Long-Term Care COVID-19 Commission Meeting

Dr. Vivian Stamatopoulos
on Wednesday, March 10, 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 10th day of March, 2021, 3:00 p.m. to 4:00 p.m.

BEFORE:
The Honourable Frank N. Marrocco, Commission Chair
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PRESENTER:
Dr. Vivian Stamatopoulos, Associate Teaching Professor

PARTICIPANTS:
Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Rose Bianchini, Senior Policy Analyst, Long-Term Care Commission Secretariat
Angela Walwyn, Senior Policy Analyst, Long-Term Care Commission Secretariat
John Callaghan, Co-Lead Commission Counsel Gowling WLG

--- Upon commencing at 3:00 p.m.

JOHN CALLAGHAN: This afternoon we have Vivian Stamatopoulos, who is going to do a presentation. And she is, as you know, a Doctor of Sociology who has spent a considerable part of the last year particularly focused on long-term care, both as a matter of study and as a matter of being an advocate. So we look forward to hearing her presentation.

DR. VIVIAN STAMATOPOULOS: Thank you. Do you have the slides with you or should I --

JOHN CALLAGHAN: I think you should -- if you could put them up, if you could share your screen.

COMMISSION CHAIR FRANK MARROCCO: If you can share your screen, if not, we can find some way to do that. If it's going to interfere with your -- we'll get somebody else to share the screen.

DR. VIVIAN STAMATOPOULOS: I'm not that savvy. I did send them. Knowing me, I'll probably ruin it somehow. I'll find a way.

COMMISSION CHAIR FRANK MARROCCO: Okay. Well, just a sec, we'll get this sorted out.

DAWN PALIN ROKOSH: We're just trying

to pull them up and then we will share them momentarily.

COMMISSION CHAIR FRANK MARROCCO: Let's just wait a second till we've got them and then go ahead.

DR. VIVIAN STAMATOPOULOS: So I take it I am the last person to testify probably?

COMMISSION CHAIR FRANK MARROCCO: Not necessarily, no, but getting close to the end.

DR. VIVIAN STAMATOPOULOS: You have to write your report.

COMMISSION CHAIR FRANK MARROCCO: By April 30th. Well, we will do it.

DR. VIVIAN STAMATOPOULOS: And I'm sure you'll do a great job. The extra time, I'm sure, would have been nice.

COMMISSION CHAIR FRANK MARROCCO: Doctor, we have it.

DR. VIVIAN STAMATOPOULOS: Perfect.

So I guess we can jump to number 2. I think part of the -- I really want to make sure I discuss essential family caregivers, because this has been something that has not been discussed in enough depth in my opinion. And what these families went through has truly been

terrible.

Who are essential family caregivers? It's important to note that the terminology, "essential family caregivers", was really coined as a result of families being rightly angry that they were deemed non-essential during this specific pandemic.

So generally, family have not been referred to as essential family caregivers, but this terminology was decided because of, for some reason, the curious lumping of family into the non-essential category, per Dr. David Williams, and the now infamous Directive 3.

So these are all these individuals, family members, close friends, who the resident deems to be their main support person. So usually it's a Power of Attorney, a substitute decision maker. Often it's a woman. Gender is huge in this.

And we know that pre-pandemic these family caregivers were, what I call, the crutch that holds this system together. And why, when you so abruptly pulled that crutch apart, as our government did with their Directive 3, we saw this system crumble; because they filled in

crucial care gaps that have for long been missing, and have been unfulfilled by an underfunded long-term care system, that you well now know of.

But unfortunately what we saw is that these families were really treated like the enemy during this entire pandemic, and that's exactly how they feel they were treated by this government.

What do these family members generally do? They provide that crucial social, emotional, cognitive support, physical assistance. I have families tell me they provide rehabilitation therapies, they help them with mobility, take them for walks, because there just simply isn't time for staff to do this the way that our, you know, absent care standard system is right now.

They do anything from helping to feed, toilet residents, helping them to fall asleep, especially at sundown for those with dementia. I hear a lot of families telling me this.

Also what is really important is that many of them, because their loved ones have dementia, have some sort of cognitive decline,

which is the vast majority of long-term care residents, they are the people to provide informed consent. So they require these family members to read through documents, make decisions about their care. I mean, this isn't simply a nicety. This is ethically and legally mandated in the Long-Term Care Homes Act. So the fact that they were just completely removed from these persons raised a lot of issues.

One of the main things that these families also do is trigger allegations, or they are the ones to report issues of abuse and neglect in these homes. And we know that over the past ten years -- CBC Marketplace does a lot of great research in this area and they showed that staff to resident abuse has gone up 148 percent in the last ten years. So we know that it is a problem. And it's nine times out of ten, families that are the ones triggering these critical incident complaints and are notifying the authorities of these things that are happening unfortunately. Whether we like to talk about it or not it's happening.

So when we abruptly close the door, so to speak, on them, they've lost a very critical

source of protection and stability, which is something that struck fear in their family members, knowing that they couldn't be there providing that careful set of eyes and making sure that their loved one was indeed receiving proper, dignified care.

One of the earliest things I did was write this article about how or I think it was -- was it that article? About the Bill of Rights and how this was just a flagrant breach of the Ontario Long-Term Care Homes Act, the Residents' Bill of Rights, which is in that -- outlines twenty-seven different rights.

Anything from the right to access visitors of his or her choice without interference, in a room that assures privacy. This was certainly not the case. And I heard many cases of family members not having that privacy, especially when there were virtual visits. How are you going to tell a family member if something is wrong in your care facility or if you're being abused or neglected? How are you going to tell them in front of staff? You're not, right? So this was a huge problem. There was no privacy. That privacy

was completely stripped from these families.

Not being able to have, you know, being -- there are several rights about not being abused, being properly fed and sheltered. Obviously we know that that did not happen in a lot of cases. Wild breaches to these rights in terms of the Residents' Bill of Rights.

In terms of the timeline, this was a nightmare of really six, seven months for these families. So they were locked out from March 13th. That order came down banning non-essential visitors; exception for family members of residents who were dying, right? Which didn't happen most of the time anyway; because I heard countless stories of families only being notified after their loved one had died; or only being notified too soon -- not given enough warning and they couldn't make it there in time and their loved one had passed.

So you strip that opportunity from countless families to have a proper goodbye and to be with their loved ones at the time of their death. The trauma, that alone is something that I lose sleep about.

So it took about three months

before -- after the military reports came out; after a steady stream of cases of neglect and abuse, residents losing significant weight. Just horrifying accounts of what was happening in these homes, that were getting out to the media, that the government decided to permit, I believe it was in June, mid-June, a 30-minute, once-a-week outdoor visits.

So they had to get a test and they had to be masked and physically distanced outdoors. I mean, this did nothing to actually help reduce the deterioration and the harm that the last three months of near total confinement -- because remember, many of these residents were kept in their rooms.

Imagine being in your room for three months straight, many without a television, many without telephones. Try doing that for a few hours let alone three months every day, which is what I heard was happening to countless, countless residents.

But the fact that they were forcing families, they, the government, was forcing families to get tested for an outdoor, masked, distanced visit made absolutely no sense. So we

were fighting that, as were many epidemiologists who said, Hold on. This is ludicrous. You wouldn't need to in that context. So it felt like they were actively trying to prohibit rather than, you know, allow families to have proper visitation, right?

We advocated more, fought more about this, and then another month passed. It was July now. Persistent media coverage on how terrible these outdoor visits were. I mean, once a week for a half an hour outdoors where you're literally put, often, at a table. Think about a big picnic table; your loved one at one side, you at the other; and you have to scream because many of these residents have hearing issues and mobility -- vision issues, so they can't tell who it is under the mask six, seven feet away. So you can get a sense of how useless, quite often, these visits were. And I was hearing these complaints all the time.

Forget privacy when you're screaming six feet away so your loved one can hear you; there is none. And staff were around observing you. We would hear things, if, heaven forbid, you moved a little closer to your loved one

staff would come and quickly admonish you and you'd be vilified like you were the bad guy, like you were trying to harm your loved one. I heard countless stories like this.

So we kept fighting again. We're into July now. There was a prolonged heat wave, as you well remember.

If you skip up to the slide where there is a picture of the air conditioning -- before that one I think. Sorry, I should have -- or maybe you're on this one -- yeah, yeah, this one.

So we knew that there was a heat wave, enough that Premier Ford made this big announcement that they were going to make sure that there was air conditioning. Because we knew that a lot of these homes didn't have air conditioning, but they didn't think about how dangerous it was to have the seniors come outside in the heat wave. So a lot of families were telling us it was just untenable. They didn't want to put their families through that so they just wouldn't, come because it was 40 degrees outside, we're in the middle of a heat wave. You're not going to bring your loved

one outside to, you know, it just didn't make sense. It wasn't helpful for these families.

So we were again arguing, we need to get in. We need to get inside the facility. These visits are not helpful to anybody. To nobody. We need family to be able to resume the care that they provided pre-pandemic. This is the care that will help sustain their family members, these residents.

So finally we get indoor visitation. And, you know, we hear that it's coming. We're all excited, but then we find out, you know, now we're into the end of July, I think July 22nd, where we find out we'll get indoor visits but literally it was the outdoor visit just moved inside. So they would have some communal space in the facility. You couldn't go into your loved one's room. And you, again, had to be masked, distanced and get tested.

Fine, they did all that. But, again, they weren't able to provide that care so their loved ones weren't getting any better. The deterioration was just getting worse, which is why we kept on them. We kept saying, This is not helping these people. You need the families

in the rooms able to resume things, like helping them eat. This is one of the biggest things.

And then finally in September we got the latest iteration that we have now. So you had up to two essential family caregivers, so they used the terminology now, that could go in during an outbreak. And you'd have to go under, you know, certain amounts of testing.

And then it got confusing when they decided to introduce the colour schemes. So then they had, you know, different rules based on the colour scheme. And it was just a nightmare trying to navigate this with families, because, you know, the information was always confusing, ever changing, families didn't know what was happening. And a big part of my advocacy was just trying to decipher all of this ever-changing and confusing documentation for families to make sense of.

And that was literally how I started gaining Twitter followers, because they would hear that there was somebody on Twitter trying to explain to them what all of these changing rules meant. And that was literally a big part of my first six, seven months of advocacy, just

trying to make sense of all of this for the families.

COMMISSION CHAIR FRANK MARROCCO: Can I stop you for a second, Doctor?

DR. VIVIAN STAMATOPOULOS: Yes.

COMMISSION CHAIR FRANK MARROCCO: In terms of the advocacy, how did it take place? How were you -- when you were advocating --

DR. VIVIAN STAMATOPOULOS: Very accidentally. Very accidentally. So I am somebody who, right before the pandemic struck I lost a grandmother in long-term care. And I knew -- like at the end of January. So I knew the problems that existed in long-term care. I lived it first hand. I was one of those squeaky wheels that was raising, you know, the issues with the home and going through the inspection process myself.

It was a nightmare for my family going through this entire process. And I knew how important our role was for our grandmother in that home. And I knew, I knew if we weren't there what would have happened?

She would have -- it would have been the end of her if she didn't have us there

providing the supports that we were providing. Every day we made sure somebody was there, every single day. And it wasn't even one of the for-profit homes with the known problems and the known bad reputation. So mine was one of the generally-considered better homes. It was a nonprofit home, but the problems were still there because it's systemic, it's across the board, there's varying degrees of problematic behaviours in these homes, but generally the problems are there across the board, right?

So when that -- I just started paying attention. I'm trying to grieve in my own world. And then the pandemic struck and we're all confined and I'm seeing what's happening in long-term care. And when they put down -- the first month we were all understanding. Families, advocates, we're like okay, we're figuring this out. We don't know what's happening. We figured after a month they'll let families in and then they didn't, and it kept going on. And we were like, This is immoral. This is terrible. Why?

And I just started talking. Really, I just started Tweeting. I just -- people

starting paying attention. People started reaching out to me. Families reached out to me. So I was meeting with families. I was just talking to them on my own time, trying to understand what was happening. And the more I would learn the angrier I would get. It's just my personality. I do not like seeing wrongdoing. I don't like it. And I'm not one to stay quiet when I see bad things happening. And what was happening was bad. And I was hearing from hundreds of families. So I just tried to use my big mouth to help.

And then before long media started reaching out. I would connect families to them so they could get their stories out there. That was what I did for the most part, behind the scenes, was just getting families' stories out there. And then people started to come to me for expert interviews.

And then I started engaging with others and trying to build advocacy groups, and then holding events and trying to build awareness. It just snowballed.

JOHN CALLAGHAN: Can you tell the Commissioners about your advocacy group?

DR. VIVIAN STAMATOPOULOS: So I have a couple. So there's the Doctors for Long-Term Care Justice. So that was really at the height of the second wave. We were -- there's a few of us talking behind the scenes, doing press, talking about just how terrible this was and how this government was not listening to experts, particularly your two interim reports, which were fantastic. And we didn't understand why this government wasn't listening to those suggestions and implementing them because we knew if they did it would have massively decreased the mortality we saw.

So we galvanized together and put out a letter, an action letter, and it requested a meeting with the Minister. Never got one. So that's generally the pattern within us advocates that are critical of the government. We've never, despite asking many times to meet, have never secured a meeting. They don't seem to want to know our input. Certainly not mine or the families that I've been helping.

And then there's the Canadians for Long-Term Care Standards. That's another group that I'm working with because, frankly, we just

got a little fed up looking at how slow this government was to act on the very obvious things that we knew they needed to act upon.

So we tried to take this to the federal level and tried to get national standards, because that is still something that we think is needed regardless, while we hopefully see larger changes, mainly the divestment for for-profit, but that's another thing.

COMMISSION CHAIR FRANK MARROCCO: Well, how do you see the federal engagement? I appreciate you said setting standards, but how do you see that?

DR. VIVIAN STAMATOPOULOS: Well, I don't see any real desire by this government to implement the kinds of changes we need. So things like the care standard. And this is something that experts have been calling for for years now. Years. Decades. And they know this.

So, you know, when the Ford government came out with the press conference about how this is so amazing, in five years you'll get the care standard of four hours, you got to look at terminology within that documentation; it says

"up to".

And if you look at years of lobbying for the for-profit lobby, many people tend to interchangeably use that with the Ontario Long-Term Care Association, although they represent both they have a lot of executives from the for-profit sector on Their board. So people tend to say that, right, about the OLTCA, that they're representing more of the for-profit needs, let's say.

And when you look at their advocacy over the last few years, they have been actively working against implementing a care standard. And, you know, they've said, "it's a cookie cutter approach", "it's just a way to make unions happy". There's been a variety of different things that they've said over the years. But one of them was about how -- said something here. In its annual report in 2016 the OLTCA opposed the Time to Care Act, which is something that we've been pushing for which would implement that care standard now, saying that not every resident has the same care needs, even though the legislation says four hours of care would be average. So them putting the

words "up to" makes us think that they're not going to actually provide a standard for our benchmark. And frankly that benchmark is outdated because that benchmark was created over ten years ago.

So when you talk to the people who actually created those standards, one of them being Charlene Harrington out of the U.S., and she does a lot of work with Pat Armstrong's people, she says it should be somewhere between five to seven now. Do I think the Ford government will implement that? No. That's why I want to see national standards that require a minimum standard that ideally provinces would buy into and there would be some financial carrot for those that buy into it.

So you get the money if you play ball. Not just take, take, take and give nothing in return. And this is a pattern I'm seeing, at least with this pandemic, in response to receiving federal funds from our government.

COMMISSION CHAIR FRANK MARROCCO: Okay.

DR. VIVIAN STAMATOPOULOS: So I also have two little documents that are on the screen about how we had evidence over the months that

showed that you can indeed bring in essential caregivers and it's not going to lead to increased virus transmission, which is generally what the knee-jerk fear reaction was, right? So we were using this throughout the months to lobby for more -- for better visitation obviously.

So we had the France Confinement Disease that came out in April, so really early on. And we were warning the government, you know, connecting with the press, telling them that we're getting evidence out of France that this is only a few days being confined that residents were dying from hypovolemic (sic) shock and not the result of, you know, any -- some sort of respiratory illness. They were dying from neglect. They weren't being fed properly. All the same stories we heard happening here, which is why we needed families in there. One of the biggest things that families do is feed the residents. It's one of the most important jobs they do. They usually come around meal times and this is something that keeps these residents, quite frankly, alive.

So when you removed family from that

opportunity, we saw needless dehydration deaths, needless malnutrition deaths that should never have happened. Would never have happened if family were in.

Then we had the Dutch government that engaged in --they're so smart -- engaged in a national experiment where they effectively opened up all the care homes for one week. They let essential family caregivers in, had them wear masks, did temperature screening at the door, kind of thing, and watched what happened for a week. And then after the week they closed it off for three weeks to see if there were any increases in cases. None.

So we had this evidence. And obviously they found really great positive effects of having the family in there. Obviously the residents' emotional well-being skyrocketed, so they opened up the homes based on clear evidence. We were trying to tell this government this stuff. This exists. You need to do something. Nothing's happening.

So then I teamed up with -- if we go to the next slide, some NDP -- is it the next one -- oh, sorry, this one.

So this is also things that were happening during this whole process. So we had obviously the Justice Centre launch a claim against the government that this is unconstitutional. We have the Ontario Human Rights Commission that was saying that this is also violating human rights, which they were, they were completely right.

And then the next slide. I just lost you guys. I think my slides are out of order.

Anyway, I then teamed up with Lisa Gretzky for Bill 203. And what we did was we worked with family advocates, family members that are going through this, and tried to get legislated rights for family access. Not just in long-term care but all congregate care, because we're also seeing these kinds of really punitive and draconian visitation with group homes as well, for children with disabilities and persons with disabilities. So we were working with families in that area as well.

So we went through this process, tabled the bills, went through first and second reading, both passed, and then the government is just sitting on it. You know, tomorrow, Premier

Ford could make this law.

Same with Bill 13, the Time To Care Act, which would implement the care standard now. Both of these very vital bills are just sitting, and probably will sit forever, realistically; which is sad because we went through these efforts because of the thousands of family members who were reaching out desperate for help, sharing stories that would keep you up at night about what was happening to their loved ones in these homes and what was happening to them.

And this is what they don't talk about. And this is why I really want to make sure you understand the impact that it's had on these family caregivers.

And I was hearing this throughout the months and I knew, at some point, I wanted to do research. So I had a fellow researcher at the University of Toronto reach out to me and wanted to collaborate. So we ran focus groups, seven focus groups so far with essential family caregivers, the loved ones in long-term care, across Canada, the majority being in Ontario, Dr. Charlene Chu and myself, and we just

finished that data collection.

And it was everything we thought that we would find. And certainly it just reiterated what I found in my months of talking to these essential family caregivers, that the trauma they incurred, it's like nothing I've ever seen in my now decade of research on family care giving. Trauma from what I deem a very discriminatory and unduly punitive approach to not only are seniors in long-term care, but also persons with disabilities, which was, in my opinion, based on a paternalistic and incomplete medical model that just simply prioritized the risk of viral transmission above everything else, right? Ignoring the deadly risks of confinement, which are, not to mention, morally and ethically repugnant.

But this trauma was multi-faceted. And families don't like to talk about the pain that they're going through because they're so focused on the person they're caring for, which is why I want to make sure I elaborate on that. The trauma was multi-facetted. They had the trauma of seeing their loved ones deteriorate while knowing they could help.

So loved ones seeing their residents in care, these family members losing sometimes upwards of 20 to 30 pounds, becoming skeletal, were quotes I heard often from family members; the malnutrition deaths that arised as a result, we had some notable cases. Residents telling the loved ones they wanted to die. Imagine the impact on you. You know how terribly your loved one is suffering, they're telling you they want to die. That's one of the hardest things a family member can hear. And I can't tell you how many residents were saying this to their loved ones, and how traumatic that is for your loved one to hear knowing you could help if you were allowed in, but not -- but being forcibly kept apart.

Many of their loved ones forgot who their loves ones were because the lack of cognitive stimulation from being confined in their rooms doing nothing, alone most of the day, which led to irreversible memory loss.

The trauma of being defined non-essential and how offensive and just terrible that was to these family members by being locked out like this. They were othered.

They were effectively othered by our province and treated as though they were merely vectors of viral transmission. They were not appreciated for the worth that they bring to this sector and the desperate care that they provided.

Which is why I also appreciated, one of you mentioned in your testimony that why didn't you consider hiring some of these family members? I can tell you for certain they would have happily taken a job if they could have. They would have done anything, including lighting themselves on fire and jumping through hoops if it meant getting in there to see their loved ones. They have would have done anything. Hiring them? They would have done that in a heartbeat. And I do know one home in Toronto was indeed doing that and kind of skirting the rules there, rightly so, because it was the ethically right thing to do and it helped.

And for us what we saw, the cumulative effect of this trauma is tantamount to a form of post-traumatic stress linked to forced helplessness. The collateral damage of being locked out for this long and seeing the impact

it had on their loved ones, it cannot be understated. A lot of these individuals are having telltale signs of depression, anxiety. Some have had to go on antidepressants because they can't sleep. They couldn't sleep for months.

Just -- I always just say, just try and put yourself in their shoes.

JOHN CALLAGHAN: Can I ask you, are there studies ongoing or preferably even been completed that have sort of traced the damage to residents? I mean, obviously not COVID but these other PTSD type --

DR. VIVIAN STAMATOPOULOS: Not that I'm aware of. We have a second phase slotted for interviewing residents, but because of the recent rules during the lockdown we couldn't get -- we couldn't obviously get into the facilities, and neither could the loves ones. We're hoping at some point we can actually do joint interviews. We were looking to do dyad interviews anyways. So that is something we are hoping to do when the visitation relaxes, which, by the way, is another thing that makes zero sense to me right now because the sector has been vaccinated, so why

are we still holding onto the restrictive September visitation guidelines? It doesn't make any sense.

So I have a feeling that will be my next stage of advocacy.

And if you go to next slide, I'll show you this --

COMMISSION CHAIR FRANK MARROCCO: I suppose there's also an issue, given the median length of time that the residents are in long-term care, 12 to 18 months.

DR. VIVIAN STAMATOPOULOS: Yeah.

COMMISSION CHAIR FRANK MARROCCO: If you don't capture whatever it is they can tell you in that period of time it will be lost.

DR. VIVIAN STAMATOPOULOS: Yeah, and that's true. And we've lost too many as is. Right. So we have to refer to the family caregivers a lot of the time to tell us these stories, unfortunately.

But when things start opening up, I'm sure there will be a lot of studies, when we can finally get in, right, because researchers can't get in right now. We thought about that, but you can't bring your computer and do a Skype

interview in the facility, there's no privacy. You're going to have to stop every time someone walks by, you might be nervous, you can't really elaborate. So we're hoping when we get the general offsite visits reinstated, when you can take your loved ones out that we could do those interviews then. But it's -- yeah, we've thought about that and we want to, it's just been a problem so far.

This -- these set of pictures is characteristic of what I have heard from families. So this is Barbara Mills. This is Susan Mill's family. I've been connecting with Susan from the beginning. And I want to read the quote that went with these photos. And she would email these to every single elected official and their extended family member that she could find, let me tell you. She shared this very publically. And the one quote I want to read while you're looking at these.

> "I would stand outside the window and communicate with her on the phone. It was around tea time so she'd have her tea. We walked and she was able to converse. And then as time went on

she couldn't hold the phone. Her conversation became limited. Physically we would do exercises. She couldn't follow the instruction anymore. Then as further time went on she would just fall asleep and not even be there. Didn't know who I was eventually. It was very difficult. I could see her deteriorating right before my eyes. And then five months to the day, August 14th, she told me she wanted to give up. My sisters and I stood outside her room --"

Sorry.

"-- the whole day. She reached out towards the window and all we could do is put our hands out on the window. That image, that stayed in my mind."

I mean, this is what these families saw. This is what they went through.

Other things I heard of that were notable were how disorganized the homes were to facilitate visits; and there was slim to no communication, particularly in the first wave.

Lack of staffing and resources we heard over and over from families.

Mistreatment from staff and management to the family caregivers. Numerous instances of retaliation if, heaven forbid, families would raise alarm bells of things that were happening, or worse yet, just treated as inconveniences. And we would hear this a lot from families.

A quote that really stood out was one participant who said:

"I eat crow because I am afraid they will shut me out."

And this was a fear we heard across the board. The families were scared of speaking up because they weren't there to see what would happen in their absence. We heard a lot about power trips and how these families saw these homes take on this power of being able to control their access and really yielding that in a way that was not benevolent, and families felt that very clearly.

Significant lack of just person-centred or family-centred ethos within these homes. It wasn't about looking at the needs, the cognitive and physical needs of these

individuals and trying to make the best of a bad situation, it was just trying to be as punitive as possible.

And keep in mind, another burden that isn't talked about is how often these families had to get testing, right? So they were unlike any other group. They were completely discriminated on in terms of testing. No other group was forced to get this frequent set of testing that essential family caregivers had to do.

I mean, when it came down to the lockdown and the grey or red areas, they had to get tested sometimes every three or four days because they had to provide a weekly negative test at one point.

I mean, we would hear families tell us they had 70, 80 tests at that point. Trying to negotiate work to try and get the test; taking time off; dealing with delays in getting the testing back. And if they didn't get it back in time they would miss their visit for the week. I mean, the hoops that these families had to go through. They did it. They did whatever you told them to do and they would, but they didn't

have to. Even in the Dutch example, they didn't force families to get tested. They wore PPE, they had basic training, they did temperature checks, they let them in, kept their distance where possible and everything was fine.

So, I mean, the approach we took was just wildly unnecessary. I heard numerous accounts of medication errors, chemical restraint, which is another term for using excessive sedation techniques to keep residents passive so you don't have to answer their calls for help, or don't have to change them as frequently. Frankly, they were being drugged a lot of the time.

We would hear this from families across Ontario. Quite often they weren't even provided the acknowledgment that this was happening, until they would sometimes figure it out on their own when they'd do either a virtual visit or an in-person and the person would be completely passed out, like Susan's mother. And they would probe and then find out, Oh yeah, we gave her something to calm her. No consent was given for this. How often was this happening across the sector? I don't even want to hazard

a guess, but I heard countless family members tell me this.

And not that things were bad enough already, but then I heard countless cases of things being stolen from residents. So when families were finally allowed in key pieces of jewelry were suddenly missing. I heard this countless times. So you've already been through being separated for this long, you come in and you find your mom's wedding ring is missing. There was no bottom to what these families had to go through over the course of this pandemic.

If we go forward to the next slide.

These emails would happen all the time. This is an example of a family alerting our elected officials that a family member almost died from choking because, again, they weren't there to help provide the feeding aid that they do. And you knew there was choking deaths in the military report. I mean, things like this were happening often and I would hear these accounts all the time.

That poor gentleman there, Pietro Bruccoleri, who died from literally lack of nourishment. I mean, he would be alive if his

family was allowed in. Period. Period.

Preventible deaths. How many? We'll never know, but I'm sure there's a whole lot more than will ever be advertised by this government.

The next email was an email from an Orchard Villa family who notified Christine Elliot on, what was it? April 13th, of what was happening in that home. And you well know now that the military wasn't sent in until the end of April. So these emails were being sent to elected officials.

These -- Cathy was also -- Cathy Parkes, and I think she testified with you as well with Orchard Villa families, she was calling everyone she could possibly think of, MPPs, local mayors, Premier Ford, Minister Elliot, I mean, and you saw what happened there.

So it's not to say that the families were not trying to get help. I mean, all the families I've spoken to have gone above and beyond to try call their local MPPs, email Premier Ford, Minister Elliot, Minister Fullerton, you name it. They were desperate. These emails were coming in fast and furious.

So the interesting thing, of course, is that these emails were often just unanswered. Many families just never heard anything back.

I would sometimes have to call, myself, local public health officers because getting with -- in touch with Minister Fullerton was futile. So I myself called certain public health officers warning them of PPE violations and infection prevention and control violations that families were telling me about at certain homes, and then nothing was done, and then the whole home ended up consumed in an outbreak. It was just -- it was a mess.

JOHN CALLAGHAN: Can I ask, Doctor, did you email those notifications and would you be prepared to share them?

DR. VIVIAN STAMATOPOULOS: I sent Twitter messages to Mustafa Hirji, and I also called and spoke to his assistant. So I left messages with his office and then his assistant called me back and said, of course, We're okay. Thanks for letting us know. But obviously no one was ever sent in. The home wasn't taken over by hospital. So things like this would happen.

Things with, you know, Tendercare,

Sunnycrest. I mean, if you go to the next slide, the same kinds of things.

We found that nothing would happen unless there was a media scandal. So another part of my very fun, not so fun, advocacy was really trying to kick up a you-know-what storm, so to speak, when I would get bombarded by families about certain homes in particular. So families started reaching out to me, Tendercare families, when things were getting really bad.

And I started doing what I do, contacting the media, because it would get me nowhere to try to contact the elected officials. So we would contact the media and then we were asking to get the military in there because we knew how bad it was.

And we -- I even teamed up with Doly Begum, who's an MPP in Scarborough, to hold a town hall for Tendercare families. The media were all there. Lots of coverage for that. And then the York General was sent in, but the military was never sent in. And we wanted the military in because we knew even with North York General there were still problems. So it took a while to get that home under control, but the

damage was done by the time that support was sent in.

And it's always -- this has just been the pattern. It's always reactionary. It's when the scandal hits, you know, the public that then the hospital will be sent in. It's never pro-active. I never saw one pro-active case.

And another thing that really stood out to me was how we had documented cases of negligence contributing to death. I mean, we have Sunnycrest, Tendercare, Roberta Place, all ministry inspectors were in there, either at the start of the outbreaks or just -- even a little bit before. And they documented widespread negligence, infractions. I put some of the links there for the inspection reports.

Curiously though the Sunnycrest one has somehow disappeared. I don't know why, but it was there before because I had screen shotted certain captions of it for Twitter. And I know Cynthia Mulligan also did a story about that particular one.

So we knew that there was problems, yet there's never been, once, an acknowledgment by this government of wrongdoing, of

accountability for the bad actors, and for these families, not once. We kept waiting for a press conference. We kept waiting for somebody to address what happened to Tendercare, to address what happened at Roberta Place, to address what happened at Sunnycrest, to address what happened at St. George. Not once. Not once. Families just sat there. What message does that send to families when you can't even take five minutes to give a press conference and say, you know what? We're aware the situation is not good. We're doing what we can. Anything like that to help assuage the fears of these family members. Nothing. So that was not lost on us, to be sure.

And then I also put in a little clip there of a video. And I think it would interest you to see this because in your -- and you can watch it later if you want, but I have the exact minute there you should look at, because in Minister Fullerton's testimony she referred several times to how it was Dr. David Williams responsible for the visitation, right? And then in his I believe he would say it was her, either way. When you look at this video, it clearly

says it's Dr. Williams, at one of the health pressers with Dr. Barbara Yaffe saying that those visitation rules and decisions were squarely with the Minister of Long-Term Care. So I just want you to see the conflicting statements and that evidence because that's there, and that was not lost on us as well.

And also this general ping pong of accountability. So I would hear families telling me they would contact, you know, the Ministry of Long-Term Care, because when they weren't hearing from the Minister herself I would advise them, contact the action line, contact the Ministry of Long-Term Care directly. And then they would hear, well, contact the local public health, or that's up to Dr. David Williams, or they would keep being told different things. Nobody would give these poor families a direct point of who's responsible. And it was like they were literally being pinged to different individuals.

And then, you know, I think part of the reason why they started to offload the responsibility to the local public health units, as we saw in the second wave, was so that they

didn't have to deal with the families, frankly. And that's exactly what families felt. That they kind of downloaded the responsibility to the local public health units that were completely unprepared, given their own -- the hospitals were starting to be overwhelmed and they didn't have the resources to come in and save the day, like they did in the first wave.

Which is why we were saying, over the summer you should have been engaging in a staffing blitz like Quebec. You should have been implementing infection prevention and control leads at each home. You should have been thinking about these things and nothing happened. Nothing happened, which was the most frustrating part, because we predicted that the wave -- the second wave would be more deadly. We all said, you're not doing X, Y, Z, watch what's going to happen. And exactly what we said would happen came to unfold. And watching that has been very frustrating for us advocates in particular, who are representing families, keep in mind.

If you go to the next slide. These were two things that we did. So I held that

town hall with Doly Begum, we invited Minister Fullerton to attend. We wanted her to hear what these families were going through. And something that I think is important for you to know is the almost hostility that we felt, as advocates and families, from the government.

So when we held the town halls, and we had protests, so I actually helped organize a protest outside of Tendercare with the families. And I remember a day or two after, and we were telling them what we were hearing from family members inside having to call 911 to be fed because there weren't staff around. We were telling them what the families were telling us. And then I remember, I think, it was a few days later, Minister Fullerton did an interview with Global News with Farah Nasser, and she said something like, Oh, I know there's a lot of misinformation going out there. And literally the only information that was out there was from us, was from the families and their advocates.

So it felt like an implicit message kind of like trying to downgrade what the families were saying. And that was really -- that's -- that has not sat well with us, right?

It was not lost on us that instead of listening to us and working with us and hearing us, because what we were telling you ended up being true, there was this, you know, almost attempt to say it was misinformation and present the least-worst-case scenario.

And you can see that as well with her Tweets. She started Tweeting in the second wave, in very bad form, how many cases -- how many homes had no cases, or how many had under five. So literally trying to depict the least-worst-case scenario to the public.

Meanwhile, we were at a place where we were losing seniors by the hour. So it was literally, like, we're losing a hundred seniors a day in long-term care and she's only focusing on how many homes have under five cases. It was driving families crazy to see these very insensitive Tweets while the house was on fire, right?

And then that was the action letter on the left with Doctors for Justice. Again, we asked for her to meet us. We asked for them to engage in these nine emergency actions, things we thought would immediately help to address the

bushfire that was long-term care in the second wave. You thought wave one was bad. Wave two was a disaster and a predicted disaster.

COMMISSION CHAIR FRANK MARROCCO: Do you have the nine items? I'm looking at the letter but I didn't see the items. Is it in the slides or --

DR. VIVIAN STAMATOPOULOS: No, it's in the website. So I can read them you. One of them --

COMMISSION CHAIR FRANK MARROCCO: Well, we can get it from the website too, but okay.

DR. VIVIAN STAMATOPOULOS: So things like obviously the first one, nothing we can do right now, but we want to end for-profit long-term care, okay.

The second one, we want all powers and resources to hire qualified staff, because we saw something happening where we were just getting in the least qualified helpers in there, and that was something that we clearly argued against from the beginning. We knew that there's already been this very problematic deskilling in this workforce and a race to the bottom, quite frankly, since the for-profit

sector really took hold and we knew that. So we were very against hiring just anyone with no healthcare experience, but yet that is exactly what happened.

And I remember reading your testimony with the transcript with Chartwell and that was something they called for. They wanted resident support aids, and they also were pushing for that to be funded in the accommodation, I think, or the staffing envelope, which we were very against because, to us, that's just the next level of deskilling, right?

Remember, 20, 30 years ago, nursing homes were primarily staffed by, take a guess? Nurses. That's why they were called nursing homes. Then you see over the last 20, 30 years, thanks to Mike Harris and the creation of 20,000 beds under his tenure, which were predominantly given to the for-profit sector, that's when we started to see a predominance of the for-profit sector in Ontario.

Over those past 20 years you see a very decided shift. So before it was majority nurses, maybe a few aids here and there. The staffing mix got flipped on its head, right? So

now we have a vast majority of PSWs, who are unregulated, lower-skilled profession, who then -- many of which are racialized women, many of which are new to Canada. So you are exploiting that workforce because you can pay them a lower wage, instead of hiring more nurses, which are a higher paid, regulated profession which subsequently begets a higher income.

So if you're going to cut off -- if you want to get an income, if you want to, sorry, get more profits you do that by dealing with the staffing equation. And that's exactly what happened over the last 20, 30 years.

And now, the for-profit lobby, evidenced by Chartwell's testimony wanting this new resident care program, is exactly extending that, right? It's a new care categorization who has even less skill, so to speak, so you can pay them even less. This is a big problem.

And what happened in November? Minister Fullerton put out a staffing strategy that focused on resident support aids. Isn't that interesting? So you see that what is enacted, if you go to the next slide, will be

things like what isn't enacted and what is enacted. And this is what I refer to as regulatory capture, right? So this is that economic theory that says, eventually the regulatory agencies become dominated by the interests of that agency and not in terms of the public interest.

So there's been a decided shift and, unfortunately, the result is that the agency acts in ways that benefit their interest as opposed to who they're supposed to be regulating.

So if you go to the next slide, the things that we see here are what didn't and what did happen, right? So they implemented -- the Chartwells, and generally other for-profits, were asking for these kinds things too, so to have this new care classification category. We obviously, in the area that I'm in, do not want this kind of deskilling to occur because we know it impacts care, it's problematic.

Not -- Bill 218, oh, my gosh, don't get me started on how the families were furious with this, which is supporting Ontario's Recovery Act, which is supposed to protect all

businesses from COVID liability, but there's been a lot of criticism that this ultimately created in order to protect the long-term care industry, and the many class-action lawsuits, and other lawsuits, that were starting because of what happened in the first wave. And, as you know, that was retroactive to the start of the pandemic.

So they effectively changed the rules of the game in the middle of the game. Lawyers are not happy about this. I held some special events, when it was passed, to talk about just how problematic that was. The families were also very upset by it. Obviously that supports the industry.

Not banning inter-facility movement. You guys had also revealed that in some of your interviews with people that they were still allowing the chains to have their workers move between different facilities. I mean, come on. And they also still had the exemption to allow agency workers. I remember when North York General took over Tendercare, because I attended the town halls with the families that were hosted by the hospital, because they wanted me

there. And they said themselves at one point, they had to get the help of eleven different agencies to get workers in there.

So they were still allowing temporary agency workers to go around to multiple homes, instead of doing what we had told them, mimic what Quebec had done, engage in a staffing blitz, provide them a basic, decent living wage, like Quebec had did, pay for their training and let's get the show on the road. Didn't do that. Went down this road instead.

When you look at, not just over the course of the pandemic but over the course Ford's reign to power, so to speak, the inspection process has been severely constrained. So the resident quality inspections, I'm sure you've heard of those already, the RQI's, those have gone down significantly to being all but eliminated under the Ford government. So the previous government had that they were supposed to do at least one a year per home. I think there were nine in 2019. I don't even know how many there were over this past year. No clue. So love if you guys could get that information but we certainly don't know

as the public.

What was not enacted? Not things that have been advocated by resident and family experts, people that are looking at what the actual residents and the workers need. So implement the care standard, which is also, the bill is right there, Bill 13. All you have to do is pass it. It's gone through its second reading. The NDP did the work for you. It's there. They don't want to pass it. All of your recommendations. I don't know of any of them that were passed. They were great. They didn't go through.

No staffing blitz. No IPAC leads per home, which would have been just crucial, crucial, given what we saw in the ministry inspector's report in some of those hardest hit homes. They were all IPAC violations that led to the virus just spreading like wildfire in those homes.

No home has been fined, that we're aware of, over the course of this pandemic, although we know very many cases of negligence and abuse. And the bad actors, so to speak. No revocation of licences. Indeed over the past 20

years only two licences have ever been revoked, and those were because of financial mishandling where they themselves said, Take it. We don't want to do this anymore. We don't want this.

We have a big problem in how we actually hold these bad actors accountable. We don't. And that's a big problem, right? And over the years, there have been lobby attempts to decrease fines, decrease resident regulations, have regulations that would benefit the industry and not the actual workers or the actual residents. So this is what I mean by regulatory capture.

If you want to go to next slide. This was another big problem. Andrew Russell and Morganne Campbell from Global did a story finding that there were several long-term care inspectors who were previously employed by some of the biggest for-profit chains. This is a clear conflict of interest. You can't do this kind of thing. And then we've heard from families and from other experts that even over the years, some of the RQIs, the resident quality inspections, which are supposed to unannounced, were -- sometimes they'd give them

the heads up or, you know, we'd hear these kind of things. So there's a clear problem with the inspection regime, let alone the penalties is a whole other separate issue. But these things need to be dealt with for sure.

The next slide. So, yeah, I already talked about the changes to staffing, so I think I jumped ahead there. But ultimately, what we're worried about right now is that nothing has fundamentally changed to actually address the working conditions and the pay of these workers. And these are the two biggest problems which have led to the revolving door. You all read the Gillese staffing report. And we all know, you know, there's massive turnover among the PSWs, and the PSWs are the largest workforce in long-term care.

This is a big problem for continuity of care. And we would hear this from families all the time. Tendercare families would tell me, it's always new staff. There's someone new all the time. We never got to know the workers. It's important that you have permanent full-time workers who can actually get to know the residents, know their needs. I mean, I would

hear cases all the time about agency workers inadvertently harming residents because they didn't know they had, you know, maybe it was a certain form of arthritis or a certain condition that you had to maneuver them a certain way. I mean, this is why continuity of care is so important.

It's not good for anyone if you have a continuous revolving door, but this government has not addressed any of that. All they did was throw the federal funds into pandemic pay, temporary pay increases, right? And we said, this is not going to fix the problem because you may -- you may get a few more people, right? They had the return-to-service program for up to a thousand PSWs. And, by the way, this angered so many existing frontline staff where they offered new staff, recent graduates, to come into the home and they give them $5,000. I'm sure you know about that. So there was that limited program for a thousand people, and, oh my.

So imagine if you're one of the workers who's been there and actually worked through the first wave and went through that

hellish situation, because that's a whole other situation. The separate PTSD that I'm sure those PSWs have is another area that is worth its own testimony. I'm sure you've probably heard from the Unions, but what they went through working in those conditions was abhorrent, but they didn't do anything to actually address that.

So you can get some people in there and, as I predicted, you get them in, you make them stay for six months, you give them $5000, but what's going to happen at the six-month mark? Guarantee bunch of resignations, right? Because you do nothing to address the conditions of their work. And that's the biggest problem, is that these workers, because there's no care stared, they're constantly rushed; they're in charge of, sometimes, dozens of residents per shift, even more at night, sometimes 30, 40 residents they're responsible for at night. You can't possibly provide any modicum of care.

And this is what we hear. These workers are put in working conditions where they're designed to fail. And this government knows the working conditions, you know. So when

Minister Fullerton says she doesn't know why workers want to work part time, number one, they don't want to work part time. Give me a break. They want full-time work and which is why experts have called for a 70/30 split, which is something that is needed. 70 percent full time/30 percent part time. Because of course there's going to be some people that want part time, but the vast majority will tell you they want full time, they want permanent employment with sick pay, which is why, if you have that, you wouldn't have had workers showing up to work sick; like you guys found out in the testimony with David Williams, which was striking to me when he admitted knowing that symptomatic workers were going to work sick because there wasn't paid sick leave, effectively.

I mean, c'mon, we knew what needed to happen in order to not only to attract workers but to keep them there, but this government didn't want to commit the financial resources, even though they had the resources to actually see that through, which was very upsetting.

Home care. This is my next area of concern because I know that you're probably

hearing from people, and this is what my fear is going to happen going forward, is that people are going to say, Well, no one wants to go into long-term care now because they saw what happened. And sure, part of that is right. But the other part is home care is a nightmare right now. It is an even more privatized mess than long-term care is in Ontario. And I like this quote from Pat and Hugh Armstrong that said:

> "Too often, the reality is that aging in place is more about limiting the responsibilities of government than about fully meeting the care needs of seniors."

So my fear, and going forward to next slide, you'll see that, you know, many people of -- have been very critical of a bill that has just been pushed through that would further privatize home care. So Bill 157, I believe. I don't know what the status of that bill is now, but advocates --

COMMISSION CHAIR FRANK MARROCCO: I think on your slide it's 175.

DR. VIVIAN STAMATOPOULOS: I swear I need glasses. This is the next thing I need from

working at home this whole time and staring at your computer, but anyway.

So there's a big fear about what's going to happen by further privatizing this out. Imagine long-term care and the problems we saw in the pandemic, but in private households where there's even less oversight. This is a very big fear of what's going to happen. And I've heard horror stories from families in home care and, I'll admit, I lived this experience of home care.

Most LTC residents had home care before they ended up in long-term care. There was a period of trying. My God, families tried their best to keep these loved ones at home as long as humanly possible, but it gets to a point where the care needs are too extensive. And there is no option other than either quitting your job and trying to suddenly become a full-time, unpaid labourer with zero healthcare skill yourself, which is untenable and unfeasible, or you go into long-term care. These are the options you're pretty much provided.

And I give an example on the next

slide of how unfeasible home care is for dealing with this. So an individual pulled her mother out of home care in the second wave. So the home was lucky, it didn't have any cases of COVID during the first wave, but yet her mother obviously, she was kept away and she saw the detrimental impact it had on her mom. When they got some cases in the second wave, because we knew the second wave was worse, she decided to pull her mother out. So she did.

And her mother was immobile, wheelchair bound, WC bound is wheelchair. Had mild dementia, but she had aggressive behaviours with her dementia so that made it a little difficult.

They had to continue paying for the room to secure it, so keep in mind that's 8,200 to keep that room in long-term care while they effectively did their work for them. So I don't know why they weren't refunded that, but that's another case. Then she had to hire 5,000 for three months of part-time home care through agencies, because the province wouldn't give her home care because she had long-term care.

And apparently at the three-month mark

when she ended up having to send her mother back, because she had to undergo her own surgery and couldn't provide that care anymore, and was also running out of money, they told her they would be able to give her, I think, 18 hours a week.

So not only 5,000 for that. $500 to get her mom to and from the home the two times the vaccination teams were there. So she still wanted, obviously, to get her mother vaccinated but you have to hire special taxis that are accessible to get you there. And I remember doing this myself too, it's expensive. And another 650, roughly, for incontinence and personal care supplies.

So we're talking, you know, over $14,000 for three months. And this is not even full-time help. This is her, she's retired, doing the majority of the work herself. Her sister would come every night to do the night shift. And it was -- and only because both of them don't work. It's completely untenable for anyone who has a job to be able to do this. Work and unfortunately she had to send her back because she is undergoing her own surgery next

week and has her own health issues, as many of these baby boomers are.

And I asked her, Do you think you could do this if you were working? Could you have taken your mom out? And it was a resounding, Oh gosh, no. Because there's no way.

And if you go to the next slide. These kinds of problems that we were seeing. She said, and even when her mom was in long-term care, this always stood out to me.

> "I retired in 2010 but I feel like I've never experienced retirement because my moms care was all consuming. It's turned me into a person I don't want to be."

She says this crying.

And another thing that stood out to me was when she said to me:

> "Thank god for dementia, they forget but we won't."

And I just want to reiterate that she also went through a process where before long-term care she tried to keep her mom at home as long as possible. It got to a point where

she needed 24/7 care. Went to long-term care. Had this nightmare of an experience during COVID. Tried to bring her mom out. Spent, you know, almost $15,000 to give her three months of a reprieve, but then had to send her back.

I mean, and there were cases of overbilling, scheduling inflexibility, poorly trained workers being sent. We hear constant problems with home care. It's not the solution.

COMMISSION CHAIR FRANK MARROCCO: Is that really -- is that really the point you're making then, that to the extent people would try to tell us that more home care is the solution in your view that's not correct.

DR. VIVIAN STAMATOPOULOS: No, it's not correct. Because there's always going to be people that need institutional care. I mean, obviously the kinds of care that that form take can change and, sure, we can learn from European countries in that regard.

But my fear is that this is going to be another way to divest responsibility and funding from long-term care into home care, which we know is even more so under-resourced than long-term care, and it's going to end up

driving unpaid care back into the household, primarily in the hands of women, because this is what happens. It ends up being the daughters and the granddaughters who take on these roles and then it leads to very damning consequences for their future financial stability.

Remember, a lot of senior women right now are living in poverty because they didn't work. This was an era where they didn't work. They were stay-at-home wives, they were stay-at-home mothers.

And we know that we are seeing a shift in women not being in poverty as much now because of the second phase of the women's movement and women now working, for a variety of reasons, be it for their own wellbeing or just nobody can afford to live right now on a single earner income. I mean, it's just untenable.

So there's a reason why -- larger socio-demographic reasons why we don't have this reserve army of stay-at-home labourers. And the responsibility is for -- often falls on these women to then scale back on their work, like they do for childcare anyway right now, and to scale back on other things to try to fill the

gaps that the government is not filling. And this is the problem. My fear is that they're driving this care into the unpaid household economy and they will do it through home care.

And where's the next slide? So this is another area of national standards. What I'm trying to get in the interim until we, in my opinion, in Ontario divest from for-profit based on the very egregious data we have in for-profits' failure during COVID, but we have evidence for pre-COVID as well.

But things that I've been trying to get through to the federal government. I've had some meeting with our Prime Minister and his staffers from Patty Hadju's office, Minister Hadju's office and Minister Deb Shulte. And I don't know what's happening. He has himself expressed a desire for national standards, but there are apparently certain provinces, take a guess which ones, that don't want to play ball.

But I want to see things like the care standard across Canada. I want a minimum of five hours, in my opinion. Minimum five hours. I want to see better penalties and an inspection

regime. I want to see something more akin to Australia where you actually revoke licences for bad actors, and I want to see heavy financial penalties that hit these guys where it hurts. Hit these bad actors where it hurts, in their pocketbook. I want to see something like the U.S.

So I don't know if you heard yet about what happened to Extendicare in the U.S. Did you hear about that?

COMMISSION CHAIR FRANK MARROCCO: I think we -- well, go ahead and tell us and I'll tell you.

DR. VIVIAN STAMATOPOULOS: In 2014 --

COMMISSION CHAIR FRANK MARROCCO: We heard lots about different people.

DR. VIVIAN STAMATOPOULOS: So in the U.S. in 2014, Extendicare was hit with the largest nursing home chain lawsuit by the federal government. They forced them -- because of substandard care. So they found things that we have numerous evidence for here. So things like failure to prevent serious falls and head injuries, failure to prevent bed sores, allowing patients to become malnourished and dehydrated,

developing infections that led to unnecessary hospitalizations. I mean, we have evidence for this here.

So they went after them for this. Hit them with a $38 million lawsuit. But fine, these places have money so that's not the main thing. What the main part of that was it was twofold. You have to pay $38 million and then you have to enter into a five-year corporate integrity agreement where they actually monitor. They have an independent monitor that will verify your staffing levels, because they said to them, you have to hire more staffers and more -- better trained nurses.

And instead of doing that what do you think they did? They said, Forget it. Too much work. Sold the entire portfolio in the U.S. and imagine focused on Canada. Which is hilarious that this is a Canadian company that got scared out of the U.S. but, however, here, no problem. No penalties. Written warning. Slap on the wrist. And then you wonder why nothing ever changes. It's ridiculous.

So those are things I'd like to see. Yeah, I mean, really those are the main things,

penalties, inspection regime and making sure you have a better staffing situation, which is more full-time, permanent workers and a minimum care standard. These are basic things that we can do. We can implement these and this is what I'm hoping happens at the national level, because I don't want to just focus on Ontario. I think Canadian seniors everywhere should have some basic standards in place for long-term care.

Okay.

COMMISSION CHAIR FRANK MARROCCO: I'm sure you're tired. My hands are from making notes.

DR. VIVIAN STAMATOPOULOS: Sorry.

COMMISSION CHAIR FRANK MARROCCO: I'm going to have to go on disability.

DR. VIVIAN STAMATOPOULOS: Sorry.

COMMISSION CHAIR FRANK MARROCCO: Not at all. It was -- well, assuming for a moment, Doctor, that you're finished?

DR. VIVIAN STAMATOPOULOS: Yup, I'm finished.

COMMISSION CHAIR FRANK MARROCCO: Unless one of Commissioners has a question, I just, I want to thank you for -- I want to thank

you for the presentation and for the thoughtful remarks, many of which resonate with us.

DR. VIVIAN STAMATOPOULOS: Thank you.

COMMISSION CHAIR FRANK MARROCCO: This is all -- this is an important time for us to hear this again, because we are at the time where we're writing, in one form or another, and listening at the same time because we have that April 30th deadline.

So thank you very much for taking the time and thank you for being a good sport about the lost email.

DR. VIVIAN STAMATOPOULOS: No, it's okay. Thank you.

JOHN CALLAGHAN: Thanks, Doctor.

COMMISSIONER ANGELA COKE: Thank you very much.

COMMISSIONER JACK KITTS: Thank you.

--- Meeting ended at 4:12 p.m.

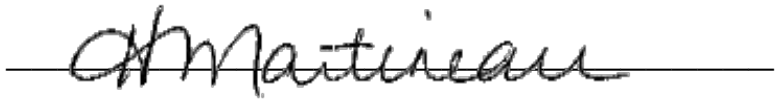
REPORTER'S CERTIFICATE

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 11th day of March, 2021.



PER: HELEN MARTINEAU

CERTIFIED SHORTHAND REPORTER

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