

# Long Term Care Covid-19 Commission Mtg.

Meeting with UNIFOR  
on Friday, October 9, 2020

neesons



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| 7  | MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION  |
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| 13 | -----  |
| 14 | --- Held via Zoom, with all participants attending |
| 15 | remotely, on the 9th day of October, 2020,         |
| 16 | 1:00 p.m. to 2:30 p.m.                             |
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8 Katha Fortier, Assistant to the National UNIFOR

9 President, Jerry Diaz

10 Tullio Diponti, President of Local 2458

11 Andy Savela, Director of Healthcare UNIFOR

12 Nancy McMurphy, President of Local 302

13

14

15 PARTICIPANTS:

16

17 Alison Drummond, Assistant Deputy Minister,

18 Long-Term Care Commission Secretariat

19

20 ALSO PRESENT:

21

22 Janet Belma, Stenographer/Transcriptionist

23

24

25

1 -- Upon commencing at 1:00 p.m.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 So are we waiting for -- well, the commissioners  
4 are here. Are we waiting for anyone?

5 KATHA FORTIER: We are all here.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Okay. As soon as Mr. -- well, then let me sort of  
8 give you kind of a -- let me give you a sense of  
9 where we're coming from, and then --

10 So typically, when there's a commission  
11 created, something has happened, and the  
12 government -- the Commission inquiries into what's  
13 happened and reports with the idea of explaining to  
14 the public what this past event was all about. And  
15 typically, it does that by investigating, hold  
16 hearings, write a report, and that whole process  
17 can take a couple of years.

18 We're a little different, we think,  
19 because we've been called into existence in the  
20 middle of something, something that's not over.  
21 And so we are, kind of, of a mind that we need to  
22 try to make some short-term recommendations  
23 immediately before we embark on a more traditional  
24 approach at looking back at Wave 1. So we're  
25 really very anxious to get any insight we can into

1 what we can recommended in short order to the  
2 Minister to deal with Wave 2 and, you know, Wave 3.  
3 And we wanted to avoid a situation where we were  
4 simply inquiring into things at the normal pace,  
5 and events were simply overtaking us repeatedly  
6 because we're into one wave and then another wave,  
7 and produce recommendations at a point in time when  
8 maybe they're not terribly helpful. So that's the  
9 perspective that we have.

10 The way we've tended to do this is as  
11 you're -- we're going along through whatever it is  
12 you're saying, as questions occur to us, we just  
13 ask them rather than waiting until we get to the  
14 end and then trying to go back seems to be kind of  
15 inefficient. So we've tended to interrupt with  
16 questions if that's -- if that's, all right, that  
17 it wouldn't cause you any undue aggravation; that's  
18 the way we've normally done it.

19 The -- probably around 2:15 or so we  
20 take a ten-minute break. So if you could let me  
21 know around that time when it's convenient, then we  
22 would break then for ten minutes or so. So that's  
23 basically the introduction. We're ready when you  
24 are.

25 KATHA FORTIER: Great. Thank you very

1 much. I appreciate that, and I appreciate your  
2 time and your reaching out to us to meet with you.  
3 As you can well imagine this is -- this has  
4 certainly been something that we care very deeply  
5 about.

6 UNIFOR represents about 15,000  
7 long-term care workers in Ontario. That's in  
8 retirement homes, nursing homes, homes for the  
9 aged. We have -- this has been, again, very into  
10 the pandemic but also the crisis beforehand.

11 And my name is Katha Fortier. I'm  
12 Assistant to the National UNIFOR President, Jerry  
13 Diaz. And I'm also -- I come out of the healthcare  
14 sector. I'm a registered practical nurse, so I'm  
15 very familiar with the -- where our members work  
16 and the work that they do. I worked in a rural  
17 hospital in Northern Ontario, but we also had a  
18 long-term care wing in that hospital as well.

19 So with me today is Andy Savela, who  
20 you can see. Andy is our Director of Healthcare.  
21 He's also -- he's also -- was an RPN. I think he  
22 let his registration slide but also has a  
23 background in healthcare.

24 And then we have Nancy McMurphy. Nancy  
25 is the President of Local 302 in London and

1 surrounding area. Nancy represents a whole lot of  
2 nursing homes and long-term care workers. And her  
3 background, she's a personal support worker as  
4 well.

5 And finally, Tullio Diponti, Tullio is  
6 the President of Local 2458 in Windsor. And  
7 between Nancy and Tullio, I think they probably  
8 represent somewhere in the ballpark of about 60  
9 nursing homes or maybe a little more. So they're  
10 very well versed in the subject and certainly not  
11 just -- not just the pandemic and what has  
12 happened, but what led to the pandemic as well.

13 So we've prepared a bit of remarks so  
14 we're not going to be repeating ourselves, and so  
15 we're going to speak in the order that we've --  
16 that I just introduced everybody in. But -- so I  
17 will start, and we're happy if you have questions  
18 as we go along.

19 I sent you some documents yesterday. I  
20 realize there was one thing that I forgot to send,  
21 and I will get it to you. And last year, that was  
22 the -- we did -- had the Ontario Health Coalition  
23 do a roundtable report after we did a number of  
24 roundtables across the province on the personal  
25 support worker shortage. It's called Caring in

1 Crisis: Ontario's Personal Support Worker Crisis.  
2 And so I will make sure that you have that document  
3 as well.

4 COMMISSIONER FRANK MARROCCO (CHAIR):  
5 Thank you. Did you want the document that you sent  
6 us yesterday on the screen?

7 KATHA FORTIER: I don't know that I  
8 really need that.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Okay.

11 KATHA FORTIER: I'm going to refer  
12 to -- I think mostly I just sent you, you know,  
13 some of the letters that we've sent to the -- this  
14 year on -- on the subject of long-term care and  
15 healthcare. And also the -- we've put together a  
16 wage document because I think it's really important  
17 that the Commission understands what's happened  
18 over the last decade in particular to wages in the  
19 long-term care sector. So I'll go through a bit of  
20 that, but I don't know that we really need it on  
21 the screen unless -- well, I guess we could do that  
22 if it makes sense.

23 But what I'd really just like to start  
24 with before we get into that is just to go back  
25 because I think it's really important that we

1 understand how long-term care has changed in the  
2 last 25 years. And it really is -- it really is  
3 crucial that we think about this.

4 So if we go back to 1995, long-term  
5 care homes did not look like they did today. In  
6 fact, residents who lived there often drove their  
7 own car. They were mobile. You know, they were --  
8 they were reasonably independent.

9 And in 1995, those people that were the  
10 most frail that had the most complex health issues  
11 were normally in chronic care hospital beds or  
12 continuing care beds in hospitals. Those would be  
13 the people, you know, with very complex issues,  
14 perhaps brittle diabetics, Alzheimer's, and often  
15 -- we often actually had psychiatric hospitals that  
16 had psychogeriatric wards that, you know, people  
17 got a really intense level of care in.

18 What happened throughout the '90s were  
19 the -- certainly, the late '90s -- were thousands  
20 of those beds were closed. The chronic care  
21 hospital beds declined greatly in hospitals and as  
22 well as psychiatric hospitals also closed which  
23 closed down some of those psychogeriatric wings.

24 Now, those people didn't just  
25 disappear. They moved into the long-term care

1 system. That was -- Harris was the premier.  
2 You'll remember the Restructuring Commission that  
3 rolled through the province that closed those  
4 hospitals beds, and you'll also remember that there  
5 was a huge increase in long-term care beds and new  
6 builds. Those new builds were mostly to the  
7 for-profit sector. That's where we really saw the  
8 growth in for-profit long-term care in Ontario.

9 Before that, we probably had about 40%  
10 of the homes being for profit, and 60%  
11 not-for-profit. Not-for-profit could mean  
12 municipal or regional run. It could be -- mean  
13 that it was run by a hospital. It could mean that  
14 a long-term care facility was run by a  
15 not-for-profit agency like a church organization or  
16 a religious organization; some of them still  
17 operate to this day.

18 So we really saw the shift to  
19 for-profit operators in the province during that  
20 five-year period. And again, we also saw during  
21 those five years that the complexity of the  
22 residents that they were caring for in nursing  
23 homes grew quite rapidly. And we've seen that just  
24 continue to skyrocket really. I mean, the  
25 complexity in a nursing home, it just today doesn't

1 look anything like it looked 25 years ago.

2           Also in 1995, the government decided to  
3 remove a minimum measurable standard of care in  
4 long-term care. Now, let me sort of just explain  
5 what that means. At the time, the minimum  
6 measurable standard of care was 2.25 hours. But  
7 again -- and what that guaranteed was, you know, in  
8 a formula for a long-term care facility, you had to  
9 work out your staffing so that nursing and personal  
10 care was delivered to each resident for an average  
11 of two-and-a-quarter hours per day. That was the  
12 minimum.

13           And it's a bit complex because, you  
14 know, straight ratios are a little bit difficult to  
15 do because, you know, the ratios could change per  
16 shift. You obviously wouldn't need as many staff  
17 on a nightshift as you would on a dayshift.

18           So there's some variables, but the  
19 minimum measurable standard of care meant a couple  
20 of things: First of all, that you had to provide  
21 certain a level of staffing, that that was actually  
22 a requirement; and when an inspector went into a  
23 facility to do an inspection, they could actually  
24 look at the formula and make sure that you were  
25 providing enough hours of care per resident per

1 day. And if you weren't, you had to do that. You  
2 had to improve your staffing levels. So, you know,  
3 that was -- removing that minimum standard, we  
4 feel, was -- was a grave mistake. It actually  
5 should have been kept in place, and it should  
6 have -- it should have actually grown because  
7 again, right now, obviously, a four-hour minimum  
8 measurable standard is what is recommended.

9 I'm just going to touch now on the wage  
10 brief that I give you. And I really want you to  
11 sort of see in particular over the last decade how  
12 wages -- real wages in nursing homes, in long-term  
13 care facilities has, first of all, not kept up with  
14 inflation, and secondly, been a deterrent. It's  
15 pushed people away from working in homes when, you  
16 know, your work does not keep up with inflation.

17 So I just want to start -- first of  
18 all, you may know this. I might -- I'm probably  
19 stating the obvious, but long-term care workers in  
20 the Province of Ontario are covered under the  
21 Hospital Labour Disputes Arbitration Act. It's  
22 illegal for them to go on strike. And so if a  
23 collective agreement isn't negotiated, they go  
24 before an arbitrator.

25 During, you know, the previous decade

1 before that, we bargained a lot of collective  
2 agreements, and they actually didn't go before an  
3 arbitrator. And we bargained some settlements that  
4 were -- that were very progressive. I think Tullio  
5 and Nancy will both remember being at a Rivera  
6 bargaining table, bargaining, you know, 2.6, 2.75,  
7 and 3% in wage increases, getting a drug card for  
8 our members which was, you know, this was a  
9 workforce often of, obviously, mostly women, but,  
10 you know, these were things -- a drug card was  
11 important in that, you know, they didn't have a lot  
12 of expendable income and being -- and, you know,  
13 having to pay for -- they had a drug plan, but when  
14 you had to pay for your medications up front, that  
15 was a huge burden on a lot of our members.

16 So, you know, through the previous  
17 decade, we were making real progress for these  
18 workers. We were actually, you know, feeling like,  
19 you know, we were -- we were doing something.

20 The work wasn't easy. It never was,  
21 and it's challenging, and it takes a real special  
22 person to do that work, but, you know, the  
23 compensation was reasonable.

24 Over the last decade --

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Can I just ask you, at that time, from '95 on, was  
2 it the same regime in the sense that you couldn't  
3 go on strike; if you couldn't reach an agreement,  
4 you went before an arbitrator? Was it --

5 KATHA FORTIER: Yes.

6 COMMISSIONER FRANK MARROCCO (CHAIR):  
7 -- always like that throughout this period?

8 KATHA FORTIER: Yes, it's been -- it's  
9 been like that -- probably I believe, since the  
10 '70s, it's been illegal for healthcare workers to  
11 go on strike.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 All right. But specifically, personal support  
14 workers, that's workers in long-term care homes  
15 were captured by that?

16 KATHA FORTIER: Yes.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Okay.

19 KATHA FORTIER: We would actually --  
20 sorry. Did you have another question?

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 No, I don't. Oh, sorry.

23 COMMISSIONER JACK KITTS: I was just  
24 going to -- I think we heard from somewhere else  
25 that personal support workers weren't considered

1 essential workers up 'til some point; is that true  
2 or not?

3 KATHA FORTIER: I would say that that's  
4 not true. If they -- again, the Hospital Labour  
5 Disputes Arbitration Act clearly covers long-term  
6 care facilities in the Province of Ontario and has  
7 done for decades.

8 So I guess, in the definition of  
9 essential, not having the ability to strike,  
10 personal support workers haven't had the ability to  
11 go on strike for decades.

12 Now, there might be some exceptions  
13 because Homecare is not covered under the  
14 hospital -- under HLDAA, is what we call the --  
15 affectionately call the Act. So Homecare personal  
16 support workers did have the ability to go on  
17 strike.

18 COMMISSIONER JACK KITTS: Oh, in  
19 Homecare. Okay. Thank you.

20 KATHA FORTIER: Yeah. Yeah, so just a  
21 matter really of where you worked, but long-term  
22 care does not have and has never had the ability to  
23 strike.

24 And I get back in those days, they  
25 were -- they were -- we were healthcare aids, not

1 personal support workers. The educational  
2 requirement changed as it probably should have  
3 because the complexity changed, but they've never  
4 had the right to strike.

5           The point I would like to really make  
6 with this is that in the last decade, we've -- and  
7 this would be, you know, for all unions, SEIU,  
8 CUPE. You know, we do a lot of work together. As  
9 unions, we probably represent the majority of the  
10 long-term care homes in the province. And, you  
11 know, we've certainly worked together on this, and  
12 even on bargaining. We've -- you know, had --  
13 certainly had conversations with each other.

14           But the reality has been in the last  
15 decade that nobody has been able to negotiate a  
16 collective agreement, that they have been set by  
17 arbitrators. Once one large nursing home group  
18 gets a settlement, then every arbitrator in the  
19 province will not stray from that pattern, and that  
20 the last decade has -- has really shown that the  
21 wage increases have just fallen below inflation.

22           I do -- there's a piece in this around  
23 municipal homes, and that comes into relevance for  
24 a few -- for a few reasons, and I'll go into them a  
25 little later, but we do talk about the average

1 wages for a number of classifications in a  
2 municipal home versus a long-term care home. And  
3 you'll see that there's a significant spread, that  
4 they're likely 2 to \$3 more. The wages are 2 to \$3  
5 more an hour in a -- in a long -- in a municipal  
6 home versus a private home.

7           You know, this, I guess, for some  
8 people, maybe \$3 an hour doesn't sound like a lot,  
9 but for, you know, a woman working in the long-term  
10 care system, I would -- I would argue that that's  
11 very significant. That's, you know, a big cart  
12 load of groceries for them every week or shoes for  
13 their children. These are -- these are significant  
14 amounts.

15           So -- and I'd also like to just raise  
16 something as well where we talk about wages, and  
17 it's the increase in part-time work, in casual  
18 work, and wage progression itself because you'll  
19 notice on the -- on the charts that we gave you,  
20 there's a start rate, and then there's -- I don't  
21 think we've printed the one-year rate, but you can  
22 assume it's somewhere in the middle. And then we  
23 have the two-year rate, which is generally the  
24 higher rate. It takes two years to get there.

25           But -- oh, nobody ever phones my house

1 phone, sorry about that, but --

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 You know, don't worry about it because my phone  
4 rings almost every single time I'm on one of these  
5 calls. And one of these days, I'm going to just --  
6 anyway, I'll spare you that, but you're not alone  
7 with this phone.

8 KATHA FORTIER: It's a telemarketer.  
9 It's somebody -- want my ducks, or, you know, I'm  
10 sure it's just one of those calls. I don't know  
11 why I have a house phone anymore.

12 But anyways, I just want to talk about  
13 progression and what happens to new workers in the  
14 long-term care system.

15 First of all, they're unable to get a  
16 full-time job. It can take you years, perhaps a  
17 decade to get a full-time job. And so you don't  
18 even move along the progression for working for an  
19 employer. One year actually translates to 1,800  
20 hours in most instances. So that means that they  
21 have to get 1,800 hours working for that one  
22 specific employer.

23 Most personal support workers and other  
24 workers that work in nursing homes don't actually  
25 have the opportunity to just have one job. They

1 work two jobs or sometimes three jobs. They work  
2 for multiple employers. So getting to that  
3 progression to get from the start rate to the  
4 two-year rate might actually take them six years.

5 So I just want to make sure that you  
6 sort of understand that it's not just everybody  
7 with two years is making the top rate because  
8 that's certainly not the case. And, you know, of  
9 course there's a real trend from employers to not  
10 have to provide benefits and sick pay. So they  
11 like to keep people part-time and casual and  
12 working multiple jobs. It works for them, just  
13 as --

14 COMMISSIONER FRANK MARROCCO (CHAIR):  
15 So then you can't get the top rate until you have  
16 worked 3,600 hours, is that -- is that the idea?

17 KATHA FORTIER: Yes. Yes. And that  
18 might take you six years to do that --

19 COMMISSIONER FRANK MARROCCO (CHAIR):  
20 Right.

21 KATHA FORTIER: -- if you're working  
22 for three different employers.

23 COMMISSIONER FRANK MARROCCO (CHAIR):  
24 Is there -- in your view, is there a place for  
25 part-time workers in -- in the system? As of --

1 you know, as opposed -- I recognize what the system  
2 is now, but in terms of what you're saying, there's  
3 too many, or there shouldn't be any? Or --

4 KATHA FORTIER: Well, there are -- I  
5 mean, there's always been part-time workers in  
6 healthcare, that's just a given. It's been very  
7 clear that that's part of the system, but the  
8 ratios have just seemed to increase dramatically.

9 So, you know, I would say that there  
10 are homes where 70% of the workforce is now  
11 part-time, where probably that -- that numbers  
12 could easily be reversed, that you could actually  
13 have more full-time workers. There's a reluctance  
14 on the part of employers to create this full-time  
15 work because once they're full-time, they have --  
16 they have -- they're able to get the benefits, and  
17 they're able to get the sick time, paid sick time.

18 And by the way, neither of which,  
19 nether the sick time nor the benefits are as good  
20 as what you would find in a hospital or what you  
21 would find in a municipal home. There's some  
22 staggering differences there as well, particularly  
23 around pensions, but also all of -- all of the  
24 benefits as well and sick time. Sick time in  
25 hospitals is particularly more generous, and in

1 municipal homes.

2           So we've given you three charts on that  
3 document as well, and they're -- it's the  
4 historical wages for two groups of for-profit  
5 operators. One is the Schlegel Homes. This is a  
6 for-profit operator. These are the actual rates  
7 that we -- that we have in our collective  
8 agreements. And the other is the Extendicare Chain  
9 where we bargain essentially with ten homes at a  
10 central table.

11           And you'll see what we've done. I'm  
12 going to put my glasses on to look at this. But  
13 you'll see what we've have done is we've actually  
14 compared the wage increases that they've received  
15 to the wage increases -- to the rates of inflation  
16 and what those differences would have been if they  
17 actually kept up with inflation.

18           So we go back to August 1st, 2011 for  
19 the Schlegel Group. Schlegel in particular has a  
20 very low start rate far lower than an Extendicare  
21 home. So, as an example, the start rate in a  
22 Schlegel home today is \$18.84 an hour. In an  
23 Extendicare home it is higher. It's \$20.83 an  
24 hour. So you can see it's a significant  
25 difference. Some of that might be because the

1 Schlegel homes are newer. They've -- they work --  
2 they opened more recently, probably within the last  
3 12 to 15 years, and they opened -- of course, it's  
4 non-union facilities, so they were paying those  
5 rates. So it was sort of the basis. You have to  
6 bargain up. Whereas Extendicare and other homes  
7 were around for a longer period of time.

8 But just to give you an example, right  
9 now at a Schlegel home, the top rate for a personal  
10 support worker is 21.04 an hour. And had they at  
11 least kept up with inflation, they would be at  
12 \$22.20 an hour.

13 The Extendicare rate right now is  
14 \$22.21 per hour, and this is -- I'm talking the top  
15 rate, the two-year rate, and if it kept up with  
16 inflation, it would be \$23.11. And then if we look  
17 at the last comparison which we gave you, which was  
18 an average municipal home, an average municipal  
19 home, this is our Brucelea Haven. It's in Tullio's  
20 local, and Gateway Haven, they're municipal homes.  
21 And that compares with a personal support worker  
22 rate right now currently of \$25 an hour.

23 And we've laid out what all of those  
24 increases were. And actually, they've been well --  
25 not well above, but above inflation. So if their

1 rates had kept up within inflation, it would be  
2 \$24.61 an hour.

3 So the reason that I compare the  
4 municipal homes, and we explain it on the final  
5 page, is because of proxy pay equity.

6 So proxy pay equity was brought in in  
7 the early 1990s, and it was done specifically for  
8 workplaces like a nursing home where you simply did  
9 not have male comparators to do a real pay equity  
10 plan. In fact, in most nursing homes, there's one  
11 male comparator. It's the maintenance person, and  
12 that just does not allow you to do a proper pay  
13 equity plan for anybody in that facility.

14 And so that was recognized by actually  
15 the Bob Rae government, and so they put in some  
16 legislation on proxy pay equity.

17 And so what proxy pay equity did was  
18 allow you to -- for these types of workplaces, was  
19 allowed you to compare to similar work with a group  
20 of workers that actually had a pay equity  
21 comparator.

22 So again, I go back to municipal homes  
23 because municipalities not just run the nursing --  
24 run a home for the aged. They also -- they also  
25 operate, you know, all sort of things. They have,

1 you know, all of the things that a city or a  
2 municipality would have to do. So you have an  
3 array of male comparators to do pay equity with.

4 So in 1994, a pay equity plan was  
5 determined at the time, and I guess just as a bit  
6 of a background, our UNIFOR homes were part of the  
7 Service Employees International Union. We left the  
8 union in 2000 to join what was then the Canadian  
9 Auto Workers Union and is now UNIFOR. But we were  
10 part of that original plan.

11 And what the plan said was that the  
12 comparator in 1994 was a municipal home and that  
13 they made \$1.50 an hour difference. And that \$1.50  
14 an hour had to be paid out. So we were still part  
15 of that plan even though we weren't members of SEIU  
16 going into the early 2000s. And I believe that  
17 plan completed the payout. It wasn't very -- it  
18 wasn't very generous. So you can imagine \$1.50  
19 over ten years is 15 cents a year. But they did  
20 get that pay equity during that time.

21 Now, as you can see since then, the  
22 rates in a municipal home have grown -- that gap  
23 has gotten even bigger than the original \$1.50 an  
24 hour. So the two unions, SEIU and ONA, have been  
25 in various disputes with the employer. We've

1 supported ourselves and CUPE because we're not  
2 named in the agreement even though we worked part  
3 of the agreement, essentially, getting the same  
4 increases. We are interveners with the Equal Pay  
5 Coalition, so we're involved in those as well.

6 So we did have a successful appeal last  
7 year, and what is -- what is -- the crux of the  
8 appeal is that these employers should have had to  
9 maintain proxy pay equity. That they -- you know,  
10 they didn't actually have to maintain it. We know  
11 that that wage gap between a municipal home worker  
12 and a nursing home worker has grown, and it hasn't  
13 been addressed, and we feel it should be.

14 So we were successful in court last  
15 year that they were ordered to maintain proxy pay  
16 equity, and the employers have -- this is the  
17 for-profit employers represented by Bass &  
18 Associates, have appealed that decision. And so  
19 that was just heard in court just this week, the  
20 employer, the for-profit operators appeal not  
21 wanting to give pay equity to those workers.

22 And in fact, for some reason that is  
23 yet to be explained to us, though we did meet with  
24 the Minister of Long-Term Care last week, and they  
25 did tell us that they would give us an explanation,

1 but the Attorney General has -- of Ontario has  
2 intervened in this case on behalf of the employers.  
3 So, you know, you've also got government actually  
4 working to stop nursing-home workers from getting  
5 the pay equity that they deserve.

6 So I just thought that that was an  
7 important piece for the Commission to understand.  
8 And if there's any questions on that, I'm happy to  
9 take those, and if not, we will move over to  
10 Nancy McMurphy for her remarks.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 I don't think we have any questions, so...

13 NANCY MCMURPHY: Okay. Thank you very  
14 much. I want to thank you as well for giving us  
15 this opportunity for come and speak with you today.  
16 As Katha mentioned, I was a previous long-term care  
17 worker for many, many years. So this is something  
18 that's very near and dear to my heart.

19 I'm one of ones that's still fortunate  
20 enough to remember a time when you left at the end  
21 of your shift feeling a sense of pride because you  
22 knew that you had improved someone's life. And  
23 sadly, that's not the case for staff any longer.  
24 They're walking out doing a mental checklist of who  
25 they didn't provide adequate care to, or who they

1 didn't provide care to based on the number of staff  
2 that were there that day.

3           So Katha has asked me if I would focus  
4 my attention on specific staffing concerns and  
5 issues. And with your indulgence, I'm going to  
6 read my comments because honestly, I just don't  
7 want to forget any of the points that I wanted to  
8 touch on because I think, you know, sometimes we --  
9 we get so engrossed with this conversation that we  
10 can just go off on a tangent and completely miss  
11 very important aspects that need to be addressed.  
12 So I'm just going to read my remarks, and please  
13 feel free to stop me at any point in time.

14           So prior to the pandemic, we were  
15 absolutely in a crisis. COVID-19 has only worsened  
16 the situation. If I could say there is one  
17 positive aspect about the pandemic, it's that it's  
18 brought a much-needed public awareness to just how  
19 dire the situation is in long-term care.

20           The funding mechanism that we have  
21 currently is obviously not working. What we see  
22 now and specific to nursing is the nursing of  
23 personal care envelope. And the funds are directed  
24 to an extensive list of staff, services, and even  
25 products are included in that envelope.

1           In order to provide quality care, there  
2 has to be a commitment of designated hands-on  
3 providers. With the current envelope system, the  
4 decision relies on individual operators and their  
5 budget.

6           So a couple of examples that I can give  
7 you have of what was happened over the last number  
8 of years with this type of funding is we will have  
9 operators that by June of each year, they decide  
10 that they're simply not going to replace the first  
11 or second sit call (phonetic). They just want to  
12 make sure that there's enough money in the budget  
13 to get them through to the end of the year.

14           We also have frequent situations where  
15 we will have an injured worker that's returned to  
16 work in a modified role. But they're being counted  
17 as part of the compliment of care providers for the  
18 shifts. They're counting them despite the fact  
19 that these individuals can probably only do a small  
20 portion of their normal routine because of their  
21 injuries that they're suffering from.

22           So with the current staffing ratios  
23 that we have already being so taxing, these types  
24 of decisions are making an already impossible job  
25 more than overwhelming. As a result of COVID, many

1 staff are now also dealing with mental health  
2 issues; they're dealing with depression; they're  
3 dealing with increased anxiety. And many of them  
4 are going through a horrible grieving process  
5 because of the loss of the residents.

6 If there isn't an investment in proper  
7 frontline care, I guess my question is what kind of  
8 message are we sending to the residents, to their  
9 families, and to the staff that we're trying to  
10 retain and recruit into these jobs.

11 Currently, it's not uncommon to see an  
12 assignment of 1 PSW to 12 residents on days or on  
13 afternoons, but on the nightshift, you can often  
14 see that it's 1 to 32 residents. These numbers  
15 would be reflective only on shifts that they aren't  
16 working shorts. So with the ever-increasing  
17 resident acuity and the diversity in the resident  
18 population, these ratios are not only unsafe to  
19 provide high quality care, but it's absolutely  
20 impossible.

21 Between an aging population and the  
22 ongoing shortage of beds for residents that are  
23 suffering from serious mental illness, staff are  
24 frequently subjected to both verbal and physical  
25 abuse. They're forced to rush the care which

1 causes anxiety for the residents and agitation of  
2 course.

3 So what we would like to see would be a  
4 minimum of -- pardon me -- a maximum ratio of  
5 residents to staff of 1 to 8 for days and  
6 afternoons and 1 to 12 for the nightshift.

7 I think that's a good starting point,  
8 and quite frankly, we'd like to see the numbers  
9 reduced beyond that. We have homes right now where  
10 we have designated Alzheimer wings. And so you're  
11 going to be facing higher behavioural issues  
12 regularly. And we think a realistic ratio for  
13 those environments would be 1 to 6.

14 Far too commonplace are shortages of  
15 two to three staff on any given shift and on any  
16 day of the week. It used to be that these  
17 shortages occurred most frequently on the weekends,  
18 and I'm sure everyone can relate to that. But  
19 that's no longer the case. Now, it's every day of  
20 the week.

21 Many of our homes are reporting being  
22 between five to ten PSWs short in a 24-hour period.  
23 Most negatively impacted are private-for-profit  
24 facilities, and even more challenges are occurring  
25 in our rural settings. Of course, I'm sure you can

1 understand why.

2           The shortage is of the result of many  
3 things. You're going to have your sick calls, your  
4 family emergencies, bereavement leave, workplace  
5 injuries. But many times, the shortages are  
6 occurring simply because there's not adequate staff  
7 to even cover the shifts when a schedule is being  
8 prepared.

9           As bad as the numbers were before  
10 COVID, they have absolutely grown worse. Workers  
11 have continued to leave the sector, and more  
12 recently we're seeing shortages in all  
13 classifications.

14           I know for some, the decision was made  
15 out of fear, anxiety, concern for the safety of  
16 their family and themselves. When we've had an  
17 opportunity to do an exit review with staff, the  
18 reasons for leaving were really quite consistent.  
19 They speak of excessive workloads that have led to  
20 complete frustration that they cannot provide the  
21 necessary care the residents need and that they  
22 deserve. There's a fear of being unsupported in  
23 the roles that they're doing. They are fearful of  
24 accusations of resident neglect simply because  
25 there aren't enough hours in the day to do the work

1 that needs to be done.

2 They're struggling with inconsistent  
3 and unrealistic schedules. As we know, many saw a  
4 reduction of stable hours because of having to  
5 choose one workplace, and every single worker that  
6 we speak to speaks out about burnout and total  
7 exhaustion.

8 I would add to that that we also have  
9 to look at the fact that daycare is very  
10 problematic in a 24/7 environment, and that has, of  
11 course, also worsened with COVID.

12 Many employers have attempted to find  
13 solutions, but the solutions that they are working  
14 on just aren't working for the homes, quite  
15 honestly. So employers are relying on agency  
16 staff, in some cases, to fill vacancies. These  
17 individuals come into the building with no  
18 knowledge of the residents or the work routines,  
19 and they honestly create more work for the staff  
20 sometimes because the staff are feeling like  
21 they're having to orientate them each time they  
22 come into the building.

23 The cost associated with agency staff  
24 is much higher, and so you can understand that's  
25 insulting and demeaning for dedicated employees

1 that have worked at the home for a number of years  
2 and someone walks in the door, but they're making  
3 several dollars an hour more than them and yet only  
4 performing a portion of the duties because, again,  
5 they don't know the job routines. Using agency  
6 workers provides very little continuity of care to  
7 the residents or to the workplace.

8 We also have seen recently the  
9 introduction of resident care aids. So these  
10 individuals are not trained. They are not  
11 qualified PSWs, but they are utilized to provide  
12 non-nursing roles of the PSW. They don't provide  
13 hands-on care. So the portion of the job that many  
14 PSWs would look forward to is what these  
15 individuals are doing. And I say that because if  
16 you've had an extremely stressful shift, sometimes  
17 if you just take that time away to go and make a  
18 few beds, you know, porter a couple of residents to  
19 the dining room, that just gives you the  
20 opportunity to regroup both mentally and physically  
21 because you're dealing with very high-intensity  
22 residents.

23 I would add that we've had to remind  
24 several of the employers the scope of these jobs as  
25 they are frequently attempting to expand the roles

1 due to the ongoing staff shortages.

2 The other issue that we've seen  
3 happening is that the PSWs are applying for these  
4 positions just to get away from the unrealistic  
5 workload of the resident care. So we're not really  
6 resolving the problem. We're just making the  
7 problem even more difficult.

8 The Canadian Institute for Health  
9 Information shows that it's imperative to address  
10 the shortages. There are approximately 40% of PSWs  
11 that leave the job the year after their graduation.  
12 There is roughly another 25% with two or more  
13 years' experience that are leaving yearly.

14 We also see the issue of an aging  
15 demographic not only in the residents but in an  
16 aging workforce. So roughly 25 of the PSWs that  
17 are currently working in long-term care are over  
18 the age of a 55. These statistics don't provide  
19 for a stable workforce. We know that many of these  
20 individuals are being offered part-time or casual  
21 employment.

22 Prior to the pandemic, we found that in  
23 order provide for the family, workers were forced  
24 to secure two, maybe three positions with different  
25 employers. And that dramatically reduces their

1 availability for call-ins with any one of those  
2 particular employers. The inconsistent schedules  
3 provide a very poor work-life balance. And again,  
4 the conditions are just not attracting workers into  
5 our sector.

6 I'll just touch on one question that  
7 was posed to Katha previously. I agree with her  
8 suggestion that we flip the 30/70 to 70/30%. We  
9 absolutely need to have part-time workers in this  
10 sector because, honestly, they are going to cover  
11 shortages for sick calls. They may help to beef up  
12 the staff so that staff can have statutory holidays  
13 off or that they could have vacations. So there is  
14 a need, but there is not as great a need as what  
15 we're seeing occurring.

16 The recently announced PSW wage  
17 enhancement, I'm confident that that was intended  
18 to be -- it was intended to be a bonus for our  
19 PSWs. But the reality is, it's very, very  
20 problematic. It's problematic first of all because  
21 it's temporary.

22 But secondly, as we see it, the  
23 band-aid fixes aren't going to aid us in recruiting  
24 or retaining staff. The announcement created a  
25 huge amount of divisiveness between workers in

1 other classifications. They're not looking at as  
2 an issue of retaining PSWs, but they rather are  
3 looking at it -- they see it as a disregard of the  
4 contribution that they provide in the jobs that  
5 they do within these homes.

6 We have one home, actually, in our  
7 local that with this PSW enhancement of the \$3,  
8 they are now making 27 cents an hour more than an  
9 RPN in that particular home. So we're having to  
10 try and address that with the operators.

11 As of yesterday, London Middlesex  
12 Health Unit, which is the area that I'm in,  
13 reported there's now six long-term care facilities  
14 in declared outbreaks. And to me, that's frankly  
15 terrifying. We have to be concerned that how is  
16 this -- how is this going to impact staffing moving  
17 forward? You know, the staff are already  
18 terrified. They're already exhausted. And now we  
19 see more and more of these outbreaks occurring. It  
20 has to -- it has to pose a great deal of questions  
21 as to what we're going to do.

22 So if anyone has any questions, I would  
23 certainly be happy to answer them for you, but  
24 that's just an overview of what's going on with the  
25 staffing currently.

1                   COMMISSIONER FRANK MARROCCO (CHAIR):  
2 Do you have a sense of why the personal support  
3 workers have been -- I was going to say  
4 traditionally -- but undervalued in terms of their  
5 contribution to the healthcare sector? Do you have  
6 a sense of why that is?

7                   NANCY MCMURPHY: No. You know what? I  
8 honestly don't because the work that they're  
9 performing is frontline work.

10                  COMMISSIONER FRANK MARROCCO (CHAIR):  
11 I understand.

12                  NANCY MCMURPHY: You know, they're  
13 providing probably 85% -- meeting 85% of the  
14 residents' needs in any given shift. So why they  
15 are being undervalued in such a manner, I think  
16 part of the problem that we're seeing right now is  
17 that there are a lot of allegations of abuse and  
18 neglect, and I'll tell you right now, not one of us  
19 in our union condone abuse of a resident.

20                  But what is really frustrating for  
21 these individuals is when they're being accused of  
22 abuse or neglect, honestly, as I said previously,  
23 because they don't have time to do the work.

24                  So if you don't answer a call bell in a  
25 prescribed period of time, that can be considered

1 neglect. But if there's no one else on the wing  
2 with you to answer the call bell, and you're with  
3 another resident, you can't leave that resident  
4 that you're with for fear that they may have a fall  
5 and then you have neglected that resident that's  
6 resulted in, perhaps, an injury to them.

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Okay.

9 KATHA FORTIER: I would just like to  
10 add to that. You know, part of the challenge is,  
11 is that personal support workers have spent a lot  
12 of time compensating for the cuts and for the  
13 increased work and the increased workload, the  
14 increased acuity of their residents. They start  
15 work early every single day. They work through  
16 their breaks. They stay late. It's not unusual to  
17 find people that come in an hour early for their  
18 shift to start their shift, and they're not paid.

19 They're -- they -- you know, and but  
20 the reality is, is that those residents become  
21 their family. I mean, you know, we've been hearing  
22 a lot about -- from families who are so distraught  
23 that they can't get in, that their access is  
24 limited to their loved ones. And that's absolutely  
25 fair.

1           But there's a whole section of people  
2 who live in long-term care, for whatever reason,  
3 who don't have any family or family lives too far  
4 away, or they just don't visit. I mean, you know,  
5 this loneliness aspect of it -- and -- it is really  
6 crucial, and it's not new. There are -- there are  
7 a lot of people in long-term care that don't have a  
8 support system other than the staff.

9           You know, I know that you talked about  
10 when I had the initial conversation -- now they're  
11 testing my fire alarm system.

12           COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Well, we were even until they tested your fire  
14 alarm system.

15           KATHA FORTIER: Okay. The test may be  
16 over. I apologize. The joys of working from home.  
17 But, you know, they've compensated. And not only  
18 have personal support workers and other workers in  
19 these homes -- they sometimes -- they replace the  
20 family. You know, they go to funerals of their  
21 residents. They bring them a coffee from  
22 Tim Hortons every day. They bring them clothes.  
23 They bake for them. You know, there's -- you know,  
24 when I think about, you know, the 1,952 residents  
25 that have died, I mean, you know, it's so

1 devastating. But you know how devastating it was  
2 for these staff as well.

3 And because this is a workforce that's  
4 mostly women and mostly come to work because they  
5 care, you know, it's easy to take advantage of  
6 that.

7 Tullio's local had an experience once  
8 where we had a retirement home where the employer  
9 stopped paying the workers, and they went to work  
10 anyway.

11 COMMISSIONER FRANK MARROCCO (CHAIR):  
12 Is there any counselling or anything offered? Has  
13 there been any counselling or anything like that  
14 for the workers who have been through Wave 1, you  
15 know, just to try to deal with so many deaths?  
16 And, you know, anyway, has that happened?

17 NANCY MCMURPHY: Some of the homes  
18 are --

19 ANDY SAVELA: Maybe I can add  
20 something -- I can add something to this and add,  
21 you know, a lot of our workplaces, we've negotiated  
22 EFAP programs and things of that nature. Some of  
23 them are very good programs and some not so good at  
24 all. But we're really finding that this is  
25 becoming an issue, and this week we've been on

1 numerous calls that our union is going to be doing  
2 webinars on compassion fatigue, burnout, and trying  
3 to just bring to people different avenues and  
4 opportunities for them to try and deal with -- you  
5 know, with emotional things that they're having to.

6 TULLIO DIPONTI: Can I say something?

7 COMMISSIONER FRANK MARROCCO (CHAIR):  
8 Just -- sure. But, Commissioner Kitts, did you  
9 want to ask a question?

10 COMMISSIONER JACK KITTS: There was a  
11 separate topic, so go ahead.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Sorry. Go ahead.

14 TULLIO DIPONTI: So Nancy laid it out  
15 really well, and I appreciate what she talked  
16 about. When you talked about being undervalued,  
17 the PSW, I think the whole industry is undervalued.  
18 It doesn't matter who works in those facilities,  
19 whether it's a dietary worker, RPN, caretakers,  
20 PSWs, and all that.

21 So I think we've got do look at the  
22 whole industry, how they're being undervalued. And  
23 then when you talked about the mental issue of it,  
24 just imagine, when we were going through this  
25 pandemic in the first wave, and the funeral homes

1 couldn't go into the homes to pick up the bodies  
2 that passed -- unfortunately passed away. Now,  
3 they put the burden on our members. And like Katha  
4 said, they become the family members. They're the  
5 ones -- and they've done this before; they clean  
6 them up and all that -- now they had to put them in  
7 body bags.

8                   Yeah, do we need mental health? Do we  
9 need some mechanism in there to help these workers  
10 deal with what's going on? We definitely do. But  
11 I just don't want to make it as if it's just a PSW  
12 issue. This is an industry-wide issue, and whoever  
13 works in this industry have always felt they're  
14 undervalued.

15                   And like Nancy said, especially now  
16 with this just targeting one sector of that --  
17 those homes, the PSW, only giving them the raise,  
18 it just magnified the problem.

19                   COMMISSIONER JACK KITTS: Yeah, just  
20 building on that, I guess my question builds on  
21 that. So we've heard they're undervalued. They're  
22 subject to verbal and physical abuse, workload is  
23 excessive. They're unsupported. They're burning  
24 out and exhausted.

25                   And I think, Nancy, you said that the

1 current wage fixes aren't going to work or they're  
2 not the solution; band-aids aren't the solution.  
3 Can you tell us what you think needs to be done as  
4 soon as possible to help out in Wave 2?

5 NANCY MCMURPHY: Absolutely. So we  
6 strongly encourage that there is a mandatory four  
7 hours of care per resident per day introduced  
8 immediately. We want to make sure that these  
9 residents can be given the care that they need and  
10 that they deserve.

11 We feel that it's vitally important  
12 that we see full-time jobs being created and  
13 full-time jobs with benefits. This is going to  
14 entice, we believe, individuals back into the  
15 sector.

16 We also would like to see, obviously, a  
17 fair wage schedule. When you look at the  
18 differences that Katha has laid out between  
19 municipal homes and private long-term care homes,  
20 it's pretty significant the wage difference.

21 And you know what? I've worked in the  
22 sector for so many years, and as Katha said before,  
23 it's not all about the money. Absolutely it's not  
24 because these individuals, some of them have worked  
25 for 20, 25 years. They're bringing in clothing and

1 personal hygiene products to the residents that  
2 they know that they need. They've stuck it out.  
3 But the workload has just increased to the point  
4 that it's beyond their capacity.

5           You have to understand that we now have  
6 residents in some of these facilities that might be  
7 as young at 21, 22 years old. And they're there  
8 because they may have suffered a traumatic brain  
9 injury, and there are no assisted living beds  
10 available in the community.

11           Then you have residents that are  
12 suffering from serious mental illness. And then  
13 you mix into that your elderly population that are  
14 suffering from the dementias, and that's just a  
15 recipe for disaster.

16           COMMISSIONER JACK KITTS: Just one  
17 supplemental. If mandatory care were implemented  
18 tomorrow or next week, would there be sufficient  
19 staff to meet that mandate?

20           NANCY MCMURPHY: I don't know that  
21 there would immediately, but I think it would go a  
22 huge way to drawing people back into the sector.  
23 If they knew that they were going to be able to  
24 perform the job safely and the way that they should  
25 be performed, I believe that it would bring people

1 back into the sector.

2 COMMISSIONER JACK KITTS: Thank you.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Yes, Commissioner Coke.

5 COMMISSIONER ANGELA COKE: You spoke  
6 before also about the issue, the temporary wage  
7 increase for the PSWs, the issues that that may  
8 cause with the RPNs; in terms of it, I guess the  
9 relativity gets shifted.

10 Are there other classifications or  
11 group that that problem is taking place in the  
12 homes, or is that mainly the group that is creating  
13 the issue there?

14 NANCY MCMURPHY: I think it's being  
15 felt by all classifications, quite frankly, because  
16 they're feeling devalued. The RPN, it's because of  
17 the, you know, they've taken into consideration  
18 they are registered. They're a registered  
19 practical nurse. And when a PSW is making 27 cents  
20 more an hour than them, then that's -- you know,  
21 that's very problematic.

22 But all classifications, because I  
23 mean, let's be frank, you can't have a home  
24 operating properly if you don't have a good  
25 cleaning staff that are looking after the infection

1 control, if you don't have a strong dietary  
2 department that are providing proper nourishment  
3 for the residents, if you don't have the registered  
4 staff that are going to be assessing the needs of  
5 the resident on a daily basis as well as  
6 administering medications. So it is an entire team  
7 in order to make the homes properly run.

8 COMMISSIONER ANGELA COKE: Thank you.

9 KATHA FORTIER: I think we'll go to  
10 Andy next for his remarks and then to Tullio.

11 TULLIO DIPONTI: Andy's on mute.

12 COMMISSIONER FRANK MARROCCO (CHAIR):  
13 Oh, you're on mute.

14 ANDY SAVELA: There I go.

15 Thank you. But I'm happy to also be  
16 able to be involved in today's discussion and offer  
17 some comments on, you know, the things that we're  
18 seeing in long-term care.

19 But I just want to start by telling you  
20 I was very happy to hear at the beginning of this  
21 call today that the Commission was, you know,  
22 considering some short-term recommendations put in  
23 place, you know, as soon as possible because  
24 frankly, you know, with the second wave approaching  
25 and -- and we're -- I'm getting calls from our

1 members who work in, you know, homes that are  
2 declared an outbreak, and frankly, some of them for  
3 the second time, it's -- you know, in all honestly,  
4 they seem to be looking for a lifeline. And  
5 there's not much that we can say at this point  
6 other than point to the work we're trying to do in  
7 terms of getting some of the things we're talking  
8 about today addressed.

9           So I'll just say that, you know, when  
10 the pandemic hit the sector, there was already a  
11 crisis with respect to the workforce in long-term  
12 care. The vast majority of the facilities,  
13 particularly those operated in the for-profit  
14 sector, had already an unstable workforce and a  
15 severe shortage of staff.

16           Katha talked about the report that  
17 we're going to forward to you that we commissioned  
18 the Ontario Health Coalition to write on our  
19 behalf. And we shared that with Minister Fullerton  
20 and her staff pre-pandemic when we had the  
21 opportunity to meet with her just before the  
22 pandemic really broke.

23           I want to say about that report we're  
24 going to forward you that it did stem from  
25 roundtable discussions that we held across the

1 province. And I think it's important to know when  
2 you read that report that we were very inclusive in  
3 terms of people who participated in those  
4 roundtables. We had all classifications of worker  
5 in long-term care facilities, residents, and family  
6 members, family councils. We had for-profit and  
7 not-for-profit operators participate, educators,  
8 physicians, and politicians.

9 So we feel that report captures, you  
10 know, a wide range of views and opinions. And I  
11 think, you know, when you read it, you'll see it  
12 clearly supports some of the things that we're  
13 recommending that need to happen today.

14 I think it was Nancy who talked about  
15 the long-term care workers having to choose a  
16 primary employer when the outbreak starting hitting  
17 facilities. And this really unfortunately  
18 exacerbated the staffing crisis.

19 The majority of long-term care workers,  
20 you know, have to piece together a number of  
21 part-time and casual jobs to make a living wage and  
22 support their families. And, you know, in many  
23 circumstances, being limited to work only -- only  
24 one employer led to workers and staff frankly  
25 finding them jobs in different sectors. And in all

1 honestly, a lot of them have left and don't intend  
2 to come back, and more, I believe, are weighing  
3 those options, particularly now as we go back  
4 into -- to outbreak.

5 Frankly, also, I can tell you that many  
6 workers left the job right when an outbreak was  
7 declared in their facility, and it was not really  
8 only related to the extra burden on -- you know,  
9 which caused the unstable workforce, but also to  
10 the lack of access to the appropriate PPE, personal  
11 protective equipment.

12 And lots of facilities -- and again, it  
13 seemed to be a worse of a problem in the private  
14 sector. You know, our workers, members reported  
15 PPE being kept under lock and key. And, you know,  
16 the problem with that is when you're on a time  
17 crunch and you're looking to get the appropriate  
18 PPE so you can perform your duties with the PPE  
19 being under key and, you know, supervisory staff  
20 would be responsible for that run off their feet as  
21 well, it just caused a problem with people getting  
22 access to the PPE that was needed.

23 And in all honestly, you know, there  
24 were debates on the floor on, you know, what PPE  
25 was needed and, you know, the things the Medical

1 Officer of Health had outlined in his directives,  
2 Directive 5. It became so bad that if you can  
3 imagine, we literally had our members in the one  
4 workplace who took pictures of themselves and  
5 reported that they had wrapped themselves in  
6 garbage bags to keep themselves safe.

7           Employers must be held accountable to  
8 comply with the directives put forward by the  
9 Medical Officer of Health to give workers the  
10 safety that they need. And in particular, we're  
11 hoping that employers will follow the newly amended  
12 Directive 5 that we participated with many in -- in  
13 coming to consensus on. I think it's more clearly  
14 written and provides more appropriate protection to  
15 a broader classification of workers. I think this  
16 will ease some of the anxiety and whatnot in the  
17 workforce.

18           So I'll end my comments there. I think  
19 we've touched on a lot, but I just want to close by  
20 saying that it's very important that long-term care  
21 workers who are going to speak to the Commission  
22 are able to go and tell their stories without fear  
23 of retribution from their employers. It's  
24 paramount that they get more protection so that  
25 they can, you know, speak openly and frankly with

1 the Commission.

2 And with that, I'm happy to answer any  
3 questions as well.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Well, and let me just say, just on that last point,  
6 we have -- we want to amend the terms of reference  
7 to make it crystal clear that we can grant that  
8 confidentiality and that only we can take it away.  
9 There's some ambiguity in the terms of reference,  
10 and that's under discussion. So we're alive to --  
11 we understand that problem.

12 ANDY SAVELA: Thank you.

13 KATHA FORTIER: We appreciate --

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Commissioner Kitts.

16 COMMISSIONER JACK KITTS: Yeah, just on  
17 a point of clarification, when you -- when you  
18 spoke about the impact of one site -- working at  
19 one site only on the workers, I want to be clear.  
20 Are you thinking or saying that perhaps we could  
21 find a way to have them work at more than one site  
22 and keep the patients and other residents -- the  
23 residents and other staff safe, if you could find a  
24 balance? Or I made a mistake?

25 ANDY SAVELA: I'm thinking that, I

1 mean, right now, I think, you know, there's a  
2 recognition that perhaps another look had to be  
3 taken at, you know, who is entering the facility  
4 and under what circumstances.

5           You've heard the -- or you will if you  
6 haven't, the concerns raised by family caregivers  
7 and people who do that thing. And, you know, in  
8 all honestly, there were -- it was frustrating for  
9 our members because, you know, here they were  
10 having a restricted income because they could only  
11 work at one employer, yet the staffing shortages  
12 were so, you know, difficult that we had agency  
13 staff who, frankly, their role was to go into any  
14 facility they're needed on any given day to enter a  
15 workplace.

16           So it just didn't seem to make a lot of  
17 sense for people. I'm sure that, you know, we  
18 could put our minds and come up with procedures and  
19 processes that would keep workers safe. But the  
20 fact that the people who counted on income from  
21 numerous employers to make ends meet, being  
22 restricted to just one job through no fault of  
23 their own really had a profound impact on staffing.

24           KATHA FORTIER: I would just like to  
25 add to that. B.C. acted far earlier than Ontario

1 did in limiting workers from being in one  
2 workplace, but they also took an added step of  
3 making sure that any worker -- they actually  
4 stabilized, brought all the wages up, but they  
5 actually made it so that those employers actually  
6 had to give workers full-time work if they were  
7 restricting them from more than one facility if  
8 they wanted it.

9           Now, I mean, I have to tell you that  
10 sometimes there are people that work a full-time  
11 job and a part-time job, so that doesn't cover all  
12 of that. But again, it would be -- it would be a  
13 step. If they're restricting them from working at  
14 a second facility, that they should at least  
15 guarantee those workers full-time hours. And, you  
16 know, like, that's just -- that's just very basic.  
17 And B.C. acted very, very early. In fact, B.C. was  
18 able to prevent a real tragedy with some of the  
19 steps that they took.

20           Oh, Nancy?

21           NANCY MCMURPHY: If I could just add as  
22 well, I think what was very troubling for some of  
23 the staff was the fact that there was no  
24 consistency. So we absolutely understood that you  
25 shouldn't have staff going from home to home to

1 home. These are very, very fragile individuals  
2 that they're dealing with on a regular basis, but  
3 when you looked at some of the directives and  
4 orders that were coming down, there was directives  
5 that would say, we're going to redeploy from the  
6 hospital. Those individuals can continue to work  
7 in the hospital, but they can also work in  
8 long-term care.

9 And so our members are feeling very  
10 frustrated saying, I had to give up my secondary  
11 job for the best interests of the residents, and  
12 yet we have these others, such as Andy suggested,  
13 the agency workers or those that were being  
14 redeployed that were continuing to work at more  
15 than one workplace.

16 KATHA FORTIER: Okay. I think we'll  
17 move to Tullio now. Tullio's going talk about --  
18 he represents the workers at the hospital, Windsor  
19 Regional Hospital and also the -- represents one of  
20 the homes, the code red, that had a code red  
21 outbreak in the province, so over to Tullio.

22 TULLIO DIPONTI: Okay. Thanks, Katha,  
23 and thank you to the Commission here for giving us  
24 this opportunity to speak to you. Obviously, it's  
25 very important to us that we make sure that this

1 gets out there, and changes have to be made. And  
2 going last makes my speech a little bit -- because  
3 the three of -- Nancy, Katha, and Andy really  
4 highlighted the issues going on in the long-term  
5 care facilities and the retirement sector.

6 So like Katha said, I want to talk  
7 about what happened here in Windsor. We had a  
8 specific home that was in code red, and that was  
9 Heron Terrace. And at that point in time, it was  
10 just overwhelming. They couldn't handle what was  
11 going on in their home. And the CEO of Windsor  
12 Regional Hospital, David Musyj, wanted help. He  
13 saw the stories. He knew what was going on, and he  
14 saw the deaths that were happening. And what he  
15 did, he came up with the idea about creating this  
16 field hospital.

17 And the field hospital was an old gym  
18 of one of our colleges, St. Clair College here in  
19 Windsor, and he was able to get that thing up and  
20 running. And I think he was able to, if needed,  
21 that he could bring in about a hundred COVID  
22 patients where they would be taken care of,  
23 hospital staff.

24 Now, that goes to what Nancy's point  
25 was or Katha or Andy in regards to -- oh, sorry, go

1 ahead.

2 COMMISSIONER JACK KITTS: Mr. Diponti,  
3 could I just ask, was this home licensed by the --  
4 was it the hospital?

5 TULLIO DIPONTI: No. No. This was a  
6 privately owned home.

7 COMMISSIONER JACK KITTS: Okay. And  
8 the hospital stepped in?

9 TULLIO DIPONTI: Well, the hospital  
10 stepped in for the whole community, not just for  
11 that home. But because of that home was in that  
12 code red and they had so many COVID patients in  
13 there, and the staffing, because of the pandemic,  
14 we had a big shortage of staffing in that home that  
15 they pretty well took 25 of the residents out of  
16 that home. I believe there was close to 40  
17 residents that tested positive in that home and  
18 quite a few of our staff and was one of the reasons  
19 why they were working short.

20 But how that worked out, it worked out  
21 great. It was a blessing for that home and for our  
22 community that we were able to do that because now,  
23 by taking those 25 residents or COVID patients into  
24 the hospital, it give the opportunity for the  
25 remaining staff at Heron Terrace the opportunity to

1 be able to really take care of these residents, the  
2 rest of the residents that were in there,  
3 whether they were -- whoever was left over as a  
4 COVID or just regular residents of long-term care.

5 And I can tell you, our staff was  
6 overwhelmed to the point --

7 (DISCUSSION OFF THE RECORD)

8 TULLIO DIPONTI: Okay. So I just want  
9 to tell you a little bit of what was happening in  
10 that home. Obviously, there was a working shortage  
11 because like Nancy says, everybody was afraid of  
12 catching the disease, bringing it home, and  
13 infecting their family. And they didn't want to  
14 get themselves infected.

15 Obviously, they got into this field to  
16 take care of residents, and that's what they wanted  
17 to do. But because they really at the beginning  
18 didn't have the proper equipment to be -- do the  
19 job, it was going rampant into that home.

20 So we had actual staff that felt  
21 comfortable enough to work for 45 days straight so  
22 in order for them to be able to take care of  
23 whatever residents was left over with COVID and the  
24 rest of those residents. They brought in trailers  
25 where they didn't even go home. They actually

1 spent the rest of their time, until they had enough  
2 relief, in these trailers. One particular member  
3 of ours pretty well was -- was reporting to us,  
4 here I go again. And she was in regards to what's  
5 it like to live in a trailer and try to do your job  
6 as a PSW, a healthcare worker, to take care and  
7 making sure that these residents are in there --  
8 got the proper care.

9           And if we didn't have this field  
10 hospital, I believe a lot of those residents -- and  
11 I think out of the 25, only 1 died in the field  
12 hospital. But you got to remember, the field  
13 hospital is a lot more staffed. It's almost like  
14 1 to 1 to those residents compared to these  
15 long-term care facilities.

16           Now, we know we'll never get to that  
17 point with long-term care, but it goes to the point  
18 about what -- how important it is to make sure that  
19 we don't have 12 or 16 people trying to be taken  
20 care of by one healthcare aid, one PSW.

21           And I could tell you, I can speak  
22 personally. I have a father-in-law that right now  
23 is going through dementia, and he should be in a  
24 home. And me dealing with all these homes and  
25 being involved in this industry, and I appreciate

1 everything our members do because they're  
2 phenomenal workers. Yeah, they're underpaid, but  
3 yet they go work and make sure they take care of  
4 those residents the way they're supposed to be  
5 taken care of. They give them dignity. They give  
6 them dignity to be able to live in those facilities  
7 and take care of them.

8 But when we're working this short, it  
9 doesn't happen. They can't do it. We've got four  
10 of us in our family, and it's so hard.

11 So now, not only do I know they're  
12 heros, they save our lives; they save our family  
13 [sic] lives. So whatever you guys do, I plead with  
14 you. You have to do everything possible to give  
15 them the tools and the ability to be able to  
16 perform their work and be able to save these lives.

17 And, you know, how do we get them back  
18 into the thing, and Nancy and Andy and Katha talked  
19 about it. What people tell us is, give us the  
20 proper tools; give us the PPE that we need. Give  
21 us the staff to be able for us to effectively do  
22 our job without cutting corners.

23 And also what they're looking for is  
24 that, we want to be valued. And how do we get  
25 value? We get appreciated. You know, it's easy to

1 say, well, these are our heroes. They're a -- we  
2 need them and we appreciate them. But show them  
3 how you appreciate them. Give them the staff; give  
4 them the PPEs; and give them the proper pay.

5 You want to get staff back in these  
6 facilities? That's what you got to promise. And  
7 it's got to be shown. It can't be just words  
8 because words don't cut it because we've been  
9 sounding the alarm way before all this started.

10 In fact, we met with the Minister of  
11 Long-Term Care in January, I believe, if I remember  
12 the date. And we brought this up to the Minister.  
13 And they told us, yeah, we understand. We know  
14 where the problems are, and we're doing something  
15 about it. Bang, COVID hit.

16 COMMISSIONER FRANK MARROCCO (CHAIR):  
17 When did -- when did you realize that COVID was  
18 going to pose a threat to the long-term care?  
19 Like, when did you sort of make the connection  
20 between what -- there's this virus out there, and  
21 long-term care homes in your backyard? Like,  
22 what -- around when?

23 TULLIO DIPONTI: I think it was right  
24 when -- in the beginning around March, maybe the  
25 end of February when the talks started getting more

1 and more in regards what this pandemic was about to  
2 do. We all knew that if it hit the home, we'd be  
3 in big trouble. Because, like, again, we've been  
4 sounding the alarm for years and years. You cannot  
5 operate in the way they were operating prior to  
6 COVID because they were just barely making it,  
7 barely making the -- barely enough staff to really  
8 take care of the residents.

9           And now, once that came up for us, we  
10 knew we were going to be in deep trouble. We were  
11 trying to figure out a way. And why didn't these  
12 homes have a pandemic plan? Because I believe  
13 that's part of their mandate is to make sure they  
14 get a pandemic plan in place. Why were they all  
15 caught off guard? Why didn't they have enough  
16 PPEs? Is it because they didn't want to spend the  
17 money, and they wanted to make -- keep the money  
18 for themselves? Because obviously, it didn't go to  
19 the frontline staff. And --

20           KATHA FORTIER: I would just add to  
21 what Tullio has said. You know, we wanted to talk  
22 about Heron Terrance very specifically because  
23 quite frankly, if that hospital had not moved those  
24 residents out of that home, several more of them  
25 would have died. It will save lives. It saved

1 lives of the residents that they took out of the  
2 home, but it also saved -- the residents were given  
3 a choice, and some stayed in the home, and it  
4 allowed them to actually provide the type of care  
5 that not only that a resident needs under normal  
6 circumstances, but when they're positive for COVID,  
7 it actually made -- you know, if the floor had half  
8 the residents on it, that actually gave you time to  
9 feed those residents, to make sure that they were  
10 hydrated, to make sure that they were turned, to  
11 make sure that they -- you know, all of the care  
12 that they needed. We found this wasn't our only  
13 code red outbreak home in the province.

14 We had Carlingview Manor in Ottawa  
15 which was a disaster. They've sent in two dozen  
16 staff from a hospital that all contracted COVID.  
17 You know, there was -- the cohorting were huge  
18 issues. But what this -- what this workplace did,  
19 and what -- well, what the hospital did was  
20 really -- was unique. It was the only community  
21 that we really saw the hospital taking that sort of  
22 action, and it saved lives.

23 And so we're moving into the second  
24 wave. We knew -- I think Heron Terrace was our  
25 first code red outbreak.

1                   And it was over Easter weekend, I  
2 believe, Tullio, and we were talking, and you were  
3 talking about the crisis in the home, the immediate  
4 crisis. You have staff that are testing positive  
5 for COVID. You have staff that think, I don't -- I  
6 have a -- I'm immunocompromised, or my child is  
7 immunocompromised; I can't go to work. You have  
8 people that also say, you know, I'm not going to  
9 look after your children. I'm your babysitter, but  
10 I'm not looking after your children anymore if you  
11 work in that home.

12                   You know, there was all sorts of the  
13 complexities to this. And as Andy has raised as  
14 well with the PPE, we had huge fights for PPE.  
15 We've had a significant win on Directive 5 which we  
16 think will better protect our members in long-term  
17 care.

18                   But quite frankly, you know, we need to  
19 make sure that that translates to the ground  
20 because we already know for-profit employers in  
21 particular are saying, well, we can't provide that  
22 level of PPE. That's just not going to happen. So  
23 it's going to be a continual fight. But I can tell  
24 you that the solution of waiting weeks, of having  
25 the army go in, of having a hospital take over

1 administration, these are -- these are too slow.  
2 We -- if there's code red outbreaks in these homes,  
3 severe outbreaks, they need to take the residents  
4 and put them in hospitals.

5 COMMISSIONER FRANK MARROCCO (CHAIR):  
6 Go ahead, Commissioner.

7 COMMISSIONER JACK KITTS: Just, Tullio,  
8 were the patients from the -- or the residents from  
9 the long-term care home admitted as patients in the  
10 hospital, or were they admitted to the tent?

11 TULLIO DIPONTI: They were admitted as  
12 patients in that field hospital.

13 COMMISSIONER JACK KITTS: In the field  
14 hospital?

15 TULLIO DIPONTI: In the field hospital.

16 COMMISSIONER JACK KITTS: Is that  
17 field -- is that field hospital still standing  
18 today?

19 TULLIO DIPONTI: Yes, they did not  
20 dismantle it because, obviously, we all know that  
21 the possibility of a second wave is real, real.  
22 And so if it does happen in the City of Windsor,  
23 there's that opportunity to -- for them to help us  
24 out.

25 I just -- I want to add on, and not

1 only did the -- they also brought some of our PSWs,  
2 like Katha said, because they become some of these  
3 residents' families, and they're comfortable seeing  
4 that familiar face. They were able to bring some  
5 of those PSWs to that field hospital to help out.

6 And Katha is absolutely right. If we  
7 did not have that field hospital in Windsor  
8 specifically for that home, it wouldn't have been  
9 just one death. It would have been at least 25  
10 deaths. And again, that saved a lot of -- a lot of  
11 those residents' lives. And we -- hopefully the  
12 rest of the communities do it.

13 Again, I've got to give kudos to that  
14 CEO of that hospital. He took it serious. He knew  
15 exactly how to try to help. And he said, he talked  
16 to me specifically, he says, Tullio, we can't just  
17 stand around and talk about it. We've got to do  
18 something about it. And I think that's why we're  
19 here today. We need to do something about it  
20 because we can't go back to that.

21 COMMISSIONER FRANK MARROCCO (CHAIR):  
22 How long did it take to turn that building into a  
23 field hospital? Do you have any idea?

24 TULLIO DIPONTI: I would say that it  
25 took them less than a month to get it up and

1 running. Obviously, they got a lot of help from  
2 the community and the government and all that.  
3 I'll tell you, though, that was a God save there,  
4 because -- and like Katha said, it was up to the  
5 residents and their family whether they wanted to  
6 go there or not. They gave them that option, but  
7 I'd say 75% of the residents that were infected  
8 went there.

9 COMMISSIONER FRANK MARROCCO (CHAIR):  
10 Okay. All right.

11 NANCY MCMURPHY: If I could just add  
12 one last comment from my perspective. I think one  
13 of the most troubling things for me that I see is  
14 that we've taken the home-like atmosphere out of  
15 these places. They've become a business more than  
16 a home.

17 TULLIO DIPONTI: Right.

18 NANCY MCMURPHY: And as I said earlier,  
19 I'm one of the lucky ones that can remember the day  
20 when I felt good about doing my job. But when we  
21 look at the aggressions that we're seeing or the  
22 violence that we're seeing, the residents that are  
23 having outbursts, so often those behaviours can be  
24 deterred by a little bit of human contact.

25 So if staff have the opportunity, they

1 could sit and have a conversation with someone that  
2 was having a rough day, that was struggling. If  
3 they could hold the hand of a resident that was  
4 passing away and didn't have a family member there  
5 with them, those are the types of personal things  
6 that make these homes, not business.

7 We are at the point now where we are  
8 nothing but an assembly line of care, and that's  
9 shameful. Just my last thoughts.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Okay.

12 TULLIO DIPONTI: Maybe I can just give  
13 you an example of what Nancy is talking about  
14 because my vice president, Shelley Smith, has been  
15 a PSW for 28 years. She works out of our local.  
16 And she always talks about a specific Mr. Jack.  
17 We'll call him Mr. Jack. Mr. Jack was a resident  
18 of her facility but didn't have no family. If he  
19 did have any family, nobody ever seen them.

20 Unfortunately, Mr. Jack, prior to this  
21 pandemic, this is, passed away, and Shelly, our  
22 vice president here working in that facility at  
23 that time, went out, bought Mr. Jack's suit to --  
24 in order for him to have something to wear in that  
25 casket. And Shelley was the only one at that

1 funeral home that stayed with Mr. Jack.

2 Just think about what these people --  
3 what these workers do for these residents. And for  
4 me, like, I talked about my father-in-law being  
5 like that. I struggle. I know there's a lot of  
6 Shelleys all over these facilities. But I know  
7 they're not -- they're always working short.

8 I struggle. Where do we put my  
9 father-in-law? We got great workers, but we  
10 can't -- they -- you can't -- we can't take care of  
11 these residents like we -- our members want to take  
12 care of them if we don't give them the tools. The  
13 biggest tool is the staffing and show them our  
14 appreciation by giving them the pay that they  
15 deserve, and obviously, because of the pandemic, we  
16 definitely need the PPEs.

17 COMMISSIONER FRANK MARROCCO (CHAIR):  
18 Okay. Well, is -- I don't think we have any  
19 further questions. Is there -- is there anything  
20 further we need to hear?

21 KATHA FORTIER: I would like to just  
22 raise a couple of things, two things in particular:  
23 First of all, the -- what happened in Quebec. I  
24 talked a little bit about B.C., how they were far  
25 more proactive than Ontario was. In fact, I think

1 initially B.C. had far more cases than Ontario did,  
2 and did have some COVID outbreaks in long-term care  
3 homes but acted very quickly.

4 But I'd just like to talk a little bit  
5 about Quebec because I think we're going to draw a  
6 lot of parallels to what happened in Quebec to what  
7 happened in Ontario during the severe outbreak.

8 But the difference is what -- what the  
9 Quebec government did over the summer. They  
10 fast-tracked training for personal support workers,  
11 and they paid them for training, thousands of  
12 them -- I've heard as 10,000 personal support  
13 workers. They paid them \$21 an hour for training.  
14 They upped the wages to \$26 an hour, and everybody  
15 was guaranteed full-time work and a government  
16 pension and benefits.

17 So, you know, those nursing homes in  
18 Quebec are, I think, I believe we're going to see  
19 in a far better position than we are in Ontario  
20 right now. We had the great numbers in the  
21 summertime where COVID rates were low, yet we  
22 failed to act.

23 And I would add to that, when we met  
24 with Minister Fullerton in February, Minister  
25 Fullerton was very clear to us that she had a

1 staffing commission, that she knew that there was a  
2 crisis, and she knew that there was -- you know,  
3 things were -- that we needed to fix, and she had a  
4 staffing commission. Her -- their government's  
5 very own hand-picked staffing commission released  
6 their report on the Friday before the long weekend  
7 in August. I think it was July the 30th. And that  
8 report has sat on the shelf, and not one of  
9 those -- not one thing has been implemented from  
10 the government's own staffing report.

11           And they did talk about a minimum  
12 staffing standard. They did talk about better  
13 wages, all of the things. In fact, one of our  
14 for-profit employers was on the staffing  
15 commission, Jamie Schlegel from Schlegel, and  
16 Tullio and Nancy and Andy and I were before this  
17 panel, and Jamie Schlegel shook his head at one  
18 point and said, yeah, I guess you are right that  
19 they have to -- you know, he's got 32-bed wards or  
20 units with three personal support workers.

21           So it's 1 to 10, 1 to 11, 1 to 12;  
22 that's the norm. And then again, they're often  
23 working short.

24           So the government's ignored their  
25 own -- their own recommendations, and they've, you

1 know -- and I mean, I guess my other comments would  
2 be, you know, we really need to look -- and I know  
3 Nancy and Tullio said this: It's not just the  
4 personal support workers. It's the cleaners are so  
5 important that -- the activation workers, the  
6 rehabilitation workers, all of these workers, the  
7 dietary workers, everybody has to play a role in  
8 long-term care.

9           And, you know, I remember the outbreak  
10 at Carlingview Manor where we actually had to file  
11 complaints and go to a mediation to get PPE for  
12 those -- the workers in the home. It's a huge  
13 home, 300 beds, one of the worst outbreaks in the  
14 province. And they were down to a point where they  
15 had four cleaners going to work.

16           If you can imagine how four cleaners  
17 could go to work and clean a 300-bed facility in  
18 the midst of a COVID outbreak. You know, so  
19 everybody's critical. Everybody plays a role. You  
20 know, we need to make sure that this is a workforce  
21 that's sustainable, a workforce that feels  
22 respected, a workforce that, you know, feels like  
23 the system has -- cares for them because they don't  
24 feel that right now.

25           And, you know, this -- the solutions

1 are there. The solutions are the same whether they  
2 come from the Health Coalition, whether they come  
3 from unions, and even whether they come from the  
4 government's own staffing commission.

5 But, you know, somebody has got to  
6 take -- make the effort. I mean, we can't -- we've  
7 had a revolving door of personal support workers  
8 coming into these homes, but other people -- it's a  
9 difficult job. And you know, this is -- this is a  
10 challenge.

11 There's personal support workers out  
12 here that if the conditions were right, we could  
13 attract them back to working into this sector. And  
14 you know, as Nancy's raised, would you be able to  
15 implement four hours of staffing right away? No.  
16 But if you made the other changes and made a real  
17 sustained effort to get workers back, it's possible  
18 to do that. And, you know, we think -- we think  
19 the solutions are really, really important.

20 And again, thank you for listening. I  
21 had one more thought in my head, and I've now lost  
22 it. I don't know if Tullio or Nancy or Andy wanted  
23 to add anything?

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Well, you know, you can -- you can -- you can

1 certainly communicate with us after. It's not as  
2 if -- it's not as if somebody's going to reply and  
3 say, time's up. So, you know, if it occurs to you,  
4 you just pass it on and just send us a note.

5 KATHA FORTIER: Yeah, and we would  
6 really love to -- you know, we have workers from  
7 the homes, particularly the ones that have been in  
8 code red outbreak that would share their stories  
9 that we think that are so important, workers like  
10 Jenna (phonetic), who worked is Heron Terrace, who  
11 worked 45 days without a day off, and many of those  
12 days were 20 hours.

13 So, you know, there's important stories  
14 from the workers that we don't think, you know,  
15 that will allow you to do your job far better than  
16 just hearing us with -- and there's my phone again.  
17 They really want to clean my ducts today, so...

18 COMMISSIONER FRANK MARROCCO (CHAIR):  
19 Okay. Now, we understand that. We just have to  
20 deal with this other issue first in order to be  
21 able to receive this in the way in which the people  
22 want to give it to us. And that's what -- that's  
23 what we're trying to do, and we will do.

24 You were asking if there was anything  
25 from -- there's no questions on our side. If

1 there's nothing further from your side, then I  
2 guess we would close this for now. We might be  
3 back. We probably will be back. I want to thank  
4 you for this because it really does help us  
5 understand this problem from the perspective of  
6 people who are actually working there.

7           And I think it helps understand how  
8 personal a relationship there can be between the  
9 support worker and the person they're looking after  
10 which I think sometimes can get lost when you read  
11 about 60% of the people not showing up for work and  
12 so on, and it gives you a kind of -- that gives you  
13 a kind of superficial impression which your  
14 presentation and -- helps -- helps us understand a  
15 little better.

16           So, on behalf of our commission, thank  
17 you very much, and we'll be in touch. And then if  
18 there's anything further, I think you know how to  
19 contact us. Don't hesitate to do that.

20           KATHA FORTIER: Yes, thank you very  
21 much, and we appreciate your time. We'll send you  
22 some more documentation, the personal support  
23 worker report of course. And, yeah, if there's  
24 anything else we can do, we're happy to  
25 participate.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Thank you.

3 NANCY MCMURPHY: Thank you very much.

4 COMMISSIONER ANGELA COKE: Thank you  
5 very much.

6 ANDY SAVELA: Thank you.

7 TULLIO DIPONTI: Thank you.

8 -- Adjourned at 2:30 p.m.

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1 REPORTER'S CERTIFICATE

2  
3 I, JANET BELMA, CSR, Certified  
4 Shorthand Reporter, certify:

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

9  
10 That all remarks made at the time  
11 were recorded stenographically by me and were  
12 thereafter transcribed;

13  
14 That the foregoing is a true and  
15 correct transcript of my shorthand notes so taken.

16  
17  
18 Dated this 13th day of October, 2020.

19  
20 

21  
22 \_\_\_\_\_  
23 NEESONS, A VERITEXT COMPANY

24 PER: JANET BELMA, CSR

25 CHARTERED SHORTHAND REPORTER

**WORD INDEX**

**< \$ >**

**\$1.50** 23:13, 18, 23  
**\$18.84** 20:22  
**\$20.83** 20:23  
**\$21** 68:13  
**\$22.20** 21:12  
**\$22.21** 21:14  
**\$23.11** 21:16  
**\$24.61** 22:2  
**\$25** 21:22  
**\$26** 68:14  
**\$3** 16:4, 8 35:7

**< 1 >**

**1** 3:24 28:12, 14 29:5, 6, 13 39:14 57:11, 14 69:21  
**1,800** 17:19, 21  
**1,952** 38:24  
**1:00** 1:16 3:1  
**10** 69:21  
**10,000** 68:12  
**11** 69:21  
**12** 21:3 28:12 29:6 57:19 69:21  
**13th** 75:18  
**15** 21:3 23:19  
**15,000** 5:6  
**16** 57:19  
**1990s** 22:7  
**1994** 23:4, 12  
**1995** 8:4, 9 10:2  
**1st** 20:18

**< 2 >**

**2** 4:2 16:4 42:4  
**2.25** 10:6  
**2.6** 12:6  
**2.75** 12:6  
**2:15** 4:19  
**2:30** 1:16 74:8  
**20** 42:25 72:12  
**2000** 23:8  
**2000s** 23:16  
**2011** 20:18  
**2020** 1:15 75:18  
**21** 43:7  
**21.04** 21:10  
**22** 43:7

**24/7** 31:10  
**2458** 2:10 6:6  
**24-hour** 29:22  
**25** 8:2 10:1 33:12, 16 42:25 55:15, 23 57:11 64:9  
**27** 35:8 44:19  
**28** 66:15

**< 3 >**

**3** 4:2 12:7  
**3,600** 18:16  
**30/70** 34:8  
**300** 70:13  
**300-bed** 70:17  
**302** 2:12 5:25  
**30th** 69:7  
**32** 28:14  
**32-bed** 69:19

**< 4 >**

**40** 9:9 33:10 55:16  
**45** 56:21 72:11

**< 5 >**

**5** 49:2, 12 62:15  
**55** 33:18

**< 6 >**

**6** 29:13  
**60** 6:8 9:10 73:11

**< 7 >**

**70** 19:10  
**70/30** 34:8  
**70s** 13:10  
**75** 65:7

**< 8 >**

**8** 29:5  
**85** 36:13

**< 9 >**

**90s** 8:18, 19  
**95** 13:1  
**9th** 1:15

**< A >**

**ability** 14:9, 10, 16, 22 58:15  
**absolutely** 26:15 28:19

30:10 34:9  
37:24 42:5, 23  
52:24 64:6  
**abuse** 28:25  
36:17, 19, 22  
41:22  
**access** 37:23  
48:10, 22  
**accountable** 49:7  
**accusations** 30:24  
**accused** 36:21  
**Act** 11:21 14:5, 15 68:22  
**acted** 51:25  
52:17 68:3  
**action** 61:22  
**activation** 70:5  
**actual** 20:6  
56:20  
**acuity** 28:17  
37:14  
**add** 31:8 32:23  
37:10 39:19, 20  
51:25 52:21  
60:20 63:25  
65:11 68:23  
71:23  
**added** 52:2  
**address** 33:9  
35:10  
**addressed** 24:13 26:11  
46:8  
**adequate** 25:25  
30:6  
**Adjourned** 74:8  
**administering** 45:6  
**administration** 63:1  
**admitted** 63:9, 10, 11  
**advantage** 39:5  
**affectionately** 14:15  
**afraid** 56:11  
**after** 6:23  
33:11 44:25  
62:9, 10 72:1  
73:9  
**afternoons** 28:13 29:6

**age** 33:18  
**aged** 5:9 22:24  
**agency** 9:15  
31:15, 23 32:5  
51:12 53:13  
**aggravation** 4:17  
**aggressions** 65:21  
**aging** 28:21  
33:14, 16  
**agitation** 29:1  
**ago** 10:1  
**agree** 34:7  
**agreement** 11:23 13:3  
15:16 24:2, 3  
**agreements** 12:2 20:8  
**ahead** 40:11, 13  
55:1 63:6  
**aid** 34:23 57:20  
**aids** 14:25 32:9  
**alarm** 38:11, 14  
59:9 60:4  
**Alison** 2:17  
**alive** 50:10  
**allegations** 36:17  
**allow** 22:12, 18  
72:15  
**allowed** 22:19  
61:4  
**Alzheimer** 29:10  
**Alzheimer's** 8:14  
**ambiguity** 50:9  
**amend** 50:6  
**amended** 49:11  
**amount** 34:25  
**amounts** 16:14  
**Andy** 2:11 5:19, 20 39:19 45:10, 14 50:12, 25  
53:12 54:3, 25  
58:18 62:13  
69:16 71:22  
74:6  
**Andy's** 45:11  
**Angela** 2:4  
44:5 45:8 74:4  
**announced** 34:16  
**announcement** 34:24

**anxiety** 28:3  
29:1 30:15  
49:16  
**anxious** 3:25  
**anybody** 22:13  
**anymore** 17:11  
62:10  
**anyway** 17:6  
39:10, 16  
**anyways** 17:12  
**apologize** 38:16  
**appeal** 24:6, 8, 20  
**appealed** 24:18  
**applying** 33:3  
**appreciate** 5:1  
40:15 50:13  
57:25 59:2, 3  
73:21  
**appreciated** 58:25  
**appreciation** 67:14  
**approach** 3:24  
**approaching** 45:24  
**appropriate** 48:10, 17 49:14  
**approximately** 33:10  
**Arbitration** 11:21 14:5  
**arbitrator** 11:24  
12:3 13:4 15:18  
**arbitrators** 15:17  
**area** 6:1 35:12  
**argue** 16:10  
**army** 62:25  
**array** 23:3  
**asked** 26:3  
**asking** 72:24  
**aspect** 26:17  
38:5  
**aspects** 26:11  
**assembly** 66:8  
**assessing** 45:4  
**assignment** 28:12  
**Assistant** 2:8,  
17 5:12  
**assisted** 43:9  
**associated** 31:23  
**Associates**

|  |   |   |   |   |
|--|---|---|---|---|
| <p>24:18<br/><b>assume</b> 16:22<br/><b>atmosphere</b><br/>65:14<br/><b>attempted</b> 31:12<br/><b>attempting</b><br/>32:25<br/><b>attending</b> 1:14<br/><b>attention</b> 26:4<br/><b>Attorney</b> 25:1<br/><b>attract</b> 71:13<br/><b>attracting</b> 34:4<br/><b>August</b> 20:18<br/>69:7<br/><b>Auto</b> 23:9<br/><b>availability</b> 34:1<br/><b>available</b> 43:10<br/><b>avenues</b> 40:3<br/><b>average</b> 10:10<br/>15:25 21:18<br/><b>avoid</b> 4:3<br/><b>awareness</b><br/>26:18</p> <p>&lt; B &gt;<br/><b>B.C</b> 51:25<br/>52:17 67:24<br/>68:1<br/><b>babysitter</b> 62:9<br/><b>back</b> 3:24 4:14<br/>7:24 8:4 14:24<br/>20:18 22:22<br/>42:14 43:22<br/>44:1 48:2, 3<br/>58:17 59:5<br/>64:20 71:13, 17<br/>73:3<br/><b>background</b><br/>5:23 6:3 23:6<br/><b>backyard</b> 59:21<br/><b>bad</b> 30:9 49:2<br/><b>bags</b> 41:7 49:6<br/><b>bake</b> 38:23<br/><b>balance</b> 34:3<br/>50:24<br/><b>ballpark</b> 6:8<br/><b>band-aid</b> 34:23<br/><b>band-aids</b> 42:2<br/><b>Bang</b> 59:15<br/><b>barely</b> 60:6, 7<br/><b>bargain</b> 20:9<br/>21:6<br/><b>bargained</b> 12:1,<br/>3</p> | <p><b>bargaining</b> 12:6<br/>15:12<br/><b>based</b> 26:1<br/><b>basic</b> 52:16<br/><b>basically</b> 4:23<br/><b>basis</b> 21:5<br/>45:5 53:2<br/><b>Bass</b> 24:17<br/><b>becoming</b> 39:25<br/><b>beds</b> 8:11, 12,<br/>20, 21 9:4, 5<br/>28:22 32:18<br/>43:9 70:13<br/><b>beef</b> 34:11<br/><b>beginning</b><br/>45:20 56:17<br/>59:24<br/><b>behalf</b> 25:2<br/>46:19 73:16<br/><b>behavioural</b><br/>29:11<br/><b>behaviours</b><br/>65:23<br/><b>believe</b> 13:9<br/>23:16 42:14<br/>43:25 48:2<br/>55:16 57:10<br/>59:11 60:12<br/>62:2 68:18<br/><b>bell</b> 36:24 37:2<br/><b>Belma</b> 2:22<br/>75:3, 24<br/><b>benefits</b> 18:10<br/>19:16, 19, 24<br/>42:13 68:16<br/><b>bereavement</b><br/>30:4<br/><b>best</b> 53:11<br/><b>better</b> 62:16<br/>68:19 69:12<br/>72:15 73:15<br/><b>big</b> 16:11<br/>55:14 60:3<br/><b>bigger</b> 23:23<br/><b>biggest</b> 67:13<br/><b>bit</b> 6:13 7:19<br/>10:13, 14 23:5<br/>54:2 56:9<br/>65:24 67:24<br/>68:4<br/><b>blessing</b> 55:21<br/><b>Bob</b> 22:15<br/><b>bodies</b> 41:1<br/><b>body</b> 41:7</p> | <p><b>bonus</b> 34:18<br/><b>bought</b> 66:23<br/><b>brain</b> 43:8<br/><b>break</b> 4:20, 22<br/><b>breaks</b> 37:16<br/><b>brief</b> 11:10<br/><b>bring</b> 38:21, 22<br/>40:3 43:25<br/>54:21 64:4<br/><b>bringing</b> 42:25<br/>56:12<br/><b>brittle</b> 8:14<br/><b>broader</b> 49:15<br/><b>broke</b> 46:22<br/><b>brought</b> 22:6<br/>26:18 52:4<br/>56:24 59:12<br/>64:1<br/><b>Brucelea</b> 21:19<br/><b>budget</b> 27:5, 12<br/><b>building</b> 31:17,<br/>22 41:20 64:22<br/><b>builds</b> 9:6<br/>41:20<br/><b>burden</b> 12:15<br/>41:3 48:8<br/><b>burning</b> 41:23<br/><b>burnout</b> 31:6<br/>40:2<br/><b>business</b> 65:15<br/>66:6</p> <p>&lt; C &gt;<br/><b>call</b> 14:14, 15<br/>27:11 36:24<br/>37:2 45:21<br/>66:17<br/><b>called</b> 3:19<br/>6:25<br/><b>call-ins</b> 34:1<br/><b>calls</b> 17:5, 10<br/>30:3 34:11<br/>40:1 45:25<br/><b>Canadian</b> 23:8<br/>33:8<br/><b>capacity</b> 43:4<br/><b>captured</b> 13:15<br/><b>captures</b> 47:9<br/><b>car</b> 8:7<br/><b>card</b> 12:7, 10<br/><b>CARE</b> 1:7 2:18<br/>5:4, 7, 18 6:2<br/>7:14, 19 8:1, 5,<br/>11, 12, 17, 20, 25<br/>9:5, 8, 14 10:3,</p> | <p>4, 6, 8, 10, 19, 25<br/>11:13, 19 13:14<br/>14:6, 22 15:10<br/>16:2, 10 17:14<br/>24:24 25:16, 25<br/>26:1, 19, 23<br/>27:1, 17 28:7,<br/>19, 25 30:21<br/>32:6, 9, 13 33:5,<br/>17 35:13 38:2,<br/>7 39:5 42:7, 9,<br/>19 43:17 45:18<br/>46:12 47:5, 15,<br/>19 49:20 53:8<br/>54:5, 22 56:1, 4,<br/>16, 22 57:6, 8,<br/>15, 17, 20 58:3,<br/>5, 7 59:11, 18,<br/>21 60:8 61:4,<br/>11 62:17 63:9<br/>66:8 67:10, 12<br/>68:2 70:8<br/><b>caregivers</b> 51:6<br/><b>cares</b> 70:23<br/><b>caretakers</b> 40:19<br/><b>Caring</b> 6:25<br/>9:22<br/><b>Carlingview</b><br/>61:14 70:10<br/><b>cart</b> 16:11<br/><b>case</b> 18:8 25:2,<br/>23 29:19<br/><b>cases</b> 31:16<br/>68:1<br/><b>casket</b> 66:25<br/><b>casual</b> 16:17<br/>18:11 33:20<br/>47:21<br/><b>catching</b> 56:12<br/><b>caught</b> 60:15<br/><b>caused</b> 48:9, 21<br/><b>central</b> 20:10<br/><b>cents</b> 23:19<br/>35:8 44:19<br/><b>CEO</b> 54:11<br/>64:14<br/><b>certain</b> 10:21<br/><b>certainly</b> 5:4<br/>6:10 8:19<br/>15:11, 13 18:8<br/>35:23 72:1<br/><b>CERTIFICATE</b><br/>75:1<br/><b>Certified</b> 75:3</p> | <p><b>certify</b> 75:4<br/><b>Chain</b> 20:8<br/><b>CHAIR</b> 3:2, 6<br/>7:4, 9 12:25<br/>13:6, 12, 17, 21<br/>17:2 18:14, 19,<br/>23 25:11 36:1,<br/>10 37:7 38:12<br/>39:11 40:7, 12<br/>44:3 45:12<br/>50:4, 14 59:16<br/>63:5 64:21<br/>65:9 66:10<br/>67:17 71:24<br/>72:18 74:1<br/><b>challenge</b> 37:10<br/>71:10<br/><b>challenges</b><br/>29:24<br/><b>challenging</b><br/>12:21<br/><b>change</b> 10:15<br/><b>changed</b> 8:1<br/>15:2, 3<br/><b>changes</b> 54:1<br/>71:16<br/><b>CHARTERED</b><br/>75:25<br/><b>charts</b> 16:19<br/>20:2<br/><b>checklist</b> 25:24<br/><b>child</b> 62:6<br/><b>children</b> 16:13<br/>62:9, 10<br/><b>choice</b> 61:3<br/><b>choose</b> 31:5<br/>47:15<br/><b>chronic</b> 8:11, 20<br/><b>church</b> 9:15<br/><b>circumstances</b><br/>47:23 51:4 61:6<br/><b>city</b> 23:1 63:22<br/><b>Clair</b> 54:18<br/><b>clarification</b><br/>50:17<br/><b>classification</b><br/>49:15<br/><b>classifications</b><br/>16:1 30:13<br/>35:1 44:10, 15,<br/>22 47:4<br/><b>clean</b> 41:5<br/>70:17 72:17<br/><b>cleaners</b> 70:4,</p> |
|--|---|---|---|---|

|   |   |   |   |   |
|---|---|---|---|---|
| <p>15, 16<br/><b>cleaning</b> 44:25<br/><b>clear</b> 19:7 50:7,<br/>19 68:25<br/><b>clearly</b> 14:5<br/>47:12 49:13<br/><b>close</b> 49:19<br/>55:16 73:2<br/><b>closed</b> 8:20, 22,<br/>23 9:3<br/><b>clothes</b> 38:22<br/><b>clothing</b> 42:25<br/><b>Coalition</b> 6:22<br/>24:5 46:18 71:2<br/><b>code</b> 53:20<br/>54:8 55:12<br/>61:13, 25 63:2<br/>72:8<br/><b>coffee</b> 38:21<br/><b>cohorting</b> 61:17<br/><b>Coke</b> 2:4 44:4,<br/>5 45:8 74:4<br/><b>collective</b> 11:23<br/>12:1 15:16 20:7<br/><b>College</b> 54:18<br/><b>colleges</b> 54:18<br/><b>come</b> 5:13<br/>25:15 31:17, 22<br/>37:17 39:4<br/>48:2 51:18<br/>71:2, 3<br/><b>comes</b> 15:23<br/><b>comfortable</b><br/>56:21 64:3<br/><b>coming</b> 3:9<br/>49:13 53:4 71:8<br/><b>commencing</b><br/>3:1<br/><b>comment</b> 65:12<br/><b>comments</b> 26:6<br/>45:17 49:18<br/>70:1<br/><b>COMMISSION</b><br/>1:7 2:18 3:10,<br/>12 7:17 9:2<br/>25:7 45:21<br/>49:21 50:1<br/>53:23 69:1, 4, 5,<br/>15 71:4 73:16<br/><b>commissioned</b><br/>46:17<br/><b>Commissioner</b><br/>2:3, 4, 5 3:2, 6<br/>7:4, 9 12:25<br/>13:6, 12, 17, 21,</p> | <p>23 14:18 17:2<br/>18:14, 19, 23<br/>25:11 36:1, 10<br/>37:7 38:12<br/>39:11 40:7, 8,<br/>10, 12 41:19<br/>43:16 44:2, 3, 4,<br/>5 45:8, 12 50:4,<br/>14, 15, 16 55:2,<br/>7 59:16 63:5, 6,<br/>7, 13, 16 64:21<br/>65:9 66:10<br/>67:17 71:24<br/>72:18 74:1, 4<br/><b>commissioners</b><br/>3:3<br/><b>commitment</b><br/>27:2<br/><b>commonplace</b><br/>29:14<br/><b>communicate</b><br/>72:1<br/><b>communities</b><br/>64:12<br/><b>community</b><br/>43:10 55:10, 22<br/>61:20 65:2<br/><b>COMPANY</b><br/>75:23<br/><b>comparator</b><br/>22:11, 21 23:12<br/><b>comparators</b><br/>22:9 23:3<br/><b>compare</b> 22:3,<br/>19<br/><b>compared</b><br/>20:14 57:14<br/><b>compares</b> 21:21<br/><b>comparison</b><br/>21:17<br/><b>compassion</b><br/>40:2<br/><b>compensated</b><br/>38:17<br/><b>compensating</b><br/>37:12<br/><b>compensation</b><br/>12:23<br/><b>complaints</b><br/>70:11<br/><b>complete</b> 30:20<br/><b>completed</b> 23:17<br/><b>completely</b><br/>26:10</p> | <p><b>complex</b> 8:10,<br/>13 10:13<br/><b>complexities</b><br/>62:13<br/><b>complexity</b> 9:21,<br/>25 15:3<br/><b>compliment</b><br/>27:17<br/><b>comply</b> 49:8<br/><b>concern</b> 30:15<br/><b>concerned</b><br/>35:15<br/><b>concerns</b> 26:4<br/>51:6<br/><b>conditions</b> 34:4<br/>71:12<br/><b>condone</b> 36:19<br/><b>confident</b> 34:17<br/><b>confidentiality</b><br/>50:8<br/><b>connection</b><br/>59:19<br/><b>consensus</b><br/>49:13<br/><b>consideration</b><br/>44:17<br/><b>considered</b><br/>13:25 36:25<br/><b>considering</b><br/>45:22<br/><b>consistency</b><br/>52:24<br/><b>consistent</b> 30:18<br/><b>contact</b> 65:24<br/>73:19<br/><b>continual</b> 62:23<br/><b>continue</b> 9:24<br/>53:6<br/><b>continued</b> 30:11<br/><b>continuing</b> 8:12<br/>53:14<br/><b>continuity</b> 32:6<br/><b>contracted</b><br/>61:16<br/><b>contribution</b><br/>35:4 36:5<br/><b>control</b> 45:1<br/><b>convenient</b> 4:21<br/><b>conversation</b><br/>26:9 38:10 66:1<br/><b>conversations</b><br/>15:13<br/><b>corners</b> 58:22<br/><b>correct</b> 75:15</p> | <p><b>cost</b> 31:23<br/><b>councils</b> 47:6<br/><b>counselling</b><br/>39:12, 13<br/><b>counted</b> 27:16<br/>51:20<br/><b>counting</b> 27:18<br/><b>couple</b> 3:17<br/>10:19 27:6<br/>32:18 67:22<br/><b>course</b> 18:9<br/>21:3 29:2, 25<br/>31:11 73:23<br/><b>court</b> 24:14, 19<br/><b>cover</b> 30:7<br/>34:10 52:11<br/><b>covered</b> 11:20<br/>14:13<br/><b>covers</b> 14:5<br/><b>COVID</b> 27:25<br/>30:10 31:11<br/>54:21 55:12, 23<br/>56:4, 23 59:15,<br/>17 60:6 61:6,<br/>16 62:5 68:2,<br/>21 70:18<br/><b>COVID-19</b> 1:7<br/>26:15<br/><b>create</b> 19:14<br/>31:19<br/><b>created</b> 3:11<br/>34:24 42:12<br/><b>creating</b> 44:12<br/>54:15<br/><b>crisis</b> 5:10 7:1<br/>26:15 46:11<br/>47:18 62:3, 4<br/>69:2<br/><b>critical</b> 70:19<br/><b>crucial</b> 8:3 38:6<br/><b>crunch</b> 48:17<br/><b>crux</b> 24:7<br/><b>crystal</b> 50:7<br/><b>CSR</b> 75:3, 24<br/><b>CUPE</b> 15:8 24:1<br/><b>current</b> 27:3, 22<br/>42:1<br/><b>currently</b> 21:22<br/>26:21 28:11<br/>33:17 35:25<br/><b>cut</b> 59:8<br/><b>cuts</b> 37:12<br/><b>cutting</b> 58:22</p> | <p>&lt; D &gt;<br/><b>daily</b> 45:5<br/><b>date</b> 59:12<br/><b>Dated</b> 75:18<br/><b>David</b> 54:12<br/><b>day</b> 1:15 9:17<br/>10:11 11:1<br/>26:2 29:16, 19<br/>30:25 37:15<br/>38:22 42:7<br/>51:14 65:19<br/>66:2 72:11<br/>75:18<br/><b>daycare</b> 31:9<br/><b>days</b> 14:24<br/>17:5 28:12<br/>29:5 56:21<br/>72:11, 12<br/><b>dayshift</b> 10:17<br/><b>deal</b> 4:2 35:20<br/>39:15 40:4<br/>41:10 72:20<br/><b>dealing</b> 28:1, 2,<br/>3 32:21 53:2<br/>57:24<br/><b>dear</b> 25:18<br/><b>death</b> 64:9<br/><b>deaths</b> 39:15<br/>54:14 64:10<br/><b>debates</b> 48:24<br/><b>decade</b> 7:18<br/>11:11, 25 12:17,<br/>24 15:6, 15, 20<br/>17:17<br/><b>decades</b> 14:7,<br/>11<br/><b>decide</b> 27:9<br/><b>decided</b> 10:2<br/><b>decision</b> 24:18<br/>27:4 30:14<br/><b>decisions</b> 27:24<br/><b>declared</b> 35:14<br/>46:2 48:7<br/><b>declined</b> 8:21<br/><b>dedicated</b> 31:25<br/><b>deep</b> 60:10<br/><b>deeply</b> 5:4<br/><b>definitely</b> 41:10<br/>67:16<br/><b>definition</b> 14:8<br/><b>delivered</b> 10:10<br/><b>demeaning</b><br/>31:25<br/><b>dementia</b> 57:23<br/><b>dementias</b> 43:14</p> |
|---|---|---|---|---|

|   |   |  |   |  |
|---|---|--|---|--|
| <p><b>demographic</b> 33:15<br/><b>department</b> 45:2<br/><b>depression</b> 28:2<br/><b>Deputy</b> 2:17<br/><b>deserve</b> 25:5<br/>30:22 42:10<br/>67:15<br/><b>designated</b> 27:2<br/>29:10<br/><b>despite</b> 27:18<br/><b>determined</b> 23:5<br/><b>deterred</b> 65:24<br/><b>deterrent</b> 11:14<br/><b>devalued</b> 44:16<br/><b>devastating</b> 39:1<br/><b>diabetics</b> 8:14<br/><b>Diaz</b> 2:9 5:13<br/><b>died</b> 38:25<br/>57:11 60:25<br/><b>dietary</b> 40:19<br/>45:1 70:7<br/><b>difference</b><br/>20:25 23:13<br/>42:20 68:8<br/><b>differences</b><br/>19:22 20:16<br/>42:18<br/><b>different</b> 3:18<br/>18:22 33:24<br/>40:3 47:25<br/><b>difficult</b> 10:14<br/>33:7 51:12 71:9<br/><b>dignity</b> 58:5, 6<br/><b>dining</b> 32:19<br/><b>Diponti</b> 2:10<br/>6:5 40:6, 14<br/>45:11 53:22<br/>55:2, 5, 9 56:8<br/>59:23 63:11, 15,<br/>19 64:24 65:17<br/>66:12 74:7<br/><b>dire</b> 26:19<br/><b>directed</b> 26:23<br/><b>Directive</b> 49:2,<br/>12 62:15<br/><b>directives</b> 49:1,<br/>8 53:3, 4<br/><b>Director</b> 2:11<br/>5:20<br/><b>disappear</b> 8:25<br/><b>disaster</b> 43:15<br/>61:15</p> | <p><b>discussion</b><br/>45:16 50:10<br/>56:7<br/><b>discussions</b><br/>46:25<br/><b>disease</b> 56:12<br/><b>dismantle</b> 63:20<br/><b>Disputes</b> 11:21<br/>14:5 23:25<br/><b>disregard</b> 35:3<br/><b>distraught</b> 37:22<br/><b>diversity</b> 28:17<br/><b>divisiveness</b><br/>34:25<br/><b>document</b> 7:2,<br/>5, 16 20:3<br/><b>documentation</b><br/>73:22<br/><b>documents</b> 6:19<br/><b>doing</b> 12:19<br/>25:24 30:23<br/>32:15 40:1<br/>59:14 65:20<br/><b>dollars</b> 32:3<br/><b>door</b> 32:2 71:7<br/><b>dozen</b> 61:15<br/><b>dramatically</b><br/>19:8 33:25<br/><b>draw</b> 68:5<br/><b>drawing</b> 43:22<br/><b>drove</b> 8:6<br/><b>drug</b> 12:7, 10, 13<br/><b>Drummond</b> 2:17<br/><b>ducks</b> 17:9<br/><b>ducts</b> 72:17<br/><b>due</b> 33:1<br/><b>duties</b> 32:4<br/>48:18<br/><br/>&lt; E &gt;<br/><b>earlier</b> 51:25<br/>65:18<br/><b>early</b> 22:7<br/>23:16 37:15, 17<br/>52:17<br/><b>ease</b> 49:16<br/><b>easily</b> 19:12<br/><b>Easter</b> 62:1<br/><b>easy</b> 12:20<br/>39:5 58:25<br/><b>educational</b> 15:1<br/><b>educators</b> 47:7<br/><b>EFAP</b> 39:22<br/><b>effectively</b> 58:21</p> | <p><b>effort</b> 71:6, 17<br/><b>elderly</b> 43:13<br/><b>embark</b> 3:23<br/><b>emergencies</b><br/>30:4<br/><b>emotional</b> 40:5<br/><b>Employees</b> 23:7<br/>31:25<br/><b>employer</b> 17:19,<br/>22 23:25 24:20<br/>39:8 47:16, 24<br/>51:11<br/><b>employers</b> 18:2,<br/>9, 22 19:14<br/>24:8, 16, 17<br/>25:2 31:12, 15<br/>32:24 33:25<br/>34:2 49:7, 11,<br/>23 51:21 52:5<br/>62:20 69:14<br/><b>employment</b><br/>33:21<br/><b>encourage</b> 42:6<br/><b>ends</b> 51:21<br/><b>engrossed</b> 26:9<br/><b>enhancement</b><br/>34:17 35:7<br/><b>enter</b> 51:14<br/><b>entering</b> 51:3<br/><b>entice</b> 42:14<br/><b>entire</b> 45:6<br/><b>envelope</b> 26:23,<br/>25 27:3<br/><b>environment</b><br/>31:10<br/><b>environments</b><br/>29:13<br/><b>Equal</b> 24:4<br/><b>equipment</b><br/>48:11 56:18<br/><b>equity</b> 22:5, 6, 9,<br/>13, 16, 17, 20<br/>23:3, 4, 20 24:9,<br/>16, 21 25:5<br/><b>especially</b> 41:15<br/><b>essential</b> 14:1, 9<br/><b>essentially</b> 20:9<br/>24:3<br/><b>event</b> 3:14<br/><b>events</b> 4:5<br/><b>ever-increasing</b><br/>28:16<br/><b>everybody</b> 6:16<br/>18:6 56:11<br/>68:14 70:7, 19</p> | <p><b>everybody's</b><br/>70:19<br/><b>exacerbated</b><br/>47:18<br/><b>exactly</b> 64:15<br/><b>example</b> 20:21<br/>21:8 66:13<br/><b>examples</b> 27:6<br/><b>exceptions</b><br/>14:12<br/><b>excessive</b> 30:19<br/>41:23<br/><b>exhausted</b><br/>35:18 41:24<br/><b>exhaustion</b> 31:7<br/><b>existence</b> 3:19<br/><b>exit</b> 30:17<br/><b>expand</b> 32:25<br/><b>expendable</b><br/>12:12<br/><b>experience</b><br/>33:13 39:7<br/><b>explain</b> 10:4<br/>22:4<br/><b>explained</b> 24:23<br/><b>explaining</b> 3:13<br/><b>explanation</b><br/>24:25<br/><b>Extencicare</b><br/>20:8, 20, 23<br/>21:6, 13<br/><b>extensive</b> 26:24<br/><b>extra</b> 48:8<br/><b>extremely</b> 32:16<br/><br/>&lt; F &gt;<br/><b>face</b> 64:4<br/><b>facilities</b> 11:13<br/>14:6 21:4<br/>29:24 35:13<br/>40:18 43:6<br/>46:12 47:5, 17<br/>48:12 54:5<br/>57:15 58:6<br/>59:6 67:6<br/><b>facility</b> 9:14<br/>10:8, 23 22:13<br/>48:7 51:3, 14<br/>52:7, 14 66:18,<br/>22 70:17<br/><b>facing</b> 29:11<br/><b>fact</b> 8:6 22:10<br/>24:22 27:18<br/>31:9 51:20</p> | <p>52:17, 23 59:10<br/>67:25 69:13<br/><b>failed</b> 68:22<br/><b>fair</b> 37:25 42:17<br/><b>fall</b> 37:4<br/><b>fallen</b> 15:21<br/><b>familiar</b> 5:15<br/>64:4<br/><b>families</b> 28:9<br/>37:22 47:22<br/>64:3<br/><b>family</b> 30:4, 16<br/>33:23 37:21<br/>38:3, 20 41:4<br/>47:5, 6 51:6<br/>56:13 58:10, 12<br/>65:5 66:4, 18, 19<br/><b>fast-tracked</b><br/>68:10<br/><b>father-in-law</b><br/>57:22 67:4, 9<br/><b>fatigue</b> 40:2<br/><b>fault</b> 51:22<br/><b>fear</b> 30:15, 22<br/>37:4 49:22<br/><b>fearful</b> 30:23<br/><b>February</b> 59:25<br/>68:24<br/><b>feed</b> 61:9<br/><b>feel</b> 11:4 24:13<br/>26:13 42:11<br/>47:9 70:24<br/><b>feeling</b> 12:18<br/>25:21 31:20<br/>44:16 53:9<br/><b>feels</b> 70:21, 22<br/><b>feet</b> 48:20<br/><b>felt</b> 41:13<br/>44:15 56:20<br/>65:20<br/><b>field</b> 54:16, 17<br/>56:15 57:9, 11,<br/>12 63:12, 13, 15,<br/>17 64:5, 7, 23<br/><b>fight</b> 62:23<br/><b>fight</b> 62:14<br/><b>figure</b> 60:11<br/><b>file</b> 70:10<br/><b>fill</b> 31:16<br/><b>final</b> 22:4<br/><b>finally</b> 6:5<br/><b>find</b> 19:20, 21<br/>31:12 37:17<br/>50:21, 23</p> |
|---|---|--|---|--|

**finding** 39:24  
47:25  
**fire** 38:11, 13  
**five-year** 9:20  
**fix** 69:3  
**fixes** 34:23  
42:1  
**flip** 34:8  
**floor** 48:24 61:7  
**focus** 26:3  
**follow** 49:11  
**forced** 28:25  
33:23  
**foregoing** 75:6,  
14  
**forget** 26:7  
**forgot** 6:20  
**formula** 10:8, 24  
**for-profit** 9:7, 8,  
19 20:4, 6  
24:17, 20 46:13  
47:6 62:20  
69:14  
**forth** 75:8  
**Fortier** 2:8 3:5  
4:25 5:11 7:7,  
11 13:5, 8, 16,  
19 14:3, 20  
17:8 18:17, 21  
19:4 37:9  
38:15 45:9  
50:13 51:24  
53:16 60:20  
67:21 72:5  
73:20  
**fortunate** 25:19  
**forward** 32:14  
35:17 46:17, 24  
49:8  
**found** 33:22  
61:12  
**four-hour** 11:7  
**fragile** 53:1  
**frail** 8:10  
**Frank** 2:3 3:2,  
6 7:4, 9 12:25  
13:6, 12, 17, 21  
17:2 18:14, 19,  
23 25:11 36:1,  
10 37:7 38:12  
39:11 40:7, 12  
44:3, 23 45:12  
50:4, 14 59:16  
63:5 64:21  
65:9 66:10

67:17 71:24  
72:18 74:1  
**frankly** 29:8  
35:14 44:15  
45:24 46:2  
47:24 48:5  
49:25 51:13  
60:23 62:18  
**free** 26:13  
**frequent** 27:14  
**frequently**  
28:24 29:17  
32:25  
**Friday** 69:6  
**front** 12:14  
**frontline** 28:7  
36:9 60:19  
**frustrated** 53:10  
**frustrating**  
36:20 51:8  
**frustration** 30:20  
**Fullerton** 46:19  
68:24, 25  
**full-time** 17:16,  
17 19:13, 14, 15  
42:12, 13 52:6,  
10, 15 68:15  
**funding** 26:20  
27:8  
**funds** 26:23  
**funeral** 40:25  
67:1  
**funerals** 38:20  
  
< G >  
**gap** 23:22  
24:11  
**garbage** 49:6  
**Gateway** 21:20  
**General** 25:1  
**generally** 16:23  
**generous** 19:25  
23:18  
**give** 3:8 11:10  
21:8 24:21, 25  
27:6 49:9 52:6  
53:10 55:24  
58:5, 14, 19, 20  
59:3, 4 64:13  
66:12 67:12  
72:22  
**given** 19:6  
20:2 29:15  
36:14 42:9  
51:14 61:2

**gives** 32:19  
73:12  
**giving** 25:14  
41:17 53:23  
67:14  
**glasses** 20:12  
**God** 65:3  
**good** 19:19  
29:7 39:23  
44:24 65:20  
**government**  
3:12 10:2  
22:15 25:3  
65:2 68:9, 15  
**government's**  
69:4, 10, 24 71:4  
**graduation**  
33:11  
**grant** 50:7  
**grave** 11:4  
**Great** 4:25  
34:14 35:20  
55:21 67:9  
68:20  
**greatly** 8:21  
**grew** 9:23  
**grieving** 28:4  
**groceries** 16:12  
**ground** 62:19  
**group** 15:17  
20:19 22:19  
44:11, 12  
**groups** 20:4  
**grown** 11:6  
23:22 24:12  
30:10  
**growth** 9:8  
**guarantee** 52:15  
**guaranteed**  
10:7 68:15  
**guard** 60:15  
**guess** 7:21  
14:8 16:7 23:5  
28:7 41:20  
44:8 69:18  
70:1 73:2  
**guys** 58:13  
**gym** 54:17  
  
< H >  
**half** 61:7  
**hand** 66:3  
**handle** 54:10  
**hand-picked**  
69:5

**hands-on** 27:2  
32:13  
**happen** 47:13  
58:9 62:22  
63:22  
**happened** 3:11,  
13 6:12 7:17  
8:18 27:7  
39:16 54:7  
67:23 68:6, 7  
**happening** 33:3  
54:14 56:9  
**happens** 17:13  
**happy** 6:17  
25:8 35:23  
45:15, 20 50:2  
73:24  
**hard** 58:10  
**Harris** 9:1  
**Haven** 21:19, 20  
**head** 69:17  
71:21  
**Health** 6:22  
8:10 28:1 33:8  
35:12 41:8  
46:18 49:1, 9  
71:2  
**Healthcare** 2:11  
5:13, 20, 23  
7:15 13:10  
14:25 19:6  
36:5 57:6, 20  
**hear** 45:20  
67:20  
**heard** 13:24  
24:19 41:21  
51:5 68:12  
**hearing** 37:21  
72:16  
**hearings** 3:16  
**heart** 25:18  
**Held** 1:14  
46:25 49:7  
**help** 34:11  
41:9 42:4  
54:12 63:23  
64:5, 15 65:1  
73:4  
**helpful** 4:8  
**helps** 73:7, 14  
**heroes** 59:1  
**Heron** 54:9  
55:25 60:22  
61:24 72:10

**heros** 58:12  
**hesitate** 73:19  
**high** 28:19  
**higher** 16:24  
20:23 29:11  
31:24  
**high-intensity**  
32:21  
**highlighted** 54:4  
**historical** 20:4  
**hit** 46:10 59:15  
60:2  
**hitting** 47:16  
**HLDA** 14:14  
**hold** 3:15 66:3  
**holidays** 34:12  
**home** 9:25  
15:17 16:2, 6  
19:21 20:21, 22,  
23 21:9, 18, 19  
22:8, 24 23:12,  
22 24:11, 12  
32:1 35:6, 9  
38:16 39:8  
44:23 52:25  
53:1 54:8, 11  
55:3, 6, 11, 14,  
16, 17, 21 56:10,  
12, 19, 25 57:24  
60:2, 24 61:2, 3,  
13 62:3, 11  
63:9 64:8  
65:16 67:1  
70:12, 13  
**Homecare**  
14:13, 15, 19  
**home-like** 65:14  
**homes** 5:8 6:2,  
9 8:5 9:10, 23  
11:12, 15 13:14  
15:10, 23 17:24  
19:10 20:1, 5, 9  
21:1, 6, 20 22:4,  
10, 22 23:6  
29:9, 21 31:14  
35:5 38:19  
39:17 40:25  
41:1, 17 42:19  
44:12 45:7  
46:1 53:20  
57:24 59:21  
60:12 63:2  
66:6 68:3, 17  
71:8 72:7

**honestly** 26:6  
31:15, 19 34:10  
36:8, 22 46:3  
48:1, 23 51:8  
**Honourable** 2:3  
**hopefully** 64:11  
**hoping** 49:11  
**horrible** 28:4  
**Hortons** 38:22  
**hospital** 5:17,  
18 8:11, 21  
9:13 11:21  
14:4, 14 19:20  
53:6, 7, 18, 19  
54:12, 16, 17, 23  
55:4, 8, 9, 24  
57:10, 12, 13  
60:23 61:16, 19,  
21 62:25 63:10,  
12, 14, 15, 17  
64:5, 7, 14, 23  
**hospitals** 8:12,  
15, 21, 22 9:4  
19:25 63:4  
**hour** 16:5, 8  
20:22, 24 21:10,  
12, 14, 22 22:2  
23:13, 14, 24  
32:3 35:8  
37:17 44:20  
68:13, 14  
**hours** 10:6, 11,  
25 17:20, 21  
18:16 30:25  
31:4 42:7  
52:15 71:15  
72:12  
**house** 16:25  
17:11  
**huge** 9:5 12:15  
34:25 43:22  
61:17 62:14  
70:12  
**human** 65:24  
**hundred** 54:21  
**hydrated** 61:10  
**hygiene** 43:1

< I >

**idea** 3:13  
18:16 54:15  
64:23  
**ignored** 69:24  
**illegal** 11:22  
13:10

**illness** 28:23  
43:12  
**imagine** 5:3  
23:18 40:24  
49:3 70:16  
**immediate** 62:3  
**immediately**  
3:23 42:8 43:21  
**immunocompro**  
**mised** 62:6, 7  
**impact** 35:16  
50:18 51:23  
**impacted** 29:23  
**imperative** 33:9  
**implement** 71:15  
**implemented**  
43:17 69:9  
**important** 7:16,  
25 12:11 25:7  
26:11 42:11  
47:1 49:20  
53:25 57:18  
70:5 71:19  
72:9, 13  
**impossible**  
27:24 28:20  
**impression**  
73:13  
**improve** 11:2  
**improved** 25:22  
**included** 26:25  
**inclusive** 47:2  
**income** 12:12  
51:10, 20  
**inconsistent**  
31:2 34:2  
**increase** 9:5  
16:17 19:8 44:7  
**increased** 28:3  
37:13, 14 43:3  
**increases** 12:7  
15:21 20:14, 15  
21:24 24:4  
**independent** 8:8  
**individual** 27:4  
**individuals**  
27:19 31:17  
32:10, 15 33:20  
36:21 42:14, 24  
53:1, 6  
**indulgence** 26:5  
**industry** 40:17,  
22 41:13 57:25  
**industry-wide**

41:12  
**inefficient** 4:15  
**infected** 56:14  
65:7  
**infecting** 56:13  
**infection** 44:25  
**inflation** 11:14,  
16 15:21 20:15,  
17 21:11, 16, 25  
22:1  
**Information** 33:9  
**initial** 38:10  
**initially** 68:1  
**injured** 27:15  
**injuries** 27:21  
30:5  
**injury** 37:6 43:9  
**inquiries** 3:12  
**inquiring** 4:4  
**insight** 3:25  
**inspection** 10:23  
**inspector** 10:22  
**instances** 17:20  
**Institute** 33:8  
**insulting** 31:25  
**intend** 48:1  
**intended** 34:17,  
18  
**intense** 8:17  
**interests** 53:11  
**International**  
23:7  
**interrupt** 4:15  
**intervened** 25:2  
**interveners** 24:4  
**introduced** 6:16  
42:7  
**introduction**  
4:23 32:9  
**investigating**  
3:15  
**investment** 28:6  
**involved** 24:5  
45:16 57:25  
**issue** 33:2, 14  
35:2 39:25  
40:23 41:12  
44:6, 13 72:20  
**issues** 8:10, 13  
26:5 28:2  
29:11 44:7  
54:4 61:18

< J >

**Jack** 2:5 13:23  
14:18 40:10  
41:19 43:16  
44:2 50:16  
55:2, 7 63:7, 13,  
16 66:16, 17, 20  
67:1  
**Jack's** 66:23  
**Jamie** 69:15, 17  
**Janet** 2:22  
75:3, 24  
**January** 59:11  
**Jenna** 72:10  
**Jerry** 2:9 5:12  
**job** 17:16, 17,  
25 27:24 32:5,  
13 33:11 43:24  
48:6 51:22  
52:11 53:11  
56:19 57:5  
58:22 65:20  
71:9 72:15  
**jobs** 18:1, 12  
28:10 32:24  
35:4 42:12, 13  
47:21, 25  
**join** 23:8  
**joys** 38:16  
**July** 69:7  
**June** 27:9  
  
< K >  
**Katha** 2:8 3:5  
4:25 5:11 7:7,  
11 13:5, 8, 16,  
19 14:3, 20  
17:8 18:17, 21  
19:4 25:16  
26:3 34:7 37:9  
38:15 41:3  
42:18, 22 45:9  
46:16 50:13  
51:24 53:16, 22  
54:3, 6, 25  
58:18 60:20  
64:2, 6 65:4  
67:21 72:5  
73:20  
**kept** 11:5, 13  
20:17 21:11, 15  
22:1 48:15  
**key** 48:15, 19  
**kind** 3:8, 21  
4:14 28:7  
73:12, 13

**Kitts** 2:5 13:23  
14:18 40:8, 10  
41:19 43:16  
44:2 50:15, 16  
55:2, 7 63:7, 13,  
16  
**knew** 25:22  
43:23 54:13  
60:2, 10 61:24  
64:14 69:1, 2  
**knowledge**  
31:18  
**kudos** 64:13

< L >

**Labour** 11:21  
14:4  
**lack** 48:10  
**laid** 21:23  
40:14 42:18  
**large** 15:17  
**late** 8:19 37:16  
**Lead** 2:3  
**leave** 30:4, 11  
33:11 37:3  
**leaving** 30:18  
33:13  
**led** 6:12 30:19  
47:24  
**left** 23:7 25:20  
48:1, 6 56:3, 23  
**legislation** 22:16  
**letters** 7:13  
**level** 8:17  
10:21 62:22  
**levels** 11:2  
**licensed** 55:3  
**life** 25:22  
**lifeline** 46:4  
**limited** 37:24  
47:23  
**limiting** 52:1  
**listening** 71:20  
**literally** 49:3  
**live** 38:2 57:5  
58:6  
**lived** 8:6  
**lives** 38:3  
58:12, 13, 16  
60:25 61:1, 22  
64:11  
**living** 43:9  
47:21  
**load** 16:12

**Local** 2:10, 12  
5:25 6:6 21:20  
35:7 39:7 66:15  
**lock** 48:15  
**London** 5:25  
35:11  
**loneliness** 38:5  
**long** 16:5  
64:22 69:6  
**longer** 21:7  
25:23 29:19  
**LONG-TERM**  
1:7 2:18 5:7,  
18 6:2 7:14, 19  
8:1, 4, 25 9:5, 8,  
14 10:4, 8  
11:12, 19 13:14  
14:5, 21 15:10  
16:2, 9 17:14  
24:24 25:16  
26:19 33:17  
35:13 38:2, 7  
42:19 45:18  
46:11 47:5, 15,  
19 49:20 53:8  
54:4 56:4  
57:15, 17 59:11,  
18, 21 62:16  
63:9 68:2 70:8  
**looked** 10:1  
53:3  
**looking** 3:24  
35:1, 3 44:25  
46:4 48:17  
58:23 62:10  
73:9  
**loss** 28:5  
**lost** 71:21  
73:10  
**lot** 6:1 12:1, 11,  
15 15:8 16:8  
36:17 37:11, 22  
38:7 39:21  
48:1 49:19  
51:16 57:10, 13  
64:10 65:1  
67:5 68:6  
**lots** 48:12  
**love** 72:6  
**loved** 37:24  
**low** 20:20 68:21  
**lower** 20:20  
**lucky** 65:19

< M >

**made** 23:13  
30:14 50:24  
52:5 54:1 61:7  
71:16 75:10  
**magnified** 41:18  
**maintain** 24:9,  
10, 15  
**maintenance**  
22:11  
**majority** 15:9  
46:12 47:19  
**making** 12:17  
18:7 27:24  
32:2 33:6 35:8  
44:19 52:3  
57:7 60:6, 7  
**male** 22:9, 11  
23:3  
**mandate** 43:19  
60:13  
**mandatory** 42:6  
43:17  
**manner** 36:15  
**Manor** 61:14  
70:10  
**March** 59:24  
**Marrocco** 2:3  
3:2, 6 7:4, 9  
12:25 13:6, 12,  
17, 21 17:2  
18:14, 19, 23  
25:11 36:1, 10  
37:7 38:12  
39:11 40:7, 12  
44:3 45:12  
50:4, 14 59:16  
63:5 64:21  
65:9 66:10  
67:17 71:24  
72:18 74:1  
**matter** 14:21  
40:18  
**maximum** 29:4  
**McMurphy** 2:12  
5:24 25:10, 13  
36:7, 12 39:17  
42:5 43:20  
44:14 52:21  
65:11, 18 74:3  
**means** 10:5  
17:20  
**meant** 10:19  
**measurable**  
10:3, 6, 19 11:8

**mechanism**  
26:20 41:9  
**mediation** 70:11  
**Medical** 48:25  
49:9  
**medications**  
12:14 45:6  
**meet** 5:2 24:23  
43:19 46:21  
51:21  
**MEETING** 1:7  
36:13  
**member** 57:2  
66:4  
**members** 5:15  
12:8, 15 23:15  
41:3, 4 46:1  
47:6 48:14  
49:3 51:9 53:9  
58:1 62:16  
67:11  
**mental** 25:24  
28:1, 23 40:23  
41:8 43:12  
**mentally** 32:20  
**mentioned**  
25:16  
**message** 28:8  
**met** 59:10  
68:23  
**middle** 3:20  
16:22  
**Middlesex** 35:11  
**midst** 70:18  
**mind** 3:21  
**minds** 51:18  
**minimum** 10:3,  
5, 12, 19 11:3, 7  
29:4 69:11  
**Minister** 2:17  
4:2 24:24  
46:19 59:10, 12  
68:24  
**minutes** 4:22  
**mistake** 11:4  
50:24  
**mix** 43:13  
**mobile** 8:7  
**modified** 27:16  
**money** 27:12  
42:23 60:17  
**month** 64:25  
**move** 17:18  
25:9 53:17

**moved** 8:25  
60:23  
**moving** 35:16  
61:23  
**much-needed**  
26:18  
**multiple** 18:2, 12  
**municipal** 9:12  
15:23 16:2, 5  
19:21 20:1  
21:18, 20 22:4,  
22 23:12, 22  
24:11 42:19  
**municipalities**  
22:23  
**municipality**  
23:2  
**Musyj** 54:12  
**mute** 45:11, 13  
  
< N >  
**named** 24:2  
**Nancy** 2:12  
5:24 6:1, 7  
12:5 25:10, 13  
36:7, 12 39:17  
40:14 41:15, 25  
42:5 43:20  
44:14 47:14  
52:20, 21 54:3  
56:11 58:18  
65:11, 18 66:13  
69:16 70:3  
71:22 74:3  
**Nancy's** 54:24  
71:14  
**National** 2:8  
5:12  
**nature** 39:22  
**near** 25:18  
**necessary** 30:21  
**needed** 48:22,  
25 51:14 54:20  
61:12 69:3  
**needs** 31:1  
36:14 42:3  
45:4 61:5  
**NEESONS** 75:23  
**negatively** 29:23  
**neglect** 30:24  
36:18, 22 37:1  
**neglected** 37:5  
**negotiate** 15:15  
**negotiated**

11:23 39:21  
**neither** 19:18  
**nether** 19:19  
**new** 9:5, 6  
17:13 38:6  
**newer** 21:1  
**newly** 49:11  
**nightshift** 10:17  
28:13 29:6  
**non-nursing**  
32:12  
**non-union** 21:4  
**norm** 69:22  
**normal** 4:4  
27:20 61:5  
**normally** 4:18  
8:11  
**Northern** 5:17  
**note** 72:4  
**notes** 75:15  
**not-for-profit**  
9:11, 15 47:7  
**notice** 16:19  
**nourishment**  
45:2  
**number** 6:23  
16:1 26:1 27:7  
32:1 47:20  
**numbers** 19:11  
28:14 29:8  
30:9 68:20  
**numerous** 40:1  
51:21  
**nurse** 5:14  
44:19  
**nursing** 5:8  
6:2, 9 9:22, 25  
10:9 11:12  
15:17 17:24  
22:8, 10, 23  
24:12 26:22  
68:17  
**nursing-home**  
25:4  
  
< O >  
**obvious** 11:19  
**occur** 4:12  
**occurred** 29:17  
**occurring** 29:24  
30:6 34:15  
35:19  
**occurs** 72:3  
**October** 1:15

|   |  |   |  |  |
|---|--|---|--|--|
| <p>75:18<br/><b>offer</b> 45:16<br/><b>offered</b> 33:20<br/>39:12<br/><b>Officer</b> 49:1, 9<br/><b>old</b> 43:7 54:17<br/><b>ONA</b> 23:24<br/><b>ones</b> 25:19<br/>37:24 41:5<br/>65:19 72:7<br/><b>one-year</b> 16:21<br/><b>ongoing</b> 28:22<br/>33:1<br/><b>Ontario</b> 5:7, 17<br/>6:22 9:8 11:20<br/>14:6 25:1<br/>46:18 51:25<br/>67:25 68:1, 7, 19<br/><b>Ontario's</b> 7:1<br/><b>opened</b> 21:2, 3<br/><b>openly</b> 49:25<br/><b>operate</b> 9:17<br/>22:25 60:5<br/><b>operated</b> 46:13<br/><b>operating</b> 44:24<br/>60:5<br/><b>operator</b> 20:6<br/><b>operators</b> 9:19<br/>20:5 24:20<br/>27:4, 9 35:10<br/>47:7<br/><b>opinions</b> 47:10<br/><b>opportunities</b><br/>40:4<br/><b>opportunity</b><br/>17:25 25:15<br/>30:17 32:20<br/>46:21 53:24<br/>55:24, 25 63:23<br/>65:25<br/><b>opposed</b> 19:1<br/><b>option</b> 65:6<br/><b>options</b> 48:3<br/><b>order</b> 4:1 6:15<br/>27:1 33:23<br/>45:7 56:22<br/>66:24 72:20<br/><b>ordered</b> 24:15<br/><b>orders</b> 53:4<br/><b>organization</b><br/>9:15, 16<br/><b>orientate</b> 31:21<br/><b>original</b> 23:10,<br/>23<br/><b>Ottawa</b> 61:14</p> | <p><b>outbreak</b> 46:2<br/>47:16 48:4, 6<br/>53:21 61:13, 25<br/>68:7 70:9, 18<br/>72:8<br/><b>outbreaks</b><br/>35:14, 19 63:2,<br/>3 68:2 70:13<br/><b>outbursts</b> 65:23<br/><b>outlined</b> 49:1<br/><b>overtaking</b> 4:5<br/><b>overview</b> 35:24<br/><b>overwhelmed</b><br/>56:6<br/><b>overwhelming</b><br/>27:25 54:10<br/><b>owned</b> 55:6<br/><br/>&lt; P &gt;<br/><b>p.m</b> 1:16 3:1<br/>74:8<br/><b>pace</b> 4:4<br/><b>paid</b> 19:17<br/>23:14 37:18<br/>68:11, 13<br/><b>pandemic</b> 5:10<br/>6:11, 12 26:14,<br/>17 33:22 40:25<br/>46:10, 22 55:13<br/>60:1, 12, 14<br/>66:21 67:15<br/><b>panel</b> 69:17<br/><b>parallels</b> 68:6<br/><b>paramount</b><br/>49:24<br/><b>pardon</b> 29:4<br/><b>part</b> 19:7, 14<br/>23:6, 10, 14<br/>24:2 27:17<br/>36:16 37:10<br/>60:13<br/><b>participants</b><br/>1:14 2:15<br/><b>participate</b> 47:7<br/>73:25<br/><b>participated</b><br/>47:3 49:12<br/><b>particular</b> 7:18<br/>11:11 20:19<br/>34:2 35:9<br/>49:10 57:2<br/>62:21 67:22<br/><b>particularly</b><br/>19:22, 25 46:13<br/>48:3 72:7</p> | <p><b>part-time</b> 16:17<br/>18:11, 25 19:5,<br/>11 33:20 34:9<br/>47:21 52:11<br/><b>pass</b> 72:4<br/><b>passed</b> 41:2<br/>66:21<br/><b>passing</b> 66:4<br/><b>patients</b> 50:22<br/>54:22 55:12, 23<br/>63:8, 9, 12<br/><b>pattern</b> 15:19<br/><b>pay</b> 12:13, 14<br/>18:10 22:5, 6, 9,<br/>12, 16, 17, 20<br/>23:3, 4, 20 24:4,<br/>9, 15, 21 25:5<br/>59:4 67:14<br/><b>paying</b> 21:4<br/>39:9<br/><b>payout</b> 23:17<br/><b>pension</b> 68:16<br/><b>pensions</b> 19:23<br/><b>people</b> 8:9, 13,<br/>16, 24 11:15<br/>16:8 18:11<br/>37:17 38:1, 7<br/>40:3 43:22, 25<br/>47:3 48:21<br/>51:7, 17, 20<br/>52:10 57:19<br/>58:19 62:8<br/>67:2 71:8<br/>72:21 73:6, 11<br/><b>perform</b> 43:24<br/>48:18 58:16<br/><b>performed</b> 43:25<br/><b>performing</b> 32:4<br/>36:9<br/><b>period</b> 9:20<br/>13:7 21:7<br/>29:22 36:25<br/><b>person</b> 12:22<br/>22:11 73:9<br/><b>personal</b> 6:3, 24<br/>7:1 10:9 13:13,<br/>25 14:10, 15<br/>15:1 17:23<br/>21:9, 21 26:23<br/>36:2 37:11<br/>38:18 43:1<br/>48:10 66:5<br/>68:10, 12 69:20<br/>70:4 71:7, 11</p> | <p>73:8, 22<br/><b>personally</b> 57:22<br/><b>perspective</b> 4:9<br/>65:12 73:5<br/><b>phenomenal</b><br/>58:2<br/><b>phone</b> 17:1, 3, 7,<br/>11 72:16<br/><b>phones</b> 16:25<br/><b>phonetic</b> 27:11<br/>72:10<br/><b>physical</b> 28:24<br/>41:22<br/><b>physically</b> 32:20<br/><b>physicians</b> 47:8<br/><b>pick</b> 41:1<br/><b>pictures</b> 49:4<br/><b>piece</b> 15:22<br/>25:7 47:20<br/><b>place</b> 11:5<br/>18:24 44:11<br/>45:23 60:14<br/>75:7<br/><b>places</b> 65:15<br/><b>plan</b> 12:13<br/>22:10, 13 23:4,<br/>10, 11, 15, 17<br/>60:12, 14<br/><b>play</b> 70:7<br/><b>plays</b> 70:19<br/><b>plead</b> 58:13<br/><b>point</b> 4:7 14:1<br/>15:5 26:13<br/>29:7 43:3 46:5,<br/>6 50:5, 17 54:9,<br/>24 56:6 57:17<br/>66:7 69:18<br/>70:14<br/><b>points</b> 26:7<br/><b>politicians</b> 47:8<br/><b>poor</b> 34:3<br/><b>population</b><br/>28:18, 21 43:13<br/><b>porter</b> 32:18<br/><b>portion</b> 27:20<br/>32:4, 13<br/><b>pose</b> 35:20<br/>59:18<br/><b>posed</b> 34:7<br/><b>position</b> 68:19<br/><b>positions</b> 33:4,<br/>24<br/><b>positive</b> 26:17<br/>55:17 61:6 62:4<br/><b>possibility</b> 63:21</p> | <p><b>possible</b> 42:4<br/>45:23 58:14<br/>71:17<br/><b>PPE</b> 48:10, 15,<br/>18, 22, 24 58:20<br/>62:14, 22 70:11<br/><b>PPEs</b> 59:4<br/>60:16 67:16<br/><b>practical</b> 5:14<br/>44:19<br/><b>premier</b> 9:1<br/><b>pre-pandemic</b><br/>46:20<br/><b>prepared</b> 6:13<br/>30:8<br/><b>prescribed</b><br/>36:25<br/><b>PRESENT</b> 2:20<br/><b>presentation</b><br/>73:14<br/><b>PRESENTERS</b><br/>2:7<br/><b>President</b> 2:9,<br/>10, 12 5:12, 25<br/>6:6 66:14, 22<br/><b>pretty</b> 42:20<br/>55:15 57:3<br/><b>prevent</b> 52:18<br/><b>previous</b> 11:25<br/>12:16 25:16<br/><b>previously</b> 34:7<br/>36:22<br/><b>pride</b> 25:21<br/><b>primary</b> 47:16<br/><b>printed</b> 16:21<br/><b>prior</b> 26:14<br/>33:22 60:5<br/>66:20<br/><b>private</b> 16:6<br/>42:19 48:13<br/><b>private-for-profit</b><br/>29:23<br/><b>privately</b> 55:6<br/><b>proactive</b> 67:25<br/><b>problem</b> 33:6, 7<br/>36:16 41:18<br/>44:11 48:13, 16,<br/>21 50:11 73:5<br/><b>problematic</b><br/>31:10 34:20<br/>44:21<br/><b>problems</b> 59:14<br/><b>procedures</b><br/>51:18</p> |
|---|--|---|--|--|

|  |   |  |  |  |
|--|---|--|--|--|
| <p><b>proceedings</b> 75:6<br/><b>process</b> 3:16 28:4<br/><b>processes</b> 51:19<br/><b>produce</b> 4:7<br/><b>products</b> 26:25 43:1<br/><b>profit</b> 9:10<br/><b>profound</b> 51:23<br/><b>programs</b> 39:22, 23<br/><b>progress</b> 12:17<br/><b>progression</b> 16:18 17:13, 18 18:3<br/><b>progressive</b> 12:4<br/><b>promise</b> 59:6<br/><b>proper</b> 22:12 28:6 45:2 56:18 57:8 58:20 59:4<br/><b>properly</b> 44:24 45:7<br/><b>protect</b> 62:16<br/><b>protection</b> 49:14, 24<br/><b>protective</b> 48:11<br/><b>provide</b> 10:20 18:10 25:25 26:1 27:1 28:19 30:20 32:11, 12 33:18, 23 34:3 35:4 61:4 62:21<br/><b>providers</b> 27:3, 17<br/><b>provides</b> 32:6 49:14<br/><b>providing</b> 10:25 36:13 45:2<br/><b>province</b> 6:24 9:3, 19 11:20 14:6 15:10, 19 47:1 53:21 61:13 70:14<br/><b>proxy</b> 22:5, 6, 16, 17 24:9, 15<br/><b>PSW</b> 28:12 32:12 34:16 35:7 40:17 41:11, 17 44:19 57:6, 20 66:15</p> | <p><b>PSWs</b> 29:22 32:11, 14 33:3, 10, 16 34:19 35:2 40:20 44:7 64:1, 5<br/><b>psychiatric</b> 8:15, 22<br/><b>psychogeriatric</b> 8:16, 23<br/><b>public</b> 3:14 26:18<br/><b>pushed</b> 11:15<br/><b>put</b> 7:15 20:12 22:15 41:3, 6 45:22 49:8 51:18 63:4 67:8<br/><b>&lt; Q &gt;</b><br/><b>qualified</b> 32:11<br/><b>quality</b> 27:1 28:19<br/><b>Quebec</b> 67:23 68:5, 6, 9, 18<br/><b>question</b> 13:20 28:7 34:6 40:9 41:20<br/><b>questions</b> 4:12, 16 6:17 25:8, 12 35:20, 22 50:3 67:19 72:25<br/><b>quickly</b> 68:3<br/><b>quite</b> 9:23 29:8 30:18 31:14 44:15 55:18 60:23 62:18<br/><b>&lt; R &gt;</b><br/><b>Rae</b> 22:15<br/><b>raise</b> 16:15 41:17 67:22<br/><b>raised</b> 51:6 62:13 71:14<br/><b>rampant</b> 56:19<br/><b>range</b> 47:10<br/><b>rapidly</b> 9:23<br/><b>rate</b> 16:20, 21, 23, 24 18:3, 4, 7, 15 20:20, 21 21:9, 13, 15, 22<br/><b>rates</b> 20:6, 15 21:5 22:1 23:22 68:21<br/><b>ratio</b> 29:4, 12</p> | <p><b>ratios</b> 10:14, 15 19:8 27:22 28:18<br/><b>reach</b> 13:3<br/><b>reaching</b> 5:2<br/><b>read</b> 26:6, 12 47:2, 11 73:10<br/><b>ready</b> 4:23<br/><b>real</b> 11:12 12:17, 21 18:9 22:9 52:18 63:21 71:16<br/><b>realistic</b> 29:12<br/><b>reality</b> 15:14 34:19 37:20<br/><b>realize</b> 6:20 59:17<br/><b>really</b> 3:25 7:8, 16, 20, 23, 25 8:2, 17 9:7, 18, 24 11:10 14:21 15:5, 20 30:18 33:5 36:20 38:5 39:24 40:15 46:22 47:17 48:7 51:23 54:3 56:1, 17 60:7 61:20, 21 70:2 71:19 72:6, 17 73:4<br/><b>reason</b> 22:3 24:22 38:2<br/><b>reasonable</b> 12:23<br/><b>reasonably</b> 8:8<br/><b>reasons</b> 15:24 30:18 55:18<br/><b>receive</b> 72:21<br/><b>received</b> 20:14<br/><b>recipe</b> 43:15<br/><b>recognition</b> 51:2<br/><b>recognize</b> 19:1<br/><b>recognized</b> 22:14<br/><b>recommendation</b> s 3:22 4:7 45:22 69:25<br/><b>recommended</b> 4:1 11:8<br/><b>recommending</b> 47:13<br/><b>RECORD</b> 56:7<br/><b>recorded</b> 75:11</p> | <p><b>recruit</b> 28:10<br/><b>recruiting</b> 34:23<br/><b>red</b> 53:20 54:8 55:12 61:13, 25 63:2 72:8<br/><b>redeploy</b> 53:5<br/><b>redeployed</b> 53:14<br/><b>reduced</b> 29:9<br/><b>reduces</b> 33:25<br/><b>reduction</b> 31:4<br/><b>refer</b> 7:11<br/><b>reference</b> 50:6, 9<br/><b>reflective</b> 28:15<br/><b>regards</b> 54:25 57:4 60:1<br/><b>regime</b> 13:2<br/><b>regional</b> 9:12 53:19 54:12<br/><b>registered</b> 5:14 44:18 45:3<br/><b>registration</b> 5:22<br/><b>regroup</b> 32:20<br/><b>regular</b> 53:2 56:4<br/><b>regularly</b> 29:12<br/><b>rehabilitation</b> 70:6<br/><b>relate</b> 29:18<br/><b>related</b> 48:8<br/><b>relationship</b> 73:8<br/><b>relativity</b> 44:9<br/><b>released</b> 69:5<br/><b>relevance</b> 15:23<br/><b>relief</b> 57:2<br/><b>relies</b> 27:4<br/><b>religious</b> 9:16<br/><b>reluctance</b> 19:13<br/><b>relying</b> 31:15<br/><b>remaining</b> 55:25<br/><b>remarks</b> 6:13 25:10 26:12 45:10 75:10<br/><b>remember</b> 9:2, 4 12:5 25:20 57:12 59:11 65:19 70:9<br/><b>remind</b> 32:23<br/><b>remotely</b> 1:15<br/><b>remove</b> 10:3<br/><b>removing</b> 11:3<br/><b>repeatedly</b> 4:5<br/><b>repeating</b> 6:14</p> | <p><b>replace</b> 27:10 38:19<br/><b>reply</b> 72:2<br/><b>report</b> 3:16 6:23 46:16, 23 47:2, 9 69:6, 8, 10 73:23<br/><b>reported</b> 35:13 48:14 49:5<br/><b>Reporter</b> 75:4, 25<br/><b>REPORTER'S</b> 75:1<br/><b>reporting</b> 29:21 57:3<br/><b>reports</b> 3:13<br/><b>represent</b> 6:8 15:9<br/><b>represented</b> 24:17<br/><b>represents</b> 5:6 6:1 53:18, 19<br/><b>requirement</b> 10:22 15:2<br/><b>resident</b> 10:10, 25 28:17 30:24 32:9 33:5 36:19 37:3, 5 42:7 45:5 61:5 66:3, 17<br/><b>residents</b> 8:6 9:22 28:5, 8, 12, 14, 22 29:1, 5 30:21 31:18 32:7, 18, 22 33:15 36:14 37:14, 20 38:21, 24 42:9 43:1, 6, 11 45:3 47:5 50:22, 23 53:11 55:15, 17, 23 56:1, 2, 4, 16, 23, 24 57:7, 10, 14 58:4 60:8, 24 61:1, 2, 8, 9 63:3, 8 64:3, 11 65:5, 7, 22 67:3, 11<br/><b>resolving</b> 33:6<br/><b>respect</b> 46:11<br/><b>respected</b> 70:22<br/><b>responsible</b> 48:20<br/><b>rest</b> 56:2, 24 57:1 64:12</p> |
|--|---|--|--|--|

|  |  |   |  |   |
|--|--|---|--|---|
| <p><b>restricted</b> 51:10, 22<br/><b>restricting</b> 52:7, 13<br/><b>Restructuring</b> 9:2<br/><b>result</b> 27:25 30:2<br/><b>resulted</b> 37:6<br/><b>retain</b> 28:10<br/><b>retaining</b> 34:24 35:2<br/><b>retirement</b> 5:8 39:8 54:5<br/><b>retribution</b> 49:23<br/><b>returned</b> 27:15<br/><b>reversed</b> 19:12<br/><b>review</b> 30:17<br/><b>revolving</b> 71:7<br/><b>rings</b> 17:4<br/><b>Rivera</b> 12:5<br/><b>role</b> 27:16 51:13 70:7, 19<br/><b>roles</b> 30:23 32:12, 25<br/><b>rolled</b> 9:3<br/><b>room</b> 32:19<br/><b>rough</b> 66:2<br/><b>roughly</b> 33:12, 16<br/><b>roundtable</b> 6:23 46:25<br/><b>roundtables</b> 6:24 47:4<br/><b>routine</b> 27:20<br/><b>routines</b> 31:18 32:5<br/><b>RPN</b> 5:21 35:9 40:19 44:16<br/><b>RPNs</b> 44:8<br/><b>run</b> 9:12, 13, 14 22:23, 24 45:7 48:20<br/><b>running</b> 54:20 65:1<br/><b>rural</b> 5:16 29:25<br/><b>rush</b> 28:25</p> <p>&lt; S &gt;<br/><b>sadly</b> 25:23<br/><b>safe</b> 49:6 50:23 51:19<br/><b>safely</b> 43:24<br/><b>safety</b> 30:15</p> | <p>49:10<br/><b>sat</b> 69:8<br/><b>save</b> 58:12, 16 60:25 65:3<br/><b>saved</b> 60:25 61:2, 22 64:10<br/><b>Savela</b> 2:11 5:19 39:19 45:14 50:12, 25 74:6<br/><b>schedule</b> 30:7 42:17<br/><b>schedules</b> 31:3 34:2<br/><b>Schlegel</b> 20:5, 19, 22 21:1, 9 69:15, 17<br/><b>scope</b> 32:24<br/><b>screen</b> 7:6, 21<br/><b>secondary</b> 53:10<br/><b>secondly</b> 11:14 34:22<br/><b>Secretariat</b> 2:18<br/><b>section</b> 38:1<br/><b>sector</b> 5:14 7:19 9:7 30:11 34:5, 10 36:5 41:16 42:15, 22 43:22 44:1 46:10, 14 48:14 54:5 71:13<br/><b>sectors</b> 47:25<br/><b>secure</b> 33:24<br/><b>SEIU</b> 15:7 23:15, 24<br/><b>send</b> 6:20 72:4 73:21<br/><b>sending</b> 28:8<br/><b>sense</b> 3:8 7:22 13:2 25:21 36:2, 6 51:17<br/><b>separate</b> 40:11<br/><b>serious</b> 28:23 43:12 64:14<br/><b>Service</b> 23:7<br/><b>services</b> 26:24<br/><b>set</b> 15:16 75:7<br/><b>settings</b> 29:25<br/><b>settlement</b> 15:18<br/><b>settlements</b> 12:3<br/><b>severe</b> 46:15 63:3 68:7<br/><b>shameful</b> 66:9<br/><b>share</b> 72:8</p> | <p><b>shared</b> 46:19<br/><b>shelf</b> 69:8<br/><b>Shelley</b> 66:14, 25<br/><b>Shelleys</b> 67:6<br/><b>Shelly</b> 66:21<br/><b>shift</b> 9:18 10:16 25:21 29:15 32:16 36:14 37:18<br/><b>shifted</b> 44:9<br/><b>shifts</b> 27:18 28:15 30:7<br/><b>shoes</b> 16:12<br/><b>shook</b> 69:17<br/><b>short</b> 4:1 29:22 55:19 58:8 67:7 69:23<br/><b>shortage</b> 6:25 28:22 30:2 46:15 55:14 56:10<br/><b>shortages</b> 29:14, 17 30:5, 12 33:1, 10 34:11 51:11<br/><b>Shorthand</b> 75:4, 15, 25<br/><b>shorts</b> 28:16<br/><b>short-term</b> 3:22 45:22<br/><b>show</b> 59:2 67:13<br/><b>showing</b> 73:11<br/><b>shown</b> 15:20 59:7<br/><b>shows</b> 33:9<br/><b>sic</b> 58:13<br/><b>sick</b> 18:10 19:17, 19, 24 30:3 34:11<br/><b>side</b> 72:25 73:1<br/><b>significant</b> 16:3, 11, 13 20:24 42:20 62:15<br/><b>similar</b> 22:19<br/><b>simply</b> 4:4, 5 22:8 27:10 30:6, 24<br/><b>single</b> 17:4 31:5 37:15<br/><b>sit</b> 27:11 66:1<br/><b>site</b> 50:18, 19, 21</p> | <p><b>situation</b> 4:3 26:16, 19<br/><b>situations</b> 27:14<br/><b>skyrocket</b> 9:24<br/><b>slide</b> 5:22<br/><b>slow</b> 63:1<br/><b>small</b> 27:19<br/><b>Smith</b> 66:14<br/><b>solution</b> 42:2 62:24<br/><b>solutions</b> 31:13 70:25 71:1, 19<br/><b>somebody</b> 17:9 71:5<br/><b>somebody's</b> 72:2<br/><b>someone's</b> 25:22<br/><b>soon</b> 3:7 42:4 45:23<br/><b>sorry</b> 13:20, 22 17:1 40:13 54:25<br/><b>sort</b> 3:7 10:4 11:11 18:6 21:5 22:25 59:19 61:21<br/><b>sorts</b> 62:12<br/><b>sound</b> 16:8<br/><b>sounding</b> 59:9 60:4<br/><b>spare</b> 17:6<br/><b>speak</b> 6:15 25:15 30:19 31:6 49:21, 25 53:24 57:21<br/><b>speaks</b> 31:6<br/><b>special</b> 12:21<br/><b>specific</b> 17:22 26:4, 22 54:8 66:16<br/><b>specifically</b> 13:13 22:7 60:22 64:8, 16<br/><b>speech</b> 54:2<br/><b>spend</b> 60:16<br/><b>spent</b> 37:11 57:1<br/><b>spoke</b> 44:5 50:18<br/><b>spread</b> 16:3<br/><b>St</b> 54:18<br/><b>stabilized</b> 52:4<br/><b>stable</b> 31:4 33:19</p> | <p><b>staff</b> 10:16 25:23 26:1, 24 28:1, 9, 23 29:5, 15 30:6, 17 31:16, 19, 20, 23 33:1 34:12, 24 35:17 38:8 39:2 43:19 44:25 45:4 46:15, 20 47:24 48:19 50:23 51:13 52:23, 25 54:23 55:18, 25 56:5, 20 58:21 59:3, 5 60:7, 19 61:16 62:4, 5 65:25<br/><b>staffed</b> 57:13<br/><b>staffing</b> 10:9, 21 11:2 26:4 27:22 35:16, 25 47:18 51:11, 23 55:13, 14 67:13 69:1, 4, 5, 10, 12, 14 71:4, 15<br/><b>staggering</b> 19:22<br/><b>stand</b> 64:17<br/><b>standard</b> 10:3, 6, 19 11:3, 8 69:12<br/><b>standing</b> 63:17<br/><b>start</b> 6:17 7:23 11:17 16:20 18:3 20:20, 21 37:14, 18 45:19<br/><b>started</b> 59:9, 25<br/><b>starting</b> 29:7 47:16<br/><b>stating</b> 11:19<br/><b>statistics</b> 33:18<br/><b>statutory</b> 34:12<br/><b>stay</b> 37:16<br/><b>stayed</b> 61:3 67:1<br/><b>stem</b> 46:24<br/><b>Stenographer/Tra nscriptionist</b> 2:22<br/><b>stenographically</b> 75:11<br/><b>step</b> 52:2, 13<br/><b>stepped</b> 55:8, 10<br/><b>steps</b> 52:19</p> |
|--|--|---|--|---|

**stop** 25:4 26:13  
**stopped** 39:9  
**stories** 49:22  
54:13 72:8, 13  
**straight** 10:14  
56:21  
**stray** 15:19  
**stressful** 32:16  
**strike** 11:22  
13:3, 11 14:9,  
11, 17, 23 15:4  
**strong** 45:1  
**strongly** 42:6  
**struggle** 67:5, 8  
**struggling** 31:2  
66:2  
**stuck** 43:2  
**subject** 6:10  
7:14 41:22  
**subjected** 28:24  
**successful** 24:6,  
14  
**suffered** 43:8  
**suffering** 27:21  
28:23 43:12, 14  
**sufficient** 43:18  
**suggested** 53:12  
**suggestion** 34:8  
**suit** 66:23  
**summer** 68:9  
**summertime**  
68:21  
**superficial** 73:13  
**supervisory**  
48:19  
**supplemental**  
43:17  
**support** 6:3, 25  
7:1 13:13, 25  
14:10, 16 15:1  
17:23 21:10, 21  
36:2 37:11  
38:8, 18 47:22  
68:10, 12 69:20  
70:4 71:7, 11  
73:9, 22  
**supported** 24:1  
**supports** 47:12  
**supposed** 58:4  
**surrounding** 6:1  
**sustainable**  
70:21  
**sustained** 71:17  
**system** 9:1  
16:10 17:14

18:25 19:1, 7  
27:3 38:8, 11,  
14 70:23  
**< T >**  
**table** 12:6  
20:10  
**takes** 12:21  
16:24  
**talk** 15:25  
16:16 17:12  
53:17 54:6  
60:21 64:17  
68:4 69:11, 12  
**talked** 38:9  
40:15, 16, 23  
46:16 47:14  
58:18 64:15  
67:4, 24  
**talking** 21:14  
46:7 62:2, 3  
66:13  
**talks** 59:25  
66:16  
**tangent** 26:10  
**targeting** 41:16  
**taxing** 27:23  
**team** 45:6  
**telemarketer**  
17:8  
**temporary**  
34:21 44:6  
**tended** 4:10, 15  
**ten-minute** 4:20  
**tent** 63:10  
**terms** 19:2  
36:4 44:8 46:7  
47:3 50:6, 9  
**Terrace** 54:9  
55:25 61:24  
72:10  
**Terrance** 60:22  
**terribly** 4:8  
**terrified** 35:18  
**terrifying** 35:15  
**test** 38:15  
**tested** 38:13  
55:17  
**testing** 38:11  
62:4  
**Thanks** 53:22  
**thing** 6:20 51:7  
54:19 58:18  
69:9

**things** 4:4  
10:20 12:10  
22:25 23:1  
30:3 39:22  
40:5 45:17  
46:7 47:12  
48:25 65:13  
66:5 67:22  
69:3, 13  
**thinking** 50:20,  
25  
**thought** 25:6  
71:21  
**thoughts** 66:9  
**thousands** 8:19  
68:11  
**threat** 59:18  
**Tim** 38:22  
**time** 4:7, 21  
5:2 10:5 13:1  
17:4 19:17, 19,  
24 21:7 23:5,  
20 25:20 26:13  
31:21 32:17  
36:23, 25 37:12  
46:3 48:16  
54:9 57:1 61:8  
66:23 73:21  
75:7, 10  
**times** 30:5  
**time's** 72:3  
**today** 5:19 8:5  
9:25 20:22  
25:15 45:21  
46:8 47:13  
63:18 64:19  
72:17  
**today's** 45:16  
**told** 59:13  
**tomorrow** 43:18  
**tool** 67:13  
**tools** 58:15, 20  
67:12  
**top** 18:7, 15  
21:9, 14  
**topic** 40:11  
**total** 31:6  
**touch** 11:9  
26:8 34:6 73:17  
**touched** 49:19  
**traditional** 3:23  
**traditionally**  
36:4  
**tragedy** 52:18  
**trailer** 57:5

**trailers** 56:24  
57:2  
**trained** 32:10  
**training** 68:10,  
11, 13  
**transcribed**  
75:12  
**transcript** 75:15  
**translates** 17:19  
62:19  
**traumatic** 43:8  
**trend** 18:9  
**trouble** 60:3, 10  
**troubling** 52:22  
65:13  
**true** 14:1, 4  
75:14  
**trying** 4:14  
28:9 40:2 46:6  
57:19 60:11  
72:23  
**Tullio** 2:10 6:5,  
7 12:4 40:6, 14  
45:10, 11 53:17,  
21, 22 55:5, 9  
56:8 59:23  
60:21 62:2  
63:7, 11, 15, 19  
64:16, 24 65:17  
66:12 69:16  
70:3 71:22 74:7  
**Tullio's** 21:19  
39:7 53:17  
**turn** 64:22  
**turned** 61:10  
**two-and-a-**  
**quarter** 10:11  
**two-year** 16:23  
18:4 21:15  
**type** 27:8 61:4  
**types** 22:18  
27:23 66:5  
**typically** 3:10,  
15  
**< U >**  
**unable** 17:15  
**uncommon**  
28:11  
**underpaid** 58:2  
**understand** 8:1  
18:6 25:7 30:1  
31:24 36:11  
43:5 50:11

59:13 72:19  
73:5, 7, 14  
**understands**  
7:17  
**understood**  
52:24  
**undervalued**  
36:4, 15 40:16,  
17, 22 41:14, 21  
**undue** 4:17  
**unfortunately**  
41:2 47:17  
66:20  
**UNIFOR** 2:8, 11  
5:6, 12 23:6, 9  
**Union** 23:7, 8, 9  
36:19 40:1  
**unions** 15:7, 9  
23:24 71:3  
**unique** 61:20  
**Unit** 35:12  
**units** 69:20  
**unrealistic** 31:3  
33:4  
**unsafe** 28:18  
**unstable** 46:14  
48:9  
**unsupported**  
30:22 41:23  
**unusual** 37:16  
**upped** 68:14  
**utilized** 32:11  
**< V >**  
**vacancies** 31:16  
**vacations** 34:13  
**value** 58:25  
**valued** 58:24  
**variables** 10:18  
**various** 23:25  
**vast** 46:12  
**verbal** 28:24  
41:22  
**VERITEXT** 75:23  
**versed** 6:10  
**versus** 16:2, 6  
**vice** 66:14, 22  
**view** 18:24  
**views** 47:10  
**violence** 65:22  
**virus** 59:20  
**visit** 38:4  
**vitality** 42:11  
**< W >**

|  |   |   |   |  |
|--|---|---|---|--|
| <p><b>wage</b> 7:16 11:9<br/>12:7 15:21<br/>16:18 20:14, 15<br/>24:11 34:16<br/>42:1, 17, 20<br/>44:6 47:21<br/><b>wages</b> 7:18<br/>11:12 16:1, 4,<br/>16 20:4 52:4<br/>68:14 69:13<br/><b>waiting</b> 3:3, 4<br/>4:13 62:24<br/><b>walking</b> 25:24<br/><b>walks</b> 32:2<br/><b>wanted</b> 4:3<br/>26:7 52:8<br/>54:12 56:16<br/>60:17, 21 65:5<br/>71:22<br/><b>wanting</b> 24:21<br/><b>wards</b> 8:16<br/>69:19<br/><b>Wave</b> 3:24 4:2,<br/>6 39:14 40:25<br/>42:4 45:24<br/>61:24 63:21<br/><b>wear</b> 66:24<br/><b>webinars</b> 40:2<br/><b>week</b> 16:12<br/>24:19, 24 29:16,<br/>20 39:25 43:18<br/><b>weekend</b> 62:1<br/>69:6<br/><b>weekends</b> 29:17<br/><b>weeks</b> 62:24<br/><b>weighing</b> 48:2<br/><b>whatnot</b> 49:16<br/><b>wide</b> 47:10<br/><b>win</b> 62:15<br/><b>Windsor</b> 6:6<br/>53:18 54:7, 11,<br/>19 63:22 64:7<br/><b>wing</b> 5:18 37:1<br/><b>wings</b> 8:23<br/>29:10<br/><b>woman</b> 16:9<br/><b>women</b> 12:9<br/>39:4<br/><b>words</b> 59:7, 8<br/><b>work</b> 5:15, 16<br/>10:9 11:16<br/>12:20, 22 15:8<br/>16:17, 18 17:24<br/>18:1 19:15<br/>21:1 22:19</p> | <p>27:16 30:25<br/>31:18, 19 36:8,<br/>9, 23 37:13, 15<br/>39:4, 9 42:1<br/>46:1, 6 47:23<br/>50:21 51:11<br/>52:6, 10 53:6, 7,<br/>14 56:21 58:3,<br/>16 62:7, 11<br/>68:15 70:15, 17<br/>73:11<br/><b>worked</b> 5:16<br/>14:21 15:11<br/>18:16 24:2<br/>32:1 42:21, 24<br/>55:20 72:10, 11<br/><b>worker</b> 6:3, 25<br/>7:1 21:10, 21<br/>24:11, 12 25:17<br/>27:15 31:5<br/>40:19 47:4<br/>52:3 57:6 73:9,<br/>23<br/><b>workers</b> 5:7<br/>6:2 11:19<br/>12:18 13:10, 14,<br/>25 14:1, 10, 16<br/>15:1 17:13, 23,<br/>24 18:25 19:5,<br/>13 22:20 23:9<br/>24:21 25:4<br/>30:10 32:6<br/>33:23 34:4, 9,<br/>25 36:3 37:11<br/>38:18 39:9, 14<br/>41:9 47:15, 19,<br/>24 48:6, 14<br/>49:9, 15, 21<br/>50:19 51:19<br/>52:1, 6, 15<br/>53:13, 18 58:2<br/>67:3, 9 68:10,<br/>13 69:20 70:4,<br/>5, 6, 7, 12 71:7,<br/>11, 17 72:6, 9, 14<br/><b>workforce</b> 12:9<br/>19:10 33:16, 19<br/>39:3 46:11, 14<br/>48:9 49:17<br/>70:20, 21, 22<br/><b>working</b> 11:15<br/>16:9 17:18, 21<br/>18:12, 21 25:4<br/>26:21 28:16<br/>31:13, 14 33:17</p> | <p>38:16 50:18<br/>52:13 55:19<br/>56:10 58:8<br/>66:22 67:7<br/>69:23 71:13<br/>73:6<br/><b>work-life</b> 34:3<br/><b>workload</b> 33:5<br/>37:13 41:22<br/>43:3<br/><b>workloads</b> 30:19<br/><b>workplace</b> 30:4<br/>31:5 32:7 49:4<br/>51:15 52:2<br/>53:15 61:18<br/><b>workplaces</b><br/>22:8, 18 39:21<br/><b>works</b> 18:12<br/>40:18 41:13<br/>66:15<br/><b>worry</b> 17:3<br/><b>worse</b> 30:10<br/>48:13<br/><b>worsened</b> 26:15<br/>31:11<br/><b>worst</b> 70:13<br/><b>wrapped</b> 49:5<br/><b>write</b> 3:16<br/>46:18<br/><b>written</b> 49:14</p> | <p>&lt; Z &gt;<br/><b>Zoom</b> 1:14</p> |  |
|  |   | <p>&lt; Y &gt;<br/><b>Yeah</b> 14:20<br/>41:8, 19 50:16<br/>58:2 59:13<br/>69:18 72:5<br/>73:23<br/><b>year</b> 6:21 7:14<br/>17:19 23:19<br/>24:7, 15 27:9,<br/>13 33:11<br/><b>yearly</b> 33:13<br/><b>years</b> 3:17 8:2<br/>9:21 10:1<br/>16:24 17:16<br/>18:4, 7, 18 21:3<br/>23:19 25:17<br/>27:8 32:1<br/>33:13 42:22, 25<br/>43:7 60:4 66:15<br/><b>yesterday</b> 6:19<br/>7:6 35:11<br/><b>young</b> 43:7</p>  |   |  |