STANDING UP FOR SENIORS

ENDING 40+ YEARS of NEGLECT

Why Manitoba Needs A Seniors' Advocate & A New Model for Long Term Care

Manitoba Liberal Caucus January 2021

“The critical issues facing personal care homes are not new, and we have been raising them with government for a decade.”

- Julie Turenne-Maynard, Executive Director, Manitoba Association of Residential and Community Care Homes (MARCHE) July 13, 2020[1]

“The recipe for disaster additionally requires errors, lapses, or mistakes to go unattended, unappreciated, or unresolved for an extended period of time.”

- The Normalization of Deviance in Healthcare

“We often hear directly from Manitobans who were mistreated, and who have nowhere to turn – yet are afraid to speak up for fear of political payback.”

- Liberal MLA Cindy Lamoureux (Tyndall Park) has been pushing for the creation of a seniors advocate since 2016 and was part of the party’s election platform in 2019.

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Chapter 1 - How the Covid-19 Pandemic Revealed a Rotten System

On March 2, 2020, before a single case of Covid-19 arrived in Manitoba, the Manitoba Liberal Caucus called on the PC government to come up with a six-point Pandemic plan, including protecting First Nations and Personal Care Homes(PCH)[2].

The Covid-19 virus was spreading around the world and it was clear PCHs were particularly at risk. There has been serious outbreaks and deaths in personal care homes in Washington State and in British Columbia, so the risk was known.

Quebec and Ontario faced terrible outbreaks in personal care homes in April and May. The military came in and later prepared a report about the inhumane conditions. Outbreaks meant that staff were sick, or had to self-isolate, which emptied facilities of staff and left residents uncared for – lying soiled in beds, with no food, water or help.

- On May 22, 2020 Manitoba Liberals called on the PC government to prepare "Rapid Response Teams" who could help cover for staff in up to three PCHs at once in the event of an outbreak. The Premier brushed the recommendation aside. In June, the Manitoba Government shut down its Incident Command Centre.

- By August, 2020, it was known that when it came to long-term care deaths, Canada had the worst mortality rates of any OECD country. As CIHI reported, Canada had the highest proportion of deaths occurring in long-term care. LTC residents accounted for 81% of all reported COVID-19 deaths in Canada, compared with an average of 38% in other OECD countries (ranging from less than 10% in Slovenia and Hungary to 66% in Spain)"[3]

- The Manitoba Government was informed of this by the Long Term and Community Care Association of Manitoba (LTCAM) in a report released August and revised in September, 2020. That report stated that:

  "the Manitoba Government and the Regional Health Authorities have not committed to funding any Covid-19 related incremental costs incurred due to the guidelines, directives and public health orders that Supportive Housing has been mandated to follow."

The Manitoba Government ignored these repeated and public warnings. When outbreaks started in Manitoba's care homes, they were unprepared and appeared to be either unwilling or unable to act.

The most high-profile tragedy was at the Revera-owned Maples Care home, where after days of telling family members that residents were fine, multiple ambulances were called to the home. The next day, families were told their loved ones were “unresponsive,” only to be told hours later that they had died.

While there is no doubt the PC Manitoba Government failed to prepare for the Covid-19 second wave, the conditions that made Manitoba’s personal care homes so dangerous were not just years, but decades in the making.

Chapter 2 - A Deeper Problem: 40+ Years of Neglect

During legislative debates about the uncontrolled outbreaks in Manitoba PCHs in October 2020, questions were raised about inspections at Parkview Place. It emerged that a March 2020 inspection, which took place as the global pandemic was first declared, found unclean conditions and a cockroach infestation.

When the Leader of the Opposition NDP asked about a report showing the infestation had been in place since 2019, the PC Minister of health responded that it had been there for ten full years under the NDP - since 2006.

Funding to PCHs in Manitoba was cut under the PCs, but it was frozen in 2005 by the NDP government.

"For more than 50 years, appeals for operational and infrastructure funding to upgrade and improve the physical care environment, especially for dementia care, infection prevention and control, and safety have been submitted and largely ignored." - LTCAM

Selected Timeline

We do not have to look far to find that the problems plaguing Long-Term Care facilities in Canada have been there for decades.

A review of news stories and reports show a consistent pattern of reports and recommendations being made, then ignored.

> **1970 –** "As early as 1970, there was mounting concern about the growing corporate ownership of nursing homes." [4]
>
> **1980** – "Manitoba Homes for Aged Operate Below Standards"
>
> "All but one of Winnipeg's 23 group homes for the elderly fall short of provincial standards and are operating without licenses, says a Community Services Department spokesperson." – Winnipeg Free Press
>
> **1983** – A report by a Canadian Medical Associations task force recommends the elimination of profit-making institutions, and the expansion of non-profit homes.
>
> **1988** – "A random sample of inspection reports on seventeen different nursing homes between 1986 and 1988, obtained through the Manitoba Freedom of Information Act, shows that the homes usually fall short of these [government] standards. The reports reveal homes that are dangerous, dirty, depressing and de-personalized."

1989 – "In Ontario, nursing home operators are given no advance warning of enforcement-style government inspections. But in Manitoba, nursing home administrators are informed well in advance of an inspector's visit. Manitoba Liberal Leader Sharon Carstairs criticizes this policy. "What's the point, if you're telling them you're coming?" [5]

Dec 14, 1993 – "Residents of privately run care homes run significantly higher risks of having conditions that indicate a low quality of care that those in non-profit facilities… A study by the Manitoba Centre for Health Policy says that between 1987 and 1991, patients in privately run facilities were 20 per cent more likely to have falls, fractures and pneumonia and nearly 40 per cent as likely to be dehydrated." - Winnipeg Free Press

1992 - Rusen inquest recommends better staffing after the PCH death of Anne Sands

1995 – "There is no specific legislated requirement for care homes to develop protocols/ procedures for handling allegations of elder abuse, but Manitoba health does encourage their development.

It is also not mandatory for personal care homes to report any complaints or allegations received to the Long-Term Care and Hospitals and Community Health Branches of Manitoba Health … nor is it mandatory for them to report major incidents or accidents involving residents to these authorities. However, Manitoba Health encourages care homes to report incidents/complaints."

- **Manitoba Government Report** [6]

1998 Report of the inquest into the death of Julius Molnar on February 20, 1997.

Recommendations include:

1) All future and present nursing homes should be accredited
2) All nursing homes be subjected to regular unscheduled inspections
3) Sanctions should be put in place and enforced to ensure that standards are met
4) Create a unified system for screening and entry into nursing homes
5) To ensure equal treatment for referrals, standard forms for medical, psychiatric and social workers involved with the individual
6) Panelling and placement procedures to reduce the current (1998) wait time of two years
7) Establish Admissions Committees to screen referrals and ensure facilities can accommodate individual residents' requirements
8) Screening residents for appropriate room placement
9) Improved training for all staff for dealing with aggressive behaviour

10) Establish a communications network between all agencies and nursing homes
11) Better communications about daily occurrences with residents, including medical, mental health and behavioural issues
12) Create "safe room" facilities where residents who are acting out can be placed so they are safe

March 22, 1999 –Care home staffing still "woefully" inadequate.

- Winnipeg Free Press

"It's been more than four years since an inquest judge ruled "woefully inadequate" staff levels contributed to the death of Anne Sands at a Winnipeg nursing home in 1992. Sands' daughter Pauline Rowe is still waiting.

"It's been six years and I'll still fight for this," said Rowe, 57.

In his 1994 inquest recommendations, Rusen noted there were only five staff in charge of 85 residents at the Heritage Lodge Personal Care Home, when Ann Sands died of asphyxiation in July 1992.

Sands, an 85-year-old who suffered from Alzheimer's disease and was known to wander died after her head became caught between the headboard and the side rails of her bed.

January, 2000 "NDP Rejects care home staff ratios: despite inquests' red flags, gov't says that numbers not the answer"

– Winnipeg Free Press

"The NDP will not establish mandatory staffing levels in personal care homes even though the shortcoming was flagged in two separate judicial inquests and raised repeatedly by the party during their years in opposition."

2006 –Manitoba Nurses' Union Report [7]

"Based on evidence from nurses, the standards of long-term care facilities in Manitoba are not consistent and, in many cases, do not meet what most would consider a minimum level necessary to provide a decent living environment for residents and a safe working environment for staff. In a number of cases facility management are restricting the availability of supplies to the point of compromising the health and safety of residents and staff."

- ***Nurses do not have as much time to provide direct care and the physical assessments that are needed to observe the changes in Residents' physical and***

mental health. We are unable to catch acute problems as early and the mental health deterioration that causes care problems.

2015 – "Existing Conditions in PCH infrastructure for the 39 PCHs in Winnipeg show that almost 50% were categorized as in "poor condition, issues identified should be addressed ASAP as funding allows." In the majority of cases, little change occurred.

LTCAM, Shining a Light.

2017 - "From October 2015 to December 2017 The WRHA logged just under 7,000 reports of abuse or assault by residents in 38 Winnipeg personal care homes. Of those, 504 resulted in injury to another residents**." - CBC**

2019 MARCHE REPORT

"Over the last 10 years, non-salary operating costs have been increasing at MARCHE PCHs with minimal or no funding increases allotted for these items. Certain expenses increased as expected and are largely outside the control of PCH facilities. Dietary expenses increased by 36% (3.3% a year) because of an increase in food quantity, quality, and price. There has been a significant increase in food thickeners and supplements due to the advanced care needs of current residents, which has contributed to increasing overall dietary expenses.

The average age of the PCHs presented in Appendix 3 is 38 years; provincewide, the majority of current personal care home infrastructure is over 40 years old (Long Term & Continuing Care Association of Manitoba). Some MARCHE PCHs have not had any expansions or additions to their buildings since the 1960s.

Capital Equipment funding levels have not been increased for over 25 years.

2020 – March 12 – Global Pandemic Declared

June - PC Government fiscal update includes funds for "infrastructure upgrades" to PCHs, none of which is Covid-19 related. It includes funding to add sprinkler systems, to facilities which are currently deficient in basic safety – like fire prevention.

Chapter 3 - Understaffed and Underpaid: Workplace Conditions are the Conditions of Care

As noted above, inquests, nurses and other reports have been recommending improvements to staffing hours as well as pay for over 25 years.

In 2019, Manitoba's Bill 201 amended *The Health Services Insurance Amendment Act (Personal Care Home Staffing Guidelines).* Under current provincial guidelines, "personal care homes must provide each resident with 3.6 paid hours of care each day. Depending on the number of residents, up to 35% of the care must be provided by nursing professionals."

This is falls badly short of what is required. It is a "Standard" not a "Regulation" under section 3.1(3) "A standard required under this section is not a regulation within the meaning of The Statutes and Regulations Act." This means it cannot be effectively enforced.

It is also not enough time to provide care. As *the November 2019 MARCHE report read:*

• Provincial guidelines call for 3.6 paid hours of care per resident per day (HPRD) for nursing staff. Paid HPRD includes indirect time on training. According to the Manitoba Centre for Health Policy, each resident, depending on their condition, requires different levels of care, and they are designated based on their required Level of Care (LOC) - In Personal Care Homes (PCH). This standard has not been updated since 2011.

Despite the important work they do, Health Care Aides' pay in a PCH averages. $17.75 per hour, or between $25,000 and $33,000 per year, so that workers cannot pay their bills or support themselves or their families without working multiple jobs, sometimes in more than one PCH.

The quality of the interaction between Health Care Aides and residents, especially a resident who has no family, is paramount to the quality of their life in a PCH. It is very difficult to forge a caring and trusted relationship between an overworked HCA who is forced to rush between residents at multiple care homes each day and the residents they care for.

Chapter 4 - The Necessities of Life: Failing to Provide Care Essential to Dignity

Inadequate Hygiene, Food and "Chemical Restraints"

There are a number of common complaints that are all directly related to a lack of adequate funding for basic care.

Quality food and feeding

Food and water are necessities of life, and failure to provide them is criminal. The fact that being dehydrated is more common in for-profits seniors' homes speaks to catastrophic and consistent failure in care.

A common complaint from many family members is the food. Although often judged by an outsider's lens, food quality is often described as unappetizing and disgusting.

Depending on the choice by facility, and capability to choose between frozen to reheat (hospital-type food or in-house cooked food) cost is the issue. Cultural foods are rarely or never offered, and "disliked" food often appears on the trays.

Out of necessity, many seniors in PCHs will be served food that is geared towards that which is edible by the least able. Meaning that instead of food that is nutritious, appetizing, or freshly prepared and meals that cater to the varied nutritional needs, there is a default to the most cost-effective manner.

Often, we are told that residents who have difficulty feeding themselves have had a tray dropped off and forgotten about. Without the ability to feed themselves, the food soon becomes a cold and more unappetizing. This is a waste of food and money. This is where volunteers and/or family members often provide assistance.

It should not take a family member or a volunteer's intervention to ensure that a resident gets adequate food and water.

Basic Hygiene

The most common complaints are about hygiene: that family members complain that their loved ones are forced to defecate or urinate into a diaper, rather than be assisted to a toilet. Indignity aside, these incontinence devices are not changed regularly resulting in recurring Urinary Tract Infections (UTIs), and in many reported case, sepsis. In their first year in power, the PCs stopped buying higher-quality diapers and face cloths.

This risky and unacceptable practise is a cost-saving measure. Facilities use "long-use" diapers because they are cheaper than paying people to care for residents.

There is often no oral care: Teeth not being brushed, leading to cavities; improper denture care leading to them not being used; results in pain and discomfort for the resident and affects not only their attitude, but their ability to eat, and therefore their nutrition and overall health. There are cases where partial plates are left in residents' mouths without cleaning.

One identifier of poor care levels is grooming and clothing. We hear of residents who have not been bathed, or had their hair washed, smelling of body odour, and wearing the same article of clothing for many days on end. Some residents arrive in care with the clothes on their back, and not much else.

This failure to provide basic care can lead to serious and avoidable medical complications that create suffering for residents and extra costs for the health care system.

Most PCHs do not have a a nurse practitioner or doctor on site 24/7, so serious infections may require hospitalization and a trip by ambulance.

Trips to ERs are highly discouraged by the WHRA. The antibiotics, treatments and care they receive in hospital starts to improve their health, only for them to be returned back to the very circumstances that caused the condition in the first place. Lather, rinse, repeat.

Chemical Restraints

There are many challenges around aging and dementia, as a person's mental capacity and ability to communicate may be impaired.

There have been changes in the way some centres are dealing with patients who are labelled "difficult" or aggressive – namely that they are expressing agitation and the response must be calming.

However, residents labelled as "Troublesome" due to their attitude, or insistence to not be confined to their bed or room, are often treated inhumanely and may be restrained. The restraints may be physical, but they are also often chemical – anti-psychotic medications are regularly used to "calm" residents. The use of "chemical restraints" is so common that it is part of a routine inspection checklist.

There are more humane techniques for dealing with Dementia, like the "Validation" technique developed by Naomi Feil.[8] This technique has been proven to improve the quality of life for residents with dementia, and therefore their overall health and the types of care that they require. Using her techniques, difficult residents can be treated with dignity and cared for properly, reducing the reliance on risky medications and their accompanying side effects.

Black Box warnings for these chemical restraints are never made known to relatives or those with legal responsibility. In the UK, use of medications in this way is considered to be "malpractice," because of the use of these as a quieting measures are given without a proper diagnosis for use. It is not recommended by National Psychiatry (UK). There must be non-pharmaceutical interventions.

This also has the effect of improving relationships and interactions with family and caregivers.

Mental Health

The current design of many PCHs is like a hospital ward, rather than a community. Although newer thinking is headed towards designs that facilitate social spaces and interaction, with gardens, nature, sunlight and more, the existing designs tend to lack these in favour of a more clinical setting.

“Aging in place” has been determined to be best for people as we age. Familiar surroundings and a sense of belonging is important to our mental and physical health.

An expert in seniors’ care wrote:

“Unfortunately in facilities over two stories high, those on the higher floors will rarely ever see the outside again. Because of the stigma around those with dementia caused by sensational cases in the newspapers, even the residents can be included in the name calling and jeering of those who have a cognitive impairment. Staff may not intercede to stop this from happening. The right type of facility, like in the Butterfly project, brings out the natural calm behaviours for most with cognitive impairment and not found in any PCH that looks like a mini hospital.

I was reminded by a new manager who initially was determined to improve the lot of her residents, who soon found out that she could not do what she wanted to and was told to behave in a proper manner towards residents and family - distant and non-committal. She told me that these places are not the residents' home, these are institutions so that is how they will be treated. The culture comes from the model of care and the condition of care follows as such. Until the model of care is changed, there will be no changes in LTC.”

All PCHs require suitable recreation spaces and staff who can assist in bringing people together and facilitating new relationships.

Chapter 5 - Beyond the Law: Injuries and Deaths - But No Consequences

"85% of Ontario nursing homes break the law repeatedly with almost no consequences, data analysis shows"

– CBC Marketplace, Oct 23 2020[9]

One of the most shocking aspects of the tragedies in Personal Care Homes is that when something goes wrong, and a person dies or is hurt, whether through negligence or deliberate malice, it is rare that anyone is held to account. Medical examiners or coroners often do not perform autopsies.

This was a finding in Ontario[10] after a nurse, Elizabeth Wettlaufer, confessed to killing 47 people between 2007 and 2016 in Southern Ontario. As the inquiry into the deaths reported, "Wettlaufer committed all but the last Offence in licensed, regulated, long-term care (LTC) homes in southwestern Ontario. She committed the last Offence in a private home where she was providing publicly funded nursing care."

The three principal findings of that inquiry were that:

- "if Wettlaufer had not confessed, the Offences would not have been discovered;
- the Offences were the result of systemic vulnerabilities, and therefore, no findings of individual misconduct are warranted; and
- the long-term care system is strained but not broken."

If a person at home or at a school failed to feed a loved one, left them in their own waste until they developed infections or sores, or if they died from a fall, they would face criminal charges.

In Canada, this doesn't happen. In the summer of 2020, CBC Marketplace investigated some of the most serious breaches of Ontario's long-term care home safety legislation. Six in seven care homes are repeat offenders, and there are virtually no consequences for homes that break that law repeatedly.

Manitoba has the "Protections for Persons in Care Act" – PPCO. An individual familiar with PPCO said it "has been ineffective in identifying at-fault cases and only investigating complaints by calling the LTC facility and asking if everything is okay - and not reporting anything back to the reporter of the complaint."

The PC government has now effectively removed everything previously reported In their PPCO's annual reports (PPCO).

This is the current status of the PPCO's updates on their website.

Statistics

Fiscal Year	Number of Reports of Abuse Neglect Received	Number of Educational Sessions Delivered
2019-2020	2,526	35
2018-2019	2,675	42
2017-2018	2,266	26
2016-2017	2,505	46
2015-2016	2,771	57

The Protection for Persons in Care Office
300 Carlton Street
Winnipeg MB R3B 3M9

Winnipeg: 204-788-6366
Toll-free: 1-866-440-6366
Fax: 204-775-8055
TTY Winnipeg: 204-774-8618
TTY Toll-free: 1-800-855-0511
E-mail: protection@gov.mb.ca

For full disclosure to the public, all PCHs must have on the website of every LTC facility:

- Critical incidents
- Medical incidences of pressure sores, falls and inspection reports and
- Licenses held or withdrawn
- Ownership of the homes - who owns them and how to contact those who own facilities

When a death, abuse, or neglect happens, there has never been criminal charges laid against the care home. In rare past cases, there have been criminal charges against nurses or personal support workers. The proposed Criminal Code amendments and new national standards could signal a desire to make a change so that long-term care home owners and operators could be held criminally responsible.

To respond to the needs of seniors and their families, we need an advocate who can take on cases across the province and hold government and institutions to account. We also need the evidence and research that an advocate could provide.

The regulations governing care must be enforceable, and those who break them, especially repeatedly, must be held accountable, and risk closure of their business, or loss of a job, and if required, face criminal charges where applicable.

The list of issues and allegations we hear most often include, but are not limited to:

- Housing of Covid-19 patients with residents who had not tested positive
- Staff being aggressive with residents
- Residents calling for help with no response for hours
- The presence of insects, especially cockroaches
- Residents going hungry or thirsty
- Resident falls being ignored or not reported
- Neglect leading to health risks due to bedsores

Even where problems are confirmed, including in the most serious cases, there is no accountability. The province, as regulator, does not appear to enforce regulations, and incidents resulting in serious injury or death are never prosecuted.

Families feel that they have no recourse. One woman, whose mother was assaulted and eventually died, fought for years to get accounting and justice without any success.

This was a CBC story on violence in Winnipeg Nursing homes:

It is heartbreaking': Violence at Winnipeg nursing homes causes 500 injuries to residents in 2 years[11]

Residents are routinely abusing or assaulting other residents in Manitoba personal care homes, leading to two deaths in 2016 and more than 500 cases of injury in Winnipeg alone over the last two years, CBC News has learned.

"It is heartbreaking to hear this is still going on," said Joanne Rislund, whose 87-year-old father, Frank Alexander, was a nursing home resident who died in 2011 after being pushed by another resident.

- *Man, 87, dies after Winnipeg care home assault*
- *Daughter testifies at inquest into death of elderly assault victim*
- *In one case in 2016, a resident aggressively removed another resident's feeding tube. The tube had to be surgically re-inserted and the patient died from complications two days later.*
- *In the other case, one resident pushed another resident to the ground. The fall fractured the resident's hip and the victim died four days later.*
- *Another 965 injuries to staff members were reported*

Lawyers point out that current accountability measures are not working and the federal government should be looking to amend the Criminal Code because the current regulatory framework to hold homes accountable isn't effective.

"Right now, the Ministry of Long-Term Care can go in, do an investigation and implement sanctions, up to and including shutting down the home. But we don't even see an exercise of all of the available remedies in our regulatory scheme being used," she said.[12]

It has long been said that people need an advocate to navigate our health care system, as well as seniors care. When families tell us of witnessing mistreatment of their loved ones in LTC, they may be reluctant to register a complaint for fear of reprisal.

The Canadian Centre for Policy Alternatives – Manitoba (CCPA-M), said a Seniors Advocate would "lift the veil of secrecy surrounding seniors care and propose a better path forward." The CCPA-M also points out the Manitoba already has a precedent in the Manitoba Children and Youth Advocate.

Chapter 6 - Private For-Profit Vs. Public

The debate over private or for-profit care, as compared to public ownership needs to be unpacked.

Much attention has been brought to the fact that Revera is one of the largest operators of seniors' residences and long-term care homes in Canada. Their care homes have the dubious distinction of being known as the worst in terms of care, and have proportionally higher rates of resident deaths due to Covid-19.

Revera is a wholly owned subsidiary of the Public Sector Pension Investment Board (PSP), a federal Crown corporation charged with investing funds for the pension plans of the federal public service, the Canadian Forces, the Royal Canadian Mounted Police and the Reserve Force. More than 55,000 seniors live in a property owned somewhere in the world by Revera.

As of early May, as many as 82 per cent of all Covid-19-related deaths in Canada – 3,436 out of a total of 4,167 deaths – were of residents in long-term care settings, according to the National Institute on Aging. In May, PSAC called for the Federal Government to take over Revera[13].

At one point during the Manitoba's second wave, more than half of the province's Covid-19 deaths were in care homes owned by Revera. As the virus spread more to the general population, those percentages of deaths have changed, but remain high in terms of reported deaths due to outbreaks in PCHs. As happened in Ontario, the pandemic shone a spotlight on the actual level of care being provided in such care homes.

A $50 million class action lawsuit was launched against Revera on behalf of the families of Covid-19 victims at the company's long-term care facilities in Ontario, and others are in the beginning stages in Manitoba and other provinces. The company is being sued for negligence and breach of contract.

Having governments take over some private, for-profit homes that have consistently failed residents must be considered. It must be recognized that this is not just a private sector failure, but a failure of successive NDP and PC governments in Manitoba to adequately inspect and fund seniors' care.

At least since 1980, Manitoba governments turned a blind eye to inspections and ignored orders from inquests, families, residents and the industry to increase funding, improve staffing and pay.

Manitoba has a total of 125 long-term care homes; 57% are publicly owned, 13% are owned by private for-profit organizations and 30% are owned by private not-for-profit organizations.

There is no point in taking over private homes that have been responsible and kept their residents safe.

All homes must be held to standards of care, public supports, and everyone should have access to quality care.

The standard of care also requires public engagement from those with lived experience advocating for relatives.

The debate is not just public vs. private. The actual model of care matters and sets the culture of the facility.

Canada has one of the highest number of institutionalized seniors in the world. There can be little doubt that this has contributed to the appalling death rate in our PCHs.

The model we have been following in Canada has been to warehouse seniors, in a "hospital lite" setting, instead of providing health and living supports in a home setting.

There is an alternative.

The Danish Model: Home, Not "Hospital-Lite"

Thirty years ago, Denmark decided to concentrate its health-care investments on the home and community care sectors, deciding that the elderly are better taken care of at home.[14,15]

Denmark has not built any new conventional nursing homes in 20 years but the elderly still receive excellent care where they live by well-trained staff. The law requires each municipality to offer at least one proactive visit per year by a community-based professional to every resident aged 75 and over.

When they do build new, the Danes opt for small independent apartment units, linked to a common kitchen and garden, where seniors can age independently in a protected environment. This concept has been pursued here in Winnipeg by a group called "Positive Spaces", to provide safe housing for members of the 2SLGBTQ* community as they age.

The result is that only 36 per cent of long-term care funding in Denmark goes to special buildings like nursing homes, with the remaining 64 per cent going on home and community-based care. That's the ratio of what occurs in OECD countries like Canada.

The number of seniors in all age groups is expected to continue to rise, and by 2041, seniors are projected to comprise nearly a quarter (24.5%) of the Canadian population, as

compared to 14.8% today. In Manitoba between 2011 and 2016 alone, the population of persons 65 and over grew by 15.4%. Those aged 85 and over are expected to nearly triple to 5.8% of the total population by 2041.

Thorvaldson's Care home in Osborne Village in Winnipeg is an example that we know works well.[16]

They are an 'Intermediate' care facility for people who require more support than what is offered in the community, yet are not quite ready for placement in the clinical environment of a Personal Care Home.

These include, but are not limited to:

- 24 hour care by Health Care Aides with First Aid training
- An on-site Registered Nurse
- Daily assist with catheters/oxygen
- Health assessment/treatment/monitoring
- Frequent, in depth communication with medical practitioners
- Monitor blood sugar/blood pressure/weight/oxygen levels
- On-site preliminary testing for urinary tract infections
- Weekly Lab visit (blood, urine collected)
- Focus on health maintenance to prevent emergency medical needs
- Special diets accommodated
- Housekeeping & laundry (personal & linens)
- Accredited Recreation directors; Private, bedsitting rooms with washroom; and more

This environment is such that the residents lived long and enjoyable lives. We were told that typically, unless there was a significant disease issue, should a resident be moved to a typical PCH, it was only to receive important medical care during their last ***days***, that could not be provided at Thorvaldson's.

Summary of The Danish Model

The history of social housing for older people in Denmark goes back to the 1980s when the construction of nursing homes was generally abandoned, and rules on housing for dependent people were separated from rules on the provision of care. The national legislation concerning social housing for older people is effective for all types of housing for (older) people in need of care.

In 1996, the legislation regulating housing for dependent (older) people became part of the general Act on Social Housing. The most relevant rules within this legislation state that housing for older (dependent) people should be built under the general rules of social

housing. Among other things, this means that the residents of dwellings with related long-term care services are considered as tenants and not as clients or even as patients, with easy access to all integrated care facilities. This serves to 'normalise' the status of older people. According to this legislation, municipalities could no longer build conventional nursing homes, where there was less autonomy; for example, residents received pocket money from the institution rather than managing their own pensions.

The basic intention behind this national initiative has been to secure continuity in the life course, so that lifelong external support systems as well as autonomy are preserved to ensure self-determination for dependent (older) people. In addition, the negative stereotyping that comes from being labelled a patient is avoided.

The example demonstrates that it is possible to amend the legislation in a way that the autonomy of older and dependent people can be significantly maintained and increased.

In Denmark, the intention of passing a legislation where general rules on social housing apply to housing for older (dependent) people and of abandoning nursing homes was to increase continuity in the life course and self-determination for people in need of extensive care.

In an institution, the autonomy and individual activity of residents is reduced, while living as a tenant in an ordinary dwelling with easy access to necessary integrated care services is more preferable than living in a nursing home, as older people can continue their "normal" life.

In Denmark, [institutional] nursing homes are now non-existent and all types of newly built housing for seniors with care needs come under the auspices of social housing and can be called assisted living arrangements. People living in a dwelling with integrated long-term care services can choose a package of services from the housing facility. While most residents make use of these services, it is still possible to choose which services are needed from the facility and which will be received from outside of this arrangement. There are no doctors attached to the facilities - the residents continue to see their GP.

The general rules, as well as the construction of the new types of long-term care dwellings, give the residents the opportunity for maintaining autonomy and to be respected as an individual.

Chapter 7 - Conclusions and Recommendations

There are a number of important conclusions we must accept.

The first is that the tragedy of widespread Covid-19 deaths in Canada is not just the result of a short-term lack of preparation, but the consequence of decades of governments turning a blind eye to enforcement, and not investing in better care.

Polling revealed the vast majority of Canadians, and almost 100% of those over 65 years of age, wanted to age in place in their homes and not go to either a retirement home or PCH for as long as possible. Without the needed services in the community provided by government, the only option available for 99% of people is LTC facility living.

In the case of for-profit care models based on warehousing seniors at minimum expense, shareholders were profiting by running risks with the safety of residents. It is past due time to recognize this is not morally or politically acceptable.

This is why Manitoba needs an independent Seniors' Advocate – a watchdog with bark and bite – with resources to investigate, research and make recommendations to stand up for seniors across the province.

Manitoba also needs to move away from a reliance on "hospital lite" models of care and invest in new models – social care models that are kinder, more caring, and help ensure independence, dignity and a better quality of life for seniors. Canadians are living longer, and our population is more diverse. We need care that is culturally appropriate, including food.

RECOMMENDATION 1: Establish an Independent Manitoba Seniors' Advocate

Throughout those years, Manitoba Liberals have been vocal advocates for seniors and their families.

As PC and NDP MLAs and governments turned a deaf ear and a blind eye to complaints, it fell to Manitoba Liberal MLAs to advocate for seniors and their families.

The Role of the Seniors' Advocate

The Seniors' Advocate in British Columbia receives complaints, makes investigations and performs research and studies on every aspect of public policy affecting seniors' lives.

The Office of the Seniors Advocate should include:

- Monitoring and reporting the provision of all seniors' services – including health care, housing, transportation, income, and personal supports.
- Researching issues that are important to the welfare of seniors
- Advocating in the interests of seniors.

In BC, a "Monitoring Senior Services" report is released every year to show areas that need the most improvement. Ontario is in the process of passing a bill to create a Seniors' Advocate Act, 2020, which sets out responsibilities as: "(a) monitor the provision of seniors' services, including those provided by the Government of Ontario; (b) analyze the policies of the Government of Ontario with respect to their impact on seniors; (c) analyze issues that the Seniors' Advocate believes to be important to the welfare of seniors generally; and (d) advocate in the interests of seniors and their family members who act as caregivers."

RECOMMENDATION 2: Focus on Care in Homes & the Community, not "Hospital-Lite" settings

New investments must include services that are needed for seniors to remain in their homes wherever those are.

One better and more efficient option is the Buurtzorg Neighbourhood Care Teams as created in the Netherlands. They are responsible for all care needs, referring to specialists like the Geriatric Team, who can provide Physical Therapy, Occupational Therapy, nutrition, speech pathology, pharmacy for de-prescribing, and more.

The social care needs can be met with a separate organized team of HCAs and those who specialize in social care needs (like Daughters on Call which originated in rural Manitoba, but offers services in Winnipeg now too). The UK is trying "parish nurses" who work out of neighbourhood places of worship to provide home services.

These are the services that reduce Alternate Level Care (ALC) beds, keep seniors out of Emergency departments and urgent care centres - especially the Geriatric teams set up to respond to seniors who show up in ED or UC centres and prevent inappropriate admissions and the slippery slope to LTC.

These are what will keep seniors in their homes and out of facilities where many don't want to go to really unless there is a specific need that is not being met - such as the wanderers with dementia who would be unsafe at home. 61% of those with dementia in 2015 CIHI Seniors in Transition, are in the community being looked after by family because there are no services to help supplement care by family or respite.

Other new investments in care should be the expansion of "intermediate" homes.

- Every effort should be made to encourage seniors to age in place
- Homes should be run as non-profit organizations with adequate staffing, including medical supports
- Staff must be trained and properly compensated

There is true value in quality care because it increases residents' quality of life while preventing more serious complications. There should be a focus on ensuring staff are trained and amenable to working with the elderly, with a focus on patience; teamwork; empathy; compassion; Validation training; while allowing for adequate time to build a relationship with those in their care.

It should be an affordable option for anyone who needs it. If they are to require medical care, it should not be in a clinical setting, but rather in a comfortable home-like environment.

In closing, we must challenge another myth: the common and conservative idea that we cannot afford to care properly for seniors. This amounts to saying that we cannot afford to do the right thing.

For the same 40 years that we have been neglecting seniors care in Canada, conservatives have been saying that health care and education are too expensive, and that we can't afford it. This is not based on evidence, but in anti-government ideology.

Quality public health care, education and infrastructure are not "costs". They are the cornerstone of community. Investing in keeping people healthy and increasing their knowledge and skills grows the economy.

In the long run, doing things properly is always more cost-effective than doing them badly.

It is past due time to set things right and put an end to 40+ years of neglect with a new era of care.

Appendix 1: Personal Care Home Standards Review Processes and Results

There are a total of 26 standards for personal care home operations.[17]

Reviews of PCHs take place every two years and are conducted by a "Standards Review Team" consisting of Manitoba Health and Regional Health Authority staff. Unscheduled visits also take place. The 26 standards are divided into three sections. Five standards that are considered CORE and are reviewed at each visit. Of the remaining standards, only seven others need be reviewed for a total of 12 of the 26 that are conducted every two years.

The Core Standards are:

- Standard 7 – Integrated Care Plan
- Standard 9 – Use of Restraints
- Standard 12 – Pharmacy Services
- Standard 19 – Safety and Security
- Standard 24 – Staff Education

The Remaining "Optional" Standards are:

- Standard 1 – Bill of Rights
- Standard 2 – Resident Council
- Standard 3 – Eligibility for Admission
- Standard 4 – Information on Admission
- Standard 5 – Participation in Care Plans
- Standard 6 – Initial Care Plan
- Standard 8 – Freedom from Abuse
- Standard 10 – Medical Care
- Standard 11 – General Nursing Services
- Standard 13 – Health Records
- Standard 14 – Dietary Services
- Standard 15 – Housekeeping Services
- Standard 16 – Laundry Services
- Standard 17 – Recreation
- Standard 18 – Spiritual and Religious Care
- Standard 20 – Disaster Management
- Standard 21 – Infection Control Program
- Standard 22 – Person in Charge
- Standard 23 – Qualified Staff

- Standard 25 – Complaints
- Standard 26 – Reports about Occurrences

To receive a met rating, all mandatory measures must be met. At least 80% of all the seven other measures must also be met. But what about the remaining 12?

Part of the process is for the PCH to complete a self-assessment of all 26 Standards and submit this to the Standards Review Team at least ten days prior to the scheduled visit. At the time of the scheduled standards visit, one of the three evaluation tools will be selected as the basis for the standards review. The tool to be used is not revealed to the PCH until The Standards Review Team has received the self-assessment (sometimes not until one week before).

The typical standards visit takes one full day. During the visit, the Standards Review Team tours the home, and assesses the care as it is being delivered. They are supposed to review selected resident charts as well as facility policies, procedures and reports applicable to the standards they are reviewing. There may also be interviews with staff, residents and families as applicable.

At the end of the standards visit, the Standards Review Team will meet with the PCH team and review the results.

A report is written by the Standards Review Team and sent to the RHA, the RHA will forward the report to the Personal Care Home. The report details the standards that were met, partially met or unmet and the home has 100 days to submit an action plan to address any standards that were either partially met or unmet.

To demonstrate the folly of this system, we present excerpts from a CBC investigation on the inspection findings of the March 9 and 10 biennial inspection of Parkview Place, one of Winnipeg's most notorious "care" homes. Many of our caucus' cases are related to residents of Parkview.

The inspectors looked at 12 pre-set standards, including use of restraints, pharmacy services and disaster management. Parkview passed every single standard review.

However, under the safety and security standards section reviewers noted infection control issues. They found:

- Numerous washrooms in need of attention in their flooring, undersized toilets and a strong smell of urine.
- Cockroach issues dating back to 2018, based on a review of exterminator reports.
- Outstanding repairs recommended to prevent insects from getting into the kitchen were not completed.

- High surfaces in kitchen including top of range hood over cook stoves found to have very heavy grease-laden dust.
- Numerous cracks, gaps and missing baseboards which provided a collection point for dirt.
- Damaged drywall.
- A need for "greater attention to high-level cleaning is required.

It is very important to note several things from this report, with the realization that it took place during a pandemic where 29 deaths were reported related to Covid-19 and over 108 positive cases in residents and staff.

1. Cockroaches in Personal Care Homes have been a known issue by both previous provincial governments, dating back to 2006, yet still remains an “ongoing issue”.
2. None of the standards that family members bring to our attention such as:
    - Resident’s Bill of Rights
    - Freedom from Abuse
    - Medical Care
    - General Nursing Services
    - Dietary Services
    - Infection Control Program

…were part of the inspection report. This leads us to surmise that the inspectors take management at their word that all is OK in those areas. These six points can be made for any case at a personal care home that has been mentioned in the news, or by family members who come to us for help.

Appendix 2: Family & Residents' Accounts

Family 1

- My 87-year-old mom has been a resident in Bethesda Place in Steinbach for 3.5 years, from day one there has been not enough staff per residents.
- Most staff do not have full-time hours and wish that they did. This would be so beneficial for both the consistency of care & development of relationships with residents and for financial security for the staff member.
- My mom will sit for hours in her room with the door closed & not see anyone. With Covid this has gotten much worse especially with the outbreak there.
- I was visiting tonight for 1.5 hours & did not see any staff the whole time I was there. I had to get someone washing dishes to let me out of the building
- This has such a negative impact on their physical, mental & emotional well-being. All the residents have is the staff to interact with & they are run off their feet and have no time to visit with residents.

Family 2

- We sent letters to Brian Pallister, Cameron Friesen and the President and CEO of Riverview, Norman Kasian. Norman met with us and explained that his hands were tied for hiring more staff or adjusting the 3.6 hours per resident used for staffing.
- Director of Resident Care Services met with mom regularly to adjust her Care Plan to meet her needs better. The improvements have made a difference but my mom has to live with the burden that if she is getting the care she needs met, those that can't speak for themselves are not receiving the care they need because there is not enough staff to meet the needs of everyone.
- She is observing clear signs of staff burn out which puts her and the other resident's health at risk from mistakes that could even allow an inadvertent COVID outbreak to happen.
- We tried to start a group with the families of the residents when the number of residents on the floor were increased but we were blocked from contacting them with posters. We manually handed out posters to visiting families on Mothers Day in 2019 but didn't get much of a response.
- My mom is grateful for the level of care that she is provided by the staff in the Personal Care Home. She has concerns how the PCH is understaffed though and how her health and those of the other residents are at risk because of inadequate staffing. She has been trying to get her voice heard since May 2019 when the number of residents were increased on her floor but staffing was not increased. Her level of care declined drastically.

- We sent letters to Brian Pallister, Cameron Friesen and the President and CEO of Riverview, Norman Kasian. Norman met with us and explained that his hands were tied for hiring more staff or adjusting the 3.6 hours per resident used for staffing. Joanne Dinicola from the WRHA met with my mom with a similar response.

Family 3

- I came to visit my mother early Friday evening and found her hanging halfway out of her bed. I put her back in her bed and asked her what happened. She had called for assistance to the washroom and the aide did not use the device that was posted for the staff to use in getting her in and out of bed. I reported the situation to the floor LPN who said she had not been told of any incidents. The aid said that my Mom had fallen out of bed while she was assisting her into bed. The staff is so rushed to do their work which is more than they can handle safely that they cut corners.
- I learned of the issue of residents waiting for over 30 minutes to receive assistance to the washroom, with most needing to be cleaned. My mother-in-law needed assistance to the washroom and thus she frequently had UTI's.
- Parkview: another cost cutting measure that this establishment uses is that the charge nurse on each floor is an LPN and the head nurse over all is a BN. I guess because there are so many floors in Parkview that having a BN on each floor would cut into their profits.
- Not only are there not enough (staff) but they are poorly paid. I say shame on the company but more so shame on the government.

Family 4

- In October of 2011 my Mother (age 97) was placed in Parkview Place, over time I found out that in all of the Revera nursing homes at least, many clients are diapered. This is to avoid them soiling their beds and allowing the staff to clean the client up. And on the surface that seems reasonable. However, it allows Revera to hire less staff. So, when the clients are returned to their rooms after dining many of them press their call buttons to get assistance to the washroom. But there are only a few aids assigned to a large number of clients thus many of them wait and wait until finally they cannot wait any longer, and they soil themselves. Then they sit in their own feces and urine until an aid can come and clean them.
- I came every day to see my Mom and I believe it was the second week that she had her first bath. I came to visit and she asked me if it was okay if she didn't have any more baths, it was an awful experience, she said the water was cold
- Can you see how few staff can be stretched to the limit? It is not the staff; it is the staffing numbers that are insufficient to actually care for the residents.

- Parkview has a variety of residents, many of whom have no families to advocate for them and they are the most susceptible to the short comings of the system. Because Parkview is large, old and complex it is no wonder that COVID spread so easily. I doubt if infection control practices were done or monitored. Again, staffing is an issue because of the cost.

Family 5

- In the first few weeks of residing at Maples PCH, mom spoke of being treated poorly, the quality of the food was not good, missed receiving her medication and that water for her CPAP machine was not attended to properly.
- On November 2 she did not sound good and she stated that no one was attending to her and that she was sitting in her own urine-soaked diaper and bed. If it was not for the fact that she had her own phone in her room, we might not have known about the issues surrounding her care and her health. Paramedics were called and requested to attend upon her.
- A nurse advised that she was going to get to his mother eventually but that she was "just one nurse to 60 residents".
- The paramedic advised that his mom had been showing symptoms of influenza for 3 days. We were never informed that she was symptomatic and we found out that afternoon that she was positive for Covid-19. We were advised that she would currently continue to be monitored at the home. They stated that she was stable, not eating but taking fluids. the next morning we received a call at 5:00 a.m. that she was being transferred to the hospital.
- Once in the hospital the Covid-19 progressed so quickly that we couldn't even bring all the family together. When we spoke with her, she was still coherent and telling us she would continue to fight the Covid-19. On Friday, the doctor called to advise that she was not progressing in the right direction and it was time to make her comfortable.
- Watching someone pass away from Covid-19 is the worst thing you will see in your life. After 12 hours she passed. On Friday, at around 11:40 p.m. we received the call that she was gone.
- To find out shortly thereafter the chaos and disturbing details that ensued at Maples PCH tells us that she did not receive the care she should have and that they for whatever reason Revera actively refused to make known the problems they were having.

Family 6

- And how does 1 HCA get 35 residents up in an hour, its ridiculous, when visiting, all you hear are bells going and people asking for help!
- The HCAs are wonderful, but never stay. I wonder why? The burn out level for them is phenomenal!
- We do realize that there were also staff going above and beyond which we greatly appreciated.
- When my mother was in care, she didn’t always get her treatments daily if we were not in attendance and asking for them.

- Once she had a treatable UTI, and instead of treating it, they used it as a platform to try and change her DNR, they called in the family, asking if we really felt this should be treated at her age. Imagine, a UTI, treatable with antibiotics, and they are asking us to let her get septic and die!

Family 6

- His room often smelled of urine, his laundry done by staff was often lost, and on several occasions, we heard very loud staff yelling at him while we waited outside of his room.
- During his stay staff repeatedly said how unhappy and over worked they were and that they were so under staffed they could not take him for his daily hall walk or exercise sessions. Over 5 months he became immobile due to inactivity and lack of proper care and attention.

Son

- On September 18th, dad had a serious breathing issue. His condition was so poor that his son took him to the Health Sciences Centre Emergency Room. Dad was immediately triaged as he looked very frail and very dehydrated. He was given fluids intravenously to enable him to be properly hydrated, which alleviated his breathing issue. He was released on September 20th and returned to the care home, where the symptoms of fluid in his lungs soon returned.
- We voiced our concerns many times with staff in management positions with very few results. He inevitably ended up back in the hospital a few months later with bed sores so infected that doctors mentioned how sad it was to see patients arriving in such poor health condition from the care homes due to neglect.
- Regrettably our father did not survive his condition as hard as hospital medical staff worked to save him. Many of our elderly relatives are now very critical of the system and hope that they never have to face such distressing care conditions.
- Our struggle occurred when our father with dementia went into a Winnipeg care home 5 years ago. He was put on heavy medication to calm his agitated behaviour without our consultation to the point that he did not recognize his own family. He was so overdosed by staff that they had to rush him to emergency.

Family 7

- My Dad lived at Maples Personal Care Home for several years, a few years back, before passing away just months before his 105th birthday. I can't say enough for the care given him. Weekends were the times most often they were short staffed.
- Considering most living there had different degrees of dementia, I was amazed at how smoothly everything seemed to run. The atmosphere was comfortable, everyone was treated with the utmost respect - the meals were always tasty and served at the proper temperature - and if there was ever a situation where an individual needed to be taken to their room during lunch, someone was always there to step in and help -- or continue feeding whoever needed assistance.
- We really liked the personnel who worked at the Maples. They were kind, compassionate, helpful, friendly -- the atmosphere so comfortable.

- I know that everyone we became friendly with, who worked at the Maples always said they were the lowest paid employees of Revera -- they never had enough staff to cover illness or emergency situations. Everybody just worked double time.
- He had several falls -- the worst being the time he fell into the tv stand in front of the Nursing Station. That sent him straight to the hospital. We met him there (his head lying in a pool of blood until he was 'repaired' and resting comfortably.) The Doctors explained they couldn't do much because of his age and hoped the bleeding in his head would be absorbed. It did, over time.
- Most of the falls Dad had were because he persisted in trying to do things he was told not to. He wouldn't press the button if he needed to go to the bathroom, as he didn't want to 'bother' anyone. He thought he could do it himself. Couldn't blame that on dementia.
- Our whole family is stubborn. Most of the falls Dad had were because he persisted in trying to do things he was told not to. ie. 'If you need to go to the bathroom, press the button and we will come and help." He wouldn't press the button as he didn't want to 'bother' anyone. He could do it himself. Couldn't blame that on dementia.

Family 8

- I was told today that they don't have staff to toilet residents on evening shift when I checked if mom had been toileted after lunch.
- On Saturday I came to see mom after supper at 5:45. They get served at 4:15 or earlier but mom's supper was still wrapped in cellophane, untouched, and sitting in the fridge. There hadn't been any attempts made to feed her, nor did anyone come to apologize that she wasn't fed! The excuse I got was, "there's only two of us, and they're all (21 people) feeders!"
- Today I spoke to another resident's family member on the adjoining unit, and she stated that she has seen this as well on their unit. That the people, especially those who cannot speak for themselves, are not getting their meals. She also has seen full meal trays wrapped and sitting in the fridge; and other residents have told her they are hungry!

Family 9

- My 87 year old mother is in Supportive housing for dementia and the initial lockdown was a nightmare for her. She struggled and deteriorated immensely and also not allowed to leave building, so was denied healthcare by not being able to see her GP.
- She fell in her apartment in July and staff couldn't tell me what happened
- They have no medical staff in this facility, so a homemaker told me "she was fine".

- I was told there was no one to monitor my mom's cellulitis because not a medical facility. Supportive housing for dementia falls under the umbrella of Long Term Care, but has no medical staff, only home care that comes in.
- Dementia patients do not do well without family caregivers and one staff homemaker to 12 residents

Family 10

- My Mum, was 89 when she moved into Supportive Housing in August of 2019.
- She had been diagnosed with Alzheimer's disease, and needed a lot more support in daily living, but was physically doing well.
- In February of this year, she and another woman collided walkers while coming back from the afternoon activity. Both were sent to hospital. She had a severe ankle fracture that required surgery. Within 10 days, she had acquired pinkeye, thrush, and impetigo.
- To make a long story short, she was to be non-weight bearing for 10 weeks, and while in the hospital, declined so much that she would be unable to return to Supportive Housing. We also discovered at that time that she had Congestive heart failure (CHF) that was quite severe.
- Our preferred PCH did not have a bed available, and, under threat of a $200/day fee to stay in the hospital, we accepted a bed at a less than ideal PCH, in the hope that a bed would open up at our preferred home. She turned 90 the day after she arrived at the PCH.
- From the beginning, we were concerned, because of shared rooms at that facility. We wondered if she would be ok with a room mate. We arranged to pick up a week's worth of clothing, and some of her small possessions, and bring them over to her. I discovered two weeks later that all of her things were promptly lost for good, when the floor nurse called to ask if I was bringing any clothes for her. I discovered that they had been dressing her in her hospital gown and a pair of pants from the lost and found. My heart broke.
- Right from the beginning, communication was difficult. The doctor for the facility, the director of care, any administrative staff, really…nobody was ever available. Mum's follow up appointment with her surgeon was cancelled, as it was considered to be unsafe for her to go into a hospital and then return to the facility. At the same time, the appointment for a mobile x-ray never happened, as the technician didn't show up.
- I got weekly calls from the floor nurse, telling me how well Mum was doing. They said her ankle dressing was changed and inspected weekly. Then one day she told me that, "We can kind of see the screws in your mum's ankle."
- The surgeon was very upset, and obviously, so were we. It was thought that the hardware was now "colonized by bacteria", and she may need to have it removed in

order for the wound to close. The words “possible below the knee amputation-worst case scenario” were used.

- At this time, I requested an investigation by the Office for the Protection of Persons in Care, and after some time, was told that “some deficiencies in training and procedures have been identified”.
- Fast forward to July of 2020, when we receive a frantic call from the floor nurse. Mum has been “found in bed” with a broken hip. Off to Concordia by ambulance, where both the staff doc and the surgical resident agreed that she, despite her other issues, had good bone density, and that it was unlikely in the extreme that she had spontaneously fractured her femur, while turning in bed, for example. All agreed (including me) that the most likely scenario was that she had fallen out of bed, and someone had put her back in without reassessing her. She required surgery to repair the hip.
- I requested another investigation, and this time received very little in the way of communication or feedback from the WRHA.
- Finally, Mum was able to get a bed at our preferred home, and we moved her back there with lightning speed. However, after all that she had been through, she was never the same. Trauma and isolation had accelerated her cognitive and physical decline, and she died September 24th.

Family 11

- For the first several months, it was (the son’s) strong impression that his father was being overly medicated. He was put on many medications including anti-psychotic medications to the extent that he was almost always somnolent and only partly responsive. During this period, he had five falls in only two months. The falls were never reported to the son by staff, only by other residents or made evident by bruises etc.
- Thanks to the presence of a new Director of Care for three weeks during September of 2019. Dad’s medications were substantially reduced and he became much more alert and responsive, and consequently he was no longer having falls. However, since the departure of that director, dad’s condition has once again deteriorated.

Family 12

- I learned that the doctor who was looking after my father, also provided care (if you could call it that!) at two other Winnipeg personal care homes. I wasn’t impressed with the care my father was receiving and wondered how she could manage looking after so many seniors in three different care homes.

Family 13 (an Ontario resident with a father in Manitoba)

- My father, aged 99 years, went into long term care at the end of May, in the midst of this pandemic. He was forced to do it without family support and has been in a state of confusion ever since. The list of complaints I have is long and involved. I have been given misleading information, I have been lied to on several occasions that I am aware of, and I have been denied access. I am afraid to say too much or to identify my father or the home lest there be recriminations. I am already labelled negatively as I question things and have demanded to be given a copy of the medications list and the plan of care, even though they would assure you that family has full access to this information.

Family 14

- Like many other Manitobans we are extremely concerned about the warehousing of seniors in long term care homes.

- The bottom line for us is: none of these homes should be run for profit. The Provincial Government needs to act immediately to integrate these homes into the overall health care system. They are, after all, essentially hospitals as well as residents' homes.

- Although we agree with the National recommendations, they are too focussed on the conditions during Covid-19, and not on the fact that Covid 19 has just exposed serious issues which have been present in long term care for many, many years.

Resident 1

1) Requested, "In order to improve my health and well-being the following is a list of necessities that would help me achieve that goal:
    a. Reasonable access to exercise and proper diet to stay healthy
    b. Reasonable access to computer, phone etc. to enable productivity
    c. Access to adequate health care and better physiotherapy
2) In about May 2017 I contacted Dr. Jon Gerard, MLA about my situation. On my behalf he wrote to the Minister of Health Seniors and Active Living. After his intervention the situation was looked into by the facility management; however, to date nothing has been done to improve my situation.
3) I believe that the home failed to reasonably accommodate my special needs which are based on my disabilities (paralysis and weight) without bona fide and reasonable cause, in the provision of service, contrary to Sections 9(1)(a) & 13 of The Human Rights Code. I further believe that I have been impacted by the Respondent's contravention of The Human Rights Code and will be requesting all appropriate remedies under section 43(2) of The Human Rights Code.

Resident 2

- In 2010 I had a stroke which left me paralyzed on my left side. Since that time, I have gained weight and currently have a large body. If I had a proper lift, I would most likely would be able to get out of bed. I wish I could return to work one day. As a truck driver.
- Following my stroke, I received care at the Selkirk Mental Health Centre in their Acquired Brain Injury Program. I received physiotherapy and was able to reduce my weight. While I was there using a Sarah Lift and a turn disc, I was able to get out of my wheelchair and use the toilet.
- I am now a resident of Revera Long Term Care Inc. o/a Charleswood Personal Care Home. My weight has increased. I was never considered for bariatric surgery. I am not receiving the level of activity needed for me to continue to reduce my weight.
- As a person with a disability, I believe I should have a certain level of accommodation which would allow me to function with my disability. I should have a bed and a wheelchair which are consistent with my size, and I should have the ability to be transferred from my bed to my wheelchair. I do have a bed which is functional for me. I do not have a wheelchair.

Family of Resident 2

Email dated Oct 20,2020; Please accept my apologies for the delay in reporting a couple incidents to you – things have been extremely hectic lately.

1) Your father had:
   a) September 04/20 –Witnessed fall at 10:30am. A companion saw Mr. Resident 2 Sr sit on the floor in his room. The Resident Care Manager was advised and came and assessed Mr. Resident 2 Sr. Dr. Oliver was notified about the incident. Mr. Resident 2 Sr was monitored for adverse effects for 24 hours.
   b) September 18/20 – Witnessed fall at 7:40pm. Mr. Resident 2's vitals are stable. No injuries noted. Being monitored for 24 hours. September 19/20 – Staff witnessed another resident push Mr. Resident 2 Sr which resulted in the fall noted above. PPCO was notified and a report filed. Mr. Resident 2 Sr. Has no injuries and is doing fine.
   c) September 29/20 – Witnessed fall. Mr. Resident 2's vitals are stable. No injuries noted. Being monitored for 24 hours.
   d) October 12/20 - Witnessed fall. Mr. Resident 2 Sr was walking on the unit, was redirected to his room, his feet got tangled up and he fell. He has two small skin tears – right elbow and right hand. Was wearing his hip protectors. No other injuries. Monitored. Vitals good.
   e) October 16/20 – Witnessed fall. Mr. Resident 2 Sr laying on floor. Did not hit his head. Had his hip protectors on. On small skin tear on his left arm. No other injuries. Vitals good. Monitored. I understand that Mr. Resident 2 Sr remains in good spirits and is watched for ongoing fall risks.

These are 5 “reported falls” in a six-week period. Not responsibility was accepted or offered by the staff or management. If this happened anywhere else, there would be charges of negligence or endangerment brought forward.

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