

Long Term Care Covid-19 Commission Mtg.

Fero International Inc.
on Thursday, November 26, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 26th day of November, 2020,
9:00 a.m. to 9:40 a.m.

BEFORE:

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

1 PRESENTERS:

2 Sabrina Fiorellino, Chief Executive Officer,
3 Fero International Inc.

4 Alex Scopacasa, Chief Operating Officer
5 Fero International Inc.

6
7 PARTICIPANTS:

8
9 Alison Drummond, Assistant Deputy Minister,
10 Long-Term Care Commission Secretariat.

11 Ida Bianchi, Counsel, Long-Term Care Commission
12 Secretariat

13 Sanjay Bahal, Team Lead for Operations, LTCC

14 Derek Lett, Policy Director, Long-Term Care
15 Commission Secretariat

16 Adriana Diaz Choconta, Senior Policy Analyst for
17 the Operations Branch, Long-Term Care COVID-19
18 Commission Secretariat

19 John Callaghan, Gowling LLP

20
21 ALSO PRESENT:

22
23 Janet Belma, Stenographer/Transcriptionist

24

25

1 -- Upon commencing at 9:00 a.m.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, our -- I guess we're all here.

4 Alex, is it?

5 ALEX SCOPACASA: Yes.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 All right. So are you -- are you the person -- are
8 you the person we're interviewing today?

9 ALEX SCOPACASA: It's Sabrina and
10 myself, correct.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 How do you do? Good morning.

13 SABRINA FIORELLINO: Good morning.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 I'm Frank Marrocco. I'm one of the Commissioners.

16 There's Dr. Jack Kitts --

17 COMMISSIONER JACK KITTS: Good morning.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 -- and Commissioner Angela Coke. Janet is our
20 court reporter, so she'll take down what goes on,
21 and there's a transcript.

22 So I think you know, generally, the
23 issues that we've been dealing with. We're looking
24 back at what happened in Wave 1 as far as long-term
25 care homes are concerned and more importantly,

1 looking forward to see if there are recommendations
2 that we should be making to try to prevent a
3 reoccurrence of that. We made one interim report.
4 We may make and probably will make a second one
5 before the end of the year.

6 So we're, you know, interested in --
7 one of the issues that presents itself is how
8 you -- how you deal -- how you deal with homes that
9 get into this kind of a situation, what are your
10 opportunities to create a safe space on a temporary
11 basis where you can remove people, and so on. So
12 that's what we're about, and we're all here.

13 We tend to ask questions as we go
14 along, if that's okay, rather than wait. You may
15 be on -- you may be on mute.

16 ALEX SCOPACASA: Oh, we're -- can you
17 hear us?

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Yeah, I can hear you now. So, you know, I think
20 we're ready when you are.

21 SABRINA FIORELLINO: Perfect. Yeah,
22 our preference is also for you to interrupt us as
23 much as possible so it can be more of a dialogue.
24 Just a note, just so we don't -- you understand
25 we're actually -- we do practice social distancing

1 and masking, but we're in a bubble of two, so
2 that's our full bubble, and that's why we often
3 present together in the same room.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay. I assumed that, actually.

6 SABRINA FIORELLINO: So just a bit of
7 background before we start, my name's
8 Sabrina Fiorellino. I'm the CEO of FERO. My
9 background, I'm a lawyer by training. I did
10 several years on Bay Street in mergers and
11 acquisitions, but a serial entrepreneur. My
12 previous company was in construction. I've been in
13 a number of different fields.

14 But when the pandemic broke and turned
15 the world upside down, I decided, with a group of
16 partners, that we had to do something to help. So
17 it touched my family and continues to touch my
18 family in a particular way. My mom is a double
19 lung transplant recipient who is immunocompromised.
20 Hospital, obviously, shut down transplant, and she
21 couldn't go to her appointments. And I fully
22 understood if she was at the wrong place at the
23 wrong time, she wouldn't have gotten her
24 transplant.

25 My brother's an anaesthetist. My

1 sister-in-law's a frontline worker. They have a
2 baby at home, and, obviously, we -- family can't
3 see each other under those circumstances.

4 My grandfather also, unfortunately,
5 passed during the first wave in hospital. It was
6 his first hospital admission, and I couldn't stay
7 with him. And obviously, that was quite difficult
8 for me.

9 I'll let Alex introduce himself, and
10 then we can get into our slide deck and, you know,
11 happy to field questions along the way.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 That's fine.

14 ALEX SCOPACASA: Hi, everyone. My name
15 is Alex Scopacasa. I'm the CEO at FERO
16 International. I have a background in project
17 management and operations managements. I actually
18 worked for Sabrina for a number of years and
19 started -- started with FERO with her as well.

20 SABRINA FIORELLINO: Thanks. So I'm
21 just going to go through the first few slides
22 quickly. I think you understand the challenges
23 even more than we do. We know the Canadian health
24 system, both long-term care and acute care, is
25 struggling to keep up with increasing changing

1 demands. Obviously, the pandemic has tested the
2 limits of the system, and we understand there's
3 been heroic efforts made by, you know, frontline
4 workers in acute care and long-term care, but we
5 just don't have the capacity to provide best
6 possible care when faced with this kind of crisis.

7 And with limited beds and multiple
8 outbreaks in LTC homes and other congregate living
9 settings, you know, we tried to develop a solution
10 to quickly and safely increase capacity where it's
11 critically needed to protect frontline workers, and
12 above all, obviously, to ensure residents can
13 safely and effectively receive the care that they
14 need.

15 So what we do is, instead of trying to
16 fit residents or patients into existing
17 infrastructure that just doesn't work under the
18 current circumstances, we create flexible
19 infrastructure that can be flexible around
20 residents' changing needs.

21 We created by hard shell, scalable
22 mobile units, and we have breakthrough technology
23 to support long-term care and acute care.

24 We -- our hard-shell units have
25 everything needed for high quality and comfortable

1 resident care, and we help to mitigate
2 cross-contamination within congregate living during
3 an outbreak so residents can be effectively cared
4 for while keeping frontline workers and fellow
5 residents safe.

6 The other thing that we've done is
7 constantly collaborate with the frontlines to
8 develop new solutions and to adapt our existing
9 offerings to meet their needs. So we've had a
10 number of meetings with acute-care providers and
11 long-term care providers and associations to ensure
12 that our solution is what they want because they're
13 the frontlines, and they know better than we know.

14 Our units themselves, so this is -- we
15 create them out of shipping containers. We can
16 create custom enclosures, but because shipping
17 containers are the most cost efficient, we start
18 with that. They're also the most scalable and
19 rapidly deployable. The units are pressurized,
20 so -- and they're meant to help with surge capacity
21 and bed shortages to deal with outbreaks. I think
22 some of the countries that have been most
23 successful in dealing with LTC outbreaks have
24 decanted their homes, and so we've tried to create
25 a solution that allows for rapid decanting where

1 and when needed.

2 The units can serve as isolation to
3 accommodate infections where there's space
4 constraints and that design requirements of the
5 existing infrastructure limit the ability of
6 operators to separate infected residents from those
7 who are well. For some residents, this can
8 eliminate the need to transfer the residents to
9 hospital. Units, obviously, can be customized for
10 a large variety of uses, and we can create
11 full-scale nursing stations, communications
12 capabilities, and more.

13 And our goal is always to work with
14 long-term care operators as well as acute-care hubs
15 and government to produce tailored solutions to
16 challenges in relation to both physical space and
17 staffing.

18 ALEX SCOPACASA: So a little bit about
19 our units and the capacity of our units: Each
20 proposed unit would provide approximately 600
21 square feet to each -- to two residents, and they
22 actually are separated from one another. The units
23 can be scaled up or down to a fully connected
24 solutions to ensure residents are isolated safely
25 and comfortably. So what we --

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Excuse me, Alex. Is each unit -- how many -- like,
3 one person per unit, or how does that work?

4 ALEX SCOPACASA: The units actually
5 interconnect using our proprietary technology to
6 provide a larger living space. So you're not just
7 putting one resident in one unit. We're
8 interconnecting the units to provide a large living
9 space.

10 SABRINA FIORELLINO: I think -- I think
11 what you were getting at, Frank, is do we put
12 multiple residents in the same unit, and the answer
13 is no. Each unit has their -- each resident has
14 their own space, and the way our system is created
15 is that each unit has their own HVAC, which we'll
16 get into, but I'll just address it now since you
17 raised it.

18 Our HVAC does up to 30 air exchange an
19 hour, so we exceed CDC requirements, and there's no
20 cross-flow of air between any of the resident
21 rooms. That was extremely important for us to
22 ensure that if -- you know, we try to decrease
23 viral load as much as possible and ensure that even
24 if there's only sick residents in these units,
25 frontline workers continue to be safe and the air

1 doesn't spread throughout the unit to make sick
2 residents sicker.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 M-hm.

5 ALEX SCOPACASA: Yeah, so going from
6 that point there, just continuing on, unless
7 there's any other questions?

8 COMMISSIONER JACK KITTS: Well, let
9 me -- let me see if I understand. So I think the
10 picture there has -- looks like three units --
11 three separate units joined by one walkway. And in
12 each of those units, each of those units is 600
13 square feet, and you have two people in a unit; is
14 that right?

15 SABRINA FIORELLINO: Oh, I will --
16 maybe what -- I'm just going to go down through the
17 slide deck so I can show you, and then we'll go
18 back up.

19 Okay. So here's a more zoomed-in
20 picture you can see. So on the right, you see a
21 hallway in between. On the right side of the
22 hallway, there's two resident rooms here.

23 Each of the resident rooms is 300
24 square feet, so 600 square feet together.

25 COMMISSIONER JACK KITTS: Yeah.

1 SABRINA FIORELLINO: Each resident room
2 has a bedroom and a living room and a washroom.
3 However, the air between those resident rooms
4 doesn't cross between the two rooms. Each of those
5 rooms has its own HVAC. Each of those rooms
6 achieves 30 air exchanges an hour. Each of those
7 rooms is independently temperature controlled from
8 minus 50 to plus 50 and dehumidified.

9 ALEX SCOPACASA: Yeah, so these -- this
10 room here, there's a dividing wall in the centre of
11 these units. The HVAC units are all serviced from
12 the outside, so you have your electrical room and
13 your HVAC room serviced from the exterior, and each
14 of these resident rooms has its own HVAC and
15 electrical room that gets serviced (phonetic) from
16 the outside so there's no air that ever crosses
17 between each room.

18 SABRINA FIORELLINO: Is that -- is that
19 more helpful?

20 COMMISSIONER JACK KITTS: There's four
21 patients in a square there?

22 SABRINA FIORELLINO: That's right.

23 COMMISSIONER JACK KITTS: Yeah.

24 SABRINA FIORELLINO: But all
25 independent air handlings per each room.

1 ALEX SCOPACASA: Yeah.

2 COMMISSIONER JACK KITTS: And is that
3 square the 600 square foot unit?

4 SABRINA FIORELLINO: No. Each resident
5 room is 300 square feet, so this would be -- in
6 this iteration, you have, I believe, 40 feet by 40
7 feet.

8 ALEX SCOPACASA: So you have 1, 2, 3,
9 4, 5 containers connected together. There's a wall
10 that is a completely open concept here, so there's
11 no dividing wall between here. There's just a
12 dividing wall to separate the actual residents.

13 SABRINA FIORELLINO: They're like a
14 real room, as an example. It's a real 300 square
15 foot, like we mentioned, with its own HVAC.

16 COMMISSIONER JACK KITTS: Okay. As we
17 go forward, are we talking about just the two beds
18 and the HVAC? Is that the unit -- is that the unit
19 you're going to be talking about? Or are you going
20 to be talking about the whole square?

21 SABRINA FIORELLINO: No. So we can --
22 I can show you if we go down. So this is what a
23 solution could like look when you put units
24 together to create a full, let's say, decanting
25 solution. So the idea would be to -- for example,

1 we partner with the University Health Network to
2 test our units to ensure they're safe for use, so
3 both Toronto General and Toronto Western, both on
4 the acute-care side and the long-term care side.

5 And so the idea is, for example, the
6 UHN has 15 long-term care homes. We would find a
7 central location to put down our hub where any
8 COVID-positive resident from any one of those homes
9 could be decanted into one of our spaces, and then
10 we'd work with UHN and maybe the MEST teams to
11 staff the units to ensure there's a manager on
12 site, a physician, and then appropriate nurse --
13 nursing staff. We have our own staffing solution
14 as well, but understand that we need to work with
15 both acute care and long-term care to make it work
16 effectively.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 So when -- so when you put -- and I don't want to
19 get ahead, you know, if you want me to wait with
20 the question, just say so.

21 SABRINA FIORELLINO: No. Go ahead.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 But -- so when you put the unit down, one unit, it
24 will create two spaces that function as two
25 separate rooms would function in a hospital?

1 SABRINA FIORELLINO: That's right.
2 Completely separate, complete -- the air is
3 completely separate.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Yeah.

6 SABRINA FIORELLINO: Yeah, you got it.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 All right.

9 SABRINA FIORELLINO: You got it.

10 COMMISSIONER ANGELA COKE: So just --
11 sorry, just to confirm what I'm seeing, so there's
12 the bedroom, and then there's some sort of living
13 area; is that what you said?

14 SABRINA FIORELLINO: Yeah.

15 COMMISSIONER ANGELA COKE: Okay.

16 SABRINA FIORELLINO: We can create it
17 any way required. If it's only bedrooms that are
18 required, we can create that and put patient lifts
19 in all of the bedrooms and whatever equipment is
20 required.

21 If we require bedroom and living room
22 and washroom, we can create that. If we require
23 nursing station or supply rooms, clean and soiled
24 utility rooms, those are easy for us. It's almost
25 like Lego blocks because they're separate air

1 handling for each unit. So the beauty is we can
2 also scale up and scale down where outbreaks exist,
3 so we can receive a phone call and say we need four
4 resident rooms tomorrow; and then, you know, ten
5 days later, we need another six resident rooms
6 because the outbreak is getting worse, we can
7 deliver those and connect them, and then we can
8 scale down in the same manner.

9 COMMISSIONER ANGELA COKE: So, sorry,
10 just one other thing: You mentioned that you also
11 have a staffing solution. Is that an HR supply
12 agency or something that goes with it?

13 SABRINA FIORELLINO: Yes, that's right,
14 but I think we would still need to work with, you
15 know, the LTC provider, the acute care hubs,
16 potentially a MEST team to make sure that there's
17 proper management, there's at least one physician;
18 and our recommendation would always be to have
19 dedicated staff servicing this unit also to ensure
20 that there's no cross-contamination through
21 staffing.

22 COMMISSIONER ANGELA COKE: Okay. Thank
23 you.

24 SABRINA FIORELLINO: You're welcome.

25 ALEX SCOPACASA: I'm just going to back

1 up to where we were just to continue off there.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Sure.

4 ALEX SCOPACASA: So as we were saying,
5 so each resident will be isolated from one another,
6 and then residents will actually be able to
7 communicate with their families through
8 sophisticated video-conferencing software or in
9 person through large transition privacy glass
10 windows while the patients -- while the residents
11 or patients are being safely isolated.

12 So you can't see it in this render
13 iteration, but in each resident room, there will be
14 a large transitional privacy glass window that will
15 allow for in-person visitation. Once you clear the
16 glass up, you can see the person on the other side,
17 and then we've also made it safe for residents to
18 visit because not only is our air HEPA-filtered
19 coming in, but also, it's -- the exhausted air is
20 HEPA-filtered as well, so no visitors are getting
21 sick walking by the units from the air.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 So you filter the air as it comes in, and you
24 filter the air as it goes out.

25 ALEX SCOPACASA: Yes.

1 SABRINA FIORELLINO: That's right.

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 Okay.

4 ALEX SCOPACASA: And then we had
5 mentioned part of our proprietary technology is
6 that each room has two independent rooms that can
7 be pressure controlled separately. So in a
8 hospital setting, you can have one room acting as a
9 negative -- in negative pressure, the other room
10 beside it acting in positive pressure so you can be
11 doing a procedure on one side and then have an ICU
12 bed on the other side in -- or any long-term care
13 home, you can have both units acting in negative
14 pressure.

15 So this is a unique technology that's
16 available through our proprietary technology that's
17 not available in Ontario health facilities right
18 now, only in our facilities.

19 So the units can be cooled and heated
20 to accommodate Canadian weather fluctuations, as we
21 mentioned, plus 50 to minus 50, and it also
22 includes dehumidification, so we're able to handle
23 the Canadian extreme weather fluctuations. And I
24 mentioned that the air is filtered, incoming and
25 exhausted, and we can achieve up to 30 air

1 exchanges per hour in our units.

2 On the interior of our units, we have
3 all medical-grade finishes, no seams, no drywall,
4 and making the units very easy to clean and
5 sterilize in the hospital settings or in long-term
6 care settings. So we don't use any drywall, any
7 wood. All our wall is green-grade powder-coated
8 aluminum to allow for high flash points of over
9 2,000 degrees to making it very fire retardant, and
10 obviously, all these seams -- there's no seams in
11 the rooms to allow for infection control.

12 SABRINA FIORELLINO: So -- in what we
13 always propose to deliver in a long-term care
14 setting is resident rooms that, obviously, don't
15 look like this but look like real room rooms, like
16 bedrooms and living rooms and are just as
17 comfortable as an existing home would be.

18 But we would propose to deliver also
19 some treatment rooms where more aggressive
20 treatment could be provided to avoid having a
21 resident go to hospital where, you know, they could
22 do vitals every hour and provide some additional
23 level of care if they could avoid the hospital
24 visit.

25 So in these type of rooms that, like I

1 mentioned, UHN's tested, there's oxygen suction,
2 medical gas lines available. We have
3 hospital-grade headwall units. Throughout our
4 whole system, all of our electrical outlets operate
5 on independent circuit breakers so you can't
6 overload any outlet.

7 We also have a dedicated UPS backup
8 system to ensure that equipment's not affected by
9 any external power failures. As Alex mentioned, we
10 have a wireless communication system for residents
11 and frontline workers to communicate with resident
12 families and remote medical professional access to
13 residents by camera and monitoring capability which
14 assists when there's limited staff.

15 So you --

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Does that -- you can also -- you could also do that
18 not just where you needed physicians but with any
19 kind of staff.

20 SABRINA FIORELLINO: That's right.

21 Yeah, they could --

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Could it be organized in such a way that if, say,
24 my father was in one of those units, that -- and I
25 was at home on the Internet, that I could, sort of,

1 take a look and make sure that he was okay and then
2 go off and --

3 SABRINA FIORELLINO: Yeah, we'd create
4 a secure login for family that would be verified
5 ahead of time that would allow family access with
6 resident consent or if a resident is unable to give
7 that consent so long as there was -- you had the
8 Power of Attorney for personal care --

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Right.

11 SABRINA FIORELLINO: -- for example,
12 gave consent, then we could allow secure access to
13 that.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Okay. So then in terms of checking on the welfare
16 of the family member or the loved one, you could do
17 it yourself randomly as long as you had an Internet
18 connection.

19 SABRINA FIORELLINO: That's right.
20 Yeah, that's right. So I think we've already
21 mentioned the units can be scaled up and scaled
22 down. If we have a fleet of units ready to deploy,
23 they can be operational within hours. They require
24 minimum-type site preparation, so -- and we --
25 we've done that intentionally to ensure that

1 there's not a hundred workers on site who are going
2 to get sick, that they can be connected and up and
3 running very quickly and easily. And we can
4 accommodate a broad -- a broad variety of medical
5 needs such as entry units, hallways, anterooms,
6 nursing station, pharmacies, medical gas, pour
7 generation units, utility rooms, restrooms.

8 We can, obviously, rapidly deploy
9 anywhere in Ontario with truck, train, or plane,
10 and like I mentioned, we require minimum time to
11 install. Our units are all prefabricated. We've
12 created the collaborations with some of the biggest
13 medical device suppliers in the world, and we don't
14 take a markup on any of those supplies. It's just
15 a pass-through for us, but it's so we can provide a
16 turnkey solution to ensure that we can streamline
17 the process.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Can I just interrupt you? And sorry to keep doing
20 this.

21 SABRINA FIORELLINO: No problem.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 But I want to make sure I understand this. If you
24 have the container --

25 SABRINA FIORELLINO: Yeah.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 -- then you said you can deploy virtually
3 immediately. What does that mean in terms of if
4 somebody called you this morning at 9 o'clock, you
5 had the container available, how quickly can you --
6 can this happen?

7 SABRINA FIORELLINO: So 24 to 48 hours.
8 Obviously, if it's, like, a 35-bed or 36-bed
9 solution, it takes some amount of time. It's
10 literally us loading it onto a truck or multiple
11 trucks; driving it to site; taking the crane;
12 putting it down on site; connecting them together
13 which takes less than 15 minutes; and then
14 connecting either to generator power or site power,
15 to municipal water or our own septic system,
16 above-ground septic system; and then, if required,
17 connecting to mini-bulk gas systems, so it's
18 actually meant to be rapid, as rapid as you can get
19 for a modular solution.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Is it -- is it difficult -- is the supply of
22 containers difficult?

23 SABRINA FIORELLINO: So there are some
24 difficulties worldwide in container supply, but
25 we've gone to great lengths to secure a supply of

1 containers. Our issue is that we need to be able
2 to build them ahead of time. You know, at full
3 ramp up, we ourselves can build 60 rooms a month.
4 We've created a network of other manufacturers in
5 Ontario who can get us up over a hundred rooms a
6 month, but we do need ramp-up time to get there.

7 And so until we're able to build units
8 ahead of time, it takes some time for us to build
9 before we deploy. Once they're built, we can
10 deploy immediately.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 We had here the President of the Hospital in
13 Windsor, and he was explaining how they took an
14 auditorium and created a hundred rooms. So if you
15 were going to -- if you were using your system, and
16 you wanted to create a hundred rooms, can you --
17 can you give me an idea of how long that would --
18 that would take? Assume you had the land --

19 SABRINA FIORELLINO: Right.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 -- next to the -- next to the hospital. There's
22 land there. How long are we talking here?

23 SABRINA FIORELLINO: So from not having
24 built any units, I would say three months, three
25 months to get down the hundred rooms and have them

1 operational.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 And if you have units?

4 SABRINA FIORELLINO: I would say less
5 than a week.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Okay. So that would be 50. You would need to have
8 had 50 units?

9 SABRINA FIORELLINO: Correct.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 All right. And do you always have an inventory of
12 units, or no?

13 SABRINA FIORELLINO: No. So one of the
14 things, you know, we've been looking for is for
15 government to stockpile the units, so for them to
16 fund a government stockpile that we can build and
17 maintain and deploy for them if and when required.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Okay. Thank you.

20 Commissioner Kitts.

21 COMMISSIONER JACK KITTS: For a hundred
22 beds, you'd need 50 units, right?

23 SABRINA FIORELLINO: Correct. Correct.

24 COMMISSIONER JACK KITTS: I gather you
25 don't go vertical with these.

1 SABRINA FIORELLINO: We do. We do go
2 vertical. The only limitation to vertical stacking
3 is that we would have to put in an elevator, and so
4 it would slow down our install time. So our
5 preference is to stay horizontal, but if we need to
6 go vertical, we can. We just need TSSA to approve
7 the elevator system.

8 COMMISSIONER JACK KITTS: I'm just
9 trying to imagine how big a hundred beds would be
10 all on the one level. Is there -- how big is that?

11 SABRINA FIORELLINO: So every, let's
12 say every unit, which is two rooms, is a footprint
13 of 8 by -- oh, sorry -- 40 by 16, so then you can
14 extrapolate from there.

15 COMMISSIONER JACK KITTS: Okay.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 How -- well, let me -- maybe you can extrapolate
18 from there.

19 SABRINA FIORELLINO: Okay.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 But I would be here all day --

22 COMMISSIONER JACK KITTS: That sounds
23 like --

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 -- attempting to extrapolate from there. How big

1 an area would you need if you were going to -- if
2 you were going to build a hundred -- if you were
3 going to create a hundred beds? And let's assume
4 you were going to do them side by side rather than
5 vertically. How big an area are you talking about?

6 SABRINA FIORELLINO: So what we can
7 do -- so 600 square feet times a hundred beds,
8 right?

9 ALEX SCOPACASA: So depending on,
10 obviously, the facility.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 60,000 square feet, then?

13 SABRINA FIORELLINO: That would be
14 60,000 square feet plus if you require nursing
15 stations or communal washrooms, et cetera, so
16 that's what you would hit, yeah.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 You would hit 60, or you would be in excess of 60?

19 SABRINA FIORELLINO: We'd be in excess
20 of 60.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 So a hundred? Seventy-five?

23 SABRINA FIORELLINO: I would say less
24 than a hundred. I would say 70, 75.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 So that's the -- that's the piece of land that I'd
2 have to have is this 75,000 square feet.

3 SABRINA FIORELLINO: Right.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 And then I could get -- how -- all right. I'll
6 ask -- okay. Fine. I got it.

7 SABRINA FIORELLINO: All right. Yeah.
8 We can -- we can essentially do it, for example, on
9 a football field or something that's available
10 that's central. So, for example, I'll give the UHN
11 example. They have 15 homes. We find a football
12 field that's sort of central to all of those
13 15 homes, and we would put it there, and that would
14 be fine for us.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 All right. All right. I actually was thinking of
17 football fields. A lot of schools have them and so
18 on. Anyway, okay.

19 SABRINA FIORELLINO: So we -- I think
20 we had mentioned that, you know, we've created --
21 we've ensured that we have also a supply of medical
22 equipment so that we can deliver that, things like
23 patient lifts, et cetera, that are required in the
24 units. We're, again, fully -- we can be fully
25 operational at any location, you know, of

1 government or an LTC provider can offer.

2 Again, I think we mentioned this, that
3 we're highly customisable to accommodate unique
4 needs of each home or each hub, and we can connect
5 to existing facilities if required or be completely
6 standalone. So if there's an existing facility
7 that just needs a few beds, we can create a hallway
8 module to connect to that facility and add a few
9 beds. But if we need a full decanting solution, we
10 can do that too. I think we showed you these
11 renders.

12 ALEX SCOPACASA: So, yeah, to add to
13 the point of the question of square footage and
14 everything, we can -- we can expand these units in
15 any direction either vertically, horizontally, out
16 to the side, any footprint that is required,
17 anywhere from a 20-bed to a 40-bed and depending on
18 the facilities that are required as well. If
19 they're washrooms or staffing rooms or clean and
20 soiled utility rooms, we would be able to, you
21 know, deploy, let's say, the 30-bed solution in
22 different areas to act as the general hub for a
23 certain amount of facilities to isolate.

24 COMMISSIONER JACK KITTS: So are you
25 saying that for functionality, because I can't

1 imagine a hundred bed horizontal, that the walk
2 from one end to the other would be terrific, so you
3 said you -- you'd mentioned 20 to 40-bed units. Is
4 that what you're thinking, then, the right size is
5 for these?

6 SABRINA FIORELLINO: So the one you see
7 here is 36 beds.

8 COMMISSIONER JACK KITTS: Okay.

9 SABRINA FIORELLINO: And so what we can
10 do -- and we would never, sort of, have a situation
11 where we'd build them all in a row. We'd, sort of,
12 build down here, and there would be hallways coming
13 through this way and up here again, so it's not too
14 long. It's, sort of, almost like a full square
15 with hallways going vertical and horizontal, so
16 you're never -- you'll never have that long walk
17 from all the way from one end to another.

18 COMMISSIONER JACK KITTS: That sounds
19 good. Thank you.

20 SABRINA FIORELLINO: You're welcome.
21 So FERRO, obviously, can't do this on its own. You
22 know, we need, sort of, collaboration from
23 government and otherwise. I think we believe that
24 a well-thought-out emergency strategy is required
25 now. We believe COVID-19 will be with us for some

1 time and that long-term care homes require
2 assistance even post-pandemic due to bed shortages
3 in the entire health system.

4 We believe, especially, that a
5 collaborative approach is required between
6 long-term care and acute care, and we believe that
7 this idea requires socialization to ensure all
8 parties are on board to work collaboratively and
9 create uniform standards across areas of overlap
10 between acute care and long-term care.

11 From a safe infrastructure perspective,
12 FERO is able to act as a hub and move
13 COVID-positive residents out of homes as well as
14 take pressure off emergency departments. So FERO
15 can provide units that treat residents that require
16 additional medical support where vitals can be
17 taken every hour and where aggressive treatment can
18 be provided without sending residents to hospitals.

19 And in that manner, we can act as both
20 an input and an output, so we can act to decant
21 residents' homes and to move residents out of
22 hospitals into FERO units before they're ready to
23 return to their homes.

24 As we mentioned before, we're able to
25 provide some staffing, but understand that a

1 collaborative approach is required which ensures
2 strong managers are present. We, obviously,
3 recommend that existing homes assign designated
4 staff including physicians and nurse practitioners
5 to work in the FERO hubs. We can work with
6 long-term care homes and acute-care hubs. We can
7 assist with providing clinical managers and
8 logistics.

9 We've already had these conversations,
10 so we're just letting you know what we think based
11 on our conversations. And we can ramp up and ramp
12 down, so as fast as we can add beds, we can remove
13 them and move them to different sites if required.
14 We also believe that MEST or the Mobile Emergency
15 Support Team could be moved into a FERO unit as the
16 MEST teams include managers.

17 Overall, we understand that there's
18 difficulty in filling management roles in the
19 sector but that this endeavour requires strong
20 decisive leadership to make strategic and
21 just-in-time decisions proactively. And we also
22 believe Ministry of Health and Ministry of
23 Long-Term Care need to work collaboratively and
24 closely with one another and with long-term care
25 and acute-care providers for any solution,

1 including FERO's, to be successful.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 So how mobile -- how mobile is it? Let's assume
4 you created this 36-bed facility in Kingston, only
5 they don't have any cases. There's been a mistake;
6 people mistakenly thought there would be, and there
7 aren't, but there's a problem somewhere else, and
8 so somebody wants to move the whole thing. How
9 long would something -- how long does that take? I
10 appreciate it depends on the distance, but how long
11 does that take?

12 SABRINA FIORELLINO: Less than a week
13 for sure.

14 ALEX SCOPACASA: So it's just a matter
15 of us disconnecting the units and then putting them
16 on a truck and shipping them out to the next site.

17 So the great thing about our units is,
18 like you said, if someone made a mistake and, you
19 know, they don't have as many cases as they thought
20 they would, they can decrease on a bed-by-bed
21 basis, so rather than putting up fixed
22 infrastructure like a tent, let's say a hundred-bed
23 tent, and then that -- that site requires an
24 extreme amount of onsite trades to be present in
25 order to put up that tent and that infrastructure,

1 to take that -- to set that up and take that down
2 requires several weeks to mobilize and demobilize;
3 whereas our solution requires, you know, such --
4 much less time to mobilize and demobilize.

5 SABRINA FIORELLINO: I think the other
6 thing is we don't have to fully demobilize. As an
7 example, if there's still, you know, let's say, ten
8 residents that require care, we can leave five
9 units and move the rest somewhere else, so it's
10 very flexible in that manner.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Yeah. So you could -- in the example I gave, you
13 could leave a few units in Kingston just in case if
14 that were the consideration, move the rest of them
15 there because it's all -- they're all detachable.

16 SABRINA FIORELLINO: That's right.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Okay. I know that this is kind of an odd, awkward
19 question, but is -- can you give me a sense of what
20 the cost of what you're -- a person's looking at if
21 they decided they wanted to do this?

22 SABRINA FIORELLINO: Sure. So our
23 rooms range from a hundred thousand to 300,000,
24 300,000 being the most sophisticated ICU room that
25 runs oxygen suction and medical gas lines,

1 et cetera. You know, our visitation pods,
2 obviously, are much less expensive than that if,
3 you know, it was only a visitation pod that was
4 required, but we're --

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Yeah, I was thinking more of a situation where you
7 had residents in a long-term care facility who've
8 tested positive, and you wanted to remove them
9 to -- if -- in the interests of containing the
10 spread of the disease, so that kind of a unit.
11 What -- where is that on the range that you were
12 talking?

13 SABRINA FIORELLINO: That's closer to
14 the hundred-thousand-dollar range for sure. It
15 also depends on if negative pressure is required,
16 if you require that pressurisation or not. If the
17 pressurisation is required, it's a bit higher than
18 the hundred-thousand-dollar mark. If not, we
19 can -- we can stay closer to the
20 hundred-thousand-dollar mark per room for sure.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 Commissioner Kitts.

23 COMMISSIONER JACK KITTS: Is that a
24 hundred thousand per one pod which has two beds?

25 SABRINA FIORELLINO: It's per room, so

1 it's 200,000 per pod.

2 COMMISSIONER JACK KITTS: Okay. So
3 200,000 per pod, and do you -- do you -- do you
4 have -- the purchaser buys it. Do you lease them?

5 SABRINA FIORELLINO: We do lease them
6 absolutely, sell, lease, finance, et cetera.

7 COMMISSIONER JACK KITTS: And what
8 about other people in your market that are not
9 healthcare? Do these have a use -- like, you say
10 they're flexible, so they don't need to be hospital
11 beds.

12 SABRINA FIORELLINO: Yes.

13 COMMISSIONER JACK KITTS: They could be
14 something else. Do you have a market for that as
15 well?

16 ALEX SCOPACASA: We could provide -- so
17 we -- not only does our infrastructure do hospital
18 beds and provide facilities for long-term care, but
19 as a stockpile, if government were to purchase
20 them, we could repurpose them for infrastructure in
21 remote communities or Indigenous communities where
22 the infrastructure is lacking. We can also use
23 them for, you know --

24 SABRINA FIORELLINO: Social housing.

25 ALEX SCOPACASA: -- social housing,

1 schools, correctional facilities, and the list goes
2 on. And I can let Sabrina talk more about that.

3 SABRINA FIORELLINO: Yeah, the idea was
4 always that COVID was limited, and so we understand
5 that the need is now and there may not be a need,
6 let's say, a year from now, but they could be
7 repurposed in a number of manners including to deal
8 with ALC bed shortages, temporary shortages for LTC
9 beds, also to deal with surgical backlog to
10 repurpose for infrastructure in Indigenous or
11 remote communities for social housing for the
12 homeless, et cetera, so -- or they could be
13 stockpiled by government like a civilian stockpile
14 similar to a military stockpile where they could be
15 deployed for future pandemics or natural disasters
16 or mass casualty events.

17 COMMISSIONER JACK KITTS: That's
18 excellent. Thank you.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 The -- have you had an opportunity to demonstrate
21 in a long-term care facility or situation the --
22 how efficient this is?

23 SABRINA FIORELLINO: So not yet. Like,
24 I had mentioned, we've partnered with the
25 University Health Network both on the acute-care

1 side and the long-term care side. You know, we've
2 requested funding from government so that we could
3 deploy the units to UHN so they can be used in a
4 clinical setting on the long-term care side and the
5 acute-care side so we can demonstrate how
6 effectively they work.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 And in terms of how effective they can work, UHN is
9 obviously satisfied that they would fulfill a need
10 for UHN, or they would never have entered into the
11 agreement with you in the first place.

12 SABRINA FIORELLINO: Yeah, they've sent
13 us a written report that said that the units are
14 suitable for use. They've either sent that to
15 government or are in the process of sending that to
16 government, so, yeah.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 Okay. Well, is there -- I don't know that we have
19 any further questions. I -- on behalf of us all, I
20 thank you for this because this is a, sort of --
21 this is a concrete example of -- in the context in
22 which we're functioning, a short-term solution
23 to -- or a potential solution to a problem that we
24 have been confronting all the way along both in
25 terms of a need to deal with people who are COVID

1 positive, and also there's this ongoing issue of
2 the shortage of the -- a number of beds and an
3 anticipated shortage -- an anticipated worsening
4 situation over the next few years as the baby-boom
5 generation gets older.

6 So this is very informative from our
7 point of view, and thank you both very much for a
8 very helpful presentation.

9 SABRINA FIORELLINO: Thank you,
10 Commissioner Marrocco, and to the rest of the
11 Commissioners as well for giving us the opportunity
12 to speak with you today.

13 ALEX SCOPACASA: Thank you, guys.

14 COMMISSIONER JACK KITTS: Thank you.

15 COMMISSIONER ANGELA COKE: Thank you.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 Good-bye now.

18 SABRINA FIORELLINO: Bye-bye.

19 -- Adjourned at 9:40 a.m.

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REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified
Shorthand Reporter, certify:

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

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

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

Dated this 27th day of November, 2020.

Janet Belma.

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