

Long Term Care Covid-19 Commission Mtg.

Group Meeting
on Tuesday, January 26, 2021



77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 26th day of January, 2021,
4:00 p.m. to 5:39 p.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner
Angela Coke, Commissioner
Dr. Jack Kitts, Commissioner

PARTICIPANTS:

Adriana Diaz Choconta, Senior Policy Analyst,
Long-Term Care Commission Secretariat;
Jessica Franklin, Policy Lead, Long-Term Care
Commission Secretariat;
Kate McGrann, Counsel, Long-Term Care Commission
Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term
Care Commission Secretariat;

ALSO PRESENT:

Carissa Stabbler, Stenographer/Transcriptionist

-- PROCEEDINGS COMMENCED AT 4:00 P.M. --

JESSICA FRANKLIN: Thank you so much for joining us this afternoon. My name is Jessica Franklin, and I am the Policy Lead at the Commission Secretariat. I am joined this evening by my co-facilitator, Kate McGrann, who is counsel for the Commission, as well as a number of our fellow team members.

So Dawn Palin Rokosh is the Director of Operations. Rose Bianchini is also here. Rose is a policy analyst. And you would have met Angeline Hawthorn, who let you in to the meeting, as well as Adriana Diaz Choconta, who is also here to assist on our team.

So thank you so much for being here. We have all Commissioners for this call. I'd like to introduce you to each of them. Chief Commissioner Frank Marrocco is here. There's the wave from Commissioner Marrocco. We also have Commissioner Angela Coke and then Commissioner Dr. Jack Kitts as well.

So for this evening's call, Commissioner Marrocco will be the lead, but all three commissioners are here and listening in.

I would also like to acknowledge and

1 thank Rosemary, who's the chair for the Champlain
2 Region Family Council Network, who assisted in
3 sharing the opportunity and identifying
4 participants.

5 I also want to let people know that if
6 you do experience connectivity issues, please don't
7 fret. You can certainly rejoin the meeting at any
8 time. And if you are having technical issues and
9 are running into issues kind of getting back in the
10 meeting, please reach out to Angeline Hawthorn via
11 email, who you've been in contact with before this
12 session.

13 Also, I see that a number of
14 participants have turned on their cameras, which is
15 great, so please feel free to do so. This session
16 is not being video recorded, but if you would
17 prefer to stay off camera, that is fine as well.
18 It is whatever your comfort is.

19 I also wanted to let you know that this
20 session is being recorded by our court reporter,
21 who is present on the call, and the transcript will
22 be posted onto our website, but your names will not
23 be present.

24 So when you are speaking, you will
25 appear as your participant number, so

1 "Participant 1," for instance. And if you want to
2 refer to what another participant has said, we just
3 ask that you refer to them by their participant
4 number, which is displayed on the screen.

5 Before I turn it over to Kate, does
6 anyone have any questions about anything I've
7 mentioned?

8 Okay. Over to you, Kate.

9 KATE MCGRANN: Thank you, Jessica. One
10 more note on confidentiality in this session: As
11 Jessica has mentioned, this is being transcribed,
12 and a transcript of our meeting here today will be
13 posted to the website.

14 We've ensured that your participation
15 is anonymous through assigning you participant
16 names and numbers in our outreach to you, but the
17 information that you're sharing today will be
18 posted to the internet. So please be aware that
19 any identifiable stories that you may be sharing as
20 this -- all of this information will be
21 [INDISCERNIBLE].

22 Turning now to the agenda for this
23 meeting, we'll begin the session with some
24 introductory remarks from Commissioner Marrocco,
25 and then we'll proceed to question 1, your

1 responses from all of you in order of the
2 participant number that you've been assigned
3 starting with participant 1 and moving through.

4 We'll repeat exactly the same process
5 for question 2. Once we've finished hearing from
6 all of you on both questions, there will be some
7 concluding remarks, and then we'll wrap the meeting
8 up.

9 In order to ensure that the
10 Commissioners hear from all of you on both
11 questions, we're asking that each one of you speak
12 for up to four minutes in response to the first
13 question, and then in response to the second
14 question, again, if you could speak for up to four
15 minutes.

16 We understand that you've all been
17 through a great deal, and we know that four minutes
18 is not sufficient for you to share everything that
19 you have to discuss with the Commissioners, but the
20 four-minute time limit is here to ensure that you
21 all get to share some of your story within the
22 course of this meeting.

23 If there's additional information that
24 you wish to convey to the Commission, you can do so
25 through written submissions and other avenues that

1 I described on our website.

2 If that's something that you're
3 interested in doing, you can either get in touch
4 with us in the same way that you did as part of
5 entering this meeting or through what's described
6 on our website.

7 One last note is that we will keep
8 track of the time for you, so you don't have to
9 watch a stopwatch or anything like that while
10 you're speaking to the Commissioners.

11 As you get close to the end of your
12 four-minute mark, either Jess or I will un-mute our
13 mics and let you know that you're coming close to
14 the end of your time and ask you to try to wrap up
15 your remarks in about a minute or so. So you'll
16 have some warning so you're able to complete what
17 you're saying.

18 Are there any questions about any of
19 that? Okay. Well, then, I will turn to
20 Commissioner Marrocco for some opening comments.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Well, thank you all for agreeing to do this. In
23 order to do what we're doing, we need to stay
24 grounded in reality, and this is the most effective
25 way that we can think of to do that.

1 So your experiences we can then relate
2 to what we're told about less personal things, like
3 policies and so on. But we couldn't do our job
4 properly if all we were talking about is paper and
5 policies. We need to understand what went on, and
6 your experience has helped inform us of that. So
7 thank you very much for agreeing to do it. I know
8 it can be painful because you've done this before.

9 Let me also say that I'd like to start
10 the way all three of the Commissioners have agreed
11 to start these sessions, by observing one minute of
12 silence for those who aren't here.

13 [Moment of silence]

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Thank you all very much for that. Well, let's -- I
16 think the best way to begin is to begin.

17 KATE MCGRANN: Thank you,
18 Commissioner Marrocco.

19 So we'll begin with the first question;
20 which is, please tell us about your experience
21 caring for a loved one in the long-term care home
22 during the pandemic. How has the pandemic impacted
23 you?

24 Please go ahead, Participant 1.

25 PARTICIPANT 1: Hello. Thank you very

1 much for allowing us to do this.

2 The pandemic has affected our family
3 quite a lot. I also am chair of the family council
4 for the home as well, and so I can also speak
5 with -- for other families as well, if possible.

6 My mother has been in the home for four
7 years coming up February. She went in after --
8 with a -- you know, diagnosis of dementia, and she
9 had suffered two strokes. My father then suffered
10 a stroke, so he was not able to care for her,
11 henceforth the entry into the home.

12 During the pandemic, there was no
13 communication. We could not find out what was
14 going on. There were a number of other families
15 that I spoke with that had the same issue.

16 I ended up calling head office a number
17 of times, and at one point a person from head
18 office said, "Well, you do know that long-term care
19 is where they go to die." That was not the correct
20 response I wanted to hear at that point in time.

21 We could not find out what was going on
22 in particular with my mom and, again, with other
23 family members as well, you know, trying to find
24 out what was going on with their loved ones.

25 We've come to learn that the

1 staffing -- this home had 160 residents. They lost
2 90 residents, 80 -- pardon me, 57 that I know of
3 from COVID. The staffing levels were down. They
4 lost two staff members as well, and then the spouse
5 of another staff member passed away as well.

6 The PPE was not available. There
7 was -- at one point, the incident command was
8 called in, and when I -- they allowed me to sit in
9 on a couple of calls, and when I tried to find out
10 what was going on, I was given the pat on the back,
11 they -- we're doing everything we can speech.

12 We were not given specifics. We
13 were -- we have no idea -- even now we have no
14 idea, you know, about residents being fed or
15 cleaned with their basic personal care. I'm trying
16 to find the polite way to put that one, their basic
17 personal care looked after, so sitting in their own
18 soiled clothing for long periods of time.

19 They were not bathed. They were not
20 showered. Again, back to the eating. We have no
21 idea at this point -- my mother is nonverbal and
22 immobile, so I, you know, wouldn't be able to get
23 any information from her.

24 Just before the pandemic started, she
25 had started to cross the line of not knowing who my

1 sister and I were. She still knew my father's
2 voice. They just celebrated their 62nd
3 anniversary. She still knew my father's voice, but
4 without being able to go in, with no contact
5 whatsoever, she now does not know him at all, which
6 is harder on him obviously than it is on her
7 because that knowledge is not there.

8 Medical issues, again, not knowing.
9 The main thing being communication, I think, was a
10 huge issue, as well as staffing, PPE, all the
11 things that everybody has talked about.

12 You know, as to fixing it, I just don't
13 know the issue there as well. I did end up
14 during -- in the second wave, I wrote a letter. A
15 report came out. There was an investigation done
16 over a four-, five-week period. I can provide
17 report numbers if necessary.

18 I ended up writing a letter to
19 Minister Fullerton, MPP Blais. I wrote it to the
20 fire department. We learned that none of the
21 staff -- there was no fire drills from February
22 onwards to November. There was no fire safety
23 training done whatsoever within the home.

24 So after the flames settled down coming
25 out of my ears, I contacted all of the various

1 different government officials I could think of to
2 lodge a -- like, a major complaint about this. The
3 other reason being, like, again, there was
4 staffing -- there was nobody on in terms of nursing
5 to cover somebody who may have been ill.

6 The report that the Ministry did, which
7 is the part that really angers and frustrates me,
8 is while this investigation was going on, the
9 Ministry knew of these fire drill and fire safety
10 issues that were not being handled properly, but
11 they waited to hand the report to the new ED when
12 she stepped in in November.

13 Why was nothing done at that point in
14 time? Why did they wait? You now have
15 90 residents. I also learned that only 6 staff
16 need to be on -- in the home during a night shift.
17 That's ludicrous. How does 6 staff get
18 90 residents out of a home that are basically not
19 cognitively aware or immobile? That's just
20 outrageous.

21 KATE MCGRANN: Participant 1, I just
22 want to let you know that you're coming up on the
23 end of your time.

24 PARTICIPANT 1: Okay. So again,
25 communication about these fire drill -- you know,

1 all these different things. This is just
2 ludicrous. It should never have happened in that
3 respect.

4 And, again, 6 staff at night for
5 90 cognitively impaired residents or immobile
6 residents is another outrageous thing that -- it's
7 just not possible.

8 I'll stop there because otherwise I can
9 keep on going forever, so I will take a moment and
10 stop there. Thank you very much.

11 KATE MCGRANN: Thank you very much,
12 Participant 1.

13 Participant 2, please go ahead.
14 Participant 2, you'll want to un-mute yourself.

15 PARTICIPANT 2: Got it. Okay. Sorry.
16 I've been a caregiver for three family
17 members, two parents and an aunt. That included
18 arranging and overseeing home care followed by
19 retirement home and long-term care home residency.

20 One family member died in long-term
21 care in the first wave of COVID in a residence that
22 had a serious outbreak in which 50 percent of the
23 residents were infected, and 15 percent died.
24 14 percent of the staff were infected with no
25 deaths.

1 I've also been active in supporting
2 families and in the family council work for several
3 years.

4 Before I start, I'd just like us all to
5 pause and think of ourselves as the children we
6 were and as the older adults we will become. We
7 were important before we were old enough to become
8 productive members of our communities, and we will
9 all be important even after we are no longer
10 economically productive members of our communities.

11 Rather than describe more sad long-term
12 care pandemic stories, I have some key messages for
13 the Long-Term Care Commission that I would like to
14 explain today.

15 In order to turn long-term care around
16 from its current deficient situation, essential
17 family caregivers must be recognized as experts in
18 our families' care and with an overall general
19 knowledge of the elderly and of the long-term care
20 system often missing from other subject matter
21 experts in the sector.

22 Essential family caregivers should not
23 only be partners in care consulted in the last part
24 of the development of a new long-term care system.
25 They should be invited to be among the primary

1 stakeholders leading the process.

2 Through necessity, the pandemic has
3 caused essential family caregivers to become more
4 knowledgeable about the various policies and
5 players in the long-term care sector.

6 This increase in knowledge and in
7 comprehension of the impacts on long-term care have
8 come despite a sector that is secretive,
9 bureaucratic, and close (ph) with information that
10 might portray a home, its owners, or operators or
11 the sector in a bad light.

12 Essential family caregivers must have
13 the support of government to be recognized in
14 legislation for the essential role they play in the
15 lives of their family members in long-term care and
16 also to be recognized as essential advocates for
17 all residents in long-term care.

18 The government will find essential
19 family caregivers to be committed and highly
20 motivated in creating a long-term care system
21 that's worthy of the elders whose care is in our
22 hands.

23 The pandemic has shamed us into
24 recognizing our failures in long-term care to date.
25 While its lessons are fresh in our minds, we must

1 act on rethinking long-term care. In this effort,
2 the families who deal with the long-term care
3 system on a daily basis must be essential part of
4 designing the new elder care system.

5 Family caregivers were chosen by their
6 family member to care for them and to represent
7 their interests when they sensed that they would
8 one day no longer be able to do so themselves. For
9 this reason family caregivers in the context of
10 elder care are just as essential as parents in the
11 care of their children.

12 Family caregivers in most cases have
13 legal obligations as POAs and substitute
14 decision-makers to inform themselves about their
15 family member's most personal and medical details
16 in order to oversee their family member's care.

17 Family caregivers are not visitors.
18 That is why I use the term "essential family
19 caregiver." The long-term care system as it is
20 today does not respect the role of essential family
21 caregivers and by extension does not respect the
22 rights of the residents they represent despite the
23 resident's Bill of Rights in the long-term care
24 act.

25 Essential family caregivers are not

1 informed about their family member and about the
2 conditions in the home. Essential family
3 caregivers had to gain as much information as they
4 could during the pandemic from window visits,
5 occasionally answered telephone calls, brief
6 conversations with stressed staff outside the home
7 after their shifts.

8 Families created email networks to keep
9 one another informed as best they could with
10 information gleaned from outside the home.

11 Families were assured that all was under control
12 and that they would be informed if their family
13 member's situation changed.

14 In the meantime, homes stated that all
15 protocols and procedures were being followed. It
16 was obvious even from outside the home that their
17 assurances were empty. Many --

18 KATE MCGRANN: I just wanted to let you
19 know you're coming up on the end of your time.

20 PARTICIPANT 2: Okay. Many people call
21 themselves experts in long-term care, the Ministry,
22 the doctors, et cetera. I won't go through the
23 list. Well, if the care we have seen before and
24 during the pandemic is any indication, it's a
25 hollow claim indeed.

1 Essential family caregivers came into
2 their own during this pandemic. We realized we
3 have a broader picture than do those now considered
4 experts in long-term care. We have a very
5 meaningful knowledge of how the system works and
6 does not work, and we have ideas about how
7 long-term care might be rebuilt to serve the needs
8 of the frail elderly.

9 We have come to respect our own
10 potential contribution to rethinking long-term
11 care. Now is the time for the rest of the
12 population and for government to recognize us as
13 the experts we are. Thank you.

14 KATE MCGRANN: Thank you very much,
15 Participant 2.

16 Participant 3, please go ahead.

17 PARTICIPANT 3: Hi. I'm a member of my
18 local family and friends council and have been for
19 a couple of years since my wife was admitted. She
20 first went to an assisted living while we were
21 waiting for our number to come up within the
22 selection process.

23 She was eventually chosen by the home,
24 moved in, and I -- I especially chose a home that
25 was not-for-profit, which was -- as far as I'm

1 concerned, saved my wife's life basically.

2 She's -- she was in her previous home, and that was
3 wildlly expensive, and certainly a lot of corners
4 were being cut when it comes to the provisions for
5 staff. So I was very happy when she moved into her
6 long-term care home.

7 After the pandemic had occurred, it was
8 a number of months where there was very, very
9 little communication, especially about her as an
10 individual. But more importantly, our care plan,
11 as far as I was concerned, is the contract between
12 me, her care -- care provider. The care plan was
13 our contract.

14 And when I found that there was major
15 deviations, like there was no physio for three
16 months, and my wife is in a position where physio
17 is an absolute must, when I found out that that was
18 not provided, I was not made aware of any changes
19 in her -- delineation in her care plan that was not
20 being actioned. So I was pretty miffed about that.

21 One of the things that I have never
22 fared well with is I've never felt like I was a
23 sought-after participant in my wife's care. I
24 didn't directly find out -- or I didn't read well
25 enough that the only way I was going to be able to

1 get in to see her was by describing myself as a
2 designated caregiver.

3 I thought that that was an application
4 that I had to make to the home that I didn't feel
5 qualified, et cetera, et cetera. Well, I found out
6 I could just name myself, but that information
7 certainly wasn't made available to me willingly.

8 And so I got in, and I was very glad to
9 be able to get inside the building and to
10 participate in whatever rules were in effect in
11 order for me to be able to get in and see my wife.

12 But I -- one thing I found out that I
13 had no knowledge of and couldn't find out is when
14 there was changes in the building compared to what
15 it was pre-pandemic, I was not able to find out
16 whether that was a provincial covered --
17 provincially covered mandate or whether that was
18 something that was interpreted by the local home
19 where I was or wasn't able to do something.

20 And when it came to letting people
21 inside the home, whether we're in outbreak or not
22 in outbreak, as far as I was concerned, the whole
23 access while we're under a pandemic mode is a risk
24 management type perspective.

25 In my wife's building, there have

1 been -- well, several buildings involved, and there
2 have been a number of staff members who have caught
3 it and died. I think about seven or nine residents
4 have caught it and died.

5 And I've never felt like a sought-after
6 participant in any of the things that have happened
7 there. And the designated caregivers are even
8 more -- they're tested more often than the staff
9 members. Staff members get tested once a week, and
10 they have to show up whether their results are back
11 in or not.

12 We have to have an active -- meaning
13 the designated caregivers have to have an active
14 window within the last seven days. Well, reality,
15 it's only six days because even if we get the test
16 at 7 o'clock in the evening, our day one is
17 finished at midnight. So if we get tested
18 Wednesday at 7, our coverage ends up running out
19 Tuesday at midnight.

20 KATE MCGRANN: Participant 3, I just
21 want to let you know that you're coming up on the
22 end of your time.

23 PARTICIPANT 3: Okay. One of the
24 things I would like to know or find out is when
25 there has been an exposure of somebody on the

1 floor, did that person come into my room and
2 directly expose me? And I have no way of finding
3 out.

4 The staff know who came in, but the
5 designated caregivers are not allowed to find out
6 if somebody has -- that has had the virus has come
7 into their room or not while they were there. And
8 I have no way of going forward with that. That's
9 it.

10 KATE MCGRANN: Thank you,
11 Participant 3.

12 Participant 4, please go ahead.

13 PARTICIPANT 4: Good afternoon,
14 Commissioners. Thank you for providing this time
15 for family. I have a prepared response to
16 question 1, and it's three minutes and 59 seconds
17 in length, so I'll talk real fast. Okay?

18 Over the course of -- first of all,
19 just a note of encouragement. Over the course of
20 your mandate, you've heard some very painful and
21 troubling circumstances regarding long-term care in
22 Ontario.

23 And despite the Province not extending
24 the report timelines for the Commission, which I
25 hope they will, what you do in the process of

1 inquiry and deliberation will prove invaluable long
2 after this pandemic is relegated to a distant
3 nightmare.

4 In my experience, I have a friend of
5 30 years who is in long-term care to whom I provide
6 support, a nice fellow in his 70s with no immediate
7 family, but a person with a lifetime of complex
8 psychiatric disorders who were it not for long-term
9 care, may well have been living under a bridge in
10 Ottawa when this pandemic started.

11 However, for over three years now, he
12 has been in the care of staff at Fairview Manor in
13 Almonte. My friend is well looked after and well
14 loved by nursing and personal care staff.

15 While I cannot get in to visit and
16 spend in-person social time with him, something he
17 greatly values, staff have taken pains to connect
18 us through occasional video calls, and, of course,
19 we talk by phone.

20 While he has suffered from depressive
21 incidents, partly due to the isolation, he has
22 fared better than many.

23 I recognize that managing in this
24 pandemic has been a learn-as-you-go process for
25 everyone, but of particular concern to me at this

1 point in time is expectation management, a role
2 that must be vigorously -- rigorously set from the
3 top.

4 Our small community was made painfully
5 aware of the ravages of this pandemic when during
6 the first wave another long-term care home, a
7 private home in our community lost 28 or
8 29 residents from the coronavirus.

9 Fairview Manor has been, thank God,
10 spared this agony as management and staff have
11 worked tirelessly to interpret sometimes
12 conflicting Ministry guidelines and have found
13 themselves in the middle of difficult exchanges.

14 One example that comes to mind is while
15 Ministry was telling directors of care to isolate
16 residents to avoid in-home transmission, it was
17 allowing, even encouraging residents to be taken on
18 outings by family members.

19 I remain concerned that the Ministry
20 has not grasped the complexities of long-term care
21 administration at the ground level and that an
22 effective accountability framework and resource
23 model still does not exist.

24 I have three points that I'd like to
25 offer you.

1 1, the Province has been in the middle
2 of transitioning from a LHIN structure to this
3 regional Health Team structure. But when the
4 pandemic hit, the channels were not clear, and
5 accountabilities were muddled.

6 2, places like Fairview Manor are
7 taking it upon themselves to find innovative ways
8 to meet quality of care and performance objectives.
9 But these approaches come at a cost. Staff are
10 exhausted, management is set to focus on -- more on
11 Ministry directives and directions than in home
12 administration, and residents may be getting less
13 attention. This is a dangerous cocktail as we are
14 surely not out of the woods yet.

15 And thirdly, while vaccinations are not
16 a panacea in the short-term, communications about
17 them are part of the confused situation around
18 expectations management. My friend has been
19 anxious about when this vaccine will be
20 administered, and we just learned yesterday that
21 they're going to begin the day after tomorrow, so
22 that's good news.

23 Anyway, that's all for now. Thank you.

24 KATE MCGRANN: Thank you very much,
25 Participant 4.

1 Participant 5, please go ahead.

2 PARTICIPANT 5: Thank you. In 2015 our
3 mom moved into the long-term care that I'll be
4 speaking of today, and prior to this, she lived
5 almost a year in a retirement home where her care
6 was impacted by significant staffing shortages and
7 appalling care issues.

8 A PSW at the retirement home hit her a
9 few days before her move into long-term care. To
10 be clear, the long-term care home also has a
11 history of staffing and quality of care issues.
12 It's an old building with a high number of ward
13 rooms. Our experiences with long-term care and
14 retirement homes run deep, and I can't say they
15 have ended well.

16 On the day before the lockdown in
17 March, Mom was talking and singing with us, and in
18 the weeks that followed, we watched her rapid
19 decline through our window visits.

20 Her severe dementia, mobility, and
21 sensory issues added to the challenges of
22 communicating, and Mom never tested positive for
23 COVID-19; however, our family feels that she didn't
24 receive adequate care for hydration, nutrition, or
25 cognitive stimulation in the weeks and days leading

1 up to her death.

2 Her life diminished over the weeks.
3 With the room isolation, she was locked in her
4 dementia without the lifeline of her family to
5 reorient her to the threads of really who she was.
6 And Mom slowly slipped away and died without her
7 family by her side.

8 At the start of the pandemic, our
9 family reached out to all levels of care leaders,
10 politicians, the home administration, and CEO and
11 media. We tried to sound the alarm on the crisis
12 unfolding in our long-term care home, but the
13 response from all levels seemed be moving in slow
14 motion.

15 Calls were made to the inspections
16 branch and the Ombudsman's Office, but nothing was
17 done. I was told it was the home's responsibility
18 to reach out for help and that for-profit homes
19 like ours were less likely to ask for it. And not
20 that they didn't need the help. It's just that
21 they did not ask for it.

22 We watched the numbers of COVID
23 positive cases for residents and staff rise along
24 with the number of COVID deaths. We asked the CEO
25 of the home to call in the military to help shore

1 up staffing, and he replied that in a worst-case
2 scenario, the military may be a possibility. "How
3 much worse could it possibly get?" we asked.

4 We lived in terror over what was really
5 happening inside the home. Our mom was 97 years
6 old when she died in April of 2020.

7 By June, over 90 percent of the
8 residents had tested positive for the virus, and
9 36 percent of the residents died of COVID-19.
10 Other residents, like our mom, died because of the
11 pandemic, and these numbers are not tracked. This
12 home remains one of the hardest hit long-term care
13 homes with COVID-19 in Ontario.

14 Today in Ontario, we see more residents
15 and PSW deaths in long-term care with the most
16 recent death being a 19-year-old young man.
17 Horrific stories highlighting the ongoing systemic
18 issues continue to pour out of long-term care and
19 retirement homes across the province. And what
20 concerns me is that this crisis has become worse in
21 long-term care.

22 At the beginning of the pandemic, we
23 didn't know how to manage the virus. Eleven months
24 into the pandemic, there are no excuses for the
25 continued suffering or the continued state of

1 crisis. There have been very few strategies
2 implemented to make it safe for people living and
3 working in long-term care.

4 All of us have an obligation to those
5 who have suffered to advocate and do the work to
6 ensure transformative change happens for those most
7 vulnerable needing long-term care. Thank you.

8 KATE MCGRANN: Thank you very much,
9 Participant 5.

10 Participant 6, please go ahead.

11 PARTICIPANT 6: Thank you. My brother
12 was transferred on April 1st last year from the
13 Ottawa Hospital to Carlingview Manor, Revera
14 because the hospital needed the bed.

15 He was supposed to be in 14 days'
16 isolation, which was not true, and he was on the
17 locked floor for dementia. Residents who wander in
18 and out, who wander the halls, wander in and out of
19 rooms constantly. It was a free-for-all, and there
20 was absolutely no monitoring.

21 I raised a number of concerns during
22 this period, and I was told not to worry.

23 So on April 25th, he was tested
24 positive for COVID with breathing problems, chest
25 pain, severe headaches, and it was my worst

1 nightmare. I got absolutely no information, no
2 communication, my calls were not returned, and
3 worse, the stress and worry with him being very
4 sick and not safe. My only regular contact was
5 with him because I had given him a cell phone.

6 On May 23rd, I was advised he was
7 COVID-free. Between April 15th and May 19th, I
8 left 35 -- 35 of my calls were not answered. Nine
9 calls I left messages, and there was seven calls
10 where I was able to talk to someone.

11 I got one call from the doctor after
12 trying repeatedly from April 1st during that whole
13 period, and no -- I got a call on May 7th and no
14 updates otherwise.

15 When I was -- did manage to talk to
16 somebody, I was always told not to worry. When I
17 talked about the residents wandering in and out of
18 his room and that there was COVID on his floor, I
19 was told it was his responsibility to tell them to
20 leave. He's a person with dementia and physical
21 disabilities. I was told they were very
22 short-staffed, and they had no one to go down and
23 monitor.

24 I do completely blame them for him and
25 all the others who got COVID during this time, and

1 there's also the post-COVID symptoms. I know they
2 were very, very short-staffed, and I know they
3 continue to be short-staffed. The few times that I
4 did get to speak to someone, staff shortages were
5 always mentioned.

6 So there was a brief period of improved
7 communication after the first wave of COVID was
8 over and then went down to very little again
9 because of the second wave, and they were in
10 lockdown three times this time. But it's still
11 really, really bad.

12 During the time of the long lockdown,
13 the shower rooms were locked. If you've got
14 somebody that's disabled, cleanliness was an issue.
15 There's no laundry. The laundry that he had sent
16 down disappeared. It actually came back about a
17 month ago from April.

18 They're giving him drugs and
19 antidepressants, and we were supposed to be
20 discussing the effectiveness, but despite my
21 leaving messages, I still don't know, and no
22 discussion has taken place.

23 I had the opportunity to be visiting
24 outside during the summer, but they're back -- they
25 were back in lockdown again. I'm older than he is,

1 and I have some limitations myself, and I'm very
2 afraid of going inside that building.

3 I will say the staff did their very,
4 very best during that time being so short-staffed,
5 but things were really, really bad. There was lack
6 of care for residents, at least on the dementia
7 floor.

8 With having the shower rooms closed
9 during the lockdown, I was told because of staff
10 shortages, there was no one to sanitize between
11 users, so they had no choice other than to lock it
12 down.

13 So that's the situation. And there
14 were 138 residents on May 8 that had contracted
15 COVID, which is 43 percent, and 73 staff. And
16 sadly, at that time, there were 42 residents who
17 died. The numbers increased slightly after that.
18 They raised to 61.

19 KATE MCGRANN: Participant 6, I just
20 want to let you know that you're coming up to the
21 end of your time.

22 PARTICIPANT 6: Yes, and I'm done.
23 Thank you.

24 KATE MCGRANN: Thank you very much.
25 Please go ahead, Participant 7.

1 PARTICIPANT 7: Good afternoon, and
2 thank you for the opportunity to address this
3 catastrophic crisis of the pandemic through the
4 lens of family in long-term care.

5 I worked on an acute response team
6 which included elder abuse. Now there's a new
7 term, summed up in a very succinct way, senicide or
8 geronticide, which is the killing of the elderly or
9 their abandonment to death. This is now the abject
10 reality and lived experience of having a loved one
11 in long-term care during this pandemic.

12 COVID has truly exposed the horrific,
13 decades-old brokenness of the long-term care
14 sector. It's also been a devastated unveiling of
15 how the government has handled long-term care in
16 this crisis.

17 My father has been a resident in a
18 for-profit long-term care facility for two years
19 and 19 days. His facility was one of the earliest
20 hardest hit long-term care warehouses here in
21 Ottawa. There were over 60 deaths in the short
22 time frame.

23 Ironically, I worked in this facility
24 as a new grad 40 years ago, and it was as appalling
25 then as it is now. It was not my decision to place

1 him there.

2 My dad is a 91-year-old man that has
3 dementia and complex health issues. He yearns
4 daily to go home. My father's foremost a man who
5 spent most of his life as an outdoorsman. He said
6 he would never be in a cage again after fleeing a
7 war-torn country.

8 He values family more than anything and
9 has instilled a legacy of faith and trust in always
10 doing the right thing for others. This is why as a
11 society we are incumbent to fight for him and every
12 marginalized voice [INDISCERNIBLE] in long-term
13 care.

14 When the first lockdown happened in
15 mid-March, we were devastated to learn that we
16 weren't allowed to visit him. We were sick with
17 the realization that he would not know how to
18 navigate the sundowning that is associated with
19 dementia. We were always present from 3 o'clock
20 until he settled down for the night.

21 We knew from experience that the skill
22 to de-escalate and mitigate his anxiety and
23 agitation was essentially nonexistent in his
24 facility, especially during acute staff shortages
25 and temporary agency hires during the lockdown.

1 It was extremely difficult to hear his
2 cognitive decline and increasing inability to
3 recognize our voices over the phone and hear him
4 plead for us to come and help him. Other times his
5 very flat affect was just as distressing to us.

6 His moments of clarity were the
7 hardest. He was inconsolable and asked us what he
8 had done to deserve this existence at his age. He
9 definitely felt abandoned, and the guilt that I
10 carry about this will be with me forever. He said
11 that he'd rather die now than never see us again.

12 I worry incessantly about not being
13 able to do his diabetic foot care and that because
14 he wasn't getting that care, it would affect his
15 mobility, and it has.

16 We knew that cognitive stimulation and
17 activities were not happening. From our window
18 visits, it was clear that his hygiene and mobility
19 was compromised. He appeared unkempt and in dire
20 need of a haircut and in need of assistance to
21 stand by the window. This was not how we left him
22 before the lockdown.

23 Our attempts to communicate and voice
24 our growing concerns were not addressed in a timely
25 manner, if at all. The facility was extremely

1 inconsistent with Public Health and governmental
2 directives, always confusing.

3 I can clearly recall my first visceral
4 reaction on seeing my dad for the first time in
5 five months. He was slouched in his chair,
6 mentally unresponsive, unkempt, and there was an
7 odor. His legs were very edematous from
8 inactivity. He did not know who I was. I suspect
9 he was sedated.

10 On my second visit, I truly witnessed
11 the last few months of my dad's life. He had
12 bruises on his back from a severe fall. He had
13 cellulitis, both lower extremities, that was being
14 treated with antibiotics after I pointed out his
15 cellulitis to the staff.

16 His skin had broken down from poor
17 hygiene. His hair was long and very dirty. His
18 dentition was atrocious. He needed assistance to
19 move, and his cognition has eroded to the point
20 where I had to keep saying who I was.

21 In between the lockdown, we brought him
22 outside as much as possible. We began to notice
23 slight, incremental improvements overall. He was
24 beginning to come back to us with our love and
25 nurturing and caring.

1 Sadly, my father has begun a slow final
2 decline. The isolation and his grief over what he
3 considers an abandonment, the resulting overall
4 poor quality of his life in long-term has taken the
5 wind out of his tattered sail.

6 We grieve his life with him because
7 it's not living. It's a desolate, depressing
8 existence in present long-term care in this
9 pandemic. Thank you.

10 KATE MCGRANN: Thank you very much,
11 Participant 7.

12 Participant 8, please go ahead.

13 PARTICIPANT 8: Am I on? Oh, hi.
14 Kate, for my question number 2, the answer to
15 question number 2 is about 40 seconds, so will I
16 have a little longer with this one then?

17 KATE MCGRANN: Sure. Why don't we try
18 to give you [INDISCERNIBLE], and then we can come
19 back to you.

20 PARTICIPANT 8: Okay.

21 KATE MCGRANN: Please go ahead.

22 PARTICIPANT 8: Thank you. My major
23 concern has been the lack of strong leadership in
24 many of the long-term care homes. Managers manage
25 resources. Leaders manage change, including the

1 appropriate response during crises such as a
2 pandemic, yet for the most part, my family did not
3 see confident decision-makers.

4 We did not see the utilization of
5 critical thinking skills. We did not see solid
6 communication skills applied to residents, family,
7 staff, and other key community stakeholders.
8 Instead, we heard the description of chaos and
9 time-consuming work from some administrators.

10 On a positive note, in one home,
11 managers were assigned to a resident home area for
12 which they were accountable in terms of quality
13 care, staff training and support, liaison with each
14 resident and family on a weekly basis, et cetera.

15 In another home, when the first case of
16 COVID was identified in Toronto, the administrator
17 initiated staff screening, including temperature
18 checks on arrival to and departure from the home,
19 as well as verbally screening visitors. That home
20 has had zero COVID infections to date.

21 A second home started the screening
22 process after a staff member transmitted the virus
23 to a resident. The eventual result was numerous
24 resident deaths as well as staff infections. Those
25 examples demonstrate the significant difference

1 quality leadership can and will make within our
2 long-term care homes.

3 In my experience, I did not see any
4 prior planning for a pandemic in terms of human
5 resource needs, procurement of equipment and
6 supplies, environmental limitations, and strategies
7 to effectively and efficiently manage stakeholder
8 information.

9 Such planning is essential, and the
10 lack thereof has meant much tragedy for our
11 families, friends, and community at large.
12 Pandemic preparedness would include a plan for the
13 procurement of PPE and the fundamental need for
14 stakeholder education and training on IPAC
15 standards and practices.

16 When initial orientation, annual
17 training, and refresher training on IPAC does not
18 happen, the potential for contamination with an
19 infectious agent is widespread across that home.

20 Thus, at the outset of any outbreak,
21 reorientation of all staff, volunteers, residents,
22 and families is essential and foundational to
23 stopping the spread of the virus.

24 In many of the homes, there was no
25 dedicated area for the donning and doffing of PPE.

1 And doffing did not include the decontamination,
2 which is critical because workers can become
3 contaminated with infectious material while taking
4 off PPE.

5 Many homes did not conduct a risk
6 assessment of each staff position relative to PPE
7 required, and without that knowledge and
8 understanding, there was rapid transmission of the
9 virus. As well, many homes did not instruct staff
10 on how to safely provide resident care while
11 wearing PPE.

12 This is mandatory, especially given the
13 challenge of enforcing social distancing among
14 residents with dementia. As well, in some homes,
15 ill residents were not isolated to one wing with
16 dedicated staff and other resources despite the
17 common knowledge that cohorting is a standard
18 practice to prevent the transmission of infectious
19 agents.

20 In terms of senior staff, my concern is
21 that in many homes, the clinical leadership,
22 medical director and the nursing staff and the
23 administrator/executive director, were
24 ill-prepared, poorly organized, un-resourceful, and
25 unsupportive in their roles in this pandemic

1 situation.

2 In my experience, managers were not
3 on-site seven days a week, medical directors were
4 often not accessible, and administrative leaders
5 did not understand the need for transparency and
6 ongoing communication with residents, family, and
7 staff.

8 As well, I heard from many staff that
9 their management team did not monitor nor support
10 their efforts in keeping residents safe. Examples
11 included no PPE available, limited access to hand
12 hygiene products, PPE worn incorrectly, and the
13 same PPE utilized in multiple resident rooms.

14 In addition, many staff felt that their
15 managers did not monitor their physical and
16 psychological well-being despite the fear, anxiety,
17 and physical strain they were experiencing.

18 From a resident and family perspective,
19 I know that efforts were limited in terms of
20 ensuring the social connectedness of residents with
21 their families. This despite the technology
22 available: Email, teleconferencing,
23 videoconferencing, and a simple one-to-one phone
24 call.

25 Virtual visitation was supported by

1 many homes; however, the essential caregiver role
2 was not recognized at the outset of the pandemic.
3 The connection between residents and their families
4 must never be disregarded given the social
5 isolation that ensues and the role family members
6 play in the resident's health, well-being, safety,
7 and security.

8 I ask that the Commissioners consider
9 my experiences when preparing your final report.
10 Thank you.

11 KATE MCGRANN: Thank you very much,
12 Participant 8.

13 I'm going to turn to Jessica now to
14 read aloud question 2.

15 JESSICA FRANKLIN: Thanks so much,
16 Kate.

17 And thank you, everyone, for your
18 thoughtful and extremely informative answers to
19 question 1.

20 As we go to question 2, you know,
21 please make sure that if there was anything that
22 you didn't feel that you were able to adequately
23 cover in question 1, that you do share that with
24 us.

25 And, of course, if you need to, you

1 know -- as Kate said, if there's anything else that
2 you're reflecting on and want to share further if
3 there's not enough time during the time slot, we
4 certainly can provide you with ways to do that.

5 So question 2 is this: Reflecting on
6 your experience, is there anything that could have
7 been done that would have made the situation
8 better? What is the most important thing that the
9 Commissioners need to know as they consider
10 recommendations?

11 We'll begin with Participant 1.

12 PARTICIPANT 1: Again, thank you very
13 much. With regards to what could have been done,
14 one of the first and foremost things that I think
15 should have been done is more staff.

16 If you think about just in terms of PSW
17 care, activity care, dietary concerns, you need the
18 staff to be able to support the residents,
19 particularly the residents who are immobile or need
20 help to feed themselves.

21 The home that I'm affiliated with, if
22 you will, is -- their management staff has been
23 turned over -- like, I think we're on our seventh
24 ED since last February, executive director since
25 last February.

1 There's no continuity. There's no
2 consistency. How can a home expect to run with any
3 sort of semblance of order if their management
4 staff is turned over every -- you know, every month
5 or so? That's ridiculous. They need to have more
6 continuity.

7 I also feel that the for-profit should
8 be taken out of these homes as well, for that
9 matter.

10 It all basically boils down to
11 staffing. Communication is another huge thing as
12 well. We were not provided with the correct
13 communication to know what was going on, and,
14 again, that goes to staffing.

15 I don't think I can say much more else
16 other than everything seems to boil down to
17 staffing. Now, I understand that the government
18 has just, you know, provided X number of dollars to
19 provide more staff, and they're talking 300 staff.
20 Well, 300 staff over the province of Ontario is,
21 like, nothing. It doesn't mean anything. It's not
22 enough.

23 And they have to be paid -- you know,
24 when you hire these staff, they need to be paid a
25 living wage. They need to be paid benefits and

1 sick days and, you know, that type of thing, also
2 provided with proper PPE gear, you know, to be able
3 to care for residents. When they're moving from
4 room to room with the same pair of gloves, that
5 doesn't make any sense. It doesn't help the
6 infectious side of things. So yeah, for me it's
7 the staffing.

8 And homes need to be -- like, the
9 companies that run these homes, they need to be
10 held accountable for -- you know, for the things
11 that happen. There needs to be accountability
12 above all else.

13 I'll stop there because I think that
14 pretty well -- you know, other people have said
15 what I agree with, so, yeah, I think I'll stop
16 there. Thank you.

17 JESSICA FRANKLIN: Thank you,
18 Participant 1.

19 Participant 2, please go ahead.

20 PARTICIPANT 2: My chief
21 recommendations are add essential family caregivers
22 to the long-term care act with rights similar to
23 those described in the resident Bill of Rights in
24 the act.

25 Revise directive number 3 giving

1 essential family caregivers a separate section and
2 status and do not include them under the heading of
3 visitors.

4 Family members and essential family
5 caregivers must be viewed as primary resources
6 regarding residents and their well-being and must
7 be viewed as part of the care team. They must not
8 be viewed as spies or irritants in the long-term
9 care home.

10 Their advice, questions, and
11 interventions must not lead to reprisals against
12 the resident or the essential family caregiver or
13 other members of the resident's family.

14 2, improve staffing and staffing level
15 standards and performance against those standards.
16 Ban long-term care workers from working at more
17 than one home on a permanent basis. Control the
18 number of long shifts, that's 16 hours, and double
19 shifts and the use of agency staff.

20 Ensure that doctors, nurses, PSWs, and
21 management are personally suitable for the job of
22 working in long-term care. Adopt the advice of the
23 recent staffing study presented to the Ministry of
24 Long-Term Care.

25 3, develop and regularly update new

1 care standards that reflect current knowledge and
2 best practices in all aspects of care. Particular
3 attention should be paid to dementia care and to
4 palliative and end-of-life care, both of which are
5 currently deficient in long-term care.

6 A potential solution could be to deploy
7 community or hospital palliative care teams into
8 long-term care homes as required.

9 All care should move from the current
10 task orientation to person-centered care that
11 recognizes the whole person and individual needs,
12 especially the need for independence.

13 Train PSWs better and create a
14 licensing system for them. They must be part of
15 the registered staff in order to be considered a
16 respected part of the care team. The scope of PSW
17 work must be broadened to include observations that
18 could indicate a problem that must be addressed.
19 The scope of PSW training must include training in
20 different cultural expectations and practices among
21 residents.

22 5, pay all workers in health care
23 enough salary and benefits so that they can work at
24 one home. Pay and benefits should be the same as
25 pay and benefits of hospital workers in health care

1 facilities. Going forward, require that all health
2 care workers must comply with testing and
3 vaccinations in order to work in health care.

4 7, train long-term care home management
5 in their responsibility for regular and ongoing
6 communications with families, family councils, and
7 the public when necessary. These communications
8 should respect the important role of family members
9 and essential family caregivers in the care and
10 well-being of residents.

11 8, free long-term care home management
12 from having to report critical information to their
13 owners or operators, a requirement that can lead to
14 critical information getting delayed at best and
15 manipulated at worst.

16 Critical information must be
17 communicated in digital form directly from the home
18 to the Ministry of Long-Term Care analysts. For
19 example, when actual staffing levels fall below a
20 set standard, it should be reported to the Ministry
21 immediately.

22 Ministry of Long-Term Care must define
23 what is a crisis. For example, X percent of
24 residents are sick. X percent of staff are sick.
25 X percent of staff have left. X percent of calls

1 and emails go unanswered. X percent of residents
2 have not eaten. X percent of residents have a UTI.
3 Those are just examples.

4 In the long-term care sector, homes
5 avoid making information public for fear of
6 tarnishing the reputation of the home.

7 9, train long-term care home staff in
8 communicating with families about resident-specific
9 information and train them in resident rights and
10 essential family caregiver rights.

11 10, connect long-term care homes to a
12 supportive network of regional public health and
13 hospital groups and improve management's judgment
14 of when to ask for help.

15 11, devise new and better ways to
16 measure performance and meaningful outcomes in
17 long-term care. Reeducate the sector that process
18 indicators are not meaningful performance
19 indicators.

20 12 --

21 JESSICA FRANKLIN: Participant 2,
22 sorry, just to let you know, you're coming up to
23 the end of your time.

24 PARTICIPANT 2: Okay. Remove
25 inspectors from local areas where they become known

1 to long-term care homes. Relocate them to
2 provincial level where they can be rotated and
3 deployed as unannounced inspection teams.

4 I'll shorten the next ones. Build
5 automated systems that automatically capture data
6 from the long-term care home systems. Improve
7 cross-training and lessons learned in homes that
8 have suffered in outbreak so other homes don't
9 repeat those problems.

10 Phase out private sector involvement in
11 long-term care and in home care. Corporate goals
12 for profit and protection of corporate reputation
13 and information are inconsistent with topnotch care
14 and need for full communications and transparency.
15 Private companies just add to the government
16 bureaucracy required to oversee them.

17 I think I could stop there. Thank you.

18 JESSICA FRANKLIN: Okay. Thanks so
19 much, Participant 2.

20 Participant 3, would you like to go
21 ahead?

22 PARTICIPANT 3: Sure. The scope of how
23 I've been viewing some of this has been a lot more
24 microscopic level, not macro, big picture. The
25 other folks that have been supplying

1 recommendations are a lot more global in management
2 processing than I could ever deal with.

3 I'm someone who, in my career, has
4 always been in the trenches looking up on how to
5 get out of a problem or a situation or whatever the
6 case, and I don't have as much of a management
7 perspective.

8 However, one of the things that I am
9 most wary of is that we're going to be with this
10 virus for a very long time. I don't think that
11 we're going to be out of the water in -- within a
12 couple of years. I think there's going to be an
13 ongoing -- a problem that we're just not going to
14 be able to get ahold of.

15 And that has to do a lot with how much
16 society is going to be taking the vaccine,
17 et cetera. Like, in my wife's home, there's an
18 under 50 percent take-up rate even though Ottawa
19 was one of the designator areas, and our home was
20 one of the test facilities, and we still got an
21 under 50 percent take-up rate.

22 And most of the folks that I have
23 talked to there don't get flu shots, and they're
24 not going to take the vaccine. They just -- they
25 have their own reasons for not doing it.

1 So there's a -- certainly there's a
2 not-me-first syndrome, but a lot of people just
3 don't believe in vaccinations, and it's not going
4 to -- the problem isn't going to happen to them.

5 So I expect that we're going to be
6 dealing with this virus in many of its bounce-back
7 forms for a long term to come and how we're going
8 to be able to handle that.

9 So one of the things that I know is on
10 the list for upcoming is the rapid test. How are
11 we going to handle rapid test deployment? What is
12 our requirements? Should we have people who do not
13 take the vaccine need to undergo several of the
14 rapid tests per week, for example?

15 Could there be an education function
16 that goes out for the training of PSW and perhaps
17 even some form of an incentive program to get PSWs
18 to participate more voluntarily as opposed to a
19 punishment? Is there some form of a participant
20 inclusion that we could provide for people who want
21 to get -- to be part of the vaccination program?

22 I was lucky enough to have had the
23 second dose, and I don't know how protected I am.
24 My wife is going to be having the second dose in a
25 couple of days, so she's as protected as she can

1 be. But I'm still not allowed to be out in the
2 hallway with her. I can only be in her room.

3 Today she wanted to be in the main area
4 because they're off of lockdown as of today. She
5 wanted to be with other people to eat, so I had to
6 stay in her room while she ate. And I typically go
7 there over lunch hour to help feed her. Today she
8 wanted to be with other people, and she's a very
9 social kind of person.

10 So how do our rights unfold? What are
11 the expectations of the vaccine program? Anyhow,
12 I'm going to stop there. I'm too wrapped up in
13 this.

14 JESSICA FRANKLIN: Thanks so much,
15 Participant 3. And just to say, from the global to
16 the individual, all perspectives are very much
17 welcome, so thank you very much for sharing that.

18 And I just wanted to let participants
19 know that we are doing quite well for time, and so
20 we'd like to offer, if you would be interested, an
21 offer for you to just share one final statement,
22 just under a minute or so. We'll go and do one
23 final round.

24 If there's anything that you really
25 want to make sure the Commissioners are aware of,

1 we'll do that at the end. We'll continue on with
2 responses to question 2, but we do have enough time
3 for just one final statement if anyone would like
4 to share that. So myself or Kate will direct you
5 in doing that.

6 All right. We'll move on to
7 Participant 4 with your response to question 2.
8 Thanks so much.

9 PARTICIPANT 4: Thank you, Jessica. So
10 I want to just preface my comments by saying I am
11 by no means an apologist for the long-term care
12 system in Ontario. I believe it's in crisis. It's
13 broken, and you've heard a lot from a lot of people
14 already about what's wrong with the system.

15 I just want to say -- I want to point
16 out that there are some success stories, and to me,
17 the home that I'm associated with, Fairview Manor,
18 is one of those success stories in infection
19 prevention and control. But as we all know, this
20 can change at any moment, and, you know, we could
21 be in a very bad situation.

22 But in my humble opinion, I would like
23 the Commissioners to note that not just -- to note
24 not just what witnesses have told the Commission,
25 but to look also at who these witnesses have been.

1 And I think you will find that we
2 family members who have participated, generally
3 seniors in our 60s and 70s, white-haired or
4 no-haired, and we are ultimately the next
5 generation of residents in long-term care, so we
6 have a vested interest in getting long-term care
7 done right and done soon. So we urge you to work
8 with that thought.

9 We, ourselves, are reaching a point
10 where we rely on the home to do for our loved ones
11 what we are no longer able to do financially,
12 socially, culturally.

13 Small locally administered homes like
14 Fairview Manor are often staffed by friends or
15 family of residents who have known them for a good
16 portion of their lives. Such links between
17 residents and staff can be very important in
18 determining how exceptional care in a pandemic is
19 delivered.

20 So I humbly offer the following three
21 recommendations for your consideration: 1, I think
22 the Ministry needs to fast-track online
23 connectivity, not just for medical consultations
24 but so that audio/visual communications becomes a
25 standard feature for connecting every resident to

1 their family members. This becomes critical in
2 pandemic situations, I believe.

3 Number 2, while today the Province has
4 announced 11.8 million in funding for Ottawa area
5 homes, I think it needs to do more for homes with
6 good records too. You know, so not just to reward
7 those that have had -- you know, had failures,
8 which definitely need help, but places -- other
9 places need help too.

10 So a longer-term strategy for long-term
11 care should include smaller homes with higher
12 staff-to-resident ratios and include, if possible,
13 only single bedrooms to reduce the impact of
14 transmission in multi-bed areas. That's a big ask,
15 but I think it's something to look for in the
16 long-term.

17 And lastly, I think the accountability
18 framework for long-term care -- and you've heard
19 this said by a couple of others here. It needs to
20 be dramatically overhauled to make the pandemic
21 response of prevent, isolate, contain an
22 ever-present part of continuity planning and not a
23 one-off.

24 So for me, that's how I would wrap it
25 up. Thank you for your time and your perseverance

1 in providing the best possible report you can.
2 Thank you.

3 JESSICA FRANKLIN: Thank you,
4 Participant 4.

5 We're going to move on to
6 Participant 5. Please go ahead.

7 PARTICIPANT 5: Thank you. So I agree
8 with the comments that the participants have made
9 prior to me speaking.

10 So what could be -- what could have
11 been done that would have made [INDISCERNIBLE].
12 Well, I think the Provincial and Federal Government
13 stepping in sooner to better manage the outbreak
14 crisis in long-term care would have helped, that
15 residents' rights to safe and quality care was
16 given priority over everything else, that staffing
17 issues were addressed earlier, and planning had
18 taken place long before the second wave to ensure
19 safe -- sufficient staffing going forward including
20 recruitments, suitability, training, retention, pay
21 equity, benefits, minimum standards of care,
22 increased full-time work versus part-time and
23 casual positions.

24 And as we know, Quebec moved quickly,
25 and I know there have been issues, but they have

1 moved quickly with a plan in place. It would have
2 helped to have residents and families included at
3 the discussion and decision-making tables to truly
4 reflect what was happening from the perspective of
5 the resident and families on care needs during the
6 pandemic.

7 What essential care -- developing the
8 role of essential care partners, visits,
9 communication, and planning for subsequent waves,
10 and, of course, accountability with rigorous
11 unannounced inspections, reporting, and follow-up
12 would have gone a long way to identify standards
13 compliance.

14 Some items I would encourage you to
15 consider in your recommendations are: 1, at the
16 very heart of long-term care are the residents, not
17 politics or profits. It's about the residents and
18 their safety and care needs always.

19 2, families are the supportive voice of
20 the resident, and it only stands to reason to
21 encourage residents and families and ensure they
22 have a seat at the discussion and decision-making
23 tables to promote transparency, which is essential
24 to building trust.

25 3, over half of the long-term care

1 facilities in Ontario are managed by the private
2 sector. For-profit homes represent a conflict of
3 interest as they can prioritize profit, liability,
4 and shareholder rights over resident care needs.

5 4, I believe it's unethical to be
6 making profits off the compromised health of people
7 living in longer-term care environments, and this
8 must be stopped.

9 5, long-term care is the largest form
10 of hands-on care that's not covered under the
11 Canada Health Act, and we need national standards
12 for long-term care.

13 6, numerous reports have been written
14 over the years by experts in the field of senior
15 and long-term care offering recommendations for
16 care delivery models, best practices, policy
17 reform, staffing, standards of care, data
18 collection. We know what has to be done.

19 7, long-term care transformation must
20 include both facility- and community-based care.
21 Longer-term care is a continuum often starting with
22 support of family and community services in the
23 home with the potential for the person to move into
24 a facility-based care. Community care must be held
25 to the same standards as facility-based care.

1 8 -- I'm almost done here -- quality
2 staffing is a critical piece for any delivery of
3 care.

4 9, our provincial political leaders
5 have demonstrated they do not have the political
6 will to fully act on what is needed to protect
7 vulnerable people using longer-term care. Other
8 options must be urgently pursued for the safety of
9 those using longer-term care.

10 And finally, I encourage you to take a
11 brave and different path from what has been chosen
12 in the past, one that can transcend partisan
13 politics and be a model of care excellence in the
14 long-term care sector. Thank you.

15 JESSICA FRANKLIN: Thank you very much,
16 Participant 5.

17 Participant 6, please feel free to go
18 ahead.

19 PARTICIPANT 6: Thank you.
20 Communication is something that really needs to be
21 addressed. It was nonexistent, and it's still
22 really not good.

23 Staff. We need full-time staff with
24 better pay and benefits. They have to stop either
25 running shorthanded or calling in agency personnel.

1 They all need full-time work. We have to stop the
2 practice of having these low-paid workers going to
3 two and three different long-term care facilities
4 in order to make a living wage.

5 We have to address cleanliness. And if
6 I get the chance at the end, I will talk a little
7 bit about that on the next round.

8 They need to go back to reinstate
9 regular inspections. That really needs to be done.
10 And last but the highest of my priorities is to
11 take the profit out of long-term care. As I said,
12 my brother is at Carlingview Manor, which is part
13 of the Revera chain.

14 I am retired with 37 years in the
15 federal public service. You can't even think how I
16 feel to know that my pension owns Revera, the
17 overwhelming guilt because I'm receiving a monthly
18 pension to the detriment of my brother.

19 It's time really to end privatization.
20 I think we've seen through all of this that
21 privatization and the for-profit homes really have
22 the highest problems and the highest numbers.

23 So I am doing everything I can to make
24 Revera public, and I think that needs to be
25 followed by other long-term care facilities. Thank

1 you.

2 JESSICA FRANKLIN: Thank you,
3 Participant 6.

4 Participant 7, please go ahead.

5 PARTICIPANT 7: This is an
6 all-consuming question for me. My recommendations
7 are very lofty, but I feel that they need to be
8 voiced and heard, and God knows that the entire
9 long-term care system needs to be fixed and that
10 our vulnerable seniors deserve to be cared for in
11 an environment that is safe, healthy, humane, and
12 caring, not just during a world health crisis but
13 always.

14 1, abolish for-profit facilities
15 because placing profits over people is a repulsive
16 incentive that directly affects quality and the
17 essence of care for this demographic. There needs
18 to be a working system that places human life over
19 shareholders and pension funds.

20 Hire more nurses, social workers, and
21 psychosocial teams that are regulated, skilled, and
22 trained to ensure that our elders receive the
23 clinical interventions, observations, and
24 around-the-clock monitoring that is integral to
25 their well-being and health issues.

1 We need dedicated and skilled dementia
2 care urgently. There are thousands of seniors who
3 don't have physical medical issues but have
4 dementia, and at times, the only intervention is
5 the use of atypical antipsychotics.

6 Number 3, Bill No. 203, which is the
7 essential caregiver act, needs to be legislated
8 immediately. The number of essential caregivers
9 need to be increased to at least four people to
10 prevent burn-out and as a backup contingency plan
11 if one of the ECGs becomes ill or unavailable.

12 This is the foundation on which the
13 long-term care crisis will evolve the quickest and
14 be the most efficient and humane intervention
15 during this current disaster. This is tangible at
16 this junction.

17 Number 4, increase the number of
18 unannounced Ministry inspections.

19 Number 5, long-term care facilities
20 need to have a liaison for constant updated
21 communication with families to provide direct and
22 clear answers in a timely manner.

23 Number 6, PSWs need to have better job
24 security and benefits and pay equity. Affordable
25 and accessible child care should be made available

1 because most PSWs are marginalized women in this
2 field.

3 Aging-in-place options need to be
4 addressed ASAP. Families and the populations have
5 witnessed the horror of long-term care over the
6 past year. They are understandably reluctant to
7 place their loved ones in these facilities.

8 Home care, home support, and assisted
9 living in smaller, manageable facilities needs to
10 become a priority. Families who do not have these
11 crucial supportive measures end up placing their
12 parents or spouses in long-term care where a bed
13 could be available for those seniors who require a
14 higher level of care.

15 These families who feel that they have
16 no option left to care for their loved ones at home
17 have been forced into a deadly corner. Most
18 families want to support their people in their
19 homes.

20 As Laura Tamblyn Watts has said:

21 "Home care is the least
22 expensive option for the government
23 and the most preferred option for
24 the elderly. Keeping someone in
25 their homes costs far less for the

1 government than funding a long-term
2 care facility with full-time staff."

3 My last very utopian recommendation
4 came after a discussion with a friend who is a
5 geriatrician. I had grave concerns about the
6 medical presence, qualitative and quantitative
7 levels in these long-term care facilities. I
8 wanted to know if these were valid, and they were.

9 The physician care in long-term care
10 facilities is very variable. Some will spend a day
11 or more while others quickly do rounds on their
12 patients every two weeks. This is important
13 because it would not be allowed anywhere else.

14 All health care professionals,
15 including doctors, in long-term care need to have
16 training in geriatrics and palliative care just
17 like any other specialized medical location.

18 Continuity of health care workers,
19 including physicians, should know their patients
20 and their families so that care of these seniors
21 can be individualized with regular communication.

22 Long-term care needs an
23 interdisciplinary approach to caring for our
24 families now and certainly in the future. I did
25 say that I was an overachiever, and here I am.

1 Thank you.

2 JESSICA FRANKLIN: Thank you very much,
3 Participant 7.

4 Participant 8, we'll come to you for
5 your response to question 2. You're on mute,
6 Participant 8.

7 PARTICIPANT 8: Okay. There. I'm on.

8 JESSICA FRANKLIN: We can hear you now.

9 PARTICIPANT 8: Okay. There's an old
10 adage that says that as the leader goes, so goes
11 the rest of the organization. So my -- what would
12 make it better? An administrator/executive
13 director that is the leader in the most senior
14 position in the home accepting his or her
15 responsibility and accountability for quality
16 infection control and management. And this
17 includes the preparation of a detailed pandemic
18 plan and its communication and mock simulation on
19 an annual basis.

20 I believe that for this to be achieved,
21 all homes must recruit a leader who is qualified by
22 education and experience in health care
23 administration, has the business acumen to manage
24 the home, has the leadership qualities to provide
25 the necessary direction and guidance to staff, and

1 has the knowledge and experience to oversee quality
2 living and quality dying within the culture of
3 long-term care.

4 Thank you for this opportunity today.

5 JESSICA FRANKLIN: Thank you very much,
6 Participant 8.

7 So, as I said, we're doing very well
8 for time, and because of that, we wanted to offer
9 you an opportunity to just share any final words
10 you would like the Commissioners to hear.

11 We just ask that you keep them under a
12 minute, and we'll do the same thing that we've been
13 doing, going from Participant 1 all the way through
14 to Participant 8.

15 Then we'll have some closing remarks
16 from Commissioner Marrocco, and we'll wrap up for
17 the evening.

18 So if you're okay, Participant 1 --
19 and, again, if folks do not want to participate in
20 this, that's fine. Just say, you know, "nothing
21 further," and we'll move on to the next
22 participant, but if you do want to share something,
23 you're more than welcome to.

24 Participant 1, is there any final
25 thoughts you'd like to share?

1 PARTICIPANT 1: No, just to restate the
2 staffing levels and communication levels I think
3 are so important. I mean, there are those -- you
4 know, there are residents who have family members
5 to advocate for them, but I get concerned about
6 what about the residents that don't have anybody?
7 You know, how are they affected by all of this?

8 It needs to change. The system needs
9 to change. There's no two ways about it. And, you
10 know, we can study and investigate and do all of
11 these different things, but at the end of the day,
12 the issue is staffing, and it needs to be fixed,
13 you know, and -- yeah, exactly.

14 JESSICA FRANKLIN: Thank you very much,
15 Participant 1.

16 Participant 2, any last, final
17 thoughts?

18 PARTICIPANT 2: I just want to say that
19 at the end of the first wave, if we had recruited,
20 trained, and deployed even people trained to the
21 old -- the existing standards, which we all think
22 are insufficient, if we had done that, we would
23 have been in a better position.

24 The second wave would have occurred
25 anyway, but we would have been in a better position

1 for the second wave, and we weren't. And I still
2 cannot explain to myself why that happened.

3 And I just wanted to say thank you
4 for -- to the Commission and the Commissioners for
5 the interim recommendations which did signal that
6 this is a very urgent requirement. And I really
7 appreciated to see the interim recommendations come
8 out in support of improvements and change in
9 long-term care. Thank you.

10 JESSICA FRANKLIN: Thanks very much,
11 Participant 2.

12 Participant 3, any last words to share?

13 PARTICIPANT 3: Nothing groundbreaking,
14 but I've always been a proponent of not watching --
15 or not listening to what they say. It is watching
16 what they do. Sort of like following the money.
17 You know, talk is pretty cheap. Action says it
18 all.

19 And one of the things that I've noted
20 when I go visit my wife is the level of happiness
21 in the building is down, down, down. And the
22 person beside my wife, she wanders out to the
23 hallway, and she says, "I'm so lonely. I'm so
24 lonely." And she has focused all her efforts on
25 trying to get out of the building.

1 And I'm sad because of that, so -- and
2 I'm not in power to help her in any way. But
3 the -- it's not permitted now, so... Anyhow, thank
4 you.

5 JESSICA FRANKLIN: Thank you very much,
6 Participant 3.

7 Participant 4, any last words to share?

8 PARTICIPANT 4: Just quickly, you know,
9 I really think monitoring and reporting at the
10 accountability framework level needs to be taken
11 out from -- out of the Ministry's role and
12 responsibility.

13 We need a whistle-blower kind of
14 function, and I know that the Patient Ombudsman
15 Paul Dube does the best they can, but he just
16 doesn't have the tools in his tool belt to really
17 speak for long-term care.

18 And I think long-term care itself just
19 needs some very -- some whistle-blowing legislation
20 so that people can talk like we've been doing
21 today.

22 And I'd like to thank you too, like the
23 other people have said. You know, this is a tough
24 task that you have, and we understand that it's a
25 tough task. Thank you for your focus on this

1 issue.

2 JESSICA FRANKLIN: Much appreciated,
3 Participant 4.

4 Participant 5, any last words to share?

5 PARTICIPANT 5: Yeah, thank you. First
6 of all, I'd like to thank the Commissioners and the
7 team for allowing -- giving us all this opportunity
8 and for all of the work that you have been doing.
9 It's been no small feat reading through the
10 transcripts on the website. You've been listening
11 to some very heartbreaking presentations.

12 And I think that's a big thing because
13 part of it is that families have really lost --
14 families and residents have lost their voice in
15 this. They have not been heard. They have not
16 been listened to.

17 It has been excruciatingly difficult,
18 very, very painful, and so this work that you're
19 doing is incredibly important. And just offering
20 people a chance to be heard is a very important
21 piece of this, an important piece of the healing as
22 well.

23 What I would like to say, though, is in
24 addition, I would like to say that there is a lot
25 of inconsistency in how long-term care is delivered

1 across our region and also right across the
2 province.

3 And so being part of the Champlain
4 Region and hearing the excellent care and successes
5 that are going on in some of the long-term care
6 homes, and then taking a look in other long-term
7 care homes, the quality and the care delivery is
8 just not there.

9 And I think the -- you know, that's one
10 of the tenets of the Health Act, is that we have
11 equitable and we have equity in care delivery. And
12 it is important that we strive to provide that for
13 people living in long-term care right across the
14 sector.

15 So I'll leave it at that, and, again,
16 thank you again for all your work.

17 JESSICA FRANKLIN: Thank you for those
18 insights, Participant 5.

19 We'll turn over to Participant 6 for
20 any final words you'd like to share.

21 PARTICIPANT 6: Thank you, and I wanted
22 to -- I also want to thank the Commission for
23 allowing me to be here.

24 I raised a couple of times about
25 cleanliness is something that really needs to be

1 looked at. I want to share a post-COVID. My
2 brother started getting very severe migraine
3 headaches during COVID, and he still continues to
4 have these.

5 October 29th he had a severe headache
6 that went on for a number of days. He'd asked to
7 see the doctor, and I called and asked for the
8 doctor to see him.

9 On November 2nd, he was sick to his
10 stomach, and no one related it to the fact that he
11 had a migraine, so they put him in a different room
12 of isolation.

13 On the bed was a rough blanket and a
14 rubber sheet. The person that had been in that
15 room died. There were diapers on the -- clean
16 diapers on the windowsill, but in the bathroom was
17 the person's razors and two combs in a cup that had
18 been used and were not clean.

19 He had no clothes. They brought him
20 down. He was in the room for four days before
21 they -- before he went back to his own room with
22 the same clothes to stay in day and night. No
23 towel. On day three, they brought him a small hand
24 towel and no change of clothes.

25 The joke of this is not funny, but a

1 couple of his friends would go down and visit him
2 and say there was absolutely no one around. They
3 moved him from the room he had been in that was --
4 originally he was in supposed isolation into this
5 room, but they had not sanitized the room. They
6 had not cleaned the room after this other
7 individual died.

8 There really needs to be some kind of a
9 focus on the cleanliness and the amount of times --
10 they're short of cleaners as well as all the other
11 staff.

12 That's it. Thank you for listening to
13 me.

14 JESSICA FRANKLIN: Absolutely,
15 Participant 6. Thank you for sharing that.

16 Participant 7, please go ahead with any
17 final thoughts.

18 PARTICIPANT 7: Thank you for the
19 opportunity to speak on behalf of our loved ones.
20 It's uplifting in a way to be able to voice our
21 concerns to people who get it. They get the
22 nuances of long-term care, you know, exactly what
23 you're going through.

24 It's vital to have this type of
25 discussion with -- almost with strangers because,

1 let me tell you, you bring your family out, you
2 bring your friends, and everybody who listens, who
3 has listened to me for the past year since the
4 pandemic began.

5 It's especially important to talk like
6 this if you have a fractious relationship with a
7 facility and a company. It's important for me to
8 have said all that I said today because I don't
9 know when I'll ever get to say it again because
10 certainly the facility and the companies don't
11 listen.

12 So I thank you for this opportunity and
13 to all the Commissioners for lending us your ear
14 this evening. Thanks a lot.

15 JESSICA FRANKLIN: Thank you very much,
16 Participant 7.

17 Participant 8, any last words to share?

18 PARTICIPANT 8: Am I on? Okay. Thank
19 you. Actually just that I would like to see family
20 councils mandatory within long-term care.

21 And secondly, I would like families to
22 have an opportunity to be involved whenever the
23 inspectors come on-site. I think that would really
24 enhance the communication of the quality issues
25 that one is aware of in the homes.

1 So that's an opportunity that I think
2 should be important to family members. As I say,
3 if we go back to regular inspections, it would be
4 easy to notify families of that.

5 And I just want to say again thank you
6 to Commissioners as well for this opportunity
7 today, and thank you for the respect shown this
8 afternoon in the moment of silence. That was very
9 much appreciated. Thank you.

10 JESSICA FRANKLIN: Thank you very much,
11 Participant 8.

12 And thank you to all the participants
13 for sharing those final thoughts. I know I'm
14 extremely humbled by the fact that none of this was
15 prepared, and you've just come with such
16 thoughtful, considerate, and, you know, clear
17 sharings. So thank you very much for that. It
18 adds to our work tremendously.

19 I'm going to turn it over now to Chief
20 Commissioner Marrocco to give some closing remarks,
21 and then we will close the evening.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Well, it's -- the thanks really has to go from us
24 to you. We are going to do our level best, and
25 it's essential that we understand what is really

1 happening in long-term care.

2 The stories are varied. There are some
3 stories that are uplifting. We heard one earlier
4 this afternoon. But for those people caught up in
5 it, we didn't have to be doing this very long to
6 understand the problems around communication,
7 training, staffing.

8 And we're going to do our level best to
9 write as intelligent a report as we can. And you
10 can be sure that it will be -- we will put as much
11 into it as you put into it today.

12 And so on behalf of all of us, thank
13 you for your time. There is a website. The
14 transcripts are there if you want to see what we're
15 up to. You'll see that we're not taking any
16 holidays in there. Thank you all very much. Bye
17 bye.

18 JESSICA FRANKLIN: Thank you,
19 Commissioner Marrocco.

20 So just to let participants know, as
21 Commissioner Marrocco said, there is a website
22 where the transcripts will be posted within the
23 coming days.

24 Also, if there's anything that you
25 didn't get to cover that you would like to share

1 with the Commission, please know that you can send
2 us a written submission, and there's information on
3 how to do that on the website. We're accepting
4 those submissions. We ask that you send them by
5 January 31st.

6 And once again, thank you for the
7 courage, the bravery, the resilience that you
8 shared with us tonight. We are, you know, in
9 sincere appreciation of your time and just wish you
10 a very good evening moving forward. Thank you very
11 much.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Bye, everybody.

14
15 -- PROCEEDINGS CONCLUDED AT 5:39 P.M. --
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REPORTER'S CERTIFICATE

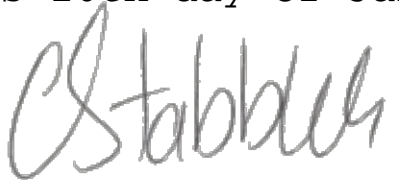
I, CARISSA STABBLER, Registered
Professional Reporter, certify;

That the foregoing proceedings were
taken before me at the time and place therein set
forth;

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

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

Dated this 26th day of January 2021.



NEESONS, A VERITEXT COMPANY

PER: CARISSA STABBLER, RPR

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