

# Long Term Care Covid-19 Commission Mtg.

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

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

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

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12 BEFORE:

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

16 Dr. Jack Kitts, Commissioner

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19 PRESENTING:

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21 Maria Elias, CEO of Belmont House

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1 PARTICIPANTS:

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3 Alison Drummond, Assistant Deputy Minister,

4 Long-Term Care Commission Secretariat

5

6 John Callaghan, Counsel, Long-Term Care

7 Commission Secretariat

8

9 Lynn Mahoney, Counsel, Long-Term Care

10 Commission Secretariat

11

12 Derek Lett, Policy Director, Long-Term Care

13 Commission Secretariat

14

15 Jessica Franklin, Ontario Long-Term Care

16 Commission Secretariat

17

18 Dawn Palin Rokosh, Director Of Operations,

19 Ontario Long-Term Care Commission Secretariat

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

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

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

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

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

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

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

11 COMMISSIONER MARROCCO: All right.

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

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

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

19 We can.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 COMMISSIONER KITTS: I'm interested in

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MS. ELIAS: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 COMMISSIONER MARROCCO: Dr. Kitts.

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

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

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

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

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

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

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

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

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

6           COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

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

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

25                  Dr. Kitts.

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

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

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

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

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

24                  COMMISSIONER KITTS: Okay.

25                  COMMISSIONER MARROCCO: Can I ask you,

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

3 MS. ELIAS: Yes.

4 COMMISSIONER MARROCCO: -- from Justice  
5 Campbell?

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

8 MS. ELIAS: Yes.

9 COMMISSIONER MARROCCO: -- what was it?

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

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

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

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

1 resources.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MS. ELIAS: Right.

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

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

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

1 Belmont House employee?

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

5 So we then -- go ahead.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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

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

25 And the physicians were told early on

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

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

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

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

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

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

1 that happened, the coroner.

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

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

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

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

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

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

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

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

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

25 And ordering swab kits from Public

1 Health can also take three to five days.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 our home.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25           So for Belmont House, in our

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25                   COMMISSIONER MARROCCO: We are. For

1 another five, no problem.

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

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

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

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

25 And long-term care homes continue to

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

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

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

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

1 And the test results are taking far too long.

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

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

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

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

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

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

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

18 COMMISSIONER MARROCCO: Well, thank  
19 you.

20 MS. ELIAS: Any questions?

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

24 MS. ELIAS: Great.

25 COMMISSIONER MARROCCO: I think we've

1 asked the questions. Thanks very much.

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

7 Thank you very much.

8 MS. ELIAS: You're very welcome.

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

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

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

15 COMMISSIONER COKE: Thank you.

16 COMMISSIONER KITTS: Thank you, bye.

17

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

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REPORTER'S CERTIFICATE

I, JUDITH M. CAPUTO, RPR, CSR, CRR,  
Certified Shorthand 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 21st day of October, 2020.

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

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