 19:*14*
guilt 18:*18* 19:*22*

< H >
hair 16:*3* 44:*15*
half 48:*21* 63:*14*
halls 20:*21*
hallway 45:*14*
hand 43:*5* 71:*4*
handle 18:*2*
hands 15:*19* 30:*15* 44:*13*
happen 20:*5* 21:*2* 49:*19* 57:*24* 71:*20*
happened 14:*19* 21:*18* 43:*3* 47:*20*
happening 3:*16* 10:*5* 12:*24* 18:*25* 23:*2* 33:*23* 39:*18* 53:*1* 65:*5*
happens 11:*15* 61:*25* 63:*12* 65:*15*
Happily 56:*7* 74:*3*, *4*
happy 42:*2*
harassed 29:*15*
harassment 29:*1*, *17* 56:*2*
hard 60:*16*
harshly 49:*22*
Hawthorn 2:*18* 5:*15* 6:*23*
Haz-mat 15:*15* 45:*3*
head 15:*19* 22:*1* 36:*3*, *13* 37:*5*, *11* 45:*15*
Health 19:*7*, *10* 54:*5*, *11*, *14* 61:*12* 70:*4*
healthcare 24:*24* 51:*21* 54:*7* 57:*12*, *14*, *25* 58:*5*
healthy 32:*21*
hear 4:*2*, *5*, *14*, *18* 6:*5* 8:*1*, *9* 35:*24* 45:*1*
heard 5:*16* 9:*12* 42:*19* 52:*10* 56:*19* 72:*3*
hearing 8:*6* 15:*10* 17:*20*
heart-felt 71:*10*
heeding 37:*16*
Heinz 17:*7*
Held 1:*15* 6:*17*
Helen 2:*22* 73:*3*, *17*
hello 5:*4* 30:*4*
help 10:*14* 11:*2*, *8*, *11*, *13* 26:*23* 27:*2*, *4*, *6* 41:*15* 71:*22*
helpful 42:*25* 71:*11*
helping 68:*23* 71:*22*
higher 69:*23*
highlight 58:*9*
hired 33:*2*, *7* 68:*20*
hiring 68:*17*
hit 3:*22*, *23* 4:*1*, *4*
hold 69:*3*
holding 69:*17*
holidays 63:*11*, *15*
home 12:*7*, *19*, *22* 13:*3*, *4*, *10* 15:*11* 16:*12* 19:*6* 21:*16*, *20* 28:*2* 33:*4*, *8*

36:5, 11, 15, 19, 21 37:2, 3, 4, 10, 19 38:6, 9, 14, 20 39:6, 13, 17 40:13 41:21 47:4, 8 48:4, 12 49:15 55:4, 9 64:11, 25 65:5, 20 66:4, 5 67:16, 23 68:14, 19 69:2, 9, 11 72:2
homes 9:20 10:25 11:19 13:1 43:3 46:21 49:10, 15 64:14 66:7, 24 69:17
home's 69:20
hope 11:10 24:1 56:9
hoped 13:18
horrible 61:3
horrific 29:7
horror 45:17
hospital 17:22 25:4
hospitals 17:21 31:10
hosted 38:10
hosting 12:16 38:1
hour 13:12 30:23
hours 13:11, 15 19:14 21:3, 25 27:17 36:24 37:1 61:14, 17
Housing 55:6
huge 20:22 39:10 44:9, 10
hundreds 28:8
hungry 49:4
husband 12:15 14:25
hygiene 26:1 48:2 68:2, 3

< I >
i.e 25:5 56:13
icing 30:16
idea 24:15
identifiable 7:21
identifying 6:15
identity 7:22
ill 48:17, 19
imagine 52:25
immediately 15:19 50:15, 20
impact 9:21 11:2 28:7 40:18 61:3, 16 71:12
impacted 10:24 12:9 24:14 27:23
Impacts 27:22 56:12
impaired 17:20 51:5
impairment 47:25 51:4
implement 10:20 55:21 70:16
implemented 56:20
Importance 49:23
important 8:22 10:22 11:9, 14 43:15 68:16 69:11, 12
importantly 28:11
impossible 31:2 50:14 63:7, 20
impression 58:4
improve 48:16
improved 40:15 42:5
improvements 28:5
improving 8:19
incapacity 66:5
incidents 13:6
including 66:17
Increase 55:15 67:17, 19
increased 40:7 47:22
independent 10:17
indicator 58:23, 25 59:4, 5, 11
indicators 58:12, 15, 17, 18, 23 59:7, 9, 21, 22 60:2
individual 14:2
industry 25:17 26:15 57:13
infection 47:2 49:9
inform 40:23
information 7:19 18:21 33:11 38:1, 17, 24 40:13 64:23 68:24
infractions 49:21 51:8
Infrastructure 55:5
initiative 50:10
injured 22:21
innovative 69:5
in-person 40:17
Inquiry 10:1
inspection 49:17 55:21, 22
inspections 49:11, 15, 16 70:4
Inspector 19:10
instance 7:11 63:11
Institute 26:7
instituted 36:14
instructions 4:8
insufficiency 65:21
insufficient 8:17
interactive 68:22
interest 13:1 53:16
Interestingly 19:13
interests 52:13
interim 10:13 40:9
interpret 16:9
interpretation 3:7, 9, 10, 19 4:9, 12, 13, 15, 20, 23 5:1, 24
Interpreter 2:23, 24
interpreters 66:11
intervention 23:20
intimidation 29:1, 17
introduced 9:15
introductory 7:24 8:14
inventing 60:15
investigate 9:19 10:3
investigation 10:7, 8, 23
investment 55:3
invite 9:3 43:17
invited 62:14
IPAC 40:4 49:7, 11 70:3
isolated 17:13
isolation 17:3 18:3 43:20
issue 43:21 54:1
issues 6:21 21:12 40:3

< J >
Jack 2:3 6:9 7:25 9:6, 12 11:24 71:6
jacket 26:22
January 34:7
jaw 28:14
Jello 48:18
job 63:20 68:8, 9
jobs 46:6
join 6:20 11:17
joined 5:12 38:18
joining 3:4
July 31:13 36:10 37:22 63:12
juncture 42:21
June 19:5 31:13
jurisdiction 54:8

< K >
keeps 15:10 29:20 57:14, 15
kept 19:7
Kind 23:6 46:12 63:21
Kitts 2:3 6:9 7:25 9:4, 5, 6, 12 11:24 12:3 71:4, 6
knew 16:19 35:2
knowledge 37:23
known 27:11 65:7

< L >
lack 14:17 19:16
lacking 25:21
language 3:12 5:24 6:5
languages 3:18 4:18
lapses 46:22
large 36:2 60:19 71:18, 24
largest 26:12 53:10
late 3:4 14:24
laughed 52:22
law 50:8
laws 56:1, 3
Lead 2:2, 14 5:13 43:7 65:19
leader 68:17, 22
leadership 37:18 38:12 39:23 42:14 68:14, 18, 21 69:11
learn 10:23 42:14
learned 14:25 15:3 32:8
leave 3:19 63:12, 19
leaves 22:7 63:16
led 6:8 33:15
left 21:21 22:12 37:9 39:18 46:6 50:3
legislation 51:19 54:24 64:7
legislative 54:13
length 32:15
lengthy 40:9, 16
letter 23:11
letters 10:13

levels 46:*12* 69:*24*
licensees 55:*23*
lies 23:*3*
life *27*:*9*, *10* 50:*3* 63:*21*, *22* 66:*5*
light 52:*9*
lighten 44:*1*
limitations 14:*22*
limited 46:*3* 49:*12*
lines 64:*4*
lip 15:*2*
lips 17:*19*
liquids 65:*21*
listen 59:*5*
listened 72:*4*
listening 71:*10*
litigation 50:*15*
live 16:*17*
lived 16:*19* 25:*10* 29:*21*
lives 11:*19* 22:*7* 27:*7* 35:*25* 59:*12*
living 22:*8* 45:*17*
local 16:*18* 17:*10* 66:*18*
location 46:*4*
lockdown 13:*4* 46:*14*
locked 39:*6*
locking 28:*14* 46:*7*
lonely 50:*4*
long 21:*25* 22:*18* 28:*20* 34:*15* 41:*7*
longer 22:*2*
LONG-TERM 1:*6* 2:*6*, *8*, *13*, *14*, *17* 5:*6*, *8* 9:*20* 10:*25* 11:*19* 12:*7* 18:*16* 23:*12*, *16* 24:*23* 25:*17*, *22* 27:*24* 36:*1* 43:*3* 48:*20* 50:*8*, *10*, *16*, *24* 51:*6* 53:*22* 54:*4*, *13*, *16* 55:*22* 57:*7*, *25* 58:*6* 66:*24* 67:*23* 68:*13*, *21* 69:*9* 72:*2*
looking 70:*11*
looks 17:*11*
losing 15:*11* 40:*23*
loss 40:*20* 65:*22*
lost 11:*19* 28:*9* 37:*1* 44:*8* 50:*5*
lot 35:*18* 38:*17* 40:*15*, *19* 64:*10* 65:*11* 67:*4*
lots 17:*8* 63:*4*
love 45:*15*
LOVED 2:*7* 5:*8* 12:*7*, *9* 18:*1* 19:*19* 20:*18* 24:*25* 35:*5* 39:*5*, *9* 41:*8* 42:*6*, *25* 47:*8* 52:*2* 53:*8* 54:*21* 62:*6*
loves 16:*23* 41:*2* 53:*15*
low 15:*6* 65:*10*
LTC 25:*17* 28:*2*, *23* 36:*15*
lucid 34:*12*
lucrative 57:*13*
lunch 27:*14*
lunches 19:*3*

< M >
made 14:*11*, *20* 20:*23* 26:*25* 31:*1* 40:*2* 43:*13* 57:*10*
magic 52:*18*
magically 57:*7*
main 43:*21*
maintain 30:*20*
majority 37:*3*
making 56:*12*, *18* 57:*1* 71:*11*
manage 10:*15* 22:*18*
management 21:*19* 23:*17*
mandate 53:*25*
March 18:*16* 32:*10* 36:*10* 37:*22* 58:*1*
Marrocco 2:*2* 6:*11* 9:*16*
Martineau 2:*22* 73:*3*, *17*
marvelous 56:*6*
mask 15:*14* 17:*19* 19:*16*
masks 44:*25* 45:*1*
mass 18:*16*
massaging 44:*13*
massive 48:*5*
matter 22:*19*
McCurry 52:*10*
meaning 22:*2*
meaningful 68:*24*
means 29:*13*, *18* 64:*1* 69:*13*
meant 48:*13* 50:*9*
measured 23:*25*
measures 38:*15*
media 29:*18* 66:*18*
medical 25:*1* 29:*5* 33:*5* 56:*22* 65:*13*
medication 21:*1* 30:*19*
medications 25:*24*
meet 46:*13*
MEETING 1:*6* 2:*6* 4:*3*, *5* 5:*6*, *22* 6:*10*, *16*, *19*, *20*, *22*, *24* 9:*11* 11:*7* 12:*1*, *16* 14:*14* 38:*24* 41:*1* 72:*8* 73:*5*
meetings 20:*3* 32:*1* 38:*2*, *11*, *22* 39:*20*
member 12:*10* 32:*4* 38:*12* 60:*11*
MEMBERS 2:*7* 5:*7*, *15* 10:*24* 11:*1* 21:*5* 33:*25* 39:*5* 41:*1* 48:*14* 64:*7* 68:*18* 71:*13*
memory 11:*18*
mental 49:*24* 56:*1*
mention 56:*25*
mentioned 51:*18* 68:*15*
message 34:*24*
messages 71:*11*
met 5:*17* 30:*21* 69:*21*
metrics 64:*22*
mic 43:*18*
Mike 52:*10*, *15*, *20*
military 23:*22* 25:*8*
million 26:*8*, *9*
millions 57:*15*
mind 53:*5*
minds 41:*15*
mine 52:*8*
minimal 47:*21*
minimum 55:*14*
Minister 32:*13*
Ministry 27:*20* 58:*10*, *14*, *16* 64:*13*, *17*, *22* 70:*4*
minutes 8:*11*, *16* 13:*12*, *14* 30:*24* 33:*14*
mistreated 29:*19*
mobile 22:*2*
Moira 56:*6*
mom 12:*19* 14:*13* 15:*5*, *6*, *23*, *24* 17:*4* 27:*5* 40:*18* 44:*10*
moment 7:*24* 11:*17*, *22*
mom-in-law 27:*4* 29:*6*
mom's 45:*10*
month 21:*11* 66:*13*
months 19:*24*
morale 34:*12* 37:*3* 38:*15*
morning 27:*3* 29:*21*
mother 27:*16* 35:*25* 36:*6*
mother-in-law 26:*23* 27:*18* 28:*1* 29:*3*
move 12:*20*, *21* 13:*1*, *4* 18:*7* 32:*6* 57:*21* 67:*9*
moved 39:*6*
moving 23:*13*
MP 14:*18*
much-needed 25:*21* 26:*2*
multiple 48:*14*
municipal 68:*19* 70:*1*
mute 24:*7*
mutual 52:*13*

< N >
nails 16:*4*
naive 28:*2*
names 7:*8*
Nathan 56:*24*
National 26:*7* 54:*15* 55:*5*, *10*
NB 2:*23*
necessary 19:*8*
needed 18:*19* 27:*2* 37:*12*, *25* 50:*11*
needs 21:*14* 27:*5*, *6* 28:*16* 42:*4* 48:*15* 52:*5* 53:*14* 57:*24* 59:*7* 68:*6* 69:*13*
negative 40:*18*
neglect 20:*25* 46:*23* 56:*1*
negligence 50:*9*, *13*
nervous 11:*6*
new 22:*8* 25:*12* 39:*16* 40:*14* 41:*19* 42:*9* 56:*3* 64:*25* 65:*24* 66:*6*, *10*, *17*, *20*, *25* 67:*1*
newsletters 38:*8*
nice 67:*18*
night 28:*13* 29:*20* 57:*15*
nights 60:*5*
no-man's-land 31:*10*
noncompliance 51:*10* 55:*24*
normal 29:*12*, *13*
Note 55:*17*

noted 19:*15* 41:*2* 51:*9*
notes 38:*21* 73:*12*
not-for-profit 68:*19*
nothing's 29:*14*
notice 24:*20* 50:*16*
noting 59:*6*
notwithstanding 54:*10*
November 30:*8*
number 7:*14* 35:*10* 43:*11*, *18*, *19* 45:*23* 51:*13*, *15* 57:*22* 58:*24*, *25* 59:*4*, *11* 64:*21* 65:*6*, *22* 66:*16* 67:*10*
numbers 21:*6*
numerical 8:*2*
nurse 32:*25*
nurses 40:*22* 53:*17* 56:*23* 61:*12*, *13*
nursing 15:*20* 67:*15*
nutritional 27:*5*
nutritionist 62:*21*, *22*

< O >
observations 35:*18*
observed 11:*22*
observing 11:*17*
occur 20:*4*
occurred 10:*2*, *4* 52:*25*
October 30:*8* 65:*1*, *2*
offered 37:*17* 46:*5*
office 36:*3*, *13* 37:*5*, *12* 41:*21*
officer 41:*24*
officers 55:*22*
offices 22:*1*
old 23:*6* 30:*13*
older 31:*20* 63:*10* 74:*3*
ONES 2:*7* 5:*8* 18:*1* 19:*19* 20:*19* 24:*25* 35:*5* 39:*5*, *10* 41:*2*, *8* 42:*25* 47:*8* 52:*2* 53:*8*, *15* 54:*21* 62:*6*
one's 42:*6*
ongoing 46:*21* 47:*12*, *18*
on-line 38:*2*
on-site 49:*5*
Ontario 2:*21* 5:*9* 6:*14* 52:*7* 56:*14*
open 14:*16* 17:*24* 19:*13* 33:*24* 45:*6*, *7*, *8*, *18* 52:*5*
opened 45:*9*
openly 25:*2*
operated 36:*1*
operating 3:*18* 48:*25*
Operations 2:*12*
opinion 58:*3* 59:*3*, *14*, *16*, *18*, *24*
opinions 59:*19*, *20*
Opportunities 18:*22* 28:*9*
opportunity 3:*6* 9:*1* 39:*7*, *9* 70:*18*
opposed 72:*2*
option 5:*25*
options 19:*1* 48:*19* 49:*2*
order 8:*2*, *9* 30:*20*, *22* 31:*2*
organization 36:*2* 64:*6*
organizations 56:*12*
original 4:*22*
Ottawa 25:*3* 60:*12*
outbreak 19:*9* 22:*24* 30:*9* 43:*25* 44:*2* 46:*11* 47:*20* 49:*12*
Outbreaks 40:*9*, *16*, *18* 41:*7*
outcomes 48:*20*
outcry 20:*22*
outreach 7:*17*
outset 47:*18*
outside 46:*16* 47:*10* 49:*8* 53:*25* 55:*1*
overall 50:*1*
overflowing 49:*5*
overseers 26:*18*
oversight 24:*25* 25:*21*
overview 63:*24*
overwhelming 18:*18*
owe 57:*11*
owned 36:*1*

< P >
p.m 1:*17* 3:*1* 72:*8*
paid 57:*11*
pain 30:*23* 31:*5*, *14*
painful 31:*5*
palatable 56:*21*
Palin 2:*12* 3:*2*, *23* 4:*1*, *24* 5:*10* 7:*5* 12:*2* 18:*5* 24:*3* 29:*24* 35:*9* 42:*16*
palliative 59:*6*
pandemic 12:*8* 23:*14* 24:*15* 32:*20*, *24* 43:*4* 46:*16*, *17* 47:*18* 49:*1* 50:*3*, *7*, *19* 58:*7* 65:*8* 66:*8*, *9*, *15*, *21* 71:*12*
panic 18:*17* 20:*14*
parent 59:*13*
parents 57:*10*
part 10:*22* 23:*10* 29:*5*, *10* 33:*1*, *7* 39:*23* 52:*21* 59:*10*
PARTICIPANT 3:*20*, *25* 7:*10*, *14* 8:*3* 12:*13*, *14* 17:*4* 18:*6*, *7*, *8*, *9* 22:*4* 24:*4*, *5*, *9* 29:*24* 30:*1*, *2*, *4* 35:*3*, *10*, *13*, *16*, *19*, *21* 42:*17*, *18* 43:*17*, *18*, *20* 45:*20*, *23*, *24* 51:*13*, *14*, *15*, *17* 57:*22*, *23* 63:*3* 65:*22* 67:*10*, *11*
participants 1:*16* 2:*11* 4:*18* 5:*23*, *25* 6:*5*, *16* 8:*2*, *4*, *6* 42:*20*, *22* 70:*24* 73:*9*
participate 6:*1*
participating 11:*6*
participation 7:*18*
particular 12:*10* 28:*4* 36:*5* 37:*15* 41:*21*
particularly 68:*3*
partly 41:*20*
partners 25:*7* 55:*13*
partnerships 55:*7*
pass 52:*19*
passed 36:*6*
path 55:*19*
patient 25:*5*
paused 52:*20*
pay 36:*19*
paying 46:*6*
Peck 64:*4*
penalize 49:*21*
penalized 49:*22*
people 16:*10* 23:*21* 31:*19*, *20*, *21*, *23* 32:*1* 35:*4* 36:*19* 42:*1*, *7*, *8* 47:*4*, *15* 48:*1*, *19* 56:*14*, *18*, *23* 60:*14* 62:*17* 63:*4* 65:*14*, *16* 66:*7*, *17*, *21* 67:*3* 68:*7*, *11* 70:*15*
percent 22:*13* 59:*16*, *17*
percentage 59:*11* 60:*3*, *5*
perfect 58:*5*
performance 58:*12*
Period 25:*22* 26:*14* 34:*15* 37:*22*
permanent 46:*4* 67:*18*
permitted 41:*6*
person 7:*12* 14:*22* 16:*19* 28:*20* 33:*6*, *10*, *21* 34:*7*, *22*, *23*, *24* 44:*7* 45:*3* 64:*25* 66:*6* 68:*12*
personal 62:*6*, *9*, *25* 63:*8*
personally 11:*3* 34:*14*
perspective 23:*12*
pharmacy 32:*16*
phone 33:*13*, *20*, *21*
physical 19:*20* 26:*3* 49:*24* 50:*5* 53:*14*
physically 51:*5*
Physiotherapy 22:*1* 49:*25*
picture 33:*9*
pill 19:*20*
pizza 19:*3*
place 19:*19* 28:*24* 42:*1* 51:*23* 70:*5*
placement 68:*1*
plan 49:*2* 58:*10* 62:*15*, *16*
Planning 48:*25* 49:*1* 62:*18*
plans 20:*2*
play 52:*19* 69:*12*, *15*
pleased 23:*19*
Plus 13:*5*
point 23:*5* 27:*6* 28:*13*, *15* 34:*2* 52:*3* 53:*7*, *10* 54:*12*, *19* 57:*4*
points 53:*5* 56:*5* 62:*4*, *5*
Policy 2:*16*, *18* 5:*19*
politically 56:*21*
poor 46:*22* 49:*7*, *17*
poorly 21:*3*
population

69:*13*
portion 9:*9*
position 53:*18*
positions 46:*5*
positive 47:*9* 48:*13*, *20* 59:*2* 68:*7*
posted 7:*7*, *19* 39:*1* 49:*18*
Powers 51:*18*
PPE 21:*8* 37:*10*, *13* 47:*1*, *14*
practicality 56:*9*
practices 49:*13* 70:*12*
practicing 47:*19*
precaution 20:*12*
precautions 17:*15* 43:*24* 45:*7*
preCOVID 29:*13*
prefer 7:*3*
preparations 48:*22*
prepare 47:*19*
prepared 20:*5* 21:*19* 58:*19* 59:*2* 60:*19*
preparedness 20:*1*
Preparing 48:*25*
presence 23:*1* 71:*21*
PRESENT 2:*20* 7:*6*
present-day 58:*15*
President 52:*11*
press 52:*11*
pressure 68:*1*
pretty 16:*4*
prevent 10:*5* 11:*4*
preventative 38:*15*
previously 68:*15*
priest 32:*15*
priests 32:*9*, *11*, *17*
primarily 6:*3*, *4*
principal 65:*19*
priority 46:*10*
prisoners 22:*10*
prisons 48:*21* 51:*2*
privilege 27:*8*
privy 38:*5*
pro-active 31:*18* 36:*12* 37:*15* 69:*5*
problem 22:*22* 23:*3* 52:*15* 64:*1*
problematic 23:*1*
problems 6:*19* 30:*15* 65:*23*
proceed 8:*1* 40:*12*
proceedings 5:*4*
process 8:*5* 14:*9*
profession 25:*1* 28:*10*
professional 57:*5*
professionalization 62:*10*
professionals 55:*18* 56:*22*
profit 50:*19*
Profits 50:*18*
Program 55:*5*, *6*
Programming 49:*24* 51:*7*
programs 22:*3* 55:*8*
promote 63:*9* 68:*10*
promoted 40:*8* 68:*6*
prompt 37:*15*
proper 25:*25* 48:*19* 68:*1*
properly 25:*25* 34:*17* 40:*24*
Prosecute 55:*25*
Protecting 54:*17*
protocol 47:*17*
protocols 19:*17* 20:*12*, *13* 26:*1* 34:*16* 40:*4* 47:*1*, *15* 49:*7*, *8* 55:*21*
proud 68:*8*
provide 9:*23* 21:*20* 25:*20* 26:*2* 31:*3* 39:*15*, *21* 48:*2* 51:*1* 61:*13* 63:*18* 64:*16* 67:*2* 68:*22*, *23*
provided 5:*25* 19:*15* 21:*10* 36:*19*, *25* 37:*5* 38:*13*, *16* 41:*18* 54:*9* 64:*6*
providing 24:*24* 37:*17*
province 36:*14* 67:*17*
provinces 70:*13*
provincial 9:*14* 25:*16* 54:*7* 55:*7* 70:*1*
proving 50:*13*
PSSPs 62:*14*
PSW 60:*8* 62:*24* 63:*13* 68:*12*
PSWs 47:*21* 53:*17* 55:*16*, *17* 56:*23* 62:*14*, *15*, *18* 63:*10*, *17*, *19* 66:*11* 67:*14*
psyche 61:*3*
PTSD 28:*12*
public 11:*13* 19:*7*, *10* 70:*7* 71:*18*, *24*
public's 43:*2*
purpose 10:*2* 33:*2*
pushed 20:*20*
put 15:*13*, *14* 18:*1* 57:*12* 60:*24* 61:*2* 67:*7*
putting 47:*5*

< Q >
qualities 69:*7*
quality 27:*15* 48:*16* 50:*2* 58:*11*, *12*, *15*, *17* 59:*9*, *21*, *23* 60:*2*
Quebec 62:*11*
question 8:*1*, *5* 9:*2* 12:*5* 18:*8* 23:*6* 24:*6* 29:*10* 30:*2* 35:*15* 42:*20* 43:*7*, *11* 51:*16* 59:*13* 60:*1*, *2*, *21*
questions 4:*25* 8:*10*, *12* 18:*10* 19:*25* 40:*10* 59:*22* 60:*20* 62:*3* 70:*23*
quickly 4:*8* 63:*20*
quietly 25:*2* 52:*20*
quite 34:*14* 35:*22*, *25* 37:*19*

< R >
rallies 19:*2*
rarely 47:*15* 49:*16*
ratio 23:*4*
rationale 54:*6*
ratios 46:*15* 50:*24*, *25* 51:*8*
reach 56:*11*
reached 19:*10* 23:*11* 38:*4*
reach-out 38:*7*
read 15:*2* 33:*3* 58:*20* 65:*11*, *18* 66:*1*
reading 34:*23*
ready 3:*3* 52:*19*
real 38:*19* 71:*12*
reality 52:*24* 64:*18*
realize 60:*13*
realized 27:*2* 37:*25*
really 18:*22* 19:*11* 23:*19* 24:*16* 34:*17*, *18* 41:*25* 42:*14* 47:*22* 52:*16* 57:*3*
reason 24:*21* 44:*2*
reasons 37:*19* 63:*19*
reassured 20:*2*
recall 26:*21*
receive 4:*11*
received 36:*12*
receiving 30:*19*
recognition 55:*16*
recognize 15:*17* 16:*6* 17:*1* 55:*18*
recognized 49:*23* 51:*19*, *20*
recognizes 25:*4*
recommend 11:*4* 45:*6*
Recommendation 54:*4* 70:*8*
recommendations 8:*18* 10:*4*, *10*, *13*, *19*, *20* 24:*18* 43:*16* 53:*24* 54:*18* 56:*19* 57:*20* 71:*17*
recorded 7:*2*, *10* 73:*9*
recounting 71:*8*
Recreational 22:*3* 49:*25*
Red 23:*22*
reduce 61:*14*
refer 7:*12*, *13*
referring 66:*3*
Reflecting 43:*12*
reflects 71:*16*
Re-funding 50:*23*
refused 25:*17*
regards 20:*25* 38:*14*
regimented 17:*14*
regular 13:*9* 21:*24* 33:*1* 38:*13* 44:*18* 70:*3*
regularly 36:*14* 49:*13*
regulations 17:*23*
relatable 35:*22*
relate 68:*4*
related 8:*18* 56:*1*
relationship 69:*19*
released 56:*7*
relief 19:*22*
remained 19:*6*
remarks 7:*24* 8:*7* 71:*5*
remind 24:*16* 25:*8*
remotely 1:*16*
removed 30:*18* 31:*8*

reorganization 50:*23*
repeat 4:*7* 8:*5* 15:*4*, *8*
repeated 11:*12* 55:*23*
repercussions 49:*17* 70:*5*
replaced 60:*7*
report 10:*10*, *18* 26:*18* 62:*13* 66:*22* 71:*16*, *22*
reporter 7:*6* 73:*4*, *18*
REPORTER'S 73:*1*
represent 18:*13*
reprimanded 47:*15*
reprisals 59:*3*, *14*
require 23:*20*
required 21:*7* 30:*20* 46:*13* 69:*7*
requirements 37:*12* 47:*21*
requires 49:*1* 67:*24* 68:*21*
reset 51:*1*
residence 30:*7*, *18* 31:*11* 35:*7* 55:*9* 58:*11* 59:*12*, *15* 60:*23* 61:*5*, *17* 62:*22* 63:*10* 64:*15* 66:*4*
residences 32:*9*, *12*, *18* 60:*18*
residence's 33:*7*
resident 37:*21* 50:*21* 55:*2* 58:*24* 59:*1* 66:*17* 67:*1*
RESIDENTS 2:*8* 5:*8* 9:*21* 10:*23* 11:*18* 18:*24* 20:*15*, *17*, *24* 21:*9* 22:*2*, *4*, *7*, *10*, *15*, *16*, *17* 25:*9* 29:*19* 30:*9* 31:*22* 32:*25* 41:*14*, *16*, *19* 44:*1*, *3* 46:*14*, *23* 47:*1*, *6*, *11* 48:*14* 49:*4* 50:*1*, *3*, *18* 59:*15*, *19* 61:*17*, *22* 64:*12*, *15*, *20* 66:*10*, *14*, *20* 67:*1*, *25* 69:*2*
resistant 20:*12*
resources 37:*13* 46:*8* 48:*23*
respect 32:*7* 42:*20* 65:*15*
respectfully 57:*5*
respiratory 65:*23*
respond 8:*3* 18:*8* 30:*2*
responded 59:*15*, *17*
response 8:*12* 21:*9* 23:*14* 35:*14*
responses 8:*1* 42:*10*
responsibilities 64:*8*
responsibility 69:*20*
responsible 34:*8* 68:*17*
rest 58:*13*
restricted 44:*6*
restrictive 13:*10*
result 37:*14* 48:*8*
resulted 46:*22*
resulting 48:*5*
results 21:*8* 48:*10*, *12* 49:*18*
retaliation 28:*25* 56:*3*
retire 52:*18*
reveal 7:*21*
reversed 50:*14*
review 63:*6*
revolt 53:*3*
ribbon 19:*3*
rigorous 55:*21*
risk 47:*6*, *11* 65:*9*
RNs 61:*13*
Rokosh 2:*12* 3:*2*, *23* 4:*1*, *24* 5:*10* 7:*5* 12:*2* 18:*5* 24:*3* 29:*24* 35:*9* 42:*16*
role 10:*18* 25:*18* 32:*8* 54:*20* 55:*17* 68:*13* 69:*12*, *15* 70:*1*
room 16:*1* 20:*25* 33:*12*
rooms 16:*13* 22:*11* 50:*4*
rough 22:*16*
rub 44:*14*
rules 17:*14*, *23* 48:*6*

< S >
safe 17:*25*
salaries 55:*15* 67:*17*
sale 12:*22*
Samantha 64:*4*
Samir 56:*23*
sanction 55:*23*
saturated 61:*24*
Saturday 60:*4*
Saturdays 13:*22* 63:*25*
save 22:*6*
saving 53:*11*
scandal 66:*18*
scores 61:*11*
scrambling 49:*3*
screen 3:*8* 4:*14* 6:*1* 7:*15* 33:*10* 34:*24*
screening 36:*15*
Secondly 65:*21*
Secretariat 2:*13*, *15* 5:*11*
secretary 52:*11*
section 13:*3*, *4* 61:*21*
segment 70:*21*
select 3:*7*, *9*, *12* 4:*15*
selected 58:*14*, *16*
self 47:*11*
Senior 2:*16*, *18* 5:*19*
seniors 17:*19* 47:*24* 48:*24* 54:*17*
sense 13:*8* 18:*18* 25:*7* 44:*4*, *7* 53:*18*, *19*
separate 49:*11* 54:*14*
September 40:*6* 62:*12* 65:*1*
series 65:*4*
serious 70:*6*
services 4:*12* 36:*13* 37:*11* 49:*23* 64:*16*
session 5:*18* 6:*17* 7:*2*, *5*, *13*, *23* 8:*8* 62:*13*
set 3:*5* 9:*19* 10:*1* 23:*15* 54:*14* 69:*2*, *24* 73:*6*
settings 55:*4*
shape 71:*22*
share 7:*19* 8:*17* 35:*11*, *14* 39:*25* 70:*25* 71:*1*
shared 42:*23*
shareholder 50:*19*
shares 50:*19*
sharing 6:*15* 11:*13* 18:*6* 29:*25* 42:*18* 45:*20* 57:*19*
she'd 15:*16* 17:*7*
shield 15:*15* 17:*21* 44:*25*
shields 20:*13*
shift 48:*10*
shocked 25:*11*
short 20:*10* 23:*4* 54:*12* 58:*22*
shortage 60:*10* 61:*16* 62:*8*
shortages 48:*5*
shortcomings 22:*6*
Shorthand 73:*4*, *12*, *18*
shoulders 28:*14*
show 47:*16*
showing 36:*17*, *21*
shut 19:*7*
shy 66:*12*
sick 34:*19* 36:*19* 47:*4* 48:*4* 57:*13*
side 15:*25* 65:*13*
sides 19:*2*
sign 15:*1*
signed 13:*13*
significant 22:*5* 28:*16* 49:*17* 56:*12*
significantly 41:*3*
signing 15:*1*
signs 34:*13*
silence 11:*17*, *22*
similar 46:*16*
Simple 25:*20*
simply 6:*20* 67:*2*
simultaneous 4:*11*, *14*, *20* 5:*24*
simultaneously 3:*17*
single 25:*10*
Sinha 56:*24*
sit 15:*25* 50:*4*
site 36:*24*
sits 17:*5* 45:*14*
sitting 12:*15* 33:*8* 43:*22* 44:*3* 45:*13*
situation 34:*15* 38:*16* 43:*14* 46:*18* 58:*1* 67:*12*, *22*
skill 68:*5*
Skype 31:*24*
sleep 28:*12* 45:*11*
slightly 3:*4*
slow 20:*17*, *20* 21:*2*
slower 21:*8*
Small 9:*9*
smaller 55:*4*
smart 28:*21*
social 41:*23*
socially 44:*22*
solid 56:*18*
solutions 56:*8*,

20
somewhat 42:*12*
son 16:*23*
soon 27:*1*
sores 68:*1*
sorry 37:*5* 58:*25* 62:*22*
sort 14:*12* 29:*12* 38:*7*
sound 23:*8* 26:*5*
sounds 23:*8*
soups 48:*18*
source 19:*1* 38:*19* 47:*2*
south 29:*22*
speak 6:*3*, *4* 8:*10* 24:*12*, *13* 25:*9* 28:*5* 52:*13* 71:*13*
speaking 3:*21* 7:*9* 8:*25*
specialists 32:*16*
specialized 67:*24* 68:*5*
specific 69:*18*
specifically 9:*25* 33:*2*
spend 27:*17*
spending 50:*25*
spent 33:*17*
sphere 35:*20*
spiritual 26:*3* 53:*14*
spoke 29:*18* 65:*6*
spoken 35:*19*
sponge 21:*10*
spouses 31:*21*, *25* 32:*2*
spread 9:*19* 10:*25* 49:*10*
staff 9:*22* 10:*24* 11:*18* 14:*18* 19:*4*, *17* 20:*7*, *8*, *9*, *11*, *15* 21:*24* 22:*14*, *20*, *25* 31:*2*, *3* 33:*1*, *7* 36:*25* 37:*4*, *6*, *21* 38:*15* 39:*14* 40:*4* 41:*13*, *22* 46:*3*, *4*, *8*, *24* 47:*3*, *14*, *23* 48:*9*, *10*, *14* 49:*5*, *8* 50:*24* 51:*8* 60:*4* 67:*13*, *14*, *15*, *16*, *19* 68:*12*, *23*, *25*
staffed 20:*10*
Staffing 21:*5*, *6* 22:*13* 23:*5* 38:*16* 46:*3*, *12*, *15* 48:*5* 50:*22*
Stall 56:*24*
stand 14:*2*
stand-alone 54:*15*
standard 23:*25* 49:*14* 50:*6* 69:*18* 70:*3*
Standardized 48:*6*
standards 23:*15* 46:*9*, *22* 50:*25* 51:*6* 69:*2*, *4*, *21*, *22*, *23*
stares 17:*5*
start 3:*3* 5:*4* 12:*4*, *13* 15:*8* 25:*15* 57:*24* 58:*6* 61:*7* 64:*8*
started 24:*16* 33:*12* 38:*1* 40:*19* 47:*13* 61:*1*
startling 26:*9*
state 59:*3*
stated 10:*22*
statements 42:*23*
status 34:*6*
stay 7:*3* 36:*19* 57:*3*, *4* 63:*3*
staying 27:*14* 57:*24*
Stenographer/Transcriptionist 2:*22*
stenographically 73:*9*
stop 67:*3*
stopped 22:*1* 28:*10*
stories 7:*21* 11:*13* 17:*8* 56:*10*
story 35:*23*, *24* 42:*13*
stranger 34:*22*
strategic 49:*1* 69:*6*
street 37:*7*, *9*
Strengthen 55:*20*
strict 34:*17*
strong 14:*1*
stuck 31:*9*
study 46:*11* 66:*1*
sub 54:*12*
subjected 31:*14*
subjects 52:*14*
submit 71:*15*, *23*
submitted 10:*11*, *13*
success 56:*10*
sudden 31:*1*
sued 50:*8*, *9*
suffer 28:*11*
suffering 22:*16* 29:*8*
suggest 56:*8*
suggestions 67:*6*
suit 26:*22*
suits 15:*15*
summer 19:*24* 63:*15*
Sunday 60:*5*
suppers 27:*14*
supplements 45:*11*
support 19:*2*, *4* 21:*20*, *25* 24:*23* 26:*3* 27:*4* 36:*13* 37:*11*, *16* 39:*14* 41:*18*, *21* 46:*14* 53:*7*, *16*, *19* 62:*7*, *25* 63:*8* 66:*21* 67:*15* 68:*23*
supported 56:*25*
supports 5:*11* 51:*3*, *7*
supposed 31:*7* 52:*18*
surgery 31:*4*, *9*, *16*
survey 58:*24* 59:*1*, *4*
surveys 59:*19* 60:*18*, *19* 61:*4* 62:*2*
survived 53:*9*
suspended 22:*3* 50:*20*
swallow 19:*20*
swiftly 49:*22*
symptoms 36:*17*, *22*
system 46:*17* 49:*20* 58:*3*, *5* 59:*9* 62:*5* 66:*14*

< T >
table 43:*22* 44:*3* 45:*13* 55:*12*
tainted 19:*22*
takes 66:*13*
talk 30:*5* 33:*22* 34:*3* 39:*24* 52:*16* 60:*14* 62:*19*
talking 15:*9* 17:*6*
talks 59:*5*
task 11:*9*
tasks 14:*11*, *13*
taught 27:*10* 28:*20*
taxing 12:*19*
taxpayers 53:*12*
Team 2:*14* 5:*13*, *15* 37:*18* 38:*12* 39:*23* 40:*23* 68:*18* 69:*3*
teams 39:*8*
tears 19:*1*
technical 3:*5* 6:*21*
teeth 28:*13*, *15* 48:*3*
terms 48:*22* 63:*24* 68:*6* 70:*9*
terrible 17:*3*
terrified 24:*1*
territorial 55:*7*
test 17:*16*, *17* 44:*20*
tested 17:*25* 20:*9*
testing 44:*18* 48:*6*, *7*
thanked 23:*14*
thankful 26:*13*
theirs 18:*14*
thing 28:*19* 43:*15* 58:*8* 62:*9* 64:*24* 68:*7*
things 8:*19*, *22* 15:*4*, *8* 16:*12* 17:*11* 28:*22* 32:*6* 39:*12* 41:*12* 43:*5* 49:*2* 58:*3* 60:*15* 65:*5*, *13*, *14* 70:*16*
thinking 23:*23* 64:*14* 65:*22*
third 65:*23*
third-party 23:*20*
thirteen 23:*21*
thought 26:*24* 27:*23* 29:*21* 47:*1*
thoughtful 42:*23*
thousands 28:*8*
threat 50:*15*
three-hour 14:*12*
thrown 21:*17*
Thursday 14:*3*
Thursdays 13:*21*
tieing 19:*3*
Tiffany 2:*21* 6:*14*
time 6:*21* 8:*25* 11:*8* 12:*20* 13:*12*, *17* 14:*1*, *4*, *5*, *10*, *23* 19:*9* 21:*7* 24:*10* 27:*15* 28:*20*, *21* 31:*23* 34:*2*, *16* 35:*6* 38:*17* 39:*3* 41:*7* 44:*15* 45:*12*, *25* 46:*1* 58:*22* 61:*15* 65:*12* 67:*2* 70:*25* 73:*6*
times 13:*24* 21:*9* 54:*3*
tired 62:*7*
today 3:*16* 5:*18* 6:*16* 7:*18* 8:*7* 9:*12*, *17* 11:*1* 24:*19* 26:*6* 42:*20* 56:*6* 57:*11* 71:*8*, *17*, *21*
today's 6:*10*, *17*

toilet 48:*1*
toileted 22:*12*
toileting 68:*2*
toiletry 21:*1*
told 19:*7* 22:*12* 23:*15* 32:*17* 63:*3*
toll 23:*24*
torture 22:*9*
touch 15:*24* 37:*24*
touching 15:*23* 44:*12*
tough 52:*4*
town 20:*21*
tragedy 10:*3*, *7* 11:*4*, *11* 52:*25* 71:*9*, *19*
tragic 10:*2*
train 47:*24*
trained 22:*14* 47:*24*
training 34:*8* 46:*24* 47:*19*, *20* 55:*15* 67:*24* 70:*2*
transcribed 73:*10*
transcript 7:*9*, *10* 73:*12*
transcripts 7:*7*
translated 9:*9*
translation 4:*22*
transparent 69:*1*
travel 60:*11*
traveled 36:*16*
travelled 36:*20*
travelling 44:*21*
treat 65:*14*
treated 22:*23*
treatment 28:*16*
tree 23:*6*
tremendously 27:*23* 29:*6*
trend 32:*3*
troublesome 26:*16*
true 19:*12* 54:*6*, *8* 56:*11* 73:*11*
truly 11:*7* 39:*18* 55:*17*
trusted 25:*5* 55:*1*, *2*
trying 14:*14* 27:*21* 29:*2*
turn 11:*25* 52:*17*
turning 7:*1* 36:*16*
type 41:*18* 68:*8*
typical 55:*1*

< U >
ultimately 69:*20*
umbrella 54:*5*
un 26:*13*
unable 33:*12*
unacceptable 46:*15*, *23*
unbearable 29:*9*
uncomfortable 26:*25*
unconditionally 53:*15*
understaffed 21:*21*
understand 11:*2*, *5*, *14* 15:*6* 16:*8*, *10* 17:*18* 18:*24* 25:*15*, *19* 33:*16* 47:*4*, *25* 49:*9* 64:*17* 66:*2*, *14* 71:*19*
understanding 43:*1*, *2* 47:*10*
understood 35:*1*
underutilized 21:*22*
unfold 10:*9*, *16*
unit 21:*20* 55:*2*
units 20:*10*
unliveable 34:*5*
unpaid 26:*12* 53:*11* 55:*13*
unprecedented 54:*2*
unprepared 46:*25*
unrecognized 26:*12*
untrained 20:*11*
updates 18:*21* 20:*18* 38:*13*
upset 19:*1*
urgency 46:*7*

< V >
valuable 38:*17*
value 51:*21*
valued 62:*18*
vastly 19:*21*
vegetable 17:*5*
verbal 56:*2*
versa 27:*16*
vested 53:*15*
vice 27:*16*
victim 28:*18*
video 7:*2*
Videoconferencing 1:*15*
view 31:*24* 52:*25* 57:*6*
viewed 26:*16*
violate 55:*25*
virtual 22:*10* 41:*5*
visit 13:*15*, *20* 14:*13* 16:*3*, *13*, *20* 34:*16* 35:*5*
visitor 25:*23* 26:*5* 27:*21*
visitors 41:*9*
visits 13:*9*, *19* 14:*6* 18:*23* 40:*17* 41:*5*, *6*
vocal 48:*17*
voice 5:*16* 12:*17* 15:*6*
void 39:*19*

< W >
wait 30:*24*
wake 28:*13*
wakes 29:*20*
walk 32:*22*
walking 65:*16*
wanted 16:*18* 33:*19* 34:*18*
wants 45:*10* 52:*16*
watch 49:*3*
watched 17:*4*
wave 10:*15* 18:*20* 20:*1* 32:*15* 50:*12*
weak 62:*4*, *5*
wear 17:*18*, *21* 60:*23*, *25* 61:*6*, *8*, *9*, *18*
wearing 19:*16* 44:*25* 61:*1*, *7*
website 7:*8*, *20* 39:*1*
week 13:*17* 15:*18* 27:*18* 30:*17* 38:*3*
weekly 38:*10*
weeks 33:*17*, *18* 61:*1* 63:*11*
weight 24:*18* 40:*19*, *23* 65:*21*
welcoming 26:*15*
well-being 49:*24*
wellness 50:*1*
Welsh 56:*6*
wheelchair 32:*23*
wheelchairs 68:*2*
wholesome 48:*23*
wife 24:*12* 27:*13*, *22* 28:*2*, *10*, *15*, *25* 29:*4*
willing 68:*25*
window 18:*23* 21:*17* 41:*5*
wish 4:*11*, *14*, *18* 7:*12* 61:*8*
witnessing 27:*25* 29:*22*
woman 66:*8*
wonder 28:*17*
Wonderful 5:*2* 24:*8*
won't 58:*22* 61:*22*
word 24:*20* 62:*11*
words 15:*3* 25:*12*
work 11:*10* 20:*8* 24:*17* 26:*14*, *22* 27:*12*, *21* 36:*22* 37:*4*, *7*, *8* 47:*9* 48:*11* 53:*11* 63:*16*, *22*
worked 17:*7* 21:*24* 70:*14*
worker 41:*23* 62:*25*
workers 60:*9* 61:*10*, *16*, *19* 62:*7*, *9* 63:*9*
working 8:*3* 48:*12* 55:*12* 63:*13* 67:*23* 69:*8*
work-life 63:*9*, *18* 64:*1*
world 61:*12*
worse 13:*5* 14:*23*
wrap 8:*8*
written 56:*6* 66:*22*
wrote 32:*13*

< Y >
yeah 25:*11*
year 10:*12* 26:*10*, *11* 31:*6* 58:*10* 62:*20*, *23* 63:*13*
years 24:*17* 28:*3*, *8* 30:*13* 31:*20* 36:*4*, *7*, *9*
young 63:*13*, *14*

< Z >
zero 13:*5*, *6*
Zoom 1:*15* 4:*14* 6:*1*, *18* 31:*24* 38:*23*