

Long-Term Care COVID-19 Commission Meeting

Sienna Senior Living
on Friday, March 12, 2021



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

neesonsreporting.com | 416.413.7755

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MEETING OF THE LONG-TERM CARE
COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 12th day
of March, 2021, 10:00 a.m. to 12:00 p.m.

BEFORE:

The Honourable Frank N. Marrocco, Commission
Chair

Angela Coke, Commissioner

Dr. Jack Kitts, Commissioner

P R E S E N T E R S:

Nitin Jain, President and Chief Executive
Officer of Sienna Senior Living

Dr. Andrea Moser, Chief Medical Officer and
Senior Vice President, Sienna Senior Living

Dr. Allison McGeer, Chief Infection Prevention
and Control Consultant, Sienna Senior Living

Adam Walsh, Senior Vice President and General
Counsel, Sienna Senior Living

Mark Polley, Counsel, Polley Faith LLP

Brookelyn Kirkham, Counsel, Polley Faith LLP

P A R T I C I P A N T S:

Alison Drummond, Assistant Deputy Minister,
Long-Term Care Commission Secretariat

Kate McGrann, Co-Lead Commission Counsel,
Long-Term Care Commission Secretariat

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

Jessica Franklin, Policy Lead, Long-Term Care
Commission Secretariat

Alain Daoust, Team Lead, Long-Term Care
Commission Secretariat

Angeline Hawthorn, Senior Policy Analyst,
Long-Term Care Commission Secretariat

Rose Bianchini, Senior Policy Analyst, Long-Term
Care Commission Secretariat

Amanda Byrd, Commission lawyer

John Callaghan, Co-Lead Commission Counsel,
Gowling WLG

Lynn Mahoney, Counsel, Gowling WLG

Kavi Sivasothy, Counsel, Gowling WLG

Patricia Brooks, Counsel, Gowling WLG

1 --- Upon commencing at 10:00 a.m.

2 JOHN CALLAGHAN: Good morning,
3 Commissioners. Today we have Sienna who has come
4 to speak to us. You'll recall that there was
5 some evidence given by the hospitals, and by the
6 inspectors, regarding some specific homes.
7 Transcripts of those interviews were given to the
8 owners of those homes and they were invited to
9 come back and speak to the Commission if they
10 chose, to be blunt. Sienna is the only one that
11 has taken up that offer as of yet and so we thank
12 them for that.

13 Mr. Polley is counsel to Sienna and
14 we've seen, I think, most of them before. I
15 don't know if we're still waiting for anybody
16 but I'll ask Mr. Polley to do introductions
17 again.

18 MARK POLLEY: It looks like we have
19 Dr. McGeer, we have Dr. Moser here as well and
20 Mr. Jain. I'll hand it over to Nitin.

21 NITIN JAIN: Thank you, Mark. And good
22 morning and thank you, Commissioners, and counsel
23 Callaghan, for having us today. As you might
24 recall I met with you in October last year by
25 myself, and today I'm joined by two of our

1 physicians, Dr. Moser and Dr. McGeer, who have
2 been a big part of our fight against COVID-19
3 across Sienna.

4 When I became CEO of Sienna in the
5 middle of wave one, which is June of 2020, I
6 recognized that we needed health care expertise,
7 we needed the right expertise for medical
8 direction, and very importantly we needed the
9 right expertise for infection prevention and
10 control; and that really led me to find both
11 Dr. Moser and Dr. McGeer.

12 Dr. Moser is one of Canada's most
13 respected, experienced and sought-after
14 practitioners in the care of the elderly, and
15 specifically medical care in long-term care. I
16 am sure you're not looking for an entire CV but
17 I just wanted to give you a bit of understanding
18 as to how confident we are that she is best
19 suited as the Chief Medical Officer for a senior
20 housing organization.

21 She's an Associate Professor in the
22 department of Family and Community Medicine at
23 the University of Toronto. She has spent her
24 entire career focusing on the care of the
25 elderly. She has co-developed a curriculum for

1 the long-term care medical director for Ontario.
2 She's a Vice-President and a Board member of the
3 Canadian Society for Long-Term Care Medicine,
4 and she's also a member of the American Board of
5 Post-Acute and Long-Term Care Medicine.

6 She joined us in July 2020 on a
7 consulting basis and moved to become our
8 full-time Chief Medical Officer in October of
9 2020.

10 Dr. McGeer, I know she does not need
11 any introduction in most rooms, and especially
12 here. She has been in front of Commissioners a
13 few times already. She's here today in her
14 capacity as a Chief Infection Prevention and
15 Control Consultant for Sienna, and will help
16 address questions around IPAC; as you know,
17 she's a leader in that field.

18 Again, just a couple of indicators of
19 her expertise. She was a Director of Infection
20 Prevention and Control at Sinai Health System
21 for nearly twenty years. She served on Canada's
22 National Advisory Committee on Immunization and
23 the Infection Control Subcommittee of Ontario's
24 provincial Infectious Disease Advisory
25 Committee. She's currently a member of the

1 COVID Expert Advisory Committee of Canada's
2 Chief Science Advisor, the Steering Committee of
3 Canada's COVID-19 Genomics Network, and
4 Ontario's COVID-19 Science Table.

5 And in addition to both of them, we
6 also in June brought Mr. Joe Mapa, who was
7 previously the CEO of Mt. Sinai Health System,
8 because we understand going forward there's
9 going to be a lot more collaboration in the
10 health space, and having someone who understands
11 the hospital system well has been a great asset
12 to us.

13 When I last joined you I spoke to you
14 about our promise of bringing on board new
15 leadership, implementing new policies and also
16 renewing our commitment to care. And Dr. Moser
17 and Dr. McGeer are -- were just two of those
18 steps in that commitment. They're joining me
19 today to explain to you and tell you what they
20 have learned about Sienna, but also to provide
21 their insight into the long-term care sector for
22 Ontario, and nationally as well.

23 Our return to speak with you today, as
24 counsel Callaghan just mentioned, was
25 specifically prompted by your meeting with

1 individuals from UHN who talked to you about one
2 of our homes in downtown Toronto, St. George.

3 It is a care community that plays an
4 important role in providing services for an
5 otherwise underserved population in downtown
6 Toronto. It is a home to residents with
7 significant social and mental health challenges;
8 many of them did not have a permanent place to
9 live until they were in fact moved into
10 St. George; many of them have severe addiction
11 issues. And the needs of those residents, both
12 medically and socially, created some distinct
13 challenges for our leaders in dealing with this
14 pandemic.

15 It is also unique in other ways. It
16 serves a younger and a more mobile population,
17 one where a large number of residents have
18 mental health issues. And it is not really a
19 population you imagine when you think of
20 long-term care overall in Ontario. But they are
21 an important population at St. George and the
22 team there is dedicated to ensure we provide
23 them a home and care that they not only need but
24 also deserve and get.

25 Similar to many other long-term care

1 homes though, what is similar is that it's
2 staffed by team members who have been coming in
3 to work whether it was wave 1, whether it was
4 wave 2, whether it was planning for wave 3,
5 whether there was no mask, whether there was
6 masks, whether they were single site. They are
7 team members who put the health of residents
8 above the health of their own, and in many cases
9 even the health of their families.

10 My goal, and Dr. Moser's and
11 Dr. McGeer's goal today is to give you a more
12 complete picture of St. George, it's community
13 and our collective response to wave 2.

14 I also want to reconfirm with you and
15 demonstrate to you, over the course of next
16 couple of hours, what I said to you five months
17 ago, which is when I took over as CEO of Sienna
18 Senior Living in the middle of wave 1, I
19 reconfirmed our company's commitment to
20 learning, improving and doing everything
21 possible to protect our residents and our team
22 members.

23 We set ourselves on the task to deal
24 with this global pandemic and we have been at it
25 every day since then. What we have learned in

1 wave 2 we have -- what we learned in wave 1 we
2 have now been using in wave 2.

3 And I would agree that we did not stay
4 unscathed from the second wave, or the war
5 against COVID-19. In fact, few of us in our
6 sector have, despite our best efforts, whether
7 it's inside Sienna or our sector in general
8 across Ontario.

9 In Toronto there were high case counts
10 in the community, especially in the downtown
11 area, which impacted St. George. But there are
12 lessons that we learned that helped us better
13 prepare in dealing with the issues of
14 St. George, and many other communities that we
15 serve.

16 It is with that experience and that
17 perspective that when I read the description of
18 St. George presented to the Commission I was
19 very disappointed that it did not have the full
20 picture of St. George. So I would like to just
21 walk you through some of those points, starting
22 with the UHN panel's concern that Sienna was
23 resistant to change.

24 I'm not really sure what it was meant
25 when they said that we were "resistant", but for

1 sure we were all surprised. As I mentioned, we
2 are a learning organization and we are still
3 learning. We are proud of all the collaboration
4 we have with many hospital partners, with public
5 health agencies, and how hard everyone has been
6 working to ensure everyone is doing the best
7 they can against -- despite with COVID.

8 I would say, and I do understand that
9 there can be differences of opinions on best
10 practices, and there has been a lot of changing
11 and inconsistent advice on how best to manage
12 the outbreak.

13 Just to give you a bit of a
14 perspective of overall Sienna, we have close to
15 6000 beds in Ontario long-term care. And while
16 we were dealing with St. George our team was
17 also dealing with 16 other outbreaks across
18 Ontario, with close to 250 active cases and
19 another 100 active team member cases.

20 Considering that Dr. McGeer has
21 tremendous experience in managing outbreaks I
22 would like her to provide a bit of an informed
23 view as to who is running the show during these
24 outbreak calls, and what some of those outbreak
25 calls and that process looked like.

1 Dr. McGeer, would you like to give
2 your perspective?

3 DR. ALLISON McGEER: Thank you
4 Mr. Jain --

5 JOHN CALLAGHAN: Before you go,
6 Dr. McGeer, I think during the course of our
7 discussion today, you know, there will be lots of
8 people reading this and we're going to have to
9 address the fact that Sienna had the number one
10 ranked deaths, according to what Mr. Hillmer told
11 us from the province. They had 403 residents'
12 deaths; 3 staff deaths; they had the longest --
13 the most number of outbreaks, being 81; the
14 average duration of the outbreaks was the longest
15 at 22.7 days; and the cumulative number of
16 residents' cases was 1,302, which was also the
17 highest, as was the staff cases, which were 724.
18 Now, they had -- they were fourth on cases per
19 100 resident beds at 23.4, and I think, I may be
20 mistaken but I think Sienna has the seconds most
21 beds in Ontario.

22 But I think when we -- when you're
23 here, I know the transcript was of St. George's
24 but there's a larger discussion. And I know
25 we've heard from Dr. McGeer about the challenges

1 at IPAC, but I think probably we would like to
2 hear how it happened at Sienna that those were
3 the numbers and how it is we get that under
4 control on a go-forward basis, and perhaps what
5 happened between Wave 1 and 2.

6 I don't want that to get missed to the
7 readers of the transcript or to the
8 Commissioners. Go ahead, Dr. McGeer.

9 DR. ALLISON McGEER: Thank you. And
10 yeah, I don't -- I don't think any of us, and I
11 include hospitals and the long-term care sector
12 across Ontario, can be particularly proud of how
13 wave 2 was managed. None of us escaped without
14 outbreaks and, as you point out, Sienna has had
15 more cases and more deaths and more outbreaks.

16 What I don't want us to lose in this
17 though is the complexity of the situation that's
18 being dealt with and the issues surrounding, you
19 know, what we could have fixed and how easy it
20 is to fix it.

21 And so I was a little bit worried
22 reading the transcript of UHN and of St. George
23 that you got a gestalt from it at the end, that
24 if the people at Sienna had just done what UHN
25 told them that it would have been okay and the

1 outbreak would have been prevented and the
2 outbreak would have been over.

3 And, you know, from my perspective
4 it's just not that simple. Yeah, if we had --
5 didn't have C-class homes, if we had more funded
6 care, if we had IPAC the way us IPAC people want
7 it in homes we wouldn't have nearly as much
8 trouble with outbreaks in long-term care.

9 But we were all stuck with the
10 situation that we had at the beginning of wave 1
11 and wave 2. And managing outbreaks once they
12 start is really difficult and complex. And then
13 we put hospitals in the situation of not really
14 coming in and providing support until the
15 outbreaks were big, right? We didn't say to
16 hospitals, You take control of any outbreak any
17 time. Because honestly they couldn't, okay?
18 Because in wave 2 all of the hospitals had their
19 own outbreaks going on, and they had multiple
20 outbreaks with multiple partners and so they
21 didn't have the resources either to be able to
22 take over and manage those outbreaks.

23 So the outbreaks deteriorated before
24 hospitals went in. And in that situation the
25 outbreak has now become really chaotic and very

1 difficult. And when you -- when you come in as
2 a hospital in that situation it's really
3 challenging, it's very difficulty, it's
4 enormously frustrating, but that's what hospital
5 IPAC people are for --

6 When I get into -- if I'm -- well, so
7 first of all, you know, there's nobody
8 technically in charge of managing these
9 outbreaks. So when you get an outbreak call, in
10 big outbreaks there can be between 30 and 40
11 people on those calls; they come from three
12 different ministries and the LHIN and the Public
13 Health unit. And a lot of the time you see
14 names but you don't actually know who the people
15 are or what their goal is in life.

16 And out of that you need to try to get
17 a consensus moving forward about what you're
18 doing. And in particular you need to recognize
19 that the -- you know, what people are hearing
20 from different experts is different. There's no
21 rules for managing COVID outbreaks. There's no
22 right thing. And all outbreaks are contextual.

23 So when -- I expect, okay, on these
24 outbreak calls -- now, there's 35 people on
25 them, none of them have had enough sleep for

1 nine months, most of them haven't had a day off
2 for nine months, everybody's under enormous
3 stress. Some people are going to be difficult,
4 okay? You're running an outbreak; you need to
5 expect that. And some people are going to want
6 to do something different than what you're
7 telling them.

8 So let me give you an example of one
9 thing that I was peripherally involved with in
10 the outbreak that -- where I would actually have
11 preferred if Sienna had been more resistant to
12 UHN's suggestions, because I think it would have
13 been better; not as an illustration of UHN
14 wasn't doing their best and UHN isn't good and
15 people shouldn't have been listening to UHN, but
16 just as an illustration of why people had
17 questions and why you need to be trying to
18 listen to everybody when you're running these
19 outbreaks.

20 So Sienna has been using a room
21 disinfectant called a "Clorox 360". It makes an
22 aerosol of bleach and you can use it to
23 disinfect soft surfaces. We don't use them in
24 hospitals because there's occupational health
25 issues associated with breathing in those

1 aerosols. And because in a hospital I can just
2 say, No soft surfaces. Right? So I don't
3 need -- I can use wet chemical disinfection for
4 everything. And if somebody has something in
5 the room that can't be cleaned I can just make
6 somebody take it home, or give it to social work
7 for a while and put it away.

8 But you can't do that in long-term
9 care. In long-term care those are people's
10 homes and you have soft surfaces and you have
11 clothes, and you can't disinfect those
12 adequately with regular chemical disinfectants.

13 So I knew Sienna was using the Clorox
14 360. I admit it gave me a little pause, but
15 they talked to me about what their protocols
16 were for making sure that it was being used
17 safely and they sounded convincing, and so I --
18 given the context I thought it was fine.

19 When UHN came in to St. George they
20 looked at that Clorox 360 and they said to
21 Sienna, You may not use it, it is dangerous.
22 And the call I got from Sienna was not -- there
23 was no resistance to that. It was very
24 definitive and people stopped using it
25 immediately.

1 That's not a trivial thing to do,
2 right? In the middle of a chaotic outbreak if
3 you have to reorganize what you're doing with
4 housekeeping and with disinfection everybody
5 needs to be trained, people need to change what
6 they're doing, you know, it's just complicated.
7 And you don't want to change things you don't
8 have to in an outbreak.

9 But the call I got from Sienna was
10 not, We think there's a problem with St. George.
11 The call I got from Sienna was, We thought you
12 knew that we were using this and that you
13 thought it was okay, and UHN is telling us that
14 we can't use it, it's dangerous. We're using it
15 in other homes. What are we supposed to do?

16 And, hard decision. I'm not an expert
17 in occupational health. And in the end I picked
18 up the phone and I called Dr. Sabatino [ph],
19 who's our occupational health IPAC expert in
20 Ontario, and said, I see both sides of this,
21 okay. I thought using this was okay. I hear
22 that UHN is interpreting the product's guidance
23 differently. What do you think? To which the
24 answer was, Yup, really difficult in the context
25 of long-term care. Homes are different. In

1 Hamilton we're using this machine and we hear
2 the issues with it but we think on balance it's
3 the best thing.

4 So I say this just because I think in
5 the course of this people who are running
6 outbreaks need to be listening to everybody's
7 context and everybody's opinion.

8 And when you're in charge of an
9 outbreak investigation and people are apparently
10 not doing what you want them to do, or need them
11 to do, you need to be asking why that's
12 happening? And finding a solution to it as
13 opposed to feeling like people just aren't
14 listening to you. Because it's rarely that
15 there's not a reason for it. None of the
16 front-line providers here, whatever you can say
17 about anybody else, there's no front-line
18 provider in any of these organizations that's
19 not just doing their best for their residents
20 and patients every day.

21 So if things aren't working you need
22 to be asking why, I think, as opposed to saying,
23 you know, they just needed to listen to me and
24 nobody listened.

25 NITIN JAIN: Thank you, Dr. McGeer. If

1 I can just maybe carry on from there and just
2 talk about -- to highlight a few other areas of
3 concern for the Commission, based on hearing from
4 the UHN personnel.

5 The next one was around HVAC audit.
6 And what you might have heard during that was
7 that UHN wanted to get an audit done on the HVAC
8 system and Sienna was resistant to do that.

9 So we completely understand the need
10 of doing an HVAC audit. And what we wanted to
11 emphasize is that the inspectors coming to do
12 those HVAC audits in fact have a negative COVID
13 test, which is in compliance with the provincial
14 guideline, and at that point UHN thought that
15 was not needed. And in our view we wanted to
16 make sure that anyone coming into our building
17 has that COVID negative test. I went into
18 St. George during the height of the outbreak and
19 I had to wait for my COVID test because I knew
20 the management team would not allow me to visit
21 that home either.

22 Similar to what Dr. McGeer talked
23 about, the Clorox 360, I know there was also
24 reference about some confusion over the
25 disinfectants we were using at St. George. I

1 just want to highlight that at all times we were
2 using a disinfectant that was approved by Public
3 Health Canada. The difference was that when UHN
4 came in they were more familiar with another
5 disinfectant. And we happened to have both in
6 stock so it was easy for us to switch, because
7 there are some things there's no reason to argue
8 about. So I don't want, in any way, for the
9 Commission to have an understanding that we were
10 trying to use something which was not safe for
11 residents to do that.

12 And maybe continuing with the theme, I
13 would like Dr. Moser to talk about three other
14 areas which I know -- where we had a bit of
15 discussion with UHN, and that is around testing,
16 around cohorting of residents, and also the
17 movement of residents from one -- from hospitals
18 to -- back to St. George.

19 Dr. Moser.

20 DR. ANDREA MOSER: Sure. Thanks. And
21 thank you, Commissioner, for allowing us to
22 present today.

23 I think -- I just want to frame this
24 in terms of St. George and the population there,
25 I know Nitin alluded to it. When you look at

1 even on CIHI and you look at the statistics of
2 the population being served, this is a very much
3 younger population than other nursing homes. So
4 only 17 percent of the population there is over
5 the age of 85; 43 percent of the residents in
6 that home have dementia, which is compared to
7 around 80 percent, which is the average in
8 Ontario; and we have a younger than 65
9 population of almost 30 percent of the
10 residents; a higher percentage of male
11 residents; and, as Nitin agreed -- Nitin had
12 spoken, a large number of those residents were
13 marginally housed prior to coming to St. George,
14 many providing care support through the Public
15 Guardian and Trustee Office of Ontario; and a
16 high degree of people who are smokers as well.
17 So that presented an additional challenge in
18 managing the outbreak.

19 There was a -- I would say a lively
20 debate between our teams, between UHN and Public
21 Health and Sienna, around testing frequency.
22 And in other outbreaks that we've been involved
23 with, and since I came on in October sort of
24 setting some new expectations for the medical
25 directors and involvement in outbreak

1 management. So our medical directors sit in on
2 those outbreak management meetings, that are
3 daily during outbreaks. And they're hearing,
4 you know, it's testing every three days, or in
5 some cases testing every five days. And it
6 really depends on the outbreak, on the
7 availability of staff to do the testing, and
8 sometimes the residents themselves. And UHN
9 felt that it was prudent to have a five-day
10 testing strategy. Our concern was that we may
11 miss cases and not get on top of the outbreak in
12 enough time, so we really had asked for that
13 testing every three days, which was quite
14 reasonable.

15 And again, moving to the testing every
16 five days, with discussing the resident
17 population and that many of the residents didn't
18 want to be tested, were resistive to testing,
19 quite upset about having the testing. So the
20 feeling was, the balances was to move to that
21 five day, as recommended by UHN, which we did.

22 COMMISSION CHAIR FRANK MARROCCO:

23 Doctor, if you don't mind me interrupting for a
24 minute? When there's a debate like this, and
25 Dr. McGeer gave us a another example, who

1 resolves -- who resolves the issue? You've got
2 30 or 40 people on a call, professional people,
3 there could be 30 or 40 opinions. Who -- how
4 does it get resolved?

5 DR. ANDREA MOSER: That's a really
6 great question. Because ultimately, you know, I
7 think -- there is a bit of a power differential
8 here between -- I mean, Public Health has
9 incredible authority and they can give us orders.
10 So Public Health, at the end of the day, can come
11 in and say, Thou must do it this way. And we
12 will do it that way.

13 COMMISSION CHAIR FRANK MARROCCO:
14 Right.

15 DR. ANDREA MOSER: And same thing with
16 the hospitals we're seeing during COVID, and we
17 have had voluntary management agreements with
18 hospitals.

19 So at the end of the day we can put
20 our case forward but it's really felt that, you
21 know, if the hospital, who have much stronger
22 IPAC resources than the long-term care sector
23 does, that we're listening to the hospital.
24 Which is why in the case of the Clorox 360 we
25 said, Okay, UHN doesn't want to do this. Oh my

1 goodness, let's reach out our other homes and
2 make sure we're doing the right thing. So it's
3 really -- that give-and-take then is really a
4 collaboration and working together.

5 And what we have to have sight on is
6 the best decisions to make our residents as safe
7 as possible and our staff as safe as possible
8 and to contain the outbreak. We're talking
9 about reducing transmission, containing the
10 outbreak and making sure we're meeting the needs
11 of our residents in those communities.

12 COMMISSION CHAIR FRANK MARROCCO: But I
13 think probably all 30 or 40 people on the call
14 would agree that what they want to do is protect
15 the residents and protect the people working
16 there.

17 What's happening is a debate or a
18 dispute about how best to do that. And was it
19 the case then that Public Health, in that
20 situation, would make a decision about how the
21 issue of the bleach, for example, was going to
22 be addressed? Or was it left to Sienna to
23 decide whether it was going to accept the
24 recommendation, or the consensus, or the view,
25 or not? What actually happened? Was there an

1 order made?

2 DR. ANDREA MOSER: There was not an
3 order made. I think the context -- and I think
4 Alison can probably speak to this even better
5 than I can because she's been involved in so many
6 outbreak situations over time.

7 It is chaotic when there is an
8 outbreak and it is frightening. And it is --
9 there are a lot of moving pieces that are
10 happening all at the same time. So at the same
11 time that you're getting results in from testing
12 and you're setting up your next surveillance
13 testing, and you're finding out that some of
14 your staff may be positive.

15 So then you're trying to make sure
16 that we have all of our staffing filled so that
17 residents are getting the care they need. And
18 you're identifying how many residents may have
19 tested positive, and where are those residents
20 in the building? And who is their roommate?
21 And who have they been exposed to? And were
22 they a smoker or not? And did they expose
23 someone who is potentially on another floor?
24 This is a moving piece and it's a puzzle that's
25 continuously adding in new puzzle pieces that we

1 have to integrate into the plan.

2 And then we have extra supports coming
3 in. So the LHIN is coming in and offering us a
4 team of PSWs and RPNs and we're saying,
5 Fantastic. And the UHN is coming in and saying,
6 We're going to bring our IPAC leaders on site to
7 help you. Thank you. Come on site.

8 So when those people who are helping
9 and collaborating, working with us, are coming
10 in and saying -- and we're trying to understand,
11 how is our outbreak progressing? And they're
12 saying, We think it's related to something
13 you're doing with your disinfectants. We're
14 going to listen to that because these are
15 experts coming in and helping us.

16 And the meetings -- I can tell you the
17 meetings are collaborative. And someone will
18 have a perspective from the home, and then
19 Public Health will have a perspective from
20 Public Health, and then the hospital will have a
21 perspective, and you're working together. It
22 happens all the time in healthcare where
23 everybody has a slightly different view of it
24 and we work together and come up with a plan,
25 and we revise that plan, which is why you have

1 those meetings every day. And the team was
2 meeting every day separately, as well, trying to
3 stay ahead of this.

4 And it is an implosion when the cases
5 rise and you have the majority of your residents
6 in a home that has ward rooms and narrow
7 hallways. And you're trying to manage everybody
8 and you don't have some of your regular staff
9 because they now have COVID. And so you have
10 this unique population of residents who have
11 these relationships with the staff. And the
12 staff understand, they understand if this person
13 doesn't get their breakfast right at the same
14 time they are not going to have a good day. And
15 the new team coming in might not know the small
16 things of each individual resident.

17 So it's really -- this is really,
18 really hard. And it's -- I don't think we can
19 express enough how hard this is to manage, all
20 of these moving pieces, and get it 100 percent.

21 I don't know --

22 COMMISSION CHAIR FRANK MARROCCO: Did I
23 take from what you said then that,
24 notwithstanding that there were 30 or 40 people
25 on these calls, and a variety of different

1 opinions, that this process was working?

2 DR. ANDREA MOSER: We felt very
3 supported on the ground by the teams that were
4 coming in. I was on site. We were working
5 with -- I was making sure that we had -- it's
6 clear when you have a long-term care home that
7 has 150 plus residents and you're now at -- you
8 have 35 residents who have COVID, and then you
9 have 50 residents that have COVID, and then five
10 days later you have 80 residents with COVID. You
11 cannot do things the way you usually do things.

12 So also a lot of those calls for us
13 was, how many more nursing staff do we need?
14 How many more personal support workers do we
15 need? Do we have enough PPE in stock? What is
16 our medical supports in that home? And we
17 ensured that we had at least one physician and
18 one nurse practitioner on every day.

19 Because it's not the same, usual
20 long-term care. Now you're running an acute
21 care hospital, or subacute care hospital, or
22 however you want to call it, in a nursing home.
23 We've got fluids being given, frequent checks of
24 residents' status. We're having a lot of people
25 who are having daily -- changing status quickly.

1 It's not about a physician coming in once a week
2 and seeing their residents and seeing a couple
3 of people who might be sick. This is now -- we
4 need to have a primary care team on board, and
5 nursing team, and personal support workers who
6 can support a large number of people who may be
7 developing more severe symptom.

8 NITIN JAIN: Dr. McGeer, do you want to
9 add? I know you have been on other outbreak
10 calls with probably, you know, during other kind
11 of outbreaks. Anything you want to add to that,
12 Dr. McGeer

13 DR. ALLISON McGEER: Yeah. I think --
14 so technically Public Health, the local Public
15 Health unit is in charge of outbreak decisions.
16 And as Andrea has pointed out, if they don't like
17 what is happening with an outbreak they have the
18 authority to write a Section 22 order and be
19 definitive about telling you what to do.

20 And, I mean, they -- Public Health
21 units very rarely write such orders and they're
22 very rarely definitive. They -- it's just in
23 the nature of Public Health that they're there
24 to support people and provide advice.

25 And I haven't -- it has happened over

1 my career that health units have written Section
2 22 orders, but it's really rare in outbreaks.
3 Usually you are dependent on a collaborative,
4 consensus process.

5 One of the things that's hard here is
6 that, generally speaking, outbreaks in long-term
7 care homes have been, preCOVID, pretty standard
8 okay? They're mostly respiratory or enteric or
9 influenza, and there's really clear rules about
10 how you manage them, and everybody knows them.
11 And there's not a lot of backing-and-forthing
12 and difficult decisionmaking.

13 Hospital outbreaks tend to be a bit
14 more complex. And Public Health and hospitals
15 have relationships where you negotiate whatever
16 is happening.

17 And when I'm doing something that is
18 technically different from recommendations then
19 the expectation is that I put a pitch in to
20 Public Health to say, This is what I'm doing
21 that is maybe a little different than usual and
22 here's the reasons why I want to do it. And we
23 have a discussion about what we can do. And
24 they can always say to me, No, you cannot do
25 that, and I would have to listen. But it's

1 really rare that you can't get a consensus about
2 the best way forward, even on these calls.

3 But you're right. It is -- it's
4 harder with Zoom calls, with a lot of people on
5 them, to be sure that you're getting that
6 consensus. It's harder to be sure that people
7 understand what the consensus is, because
8 there's so many people with so many agendas and
9 so much going on. So I think it's been an area
10 where it's hard enough that it -- there's a lot
11 of room for misunderstandings on these calls,
12 even when everybody is trying to do their best.
13 I've not seen -- I've not been on a call in
14 which the group of people on the call hadn't
15 been able to reach consensus about what they
16 think they're doing and where they're going.

17 But I also haven't managed an outbreak
18 in which what I think is going on on the ground
19 is always what is going on on the ground, right?
20 There's always this gap between what I think is
21 happening as a manager and what may actually be
22 happening when people are delivering care on the
23 front line. And that's something in an outbreak
24 that has to be watched really carefully. And
25 it's -- there are very few people that I've seen

1 in my lifetime, okay, Elizabeth Rea, who's our
2 lead investigator for managing outbreaks at
3 Public Health, and the guys from the CDC who run
4 the epidemiology intelligence service managing
5 outbreaks at a distance, those are people who
6 are really good at being able to listen to what
7 is being said on a call and to be able to
8 understand from that what the problem on the
9 ground is. But that skill is enormously
10 difficult to learn.

11 So we've had this -- us in the
12 hospital sector trying to help long-term care,
13 which is contextually different. And honestly,
14 the people we've had on from Public Health have
15 not always been the most experienced Public
16 Health people. Public Health is managing huge
17 numbers of outbreaks at any given time, and
18 they're trying to do contact tracing, and
19 they're stretched beyond belief. So they've had
20 to train a lot of new people to help manage
21 these outbreaks. And so it -- at the end of it
22 is I think it's entirely by consensus and,
23 generally speaking, I think achieving consensus
24 on those calls has -- has not usually been
25 difficult.

1 COMMISSION CHAIR FRANK MARROCCO: So
2 then notwithstanding the number of people on the
3 call, and notwithstanding the consensual nature
4 of the decision making, the process worked?

5 DR. ALLISON McGEER: Well, you can look
6 at that two ways. I think the -- I think the
7 process worked in the sense that we figured out a
8 way forward. I don't think any of us are happy
9 about the fact that, you know, when we had --
10 once these large outbreaks were established it
11 was almost impossible for anybody to successfully
12 contain them effectively.

13 And so, you know, the question of, the
14 process worked as well as the process worked
15 because people could achieve consensus and work
16 together? Or the process worked because you got
17 the outcome you wanted? And we didn't. In very
18 few of those outbreaks did we get the outcome we
19 wanted.

20 JOHN CALLAGHAN: Can I ask, Dr. Moser,
21 Ms. Richards testified and said:

22 " I think the thing that always
23 struck me with St. George is that we
24 were really concerned and we couldn't
25 somehow get the leadership on the

1 ground or corporate leadership,
2 because before the voluntary
3 management order, we did escalate up
4 through the senior team that there was
5 sort of a lack of urgency across all
6 of the leadership [...]."

7 That was the testimony of
8 Ms. Richards. So A), what do you say to that?
9 And, secondly, what was the structure pre and
10 post voluntary order? You've talked about
11 having lots of people on the ground, but what is
12 the structure in the home and how does it change
13 through this process?

14 DR. ANDREA MOSER: Sure, I can try to
15 address that.

16 I think the -- again, the -- we had
17 already brought in an IPAC lead at the beginning
18 of this outbreak. UHN had been in and out
19 because St. George had had a few outbreaks in
20 wave 2 that were contained and small, mostly
21 with staff and had been managed.

22 In terms of when we started to see the
23 numbers increasing is when I became actively
24 involved in the outbreak in terms of attending
25 all of the calls, and then on site, and that was

1 around mid-December.

2 And our teams are in place that when
3 it gets to a point when we know we need more
4 supports on the ground. So before the
5 management order we did have discussions and
6 calls with UHN and Public Health and they were
7 identifying areas that we needed to work on.
8 They identified some changes to what our PPE
9 practices would be to support the outbreak, and
10 we were listening and we were implementing that.

11 And in terms of the leadership in the
12 home, there's an Executive Director, there is a
13 Director of Care, there is a Medical Director
14 and there are Associate Directors of Care who
15 support the nursing team, as well as providing
16 some additional supports on the mandatory
17 clinical programs. There is social services
18 support, recreation therapy, behaviour support
19 lead in that home.

20 When the outbreak started to increase
21 we identified that there was a need for
22 increased leadership support and so brought in
23 another Executive Director from another home who
24 had experience, actually previously was involved
25 with St. George as well so knew the home and as

1 well as knew how to manage outbreaks.

2 And I stepped in as well to support
3 the medical team and organizing the medical
4 leadership in the home and the primary care
5 supports.

6 JOHN CALLAGHAN: Dr. Hota testified
7 that they had an ADOC who was given the title of
8 being "IPAC lead" but unfortunately did not have
9 any IPAC training; and was asked to get training
10 repeatedly but it didn't happen over the course
11 of this outbreak. So did that happen? And how
12 does something like that happen?

13 And after I'd like to hear Dr. McGeer
14 because she's already testified and talked to
15 the Commission in the past about the difficulty
16 of training for IPAC in that period. But did
17 that happen? And is that pervasive across
18 Sienna's homes where an IPAC lead is not
19 trained?

20 NITIN JAIN: I know there was a course
21 of four hours which that IPAC lead did not
22 complete. And you're correct, that course should
23 have been completed. But the same person has
24 been a registered nurse for 15 years and,
25 respectfully, I would say, if a four-hour course

1 makes someone an IPAC expert we would not be in
2 this situation. So I'm not in any way defending
3 that people should -- she should have done the
4 course, yes, he should have.

5 We are in the middle of an outbreak.
6 That home was in the fourth outbreak so it's
7 difficult to take the time.

8 And I would like to hear from --
9 Dr. McGeer did have a view on, you know, that
10 person, and also in general the other resources
11 she had. We had a corporate person who was IPAC
12 trained who was on site. We have IPAC courses
13 from Dr. McGeer and Dr. Moser there. In fact
14 there's a biweekly webinar we were doing
15 starting in August that people were attending on
16 a regular basis.

17 So, yes, a four-hour course was not
18 completed but I would not say that that person
19 didn't have any expertise in IPAC.

20 COMMISSION CHAIR FRANK MARROCCO: Just
21 a second. Dr. Moser, you were trying to say
22 something I think?

23 DR. ANDREA MOSER: I was just going to
24 say, my understanding was much to what Nitin had
25 just said. That she had taken our internal

1 infection prevention control courses and -- but
2 that that specific four-hour course, we have
3 learned, wasn't done.

4 JOHN CALLAGHAN: Well, then -- and
5 we'll hear from Dr. McGeer, but, Nitin,
6 appreciate hearing from you. How do we solve
7 this problem going forward? You just yourself
8 said a four-hour course is inadequate.
9 Dr. McGeer has already told this Commission
10 repeatedly it's inadequate. So A), how do we do
11 it? Where is the funding coming from? How do we
12 get past this to the next stage?

13 So I appreciate hearing from both, or
14 all three of you on that point.

15 NITIN JAIN: Sure. I would say I'm not
16 an IPAC expert and that's why we have Dr. McGeer,
17 I will let her chime in.

18 Just from my perspective, and I think
19 I did give a bit of a view in October, that
20 long-term care -- the type of outbreaks we dealt
21 with, as Dr. McGeer talked about, is influenza
22 outbreaks. It was one home at a time. You kind
23 of lock everything -- everything around you is
24 -- the world is running as normal. Your entire
25 company is not in crisis, hospitals are not in

1 crisis, public health is not in crisis. People
2 understand what medicine you can take to contain
3 influenza, versus what was happening in COVID

4 And one of the things which, you know,
5 I understand was part of the Commission's
6 interim report, was also around having
7 individual expertise on IPAC for each home.
8 And, you know, given what has happened with
9 COVID that that is probably where we might be
10 headed, where you need people who are well
11 trained on COVID kind of infections rather than
12 influenza, because it might actually take
13 completely two different types of training to do
14 that.

15 That's just my limited view
16 perspective. And I would ask Dr. McGeer to add
17 because I know she's an expert in this area.

18 DR. ALLISON McGEER: Yeah. So
19 specifically on this I think people not doing
20 infection control courses is not defensible. On
21 the other hand, thinking that having done that
22 course was going to have made a difference to the
23 outcome of this outbreak is not helpful.

24 Sienna did have CIC-trained IPAC
25 people on the ground at St. George. It's --

1 from early in December there was a switchover in
2 the middle of December and that probably wasn't
3 ideal.

4 And I think, you know, the new -- the
5 new CIC-trained IPAC people that Sienna hired,
6 we're up to five now I think, were still new.
7 And it's -- it's so much easier to be capable
8 when you know the organization and when you know
9 the homes and when you're familiar with what's
10 going on. So I don't think there was any
11 question that IPAC support was inadequate.

12 And as I've been sitting listening to
13 this this morning I've actually been thinking
14 about the fact that, you know, even at the
15 Provincial Infectious Disease Advisory Committee
16 discussions where we've all been watching the
17 next, slower-moving but potentially just as
18 dangerous pandemic, which is called
19 "antimicrobial resistance", and we've not been
20 controlling transmission of
21 antimicrobial-resistant organisms in long-term
22 care. And when we had the discussion at PIDAC,
23 when I was still a member, there's this --
24 there's this sort of desperation that we haven't
25 figured out how to manage the prevention of

1 transmission of infection in places that are
2 supposed to be homes to people where we need to
3 provide care. And PIDAC, to my mind, kind of
4 walked away from taking seriously the prevention
5 of transmission of antimicrobial resistant
6 organism in long-term care because we just
7 didn't see that we could effect that change.

8 So I'm really hoping that one of the
9 things that will come out of this pandemic is
10 that we can sit down together and try to work
11 out a way where we can provide home to people,
12 and care to people and good infection prevention
13 at the same time.

14 I'm -- you wanted me to answer where
15 we were going to get resources for it and the
16 answer is, I don't know. I'm pretty sure,
17 because I've spent a lot of time in infection
18 prevention, that wherever those resources came
19 from that if we could talk people into investing
20 them that it would pay back in reduction in
21 illness and death, and savings to our healthcare
22 system. But I also take the point that it's
23 really hard to get people to invest in
24 prevention. And I'm -- I don't know whether we
25 can persuade the government, long-term care

1 operators, anybody else that we can to do this
2 going forward.

3 COMMISSION CHAIR FRANK MARROCCO: Just
4 before you follow-up, Mr. Callaghan, I'm trying
5 to understand what part of -- what difficulties
6 flowed from the fact that this was someone's
7 home? We have heard from several groups of
8 residents, and their families, about the loss of
9 the right to visit, people confined to their
10 rooms for extended periods of time, infringements
11 on people's basic rights that are significant.
12 And so I'm trying to understand why the fact that
13 this is someone's home posed any restriction at
14 all to any preventative measures? It seems to me
15 the people living there during this pandemic had
16 virtually no rights.

17 DR. ALLISON McGEER: I think you're
18 right, but there are -- there are still
19 challenges.

20 So let's start with cleaning and
21 disinfection. You -- a lot of argument about
22 how important it is for COVID-19, but it's
23 really easy to do in the hospital and very
24 difficult to do in long-term care because people
25 have their own possessions.

1 We -- despite the fact that we took a
2 lot of freedom -- one of issues is we need to
3 try to figure out how to do this without
4 removing those freedoms and restrictions.
5 Right? This is -- its indefensible to me that
6 we couldn't figure out how to do this, that we
7 couldn't stop COVID transmission but that we
8 also could only do what we could do with this
9 terrible infringement of rights. That's clearly
10 not acceptable.

11 But still -- we still let people use
12 dining rooms, right? People have to eat
13 somewhere. And we -- and until people were in
14 outbreak we did not say, You have to eat in your
15 room. Because that's clearly -- it's obviously
16 important to people. We have not said, in
17 nonoutbreak homes, that there are no activities.
18 We have really substantially restricted them but
19 we haven't said nothing.

20 So there is -- there has been this
21 ongoing drive in all of the homes to try to get
22 people something. And it's not -- I'm not
23 defending it as adequate. I'm not defending it
24 as reasonable. But it does interfere with the
25 ability to control COVID transmission.

1 And it is -- you know, in hospitals
2 you can do -- we actually said in hospitals, and
3 I'm not defending this as right either, we said
4 No visitors. Under no circumstances. We've
5 allowed people to die alone because we won't let
6 single people into the hospital because we think
7 it's too dangerous.

8 At least we got essential caregivers
9 back into long-term care because in long-term
10 care it's more important. So you can't
11 impose -- and we are used to imposing many more
12 restrictions in hospitals than we -- than we can
13 do in homes because it's short term and we have
14 more control over it. But it isn't -- despite
15 the awfulness of what happened to people there
16 were still restrictions that were not imposed
17 that would have reduced the transmission of
18 COVID, because people just couldn't do them.

19 We could have emptied all the rooms of
20 people's belongings and taken all the soft
21 furniture away and made it possible to clean
22 things. We could have been much more willing to
23 move people from place to place in the home in
24 cohorting and disrupt their lives. We could
25 have said, You have to eat every meal in your

1 room off disposable cutlery for 18 months. So
2 there's some things that we can do in hospitals
3 that even in the worst circumstances you can't
4 do in homes.

5 JOHN CALLAGHAN: And I was going to ask
6 you, you had -- you said you're not an IPAC
7 specialist but you were the CFO so I assume
8 you're a financial expert. We've heard that an
9 IPAC specialist is about \$120,000 with benefits,
10 et cetera. Dr. McGeer, Dr. Johnston and others
11 have recommended, at the very least, one fully
12 IPAC trained, and with a new training system, per
13 200 residents. The government announced
14 \$20 million for IPAC, which is only about \$30,000
15 a home. And I guess the question is, is Sienna,
16 and do you think the rest of the industry, is in
17 a position to make that commitment to have the
18 fully trained IPAC specialist with the current
19 funding envelopes, et cetera?

20 NITIN JAIN: Sure, counsel, maybe I can
21 just give you of view of what we have been doing.

22 In 2020 at Sienna we spent \$52 million
23 on pandemic. Whether it was extra team members,
24 whether it was personal protective equipment,
25 whether it was IPAC expertise. And we are very

1 grateful that the government covered around 37
2 million of the 52. So we did the 15 and we
3 think that's our part of doing that, and we'll
4 continue to do this until this pandemic is over.

5 But that's not a long-term solution.
6 Because I think you have heard from others that
7 this is -- people don't make any money off the
8 care, you make money through accommodations, and
9 there is a small margin to do that.

10 So short-term, yes, the answer is
11 industry and people, like others, will continue
12 to do it. But this is -- that is not a solution
13 long term. Because 20 years ago -- the funding
14 formula has been the same for many years. And
15 you might have heard from people around, we
16 recalibrate as people get -- come with more
17 acute healthcare needs you might get more
18 funding. Actually that's not exactly true.
19 What happens is, if you want to get \$100 and
20 your health index goes to 105, the 105 becomes
21 your new 100, so everyone gets the same. You
22 say, okay, well now you're going to get the same
23 amount of money because the previous 100 is now
24 105. So it's -- so, you know, again, what the
25 Commission came in the interim report around

1 additional staffing, people in long-term care
2 have been talking about it for multiple years
3 because the acuity level is very different.

4 I go into long-term care homes, I've
5 been to 30 of them since the pandemic started.
6 You still have residents who moved in when that
7 home was built in 2006, so they've been living
8 there 14 years. But most of the people coming
9 today, counsel, they live for less than a year
10 in those long-term care homes. So the need is
11 very, very different versus the staffing is
12 still what it was 15, 20 years ago. So I think
13 IPAC is one area, you're correct, that we need
14 to address. But it also goes to more PSWs, it
15 goes to more nurses.

16 And just funding alone, which is very
17 welcomed, and I know the province of Ontario has
18 announced additional staffing hours, we actually
19 have to find these people. So during this
20 pandemic we have been actively looking for
21 people. At any -- we have hired close to 3,000
22 team members, some of them replacing, some of
23 them adding new. At any given time we have 500
24 vacancies. We have twelve people on an
25 every-day basis looking for people to join.

1 And Dr. Kitts might have a view
2 running one of the bigger hospital systems in
3 Ontario, I've been told many hospitals have
4 nursing staffing in hundreds shortages.

5 So, you know, and we talked about
6 there might be a wage difference between
7 long-term care and hospitals. So it's just not
8 about funding, it's just not about the
9 willingness, it's also how do we get more people
10 into long-term care? Whether it's PSWs,
11 whether it's registered staff and infection
12 prevention control expertise.

13 So to your point, people will be very
14 willing. No one wants an outbreak. Even from a
15 financial perspective cost goes three times, but
16 that's the last of the worry in an outbreak.
17 People are worried about people's lives, they're
18 worried about employees getting sick. So no
19 one wants this outbreak. And if hiring an IPAC
20 expert for 100,000 would solve it we would be
21 all for it.

22 JOHN CALLAGHAN: Can I ask a very
23 specific question then?

24 NITIN JAIN: Sure.

25 JOHN CALLAGHAN: Because the Commission

1 has heard from the government and they've gone
2 through the funding envelopes, and they've
3 referred to funding envelope number 4, which is
4 the one which is, frankly, the government
5 represents is going to go to other benefits to
6 the residents. And then there's the global per
7 diem of which they -- you know, two-thirds has to
8 go to fixed funding and the first three
9 envelopes.

10 But after you pay for overhead, front
11 office expenses, profit, et cetera, how much of
12 envelope 4 would actually go back, realistically
13 go back into the care of the residents? I mean,
14 is the government -- is it a proper
15 representation to say it's available after
16 you've taken all these -- and servicing of debt,
17 because you've got huge capital costs.
18 Realistically how much of envelope 4 actually
19 gets back into care?

20 NITIN JAIN: Counsel, maybe if I might
21 simplify it? I would say it's really two
22 envelopes. The first one includes care, it
23 includes food, it includes recreation programs,
24 and you might have a bit of flexibility on moving
25 them, and you cannot really make any money off it

1 so you have to invest all of it.

2 The last -- the second envelope, let's
3 call it that, other accommodation, it in fact
4 comes from the resident but the government takes
5 it, and then takes a bit of money off it to
6 cover some expenses, and then we get the money
7 from it. Most of it goes to all the overhead
8 and all the things we talked about.

9 So if you look at long-term care
10 homes, and you had some other people, as more to
11 give you a sense of the risk that is increased
12 in this -- in this sector as well. So
13 essentially when you're providing care we are
14 saying we need to -- if someone wants to be in
15 the business of long-term care you have to do a
16 very good job of providing care otherwise your
17 license is taken away. So being able to collect
18 rent you would only get the ability if you
19 provide care.

20 So there is really not much ability to
21 take that -- and to give you a sense, that other
22 accommodation envelope is \$55 per resident, and
23 the rest of it is in the 150. So I just want to
24 give you a sense, it's not the other way around.
25 And the \$50 per day from each resident you're

1 paying all your admin staff, you're paying
2 housekeeping, you're paying food servicing
3 staff, you're paying utilities, you're paying
4 property taxes, you're paying interest expense,
5 and you're paying some of the money back to your
6 investors who initially gave you the money. So
7 it is, in fact, not a lot of money left over on
8 an each-home basis, or an each-bed basis that
9 you can substantially make a change.

10 I gave you an example of us investing
11 52 million and you got funded for 37 of it.
12 That is not a sustainable formula for anyone. I
13 mean, you have municipal homes which get
14 additional \$50,000 per bed for each resident
15 because they can -- they have to go ask the City
16 to do that. And that is a good enough indicator
17 that the funding we have today is not adequate
18 to manage for everyone.

19 And for a municipal home you can go to
20 the City, in our case we just invested it. But
21 for a municipal home if they don't get the
22 funding from the City it is not a viable
23 scenario for them. And the same applies to us,
24 counsel.

25 COMMISSION CHAIR FRANK MARROCCO:

1 Mr. Jain, I'm just having a little difficulty.
2 If the funding isn't adequate why would anyone
3 want to be in the business?

4 NITIN JAIN: Commissioner, I don't want
5 to make it all apple pie, but I would tell you,
6 once you go into a long-term care home, you
7 know -- and I would actually ask this question to
8 many team members. Because when I went to
9 St. George there is a camera recording 24/7 of
10 who goes in and out from that home.

11 So not only -- in better times, during
12 this time you would ask, Why would anyone want
13 to work in long-term care? And when I was at
14 St. George one of the first employees I met she
15 was -- it was the first day back from COVID.
16 She was out sick for fourteen days and she was
17 coming back. And she said, I couldn't wait to
18 come back, even though I was sick for a few
19 days, because I want to make sure I want to take
20 care of my residents. And I don't want to give
21 you a picture that everyone is as passionate,
22 but that's a good chunk of people in long-term
23 care. So we trully believe that people who are
24 in this sector they are doing it because it is a
25 calling and it is the right thing to do.

1 But you are absolutely correct, the
2 risk framework has changed from what it was 15,
3 20 years ago. There's been all this
4 conversation about for-profit, not-for-profit.
5 So last six years the previous government wanted
6 to redevelop 30,000 bed, they wanted to add
7 15,000 beds. No one stopped any municipality,
8 or any not-for-profit, or any charity, or any
9 hospital to build the beds. No one built them
10 because it was not a viable scenario to do that.

11 So now the new government which has
12 come in there is a new program which seems to
13 work for some homes. And they've publically
14 made an announcement to spend \$600 million in
15 redeveloping these homes. But you're right, the
16 risk profile is changing. And one of the things
17 we -- as you look at what the right
18 recommendation is from the Commission, is
19 there's a huge amount of capital that is needed
20 to upgrade this.

21 The 30,000 beds which need to rebuild,
22 that just solves the problem as of today. It
23 still does not solve the 38,000 people waiting
24 in the waiting list. And home care is a Band
25 Aid in these cases, it is not a solution.

1 People in long-term care need 24/7 support when
2 they need it. It's not someone who can go there
3 for two hours and provide them -- in most cases
4 families are somehow managing it.

5 So the idea would be, how do you
6 ensure that more investment continues to flow
7 into long-term care? Because the need of that
8 investment is only going to go up higher not
9 less, Commissioner.

10 COMMISSION CHAIR FRANK MARROCCO: I
11 don't know that -- I understand what you said,
12 I'm not sure that it's responsive.

13 If there's no -- if the funding is
14 such that the transaction doesn't make any sense
15 why are people in it? Why is Sienna in it?

16 And I appreciate what you said that
17 the individual personal support workers are
18 motivated by -- perhaps motivated by concern
19 other than money, but the investors are a
20 different class of person.

21 NITIN JAIN: Sure, Commissioner. The
22 reason why investors or capital still likes
23 long-term care because in the past it was always
24 meant as infrastructure. So when people invest
25 in a long-term care no different than what we

1 invest.

2 So we have two lines of business, our
3 retirement business and our long-term care
4 business. When we buy a retirement home we have
5 an expectation, if it makes \$100 today each year
6 that number is going to go a little bit higher.
7 Maybe 102, then 104, then 106, then 108.

8 When people invest in long-term care
9 they say, I'm going to get \$100 today, I'm going
10 to get \$100 the next year, I'm going to get \$99
11 maybe the year after, maybe 101 the year after,
12 then 100 the year later. So people invest in
13 long-term care for consistency, they're not
14 looking for growth.

15 And one of the big differences -- what
16 Canada has done right versus United States, for
17 example, there is a lot of skilled nursing home
18 in the United States and a lot of time people
19 compare that to long-term care. And the big
20 issue is you have funding that goes up,
21 depending on which party is in power, there is
22 funding that goes down. So the reason why
23 people like the long-term care portion is it's
24 infrastructure like, in the past; it would not
25 have the kind of risk which we saw in COVID-19;

1 and the \$100 that you were expecting on a
2 regular basis you always used to get around that
3 \$100. You were never going to become a
4 millionaire, it was not like an Amazon
5 investment, but you also never lost your shirt.

6 So that has been the pieces of why
7 people continue to invest in long-term care.
8 But you're right, that formula did change six
9 years back where people are not investing into
10 long-term care because the risk versus the
11 reward equation has not been right for the last
12 six years.

13 COMMISSION CHAIR FRANK MARROCCO: So
14 just, and then I will leave it for Mr. Callaghan
15 to go back and ask his questions.

16 The type of person who invests in
17 long-term care, in your estimation, is someone
18 who is interested in a relatively modest but
19 stable rate of return, is that what you're
20 saying?

21 NITIN JAIN: That is absolutely,
22 correct, Commissioner.

23 And just again, maybe to give you an
24 another data point, the margin that you make in
25 long-term care is around 12 to 14 percent. And

1 the margin of what people might make in
2 retirement business might be 50 percent, because
3 you set your own rates, it has a bigger
4 accommodation, you're investing a lot more money
5 up front, there is no government grant, you take
6 a lot more risk so there is an expectation that
7 you will have a return.

8 People continue to invest in long-term
9 care because the return is relatively low but
10 it's a stable, predictable return over time.

11 COMMISSION CHAIR FRANK MARROCCO: Thank
12 you.

13 JOHN CALLAGHAN: And before we get back
14 to the presentation, while we're on this topic,
15 is it your view that there is sufficient capital
16 with respect to this new program the government
17 has issued to build the 30,000, 15,000 new and
18 15,000 redeveloped, beds? And I know it's not on
19 the back of Sienna. I'm not suggesting that
20 Sienna is going to do it, but we had asked that
21 of Morrison Park, as you know, so I thought I'd
22 ask.

23 NITIN JAIN: Sure. I would say,
24 counsel, there are a few things that have changed
25 with the new funding formula. Now, it still does

1 not work for all 30,000 beds. It is still going
2 to be challenging for GTA sites.

3 Previously the problem with the
4 formula was, if you were building in Thunder Bay
5 you are going to get that same amount of money
6 if you were building on Yonge and Eglinton where
7 the land cost is around 15 times what it might
8 be in Thunder Bay. That has now changes where
9 if you are in bigger cities you get a bit more
10 money, you get some money up front, so the
11 formula is getting better. But there's still --
12 I don't think this is a solution for everything.

13 One of the things that -- I don't know
14 if you have heard from CMHC or not, but in most
15 of the provinces you can borrow CMHC financing
16 to build long-term care where your interest rate
17 might be half. That is just not a benefit to
18 companies such a Sienna, it's a benefit to
19 charities, not-for-profit, to municipalities, if
20 you like. But there's no CMHC program in
21 Ontario, which we have been trying for last six
22 years to make it happen. It does not cost the
23 government any money. It's frankly you're
24 providing a guarantee to CMHC and you can borrow
25 money for a lot less.

1 So there are opportunities to invest
2 in this because of the infrastructure
3 characteristics this has. Again, as I was
4 answering Commissioners Marrocco's question, so
5 there is capital interested in this, counsel.
6 It is not a long list of people who want to
7 invest. And again, what people are looking is
8 for that stability going forward.

9 And the direct care hours, we have
10 been -- this whole sector has been advocating
11 for more direct care hours because the acuity
12 level has been changing but the direct care
13 hours have not.

14 JOHN CALLAGHAN: And one last question
15 before I get back to the rest of it. Sienna has,
16 and I don't have the number off the top of my
17 head, but you have made commitments with respect
18 to both redeveloped and new beds. And we talked
19 last time about some of the challenges of going
20 from approval to actually construction. And can
21 you just update the Commissioners in respect of
22 the beds, you know? When would your beds come on
23 line? And are those challenges still there that
24 I think we spoke with you about last time?

25 NITIN JAIN: So, counsel, there are two

1 kind of challenges. The first challenge is from
2 a ministry approval perspective, and the second
3 challenge is the municipal perspective, finding
4 land and taking it through the zoning.

5 So we have three projects which have
6 been in the pipeline for a bit of time before
7 this new funding formula came in, and then
8 everyone has been overwhelmed with the pandemic.
9 But our goal at Sienna is to start with two
10 projects. Both -- we would like to start with
11 two projects in GTA which are -- we have applied
12 for additional licences so that those projects
13 need to be approved. I do not know the timing
14 of it but I do understand, in working with the
15 ministry, there is a sense of urgency to ensure
16 we get those things approved sooner rather than
17 later. Because we have had projects in the past
18 where we bought land four years ago and there
19 was still challenges to approval. But now we
20 eventually have those approvals with the current
21 government and our goal would be to rebuild
22 them.

23 But it is -- it is a long process and
24 I do understand the government is working to
25 simplify it or to put a bit more streamline to

1 it.

2 JOHN CALLAGHAN: On average what is the
3 process from application to approval, and then
4 approval to -- not the process but the timeline.
5 From application to approval and approval to
6 build? We heard from the Financial
7 Accountability Office who had an expectation of
8 so many homes to be built by 2023, 2024, and
9 sensing the timeline is not going to quite work
10 for that.

11 NITIN JAIN: Counsel, it used to
12 previously take around two years to get your
13 application approved, and once your application
14 is approved it would usually -- construction
15 would take two, two and a half years. So around
16 four and a half years from when you start, that's
17 why we have 2200 of these beds.

18 And you have a question on overall
19 Sienna and infection rates and death rates. And
20 a big part of it, and I think you've heard from
21 other people, is the location. So many of our
22 homes, which used to be a matter of pride for
23 Sienna, which has been very difficult during
24 COVID, that we have the most percentage of homes
25 in GTA than any other chain, than not-for-profit

1 and municipalities.

2 So we have -- St. George is right next
3 to University of Toronto. There is -- it is so
4 hard to find land there, counsel, to build
5 anything. It basically is impossible.

6 We have close to 800 beds in
7 Scarborough, another area where the infection
8 rates in the community are extremely high. We
9 have around 600 beds in Mississauga where
10 infection rates are extremely high. We have
11 homes in North York where infection rates are
12 extremely high. We have homes in Woodbridge
13 where infection rates are extremely high.

14 So our goal so to get these 2200 beds
15 built. It's the right thing to do for
16 residents, it is the right thing to do with team
17 members.

18 But Commissioner Marrocco has a very
19 good question, I think. Whether it's lenders or
20 whether it's investors, they want to understand
21 that this is stable, and just not for Sienna's
22 lenders or Sienna's investors' stake. We talked
23 about 30,000 beds, 15,000 additional, and I
24 think that just scratches the surface because
25 you have another 38,000 people on the wait list.

1 And people always talk about this is just the
2 beginning of baby boomers retiring. I think
3 that list is only going to get bigger and bigger
4 over time.

5 JOHN CALLAGHAN: Sorry, to go back
6 to -- we took a little side detour on the
7 economics of it.

8 NITIN JAIN: So the next area I wanted
9 to discuss was really, you know, there was
10 conversation about the weak leadership at
11 St. George, and I know some of it was already
12 touched on in terms of the courses.

13 I just want to give you a sense -- I
14 did talk about the constant media attention that
15 home had, and everyone should have a right to
16 know what's happening. But it was extremely
17 hard for staff, you know, coming during an
18 outbreak. When I went to St. George I think
19 there were around a hundred cases at that point.
20 And even with personal protective equipment you
21 have -- you are worried about your health. And
22 I could clearly understand what our team members
23 are going through. And then you have a camera
24 with 24/7 recording. So our team members, for
25 lack of a better word, were frankly crossing a

1 media line to get there.

2 So this same team which had a lot of
3 difficulty in the fourth outbreak, managed three
4 other outbreaks, and because of the community
5 spread around them, and this is again Dr. McGeer
6 might be able to add a bit more how these
7 outbreaks work. We were in outbreak for the
8 first three outbreaks for close to a hundred
9 days with three active cases all together
10 combined in the first three outbreaks. So the
11 same team which had difficulty in the fourth
12 outbreak, for the first three outbreaks was able
13 to contain that to less than three people. And
14 the number of team members I think all combined
15 was close to ten in all of those three
16 outbreaks. So they had a very good outcome in
17 the first three outbreaks, and the third
18 outbreak was in fact during the wave 2, which
19 was in the month of November. So they had good
20 fortune with that.

21 And really when you go to that home
22 you realized team members were exhausted, this
23 was the fourth one that they were dealing with.
24 And what my duty as a leader is is to ensure
25 that I'm really putting the full picture of

1 St. George to you so you understand we were not
2 resistant, we had a point of view. And when we
3 realized that our point of view was not accurate
4 we were easy to change it.

5 And Dr. McGeer might have given you a
6 bit of perspective about how it was not as
7 simple to just listen to one advice. Because we
8 had sixteen other outbreaks with many different
9 hospital partners, many different public health
10 and at times we were hearing different things
11 altogether.

12 So I just -- on behalf of everyone at
13 Sienna I just want to thank you for the
14 opportunity to talk about St. George, and to
15 ensure that our team members know that we have
16 their back when it comes times to defend them
17 and to thank them for what they have done.

18 I just wanted to see if Dr. Moser and
19 Dr. McGeer having anything more to add on the
20 leadership team at St. George?

21 DR. ANDREA MOSER: I can add to that.
22 I think, you know, we had a team that was a newer
23 team and they had done well in wave 1, they had
24 done well in the beginning of wave 2. Families
25 had great confidence in them. They had great

1 relationships with their residents. They knew
2 their residents well.

3 And then when the numbers -- we talked
4 about that implosion or that, you know, that
5 increase in numbers. There comes a time when
6 can this team still support? And you never
7 really know fully, you can predict human
8 behaviour and you can predict how exhausted is
9 one, and you can predict how quickly can someone
10 shift and change. And there are so many factors
11 in this. And when we realized that the team on
12 the ground was struggling and we needed to put
13 in extra supports we put in those extra supports
14 and worked with them and supported them.

15 And that included, as we talked about
16 before, the medical team. You know, I needed to
17 get on the ground and say, How are we doing
18 rounds? How are we organizing ourselves? How
19 are we making sure we're getting the assessments
20 that need to be done? Are we calling families
21 and having those advanced care planning
22 discussions? How are we organized our
23 communications? How are we all working together
24 as a team? What extra supports are we getting
25 in place? And really trying to manage that.

1 So I think it's a very complicated
2 scenario. Long-term care is a complex
3 environment to work in. I've dedicated, you
4 know, thirty years, all of my years in practice,
5 to long-term care. And it is a really unique
6 sector to work in. It is as very rewarding
7 sector. We make differences in the lives of
8 residents and families.

9 And I completely echo and hear what
10 Commissioner Marrocco said about the toll this
11 has taken. The toll this has taken on our
12 residents, our families, all the caregivers
13 working in long-term care. And these are care
14 homes. And I think -- and we really, going
15 forward, need to make sure we're focused on that
16 and making sure we have all the right supports
17 in place.

18 But it's been exhausting and it's been
19 heartbreaking to see what has happened to a
20 sector I hold near and dear to my heart. And
21 it's the reason I came to Sienna in October and
22 just needed to work with this team, who are
23 working extremely hard and trying to do the
24 right thing, and putting the supports in place,
25 and listening to the guidance and the

1 recommendations.

2 When Dr. McGeer and I came on and we
3 would say, Hey, I need to find out this. Or,
4 Can you give me information on this? Or, How
5 are we organizing the medical services in this
6 home? Never once was there ever any resistance.
7 This team is working hard. They're doing
8 everything possible to get the right supports on
9 the ground.

10 I was on those calls, those outbreak
11 calls where we had hospitals worried about the
12 emergency department transfers, and how many
13 people were we sending over, and did we need
14 more supports? And we were trying to identify
15 how many residents we had in-house that we
16 needed to care for, and what supports we needed
17 to put in place. So you can imagine this is
18 very complicated.

19 And we had another home that had a
20 significant outbreak as well. And the same
21 thing, the emotion and the angst and people
22 trying to do the right thing. I cannot explain
23 it. I cannot express it. I can't duplicate it.

24 You know, we had an Executive Director
25 saying -- we said, Why are your blinds closed?

1 She said, I can't look at the media out there.
2 I need to focus on my residents and I need to
3 focus on my team and we need to do what we can
4 do.

5 So, yeah, we need to -- we need to
6 build our leaders in long-term care and we need
7 to support our leaders. And I think what you
8 saw in this case was when we saw that leadership
9 team was having difficulties we brought more
10 people in. And I believe that that helped us
11 get those more -- more people in that building
12 to help manage this outbreak.

13 JOHN CALLAGHAN: Dr. Moser, can I ask
14 you, it's a perplexing question but how do we
15 build more leaders? Because one of the things we
16 heard, and it's not just with Sienna, we heard it
17 with other homes, that the leadership on the
18 ground was either inexperienced, on the ones that
19 had significant problems, and so how does one
20 build leadership? I mean, it's easy to say.

21 DR. ANDREA MOSER: No, thank you for
22 that. And I love this question. Because as many
23 of you may or may not know, I said I've dedicated
24 my career to long-term care. Really, truthfully
25 this is the cornerstone of my practice. And even

1 before I went into medical school I worked in a
2 small nursing home in my small northern community
3 and I loved the environment. So this is a
4 passion for me.

5 And as I've worked with the Ontario
6 Medical Association, with the Long-Term Care
7 Physicians Associations, I've sat on ministry
8 negotiation tables, I've been working with my
9 colleagues in the U.S. and really learning and
10 trying to understand. And when we had our new
11 legislation come out in 2007 I read through the
12 legislation in detail. And then when our new
13 inspections came out in 2010, I read through all
14 of those and trying to get feedback and
15 identify.

16 We realized, or our organization at
17 that time, Ontario Long-Term Care Physicians,
18 realized there's a physician leadership gap in
19 long-term care. And so what we did with the
20 physician group is we started to develop a
21 medical director training program or curriculum,
22 and I think you've heard about that previously.

23 And I think it's about how do we
24 engage leaders? How do we identify them as
25 leaders? How do we say to our Directors of Care

1 and our Medical Directors and our Executive
2 Director, you are the leadership team in this
3 home and you need to work together. It's a
4 triad of leadership. How do we build it? And
5 it's not just about going and taking a course
6 and ticking a box. It is about how do you keep
7 that going afterwards?

8 So what we're working with right now
9 with our Medical Directors is I've been meeting
10 with them every two weeks since I've started
11 doing some consulting in the summer. And those
12 physicians are coming on board. And I've heard
13 it from our homes, and even Nitin has heard it
14 from the Medical Directors when they go out,
15 Boy, I'm getting a sense of what I need to be
16 doing. And I think this is really critical.

17 We have to build the teams. We have
18 to set expectations. We have to follow through
19 and have a way of identifying people within our
20 long-term care homes who have that leadership
21 potential and how do we build that? And we're
22 working on that. And that's something Sienna is
23 looking at. And how do we build the leaders?
24 And how do we continue to build the teams?

25 I'm thrilled to say that I heard one

1 of our Medical Directors this week, who is
2 actually taking the medical director course now,
3 talked about the things he is learning and
4 applying back at his home. So there is great
5 opportunity here.

6 People who are in long-term care are
7 in long-term care because they want to be in
8 long-term care, and it is a group that is
9 thirsty for knowledge and thirsty for support.

10 And the other one I would say, there's
11 just -- I could go on for probably an hour on
12 how we could do education and support and
13 supporting these teams, and that they're
14 valuable. I am a physician who works in
15 long-term care. I am a long-term care
16 physician. I'm not just a long-term care
17 physician. I value this work. Yes, an emerg
18 doc is an emerg doc. They're a doc, I'm a doc,
19 and we each have our area of expertise. And
20 that's how we have to elevate all of our staff
21 in long-term care, to say, we are long-term care
22 care providers and we do amazing work every day;
23 and complicated, challenging, difficult work
24 every day.

25 I'll stop, sorry.

1 JOHN CALLAGHAN: Ms. Coke.

2 COMMISSIONER ANGELA COKE: I just want
3 to ask a question. You mentioned that you've
4 built a curriculum, a course, and I'm just
5 curious as to what you think of the sort of core
6 competency or core areas where there's gaps that
7 you're trying to fill through your course?

8 DR. ANDREA MOSER: A great question.
9 So the course that I co-developed was the medical
10 director curriculum that really looked at the
11 medical director role, competencies, awareness of
12 the legislation, of the regulations, of what the
13 inspection process looks like.

14 Very rarely does an inspector, when
15 they come into a long-term care, ever ask to see
16 or talk to the medical director and medical
17 team. How do you build that? And most medical
18 directors if you ask them, Why did you become a
19 medical director? And what did you know about
20 the role? Most of them will say, and we have
21 asked them, they will say, Well, the
22 administrator asked me because they needed a
23 medical director and I agreed to do it.

24 And now what we're starting to see,
25 and I'm seeing this even in our training, we're

1 having new physicians coming in, who might be an
2 attending physician, are saying, I'm taking this
3 course because I'm being asked to be a medical
4 director and I need to know what the job is
5 before I agree to do it. So we're seeing a
6 shift in terms of people are understanding and
7 appreciating that there's a role here and we're
8 not trained for it.

9 And just like if you look at our
10 nursing leaders. And, I mean, nurses in nursing
11 school often don't have a long-term care
12 experience. They don't know what a role of a
13 Director of Care is. Physician certainly rarely
14 get into long-term care when they're in
15 training. And if they get into long-term care
16 when they're training it's usual with an
17 attending physician going and seeing a couple of
18 patients or residents clinically, but not really
19 in the leadership and that role. So it's really
20 about getting out there and getting people the
21 knowledge they need so that they can do the job.

22 When you ask physicians, Were you on
23 the outbreak management teams? I heard some
24 say, Well, I don't need to be on that. And when
25 you say, Well, were you invited? Oh, come to

1 think of it, I'm not sure I was invited. And
2 now you hear them say, I'm on the outbreak team.
3 Oh, there's a question here. Let's see what we
4 can do here. Let's talk about cohorting. Let's
5 talk about testing. Let's see what we can do in
6 terms of our management. How are we assessing
7 our residents? So that real engagement of the
8 primary care provider in the home. And I think
9 that is the same with all the staff who work in
10 long-term care. And the key competencies --
11 sorry, so that was sort of the medical director
12 leadership.

13 But if you look at clinical
14 competencies in long term care, and there's been
15 quite a bit of work done on this south of the
16 border around the key clinical competencies you
17 need do good clinical work in long-term care.
18 You have to understand dementia and how that
19 impacts a person's life. You have to understand
20 behavioural symptoms of dementia. You must be
21 skilled in resident-centred, family-centred
22 family care. This is all about residents and
23 families and how we care for them. You need to
24 have skills in end-of-life care, palliative
25 care, goals of care discussions. How do we set

1 the stage and support people? Because people
2 who are coming into long-term care are often
3 declining over the time in their journey with us
4 in long-term care. And how do we support the
5 residents in that? How do we support the
6 families and provide that end-of-life care?

7 And we also have to be able to deal
8 with complex and chronic disease management.
9 People have, you know, congestive heart failure,
10 and diabetes, and arthritis, and chronic pain
11 syndrome, and dementia, and they may be
12 depressed. We have to be able to manage all of
13 that and pull on and work with supports where we
14 can.

15 COMMISSIONER ANGELA COKE: Okay, thank
16 you.

17 JOHN CALLAGHAN: Nitin, last time you
18 were here you talked about moving from part-time
19 workers to full-time workers. You told us what
20 an improvement it had been, not just for the
21 employees but for your residents. You
22 aspirationally said you wanted to try and get to
23 67 percent of the workforce, I think. And how is
24 that going? And where is that -- where do you
25 see that going currently in the future?

1 NITIN JAIN: Sure, it's actually a bit
2 of an easy answer for today because we still have
3 single site on. So I can give you the number but
4 it's not fair because it's still 67, 70 percent.

5 But in fairness, you know, for
6 every -- if you look at, since we are a 24/7
7 organization one would argue that for every
8 full-time worker you need a part-time worker so
9 your ratio might be 50/50. But then you get
10 into, okay, well, if someone is willing to work
11 weekends and do some days you change the ratio
12 lower, because you can convert them into
13 full-time and instead of covering for one
14 full-time they are covering for two. So that's
15 an exercise we have taken on as an organization.

16 We are committed to creating as many
17 full-time roles as possible because it is the
18 right thing for residents, it's the right thing
19 for team members, and it's also the right thing
20 for bottom line. Because there is significant
21 amount of resources it takes to recruit and
22 train the right people. So we have not changed
23 our view.

24 It is hard for me to give you a number
25 because it will depend on the size of the home,

1 and a bigger home maybe you can do more because
2 you can merge two part-time into full time. We
3 are still headed in the same direction, counsel.
4 I do not have a number that we are aspiring to.

5 JOHN CALLAGHAN: Thank you.

6 NITIN JAIN: The next section I wanted
7 to cover was, I know the Commissioners heard from
8 quite a few people on the regulatory oversight.
9 And I just wanted to give you kind of our
10 perspective. Because we also have homes in BC,
11 and Dr. Moser has a lot of insight from the model
12 in the United States as well.

13 And, first of all, we completely agree
14 that there should be oversight for the sector
15 and should be a strong compliance framework.
16 But what we would maybe respectfully suggest is
17 that more is not always better. And I just want
18 to maybe share some examples with you.

19 So we looked at five of our outbreak
20 homes, the biggest outbreaks that we had in
21 2020. And we went back to inspections for 2019
22 and 2020. On an average each of these homes had
23 seven inspections per year with eleven different
24 inspector, because on some inspections you might
25 have a couple of people.

1 And each of those homes, on an
2 average, there was someone in the home
3 inspecting for seventy-five days, each of those
4 years. In fact, in some of our homes there were
5 inspectors for more than a hundred days. And I
6 don't think you will find this very different if
7 you talk to other long-term care providers as
8 well.

9 Because of the inspection focus you
10 look at all the details and it's very specific,
11 but it's very time consuming. And there might
12 be an opportunity for us to learn from BC how
13 they do inspections because it's outcome
14 focused. We can take some advice from RHRA, the
15 Retirement Health Authority, because their focus
16 is, how do you focus on high-risk home, high
17 risk of compliance areas and also outcomes?

18 And lastly, I think -- the suggestion
19 would be to move away from how do you catch
20 people not doing something but rather how do you
21 tell them to follow best practices, share ideas?
22 And, again, this is not my area of expertise,
23 but in speaking with many other hospital
24 leadership teams. I understand that there's
25 already an alternative to how we do inspections

1 in long-term care, is how hospitals get
2 inspected, which is more outcome-focused, more
3 advice-focused and solution-focused rather than
4 a checklist-focus.

5 So I wanted to say, Dr. Moser, I know
6 you have a view on inspection so I'll pass it
7 over to you.

8 DR. ANDREA MOSER: I think no one is
9 saying that there should not be inspections in
10 long-term care. I don't think I've heard anybody
11 saying that. There's an accountability, there's
12 a follow-through that has to happen. We need to
13 make sure that we're providing really good
14 quality care. And there needs to be some level
15 of oversight on that.

16 I think what needs to be balanced
17 though, and I think in the past we had
18 compliance advisors who would come in and would
19 work with the home. I think about -- when I
20 talk about doing resident-centred care, are we
21 doing to and for our residents? Are we working
22 with our residents? And I think that's the
23 same. In some way we need to bridge what we
24 have now with what we used to have. How do you
25 still have that quality assurance and making

1 sure that you're getting things right and doing
2 what needs to be done? But also, how do you
3 work with the homes so there's not this almost
4 fear base of the inspectors that come in?

5 When the inspectors come in it's
6 really, really hard and you are pulled to do
7 those inspections. And I think one -- it's
8 relevant to this discussion, I think, but didn't
9 come out of Canada. But if you look at
10 experiences in the U.S. and with -- the very
11 first long-term care outbreak in Kirkland,
12 Washington, and this was on 60 Minutes from CBS.

13 And the administrator of that home
14 spoke so eloquently about what happened in that
15 outbreak. They were, I think, at the point that
16 they had had five case and they were starting to
17 realize it was COVID and they were terrified.
18 And they were trying to get staff, they were
19 trying to get resources, they were trying to
20 make sure they had PPE, and the CMS inspectors
21 came in to do their inspection. And the home
22 tried to say, This is not -- right now we need
23 to get this outbreak under control. That
24 administrator calculated that it took about 400
25 hours of staff time to support the inspectors in

1 the home, and that took away from direct care
2 hours.

3 So, again, I think we need to reset
4 where we are with the inspections. How do we
5 make sure that we're inspecting the things that
6 are most critically important? And how do we be
7 nimble with inspections? So if we're talking
8 about doing an inspection protocol for IPAC
9 based on our legislation and our regulations,
10 nobody, no long-term care home had an infection
11 control policy that would cover what we're doing
12 for COVID. This is a new virus, this a
13 worldwide pandemic. We are all doing the best
14 we can as we learn more information.

15 And one of things the inspection
16 process, the way it's created, does is it makes
17 you stay very much -- this is the legislation,
18 we have a policy that matches the legislation,
19 we have our procedures that match our policy and
20 we're following everything exactly. If we veer
21 away from that and we don't update our policy
22 and the inspector comes in, even though we're
23 doing the right thing, so we're now universal
24 masking for all of our staff coming into the
25 nursing home, if that's not in our policy we

1 could have a finding under the inspection branch
2 of the ministry.

3 So again, I think it's really
4 important to understand what we're in. This is
5 not normal times. I think everyone would say
6 this is a year that no one else has experienced,
7 and long-term care particularly. Because we're
8 so -- we're in this frame of inspections. And I
9 think the last count I had there's 32 inspection
10 protocols. The medication management protocol
11 alone is 26 pages long, and they're ticking the
12 boxes.

13 We need a way that we can have that
14 oversight but also have some nimbleness so the
15 sector can respond quickly when things are
16 changing, like what we've seen over the last
17 year.

18 NITIN JAIN: Thank you, Dr. Moser.

19 COMMISSION CHAIR FRANK MARROCCO:

20 Commissioner Coke, you wanted to ask a question?

21 COMMISSIONER ANGELA COKE: Yes. Just
22 to follow up on your point, do you have your own
23 quality management framework that you work with
24 for continuous improvement? And do you have your
25 own sort of quality assurance process before the

1 inspectors will come on site?

2 DR. ANDREA MOSER: Yeah. So again, I
3 will say I'm new. I'm new to Sienna starting in
4 the middle of October and working with our
5 retirement homes and our long-term care homes
6 through COVID.

7 I do know, and Nitin may speak to this
8 in more detail, but we do have a quality
9 department and we do have a quality committee of
10 our Board.

11 We look at our metrics, and we look at
12 that overall for Sienna and our indicators, but
13 also at the individual home levels. So where
14 you may see one indicator we're doing right at
15 the provincial average, which is great, right
16 where we want to be. But we also look at, is
17 there some variability within the homes and are
18 there certain homes that maybe need to have more
19 focus on one specific area?

20 At Sienna I'm proud to say that we
21 have recently joined a consortium of long-term
22 care homes that's called the Senior's Quality
23 Leap Initiative, or "SQLI", it's led by Baycrest
24 Health Sciences and has nursing homes from
25 across North America contributing to it. And

1 what we do in that organization is all of the
2 homes are sharing all of our indicators and all
3 of our quality performance on
4 publically-reported indicators, as well as
5 others, and sharing that in a -- in an
6 identified manner.

7 So I can look at that and I can see,
8 how is Baycrest doing? Or how is Perley Rideau
9 Vets doing? Or how is Providence doing? And
10 then we can compare that. And also within that
11 we can share, Hey, you're doing really well on
12 your falls rate and our falls rate is higher.
13 How can we talk together and learn from each
14 other and move forward?

15 So that's something that, again, very
16 new to us at Sienna and we're very excited to
17 move forward with that.

18 COMMISSIONER ANGELA COKE: Thank you.

19 NITIN JAIN: Counsel, if you like I can
20 address one of your questions you started the
21 conversation with, just talk about over at
22 Sienna. Would you like me to do that now?

23 JOHN CALLAGHAN: Certainly.

24 NITIN JAIN: So just for context, there
25 are around, as you've heard multiple times, there

1 are around 77,000 beds of long-term care in
2 Ontario and they're managed through multiple
3 different companies, and not-for-profits and
4 municipalities. We are, in fact, the biggest
5 long-term care owners and operators in the
6 province.

7 So when you look at numbers you just
8 have to -- and it always has been a matter of
9 pride for us, but it's not going to be a matter
10 of pride when I talk about outbreak numbers and
11 mortality rates. So I don't want to in any way
12 argue around, well, our number is one percent
13 less, because it takes away from really what
14 we're dealing with here.

15 So the -- so we have 5700 beds, I
16 think the second highest number of beds at
17 around a thousand less. And then next after
18 that is around two thirds of them. So just to
19 give you the enormity of what we have been
20 dealing with there.

21 The mortality rate for Ontario, I
22 understand, is around 26 percent. For every
23 person who got COVID 26 percent of them
24 unfortunately passed away, and Sienna rate is
25 26 percent. So there's no change.

1 We did see a significant change in
2 wave 1 and wave 2. So in wave 1 our mortality
3 rate was around 36 percent and the sector was
4 34, so yes, we were two percent higher. And
5 there were two homes which have been a
6 significant challenge for us. The first one is
7 Altamont, which went into outbreak on
8 March 25th, and even though I was not in my
9 current job at that point I remember those IMT
10 calls there was no direction of how many masks
11 you need to change because there were still
12 directives, let's conserve personal protective
13 equipment because there was not enough
14 available. And even though with the size of our
15 company we never ran out there was always
16 challenge to find enough, especially as it
17 related to N95 mask.

18 And then the second one, which was
19 Camilla, which went into early April. So those
20 two homes had significant deaths in both of
21 them. And again, I don't want to get into,
22 well, let's exclude those numbers. But to give
23 you a thing of why our numbers were the way they
24 were, one was in Mississauga region, which is
25 one of the highest community outbreaks in

1 Canada, and the second one is in Scarborough.
2 The numbers are not very different in terms of
3 community outbreak.

4 In terms of in the second wave our
5 mortality rate is around 19 percent, the sector
6 is around 21 percent. So, you know, again we
7 are in that -- we were higher in the first wave,
8 lower in the second wave but overall not very
9 different than what the overall province saw.

10 And this is in spite of -- you know,
11 you've heard from many experts in terms of there
12 are two or three key things that have been --
13 that have been driving outbreaks, the first one
14 is the area you are in and the age of those
15 buildings. So we do have one third of those
16 homes which were built fifty, sixty years back;
17 and the second is our location.

18 So overall in terms of percentage of
19 beds in GTA versus nonGTA, if you look at the
20 entire province, around 30 percent of the beds
21 are in GTA and the 70 percent are outside of the
22 GTA. And again, this used to be a big area of
23 pride for us, it is not at the moment. Our
24 numbers are actually reversed, 65 percent of our
25 beds are in the GTA and 35 percent are outside.

1 And we have been able to provide resources --
2 fortunate to provide beds in areas such as GTA,
3 because if you have a loved one and live in
4 Scarborough you don't really want to be moving
5 to Peterborough to see your dad once in a while.

6 So for us it's been a matter of pride
7 to do that, but I know during COVID those things
8 became extraordinarily difficult to manage. So
9 I just wanted to give you a bit of perspective
10 on those numbers.

11 JOHN CALLAGHAN: Can I ask then a
12 question, and it's not directed at Sienna, per
13 se, but at the industry. Given the numbers
14 generally how does -- and Dr. Moser may have a
15 view of this too, how do you reestablish confidence
16 in the long-term care community? You know, we've
17 heard a lot of very tough comments not just about
18 the for-profit but generally about long-term
19 care, and people being concerned about ever going
20 to long-term care. How does one reestablish
21 confidence in the public in the long-term care
22 sector?

23 NITIN JAIN: You are a hundred percent
24 correct because -- and I think one of the ways
25 you do that, and we saw that for ourselves,

1 counsel. So we had some very difficult town
2 halls. And when I became CEO my goal was that,
3 if I'm going to ask my team to go and be in front
4 of family members and answer questions I want to
5 make sure I do that first.

6 So I went into some of the town halls
7 with some very concerned family members, and
8 rightfully so. And you heard loud and clear
9 that we were not picking up the phone timely, we
10 were not responding to them. And since they
11 couldn't come inside the home in wave 1 they had
12 no clue how their loved one was doing; so we had
13 to change that.

14 And when outbreaks started to happen
15 what we saw is that the sooner we told them that
16 something was happening, and the first two calls
17 were always more difficult and then it started
18 getting into a bit of reality check of what we
19 were dealing with.

20 And with the arrival of the vaccine,
21 so we have close to 93 percent of our residents
22 in Ontario long-term care being vaccinated. And
23 we are, again, thankful for all to the health
24 agencies and governments that make this as a
25 priority.

1 And those conversations are changing
2 from plan to really a conversation of
3 gratefulness for this vaccine to be here. So as
4 of today we have four cases in total in all of
5 Sienna with the vaccine. So the number of --
6 the vaccine has definitely taken us, you know,
7 in the right direction. And we saw that in, and
8 Dr. McGeer might be able to speak about, we have
9 a home in Bradford called Bradford Valley, which
10 was able to get vaccinated before the U.K.
11 variant was found there and we had a very
12 different outcome. We had minimal to no
13 outbreaks, versus another home that was in that
14 vicinity which had a significant outbreak. So
15 the vaccine did go a long way to make the
16 difference.

17 The second thing that people are
18 always worried about is the lack of right
19 staffing in long-term care. And again, as I
20 said, in short term companies such as Sienna or
21 the Municipality of Toronto, and others, can
22 borrow more money and ask for more money and
23 government has been helping. But that is not --
24 that is a not a long-term solution. We do need
25 to add more staffing to long-term care.

1 And the last one is not only finding
2 the funding for the staffing but actually
3 finding, whether it's through more schools,
4 whether it's through immigration, and we want to
5 be part of the solution. We formed a consortium
6 with other senior housing providers called
7 CARES, Bayview provided one-time funding for
8 people who were -- who dealt with COVID.

9 And as we look at how do we be a
10 solution provider for the sector? So our first
11 one was us investing \$600 million over the next
12 five to seven years. We do need approval from
13 the ministries and municipalities to make it
14 happen. So our goal would be, we will do this
15 as fast as the ministries and municipalities
16 would allow us to do. There would be no
17 roadblocks from Sienna's perspective. And this
18 is a strategy which has been approved by our
19 Board.

20 And the second thing is ensuring that
21 we continually get access to the vaccines for
22 the long-term care homes.

23 And invest into additional staffing in
24 terms of training them. And from a Sienna
25 perspective, we would put our efforts to

1 ensuring -- we will contribute towards putting
2 some of the money towards education. We would
3 do that ourselves because we know that is the
4 right way of finding more people for this
5 sector.

6 COMMISSION CHAIR FRANK MARROCCO: We're
7 -- there was a silence so I was wondering,
8 Mr. Jain, where you were in terms of what you
9 wanted to say to us?

10 NITIN JAIN: I thought it was -- I
11 would just respond to counsel. I did think -- I
12 did complete that.

13 You know, I don't really have many
14 more specific things to say and we are happy to
15 take your questions with Dr. McGeer and
16 Dr. Moser, Commissioners.

17 COMMISSION CHAIR FRANK MARROCCO: Well,
18 I think -- I mean, I don't know if the other
19 Commissioners -- I think we asked the questions
20 as we went along so I don't think there are any
21 more questions. Dr. Moser, you wanted to say
22 something?

23 DR. ANDREA MOSER: I did want to raise
24 one issue, if that's possible. I just wanted to
25 clarify one of the issues in the report that we

1 reviewed around metrics.

2 So there was a comment that metrics
3 were being done to sort of satisfy our senior
4 leadership, and I just want to walk people
5 through what that was.

6 So what the metrics were was a way
7 that we had developed to capture the essence of
8 what was happening in an outbreak on the ground
9 in a long-term care home. So it started with
10 what is our case count? How many residents are
11 positive? How many swabs are you pending? You
12 may have five residents positive but you're
13 still waiting 50 swab results back so we know
14 we're in that zone of not knowing which way this
15 is going to go. Of your residents who are
16 positive how many may be in hospital? Have you
17 had any deaths? What is the symptom of the
18 residents?

19 So we rolled out a treatment guide
20 based on the Public Health Agency of Canada,
21 with input from experts, and our medical
22 directors, and our nurse practitioners who are
23 working in our homes. So what defines mild
24 symptoms, versus moderate symptoms, versus
25 severe? And at each of those stages what is the

1 assessments that we are doing and what is the
2 treatments that we're putting in place? So
3 getting a sense of the burden of illness within
4 the home.

5 And that helps us understand how much
6 more staffing do we need? What are the
7 resources needed on the ground? Do we have
8 primary care on site every day? What is our
9 nursing ratios? What are our PSW supports? And
10 it may have sounded like numbers to people but
11 to us it was about understanding how do we
12 identify what the needs of this home are and the
13 resident in the home, and what extra supports
14 need to get put in place?

15 Also on that metrics tab was how many
16 staff have been swabbed positive? How many
17 staff are in the home? Are you missing any
18 people on shifts? And what's your staffing
19 ratio? So where we may have a ratio of 1 to 8
20 personal support workers that changes quickly as
21 we have more residents with either moderate
22 illness, symptomatic illness or even positive
23 COVID who are on isolation.

24 So I just wanted to give a sense of
25 that. That metrics -- it wasn't a

1 ticking-the-box exercise at all, it was
2 absolutely helping us understand what's
3 happening in that home and what supports needed
4 to be put in place to help that home.

5 And those numbers were also shared
6 with our hospital partners, with our public
7 health partners, with the LHIN so they could
8 identify, now we need to send what's called a
9 MEST team in, which is a team of registered
10 practical nurses and personal support workers to
11 fill if there's any gaps in staffing.

12 So that's really what that was. And
13 we had standardized that across Sienna so that
14 we could keep track of that. And we would also
15 bring a project manager on to help manage that
16 and make sure that that was updated and current
17 every day. So that was the metrics piece.

18 JOHN CALLAGHAN: Dr. Hota's testimony
19 -- discussion with us was to the effect that
20 there were these stats and they were coming out
21 100 percent hygiene, 100 percent PPE, and she
22 would say they just weren't accurate.

23 And we -- and the Commission has heard
24 between wave 1 and wave 2 there were all sorts
25 of homes that were self-assessing themselves as

1 being able to do stuff that when the hospitals
2 got in it was apparent that they didn't. So I
3 don't know what you say about that. Because
4 that, I think, was the issue. She was seeing
5 these results from your metrics that weren't
6 lining up and I think her comment was:

7 "[...] as it was really going
8 through a list of audits 100 percent
9 and people weren't questioned how it
10 is that all our PPE audits and your
11 hand hygiene audits are 100 percent
12 compliant but we're still facing these
13 problems."

14 [as read]

15 That was her point. I don't know what
16 you say to that.

17 DR. ALLISON McGEER: Can I just weigh
18 in on that? Coming from the hospital sector
19 where we've been reporting 100 percent adherence
20 to hand hygiene in the hospital sector for how
21 many years? When we know the number is 30.

22 You know, there's a big difference
23 between what people do when they know they're
24 being watched and they know they have to do it.
25 That's an essential piece, okay? So you have to

1 get to 100 percent on observational auditing
2 before you can take the next step and translate
3 it out.

4 And honestly, when we started with
5 hand hygiene in acute care we were at
6 40 percent. So the journey from 40 percent
7 observational auditing to 100 was painful but
8 critical for us, just not enough.

9 Same issue in long-term care. It's
10 not that -- a piece of getting those numbers --
11 to me was not about -- I know it's not
12 100 percent. The fact that those audits are
13 being done is, nonetheless, of some use. So --
14 I don't care -- I don't care that much about
15 what the adherence number is, I know it's not a
16 true number. And the number of observational
17 audits is small and people are being watched,
18 but if somebody is doing audits that's of some
19 assistance. So to me the key outcome of that
20 question is not what you're reporting as
21 adherence. Everybody who's listening needs to
22 be conscious of the fact that that's not a real
23 number. If you think that's a real number, go
24 away.

25 But the fact that you're doing them is

1 important. The fact that somebody is out
2 watching -- because one of the things you get
3 out of observational auditing, theoretically
4 anyway, is coaching. You see something and
5 somebody is not doing it right, that's your
6 in-the-moment time to say, yup, okay.

7 And you know, the other thing is that
8 it is -- the truth is that we've been having
9 transmission in both acute care and long-term
10 care in circumstances where we think people's
11 adherence is pretty good. And you know, we end
12 up in this -- you know awful argument, that we
13 don't know the answer to, which is, are we --
14 you know, is the problem that we're missing
15 adherence to small things, particular things,
16 you know, stuff we're not watching? Which I
17 think most IPAC people will tell you is likely
18 the truth. Or is the problem that we've got
19 aerosol spread and all of this stuff that we're
20 doing is not going to deal with that particular
21 issue. And so you do everything else right, you
22 reduce transmission but you don't make it go
23 away completely. As you know we're going to
24 argue about that for the next 40 years.

25 I hear Susy' issue. She's absolutely

1 right. But to me the value of the auditing is
2 that they're being done as opposed to what
3 anybody is saying about what the results are.

4 JOHN CALLAGHAN: Thank you.

5 COMMISSION CHAIR FRANK MARROCCO: Well
6 thank you. Mr. Jain, and I assume you were done?

7 NITIN JAIN: Yes.

8 COMMISSION CHAIR FRANK MARROCCO: So,
9 Mr. Jain, and everyone else, thank you very much
10 for the presentation.

11 And I should say, because Dr. Moser
12 wanted to clarify or add at the end, if
13 something occurs to you after, don't hesitate to
14 forward it to Mr. Callaghan, he will make sure
15 that it gets in front of us. So don't feel
16 constrained by the fact that the meeting is
17 over.

18 And so thank you again for your time
19 and your effort and good afternoon.

20 DR. ALLISON McGEER: May I say one last
21 thing?

22 COMMISSION CHAIR FRANK MARROCCO: Yes.

23 DR. ALLISON McGEER: Just because I may
24 not get the chance again. I just wanted to say
25 thank you to Mr. Callaghan, and all the

1 Commissioners. However challenging my life has
2 been in periods I know yours has been worse, and
3 I can't tell you how much that I personally value
4 the work that you've been doing and the thought
5 that has gone into trying to make things better.

6 I think you -- we didn't fix wave 2,
7 and I'm really conscious of my failings on that,
8 but it was better because you were there and
9 because the interim recommendations were there.
10 I think what you said about the vaccination
11 program has been really helpful in keeping us
12 focused on getting the vaccination program in.

13 And so I just wanted to have the
14 opportunity to say thank you for the work you
15 are doing. As somebody who's spent a lot of
16 time in long-term care and cares about how we're
17 doing, I really appreciate the work of the
18 Commission.

19 NITIN JAIN: Dr. McGeer, I was going to
20 say the same but you said it a lot more
21 gracefully than I would have done so thank you.

22 COMMISSION CHAIR FRANK MARROCCO: Thank
23 you, both

24 JOHN CALLAGHAN: Thank you.

25 --- Meeting ended at 11:56 a.m.

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	

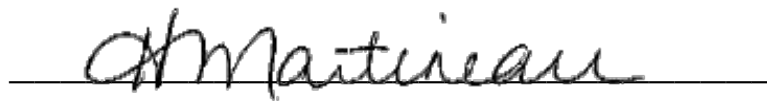
REPORTER'S CERTIFICATE

I, HELEN MARTINEAU, CSR, Certified
Shorthand Reporter, certify;

That the foregoing meeting was taken
before me at the time and date therein set
forth;

All discussions had by the
participants were recorded stenographically by
me and were thereafter transcribed;

That the foregoing is a true and
accurate transcript of my shorthand notes so
taken. Dated this 13th day of March, 2021.

A handwritten signature in cursive script, appearing to read "H Martineau", is written over a horizontal line.

PER: HELEN MARTINEAU

CERTIFIED SHORTHAND REPORTER

WORD INDEX

< \$ >

\$100 47:19
56:5, 9, 10 57:1,
3
\$120,000 46:9
\$20 46:14
\$30,000 46:14
\$50 51:25
\$50,000 52:14
\$52 46:22
\$55 51:22
\$600 54:14
93:11
\$99 56:10

< 1 >

1 9:3, 18 10:1
13:5 14:10
66:23 88:2
91:11 96:19
97:24
1,302 12:16
10:00 1:17 4:1
100 11:19
12:19 28:20
47:21, 23 56:12
97:21 98:8, 11,
19 99:1, 7, 12
100,000 49:20
101 56:11
102 56:7
104 56:7
105 47:20, 24
106 56:7
108 56:7
11:56 102:25
12 57:25
12:00 1:17
12th 1:16
13th 104:13
14 48:8 57:25
15 37:24 47:2
48:12 54:2 59:7
15,000 54:7
58:17, 18 63:23
150 29:7 51:23
16 11:17
17 22:4
18 46:1
19 89:5

< 2 >

2 9:4, 13 10:1,
2 13:5, 13
14:11, 18 35:20
65:18 66:24
88:2 97:24
102:6
20 47:13 48:12
54:3
200 46:13
2006 48:7
2007 71:11
2010 71:13
2019 79:21
2020 5:5 6:6, 9
46:22 79:21, 22
2021 1:17
104:13
2023 62:8
2024 62:8
21 89:6
22 30:18 31:2
22.7 12:15
2200 62:17
63:14
23.4 12:19
24/7 53:9 55:1
64:24 78:6
250 11:18
25th 88:8
26 84:11 87:22,
23, 25

< 3 >

3 9:4 12:12
3,000 48:21
30 15:10 22:9
24:2, 3 25:13
28:24 48:5
89:20 98:21
30,000 54:6, 21
58:17 59:1
63:23
32 84:9
34 88:4
35 15:24 29:8
89:25
36 88:3
360 16:21
17:14, 20 20:23
24:24
37 47:1 52:11
38,000 54:23
63:25

< 4 >

4 50:3, 12, 18
40 15:10 24:2,
3 25:13 28:24
99:6 100:24
400 82:24
403 12:11
43 22:5

< 5 >

50 29:9 58:2
95:13
50/50 78:9
500 48:23
52 47:2 52:11
5700 87:15

< 6 >

60 82:12
600 63:9
6000 11:15
65 22:8 89:24
67 77:23 78:4

< 7 >

70 78:4 89:21
724 12:17
77,000 87:1

< 8 >

8 96:19
80 22:7 29:10
800 63:6
81 12:13
85 22:5

< 9 >

93 91:21

< A >

a.m 1:17 4:1
102:25
ability 44:25
51:18, 20
absolutely 54:1
57:21 97:2
100:25
accept 25:23
acceptable
44:10
access 93:21
accommodation
51:3, 22 58:4

accommodations
47:8
Accountability
62:7 81:11
accurate 66:3
97:22 104:12
achieve 34:15
achieving 33:23
active 11:18, 19
65:9
actively 35:23
48:20
activities 44:17
acuity 48:3
60:11
acute 29:20
47:17 99:5
100:9
Adam 2:14
add 30:9, 11
40:16 54:6
65:6 66:19, 21
92:25 101:12
addiction 8:10
adding 26:25
48:23
addition 7:5
additional 22:17
36:16 48:1, 18
52:14 61:12
63:23 93:23
address 6:16
12:9 35:15
48:14 86:20
addressed 25:22
adequate 44:23
52:17 53:2
adequately
17:12
adherence
98:19 99:15, 21
100:11, 15
admin 52:1
administrator
74:22 82:13, 24
admit 17:14
ADOC 37:7
advanced 67:21
advice 11:11
30:24 66:7
80:14
advice-focused
81:3

Advisor 7:2
advisors 81:18
Advisory 6:22,
24 7:1 41:15
advocating
60:10
aerosol 16:22
100:19
aerosols 17:1
after 37:13
50:10, 15 56:11
87:17 101:13
afternoon
101:19
age 22:5 89:14
agencies 11:5
91:24
Agency 95:20
agendas 32:8
ago 9:17 47:13
48:12 54:3
61:18
agree 10:3
25:14 75:5
79:13
agreed 22:11
74:23
agreements
24:17
ahead 13:8
28:3
Aid 54:25
Alain 3:10
Alison 3:2 26:4
Allison 2:12
12:3 13:9
30:13 34:5
40:18 43:17
98:17 101:20, 23
allow 20:20
93:16
allowed 45:5
allowing 21:21
alluded 21:25
Altamont 88:7
alternative 80:25
altogether 66:11
Amanda 3:16
amazing 73:22
Amazon 57:4
America 85:25
American 6:4
amount 47:23
54:19 59:5

<p>78:21 Analyst 3:12, 14 Andrea 2:10 21:20 24:5, 15 26:2 29:2 30:16 35:14 38:23 66:21 70:21 74:8 81:8 85:2 94:23 Angela 2:4 74:2 77:15 84:21 86:18 Angeline 3:12 angst 69:21 announced 46:13 48:18 announcement 54:14 answering 60:4 antimicrobial 41:19 42:5 antimicrobial- resistant 41:21 anybody 4:15 19:17 34:11 43:1 81:10 101:3 anyway 100:4 apparent 98:2 apparently 19:9 apple 53:5 application 62:3, 5, 13 applied 61:11 applies 52:23 applying 73:4 appreciate 39:6, 13 55:16 102:17 appreciating 75:7 approval 60:20 61:2, 19 62:3, 4, 5 93:12 approvals 61:20 approved 21:2 61:13, 16 62:13, 14 93:18 April 88:19 area 10:11 32:9 40:17 48:13 63:7 64:8 73:19 80:22 85:19 89:14, 22</p>	<p>areas 20:2 21:14 36:7 74:6 80:17 90:2 argue 21:7 78:7 87:12 100:24 argument 43:21 100:12 arrival 91:20 arthritis 77:10 asked 23:12 37:9 58:20 74:21, 22 75:3 94:19 asking 19:11, 22 aspirationally 77:22 aspiring 79:4 assessing 76:6 assessments 67:19 96:1 asset 7:11 assistance 99:19 Assistant 3:2 Associate 5:21 36:14 associated 16:25 Association 71:6 Associations 71:7 assume 46:7 101:6 assurance 81:25 84:25 attending 1:16 35:24 38:15 75:2, 17 attention 64:14 audit 20:5, 7, 10 auditing 99:1, 7 100:3 101:1 audits 20:12 98:8, 10, 11 99:12, 17, 18 August 38:15 authority 24:9 30:18 80:15 availability 23:7 available 50:15 88:14 average 12:14 22:7 62:2</p>	<p>79:22 80:2 85:15 awareness 74:11 awful 100:12 awfulness 45:15 < B > baby 64:2 back 4:9 21:18 42:20 45:9 50:12, 13, 19 52:5 53:15, 17, 18 57:9, 15 58:13, 19 60:15 64:5 66:16 73:4 79:21 89:16 95:13 backing-and- forthing 31:11 balance 19:2 balanced 81:16 balances 23:20 Band 54:24 base 82:4 based 20:3 83:9 95:20 basic 43:11 basically 63:5 basis 6:7 13:4 38:16 48:25 52:8 57:2 Bay 59:4, 8 Baycrest 85:23 86:8 Bayview 93:7 BC 79:10 80:12 bed 52:14 54:6 beds 11:15 12:19, 21 54:7, 9, 21 58:18 59:1 60:18, 22 62:17 63:6, 9, 14, 23 87:1, 15, 16 89:19, 20, 25 90:2 beginning 14:10 35:17 64:2 66:24 behalf 66:12 behaviour 36:18 67:8 behavioural 76:20 belief 33:19</p>	<p>believe 53:23 70:10 belongings 45:20 benefit 59:17, 18 benefits 46:9 50:5 best 5:18 10:6 11:6, 9, 11 16:14 19:3, 19 25:6, 18 32:2, 12 80:21 83:13 better 10:12 16:13 26:4 53:11 59:11 64:25 79:17 102:5, 8 Bianchini 3:14 big 5:2 14:15 15:10 56:15, 19 62:20 89:22 98:22 bigger 49:2 58:3 59:9 64:3 79:1 biggest 79:20 87:4 bit 5:17 11:13, 22 13:21 21:14 24:7 31:13 39:19 50:24 51:5 56:6 59:9 61:6, 25 65:6 66:6 76:15 78:1 90:9 91:18 biweekly 38:14 bleach 16:22 25:21 blinds 69:25 blunt 4:10 Board 6:2, 4 7:14 30:4 72:12 85:10 93:19 boomers 64:2 border 76:16 borrow 59:15, 24 92:22 bottom 78:20 bought 61:18 box 72:6 boxes 84:12 Boy 72:15 Bradford 92:9</p>	<p>branch 84:1 breakfast 28:13 breathing 16:25 bridge 81:23 bring 27:6 97:15 bringing 7:14 Brooklyn 2:17 Brooks 3:21 brought 7:6 35:17 36:22 70:9 build 54:9 58:17 59:16 62:6 63:4 70:6, 15, 20 72:4, 17, 21, 23, 24 74:17 building 20:16 26:20 59:4, 6 70:11 buildings 89:15 built 48:7 54:9 62:8 63:15 74:4 89:16 burden 96:3 business 51:15 53:3 56:2, 3, 4 58:2 buy 56:4 Byrd 3:16 < C > calculated 82:24 call 15:9 17:22 18:9, 11 24:2 25:13 29:22 32:13, 14 33:7 34:3 51:3 Callaghan 3:17 4:2, 23 7:24 12:5 34:20 37:6 39:4 43:4 46:5 49:22, 25 57:14 58:13 60:14 62:2 64:5 70:13 74:1 77:17 79:5 86:23 90:11 97:18 101:4, 14, 25 102:24 called 16:21 18:18 41:18 85:22 92:9 93:6 97:8</p>
--	---	---	---	--

<p>calling 53:25 67:20</p> <p>calls 11:24, 25 15:11, 24 28:25 29:12 30:10 32:2, 4, 11 33:24 35:25 36:6 69:10, 11 88:10 91:16</p> <p>camera 53:9 64:23</p> <p>Camilla 88:19</p> <p>Canada 21:3 56:16 82:9 89:1 95:20</p> <p>Canada's 5:12 6:21 7:1, 3</p> <p>Canadian 6:3</p> <p>capable 41:7</p> <p>capacity 6:14</p> <p>capital 50:17 54:19 55:22 58:15 60:5</p> <p>capture 95:7</p> <p>CARE 1:6 3:3, 5, 6, 8, 10, 13, 15 5:6, 14, 15, 24 6:1, 3, 5 7:16, 21 8:3, 20, 23, 25 11:15 13:11 14:6, 8 17:9 18:25 22:14 24:22 26:17 29:6, 20, 21 30:4 31:7 32:22 33:12 36:13, 14 37:4 39:20 41:22 42:3, 6, 12, 25 43:24 45:9, 10 47:8 48:1, 4, 10 49:7, 10 50:13, 19, 22 51:9, 13, 15, 16, 19 53:6, 13, 20, 23 54:24 55:1, 7, 23, 25 56:3, 8, 13, 19, 23 57:7, 10, 17, 25 58:9 59:16 60:9, 11, 12 67:21 68:2, 5, 13 69:16 70:6, 24 71:6, 17, 19, 25 72:20 73:6, 7, 8, 15, 16, 21,</p>	<p>22 74:15 75:11, 13, 14, 15 76:8, 10, 14, 17, 22, 23, 24, 25 77:2, 4, 6 80:7 81:1, 10, 14, 20 82:11 83:1, 10 84:7 85:5, 22 87:1, 5 90:16, 19, 20, 21 91:22 92:19, 25 93:22 95:9 96:8 99:5, 9, 14 100:9, 10 102:16</p> <p>career 5:24 31:1 70:24</p> <p>carefully 32:24</p> <p>caregivers 45:8 68:12</p> <p>CARES 93:7 102:16</p> <p>carry 20:1</p> <p>case 10:9 24:20, 24 25:19 52:20 70:8 82:16 95:10</p> <p>cases 9:8 11:18, 19 12:16, 17, 18 13:15 23:5, 11 28:4 54:25 55:3 64:19 65:9 92:4</p> <p>catch 80:19</p> <p>CBS 82:12</p> <p>C-class 14:5</p> <p>CDC 33:3</p> <p>CEO 5:4 7:7 9:17 91:2</p> <p>certain 85:18</p> <p>certainly 75:13 86:23</p> <p>CERTIFICATE 104:1</p> <p>Certified 104:3, 18</p> <p>certify 104:4</p> <p>cetera 46:10, 19 50:11</p> <p>CFO 46:7</p> <p>chain 62:25</p> <p>Chair 2:3 23:22 24:13 25:12 28:22 34:1 38:20 43:3 52:25 55:10 57:13</p>	<p>58:11 84:19 94:6, 17 101:5, 8, 22 102:22</p> <p>challenge 22:17 61:1, 3 88:6, 16</p> <p>challenges 8:7, 13 12:25 43:19 60:19, 23 61:1, 19</p> <p>challenging 15:3 59:2 73:23 102:1</p> <p>chance 101:24</p> <p>change 10:23 18:5, 7 35:12 42:7 52:9 57:8 66:4 67:10 78:11 87:25 88:1, 11 91:13</p> <p>changed 54:2 58:24 78:22</p> <p>changes 36:8 59:8 96:20</p> <p>changing 11:10 29:25 54:16 60:12 84:16 92:1</p> <p>chaotic 14:25 18:2 26:7</p> <p>characteristics 60:3</p> <p>charge 15:8 19:8 30:15</p> <p>charities 59:19</p> <p>charity 54:8</p> <p>check 91:18</p> <p>checklist-focus 81:4</p> <p>checks 29:23</p> <p>chemical 17:3, 12</p> <p>Chief 2:8, 10, 12 5:19 6:8, 14 7:2</p> <p>chime 39:17</p> <p>chose 4:10</p> <p>chronic 77:8, 10</p> <p>chunk 53:22</p> <p>CIC-trained 40:24 41:5</p> <p>CIHI 22:1</p> <p>circumstances 45:4 46:3 100:10</p> <p>cities 59:9</p>	<p>City 52:15, 20, 22</p> <p>clarify 94:25 101:12</p> <p>class 55:20</p> <p>clean 45:21</p> <p>cleaned 17:5</p> <p>cleaning 43:20</p> <p>clear 29:6 31:9 91:8</p> <p>clearly 44:9, 15 64:22</p> <p>clinical 36:17 76:13, 16, 17</p> <p>clinically 75:18</p> <p>Clorox 16:21 17:13, 20 20:23 24:24</p> <p>close 11:14, 18 48:21 63:6 65:8, 15 91:21</p> <p>closed 69:25</p> <p>clothes 17:11</p> <p>clue 91:12</p> <p>CMHC 59:14, 15, 20, 24</p> <p>CMS 82:20</p> <p>coaching 100:4</p> <p>co-developed 5:25 74:9</p> <p>cohorting 21:16 45:24 76:4</p> <p>Coke 2:4 74:1, 2 77:15 84:20, 21 86:18</p> <p>Co-Lead 3:4, 17</p> <p>collaborating 27:9</p> <p>collaboration 7:9 11:3 25:4</p> <p>collaborative 27:17 31:3</p> <p>colleagues 71:9</p> <p>collect 51:17</p> <p>collective 9:13</p> <p>combined 65:10, 14</p> <p>come 4:3, 9 15:1, 11 24:10 27:7, 24 42:9 47:16 53:18 54:12 60:22 71:11 74:15 75:25 81:18</p>	<p>82:4, 5, 9 85:1 91:11</p> <p>comes 51:4 66:16 67:5 83:22</p> <p>coming 9:2 14:14 20:11, 16 22:13 27:2, 3, 5, 9, 15 28:15 29:4 30:1 39:11 48:8 53:17 64:17 72:12 75:1 77:2 83:24 97:20 98:18</p> <p>commencing 4:1</p> <p>comment 95:2 98:6</p> <p>comments 90:17</p> <p>COMMISSION 1:7 2:2 3:3, 4, 5, 7, 9, 11, 13, 15, 16, 17 4:9 10:18 20:3 21:9 23:22 24:13 25:12 28:22 34:1 37:15 38:20 39:9 43:3 47:25 49:25 52:25 54:18 55:10 57:13 58:11 84:19 94:6, 17 97:23 101:5, 8, 22 102:18, 22</p> <p>Commissioner 2:4, 5 21:21 53:4 55:9, 21 57:22 63:18 68:10 74:2 77:15 84:20, 21 86:18</p> <p>Commissioners 4:3, 22 6:12 13:8 60:4, 21 79:7 94:16, 19 102:1</p> <p>Commission's 40:5</p> <p>commitment 7:16, 18 9:19 46:17</p>
--	---	---	---	---

<p>commitments 60:17</p> <p>committed 78:16</p> <p>Committee 6:22, 25 7:1, 2 41:15 85:9</p> <p>communications 67:23</p> <p>communities 10:14 25:11</p> <p>Community 5:22 8:3 9:12 10:10 63:8 65:4 71:2 88:25 89:3 90:16</p> <p>companies 59:18 87:3 92:20</p> <p>company 39:25 88:15</p> <p>company's 9:19</p> <p>compare 56:19 86:10</p> <p>compared 22:6</p> <p>competencies 74:11 76:10, 14, 16</p> <p>competency 74:6</p> <p>complete 9:12 37:22 94:12</p> <p>completed 37:23 38:18</p> <p>completely 20:9 40:13 68:9 79:13 100:23</p> <p>complex 14:12 31:14 68:2 77:8</p> <p>complexity 13:17</p> <p>compliance 20:13 79:15 80:17 81:18</p> <p>compliant 98:12</p> <p>complicated 18:6 68:1 69:18 73:23</p> <p>concern 10:22 20:3 23:10 55:18</p> <p>concerned 34:24 90:19 91:7</p>	<p>confidence 66:25 90:15, 21</p> <p>confident 5:18</p> <p>confined 43:9</p> <p>confusion 20:24</p> <p>congestive 77:9</p> <p>conscious 99:22 102:7</p> <p>consensual 34:3</p> <p>consensus 15:17 25:24 31:4 32:1, 6, 7, 15 33:22, 23 34:15</p> <p>conserve 88:12</p> <p>Considering 11:20</p> <p>consistency 56:13</p> <p>consortium 85:21 93:5</p> <p>constant 64:14</p> <p>constrained 101:16</p> <p>construction 60:20 62:14</p> <p>Consultant 2:13 6:15</p> <p>consulting 6:7 72:11</p> <p>consuming 80:11</p> <p>contact 33:18</p> <p>contain 25:8 34:12 40:2 65:13</p> <p>contained 35:20</p> <p>containing 25:9</p> <p>context 17:18 18:24 19:7 26:3 86:24</p> <p>contextual 15:22</p> <p>contextually 33:13</p> <p>continually 93:21</p> <p>continue 47:4, 11 57:7 58:8 72:24</p> <p>continues 55:6</p> <p>continuing 21:12</p> <p>continuous 84:24</p>	<p>continuously 26:25</p> <p>contribute 94:1</p> <p>contributing 85:25</p> <p>Control 2:13 5:10 6:15, 20, 23 13:4 14:16 39:1 40:20 44:25 45:14 49:12 82:23 83:11</p> <p>controlling 41:20</p> <p>conversation 54:4 64:10 86:21 92:2</p> <p>conversations 92:1</p> <p>convert 78:12</p> <p>convincing 17:17</p> <p>core 74:5, 6</p> <p>cornerstone 70:25</p> <p>corporate 35:1 38:11</p> <p>correct 37:22 48:13 54:1 57:22 90:24</p> <p>cost 49:15 59:7, 22</p> <p>costs 50:17</p> <p>Counsel 2:15, 16, 17 3:4, 17, 19, 20, 21 4:13, 22 7:24 46:20 48:9 50:20 52:24 58:24 60:5, 25 62:11 63:4 79:3 86:19 91:1 94:11</p> <p>count 84:9 95:10</p> <p>counts 10:9</p> <p>couple 6:18 9:16 30:2 75:17 79:25</p> <p>course 9:15 12:6 19:5 37:10, 20, 22, 25 38:4, 17 39:2, 8 40:22 72:5</p>	<p>73:2 74:4, 7, 9 75:3</p> <p>courses 38:12 39:1 40:20 64:12</p> <p>cover 51:6 79:7 83:11</p> <p>covered 47:1</p> <p>covering 78:13, 14</p> <p>COVID 7:1 11:7 15:21 20:12, 17, 19 24:16 28:9 29:8, 9, 10 40:3, 9, 11 44:7, 25 45:18 53:15 62:24 82:17 83:12 85:6 87:23 90:7 93:8 96:23</p> <p>COVID-19 1:7 5:2 7:3, 4 10:5 43:22 56:25</p> <p>created 8:12 83:16</p> <p>creating 78:16</p> <p>crisis 39:25 40:1</p> <p>critical 72:16 99:8</p> <p>critically 83:6</p> <p>crossing 64:25</p> <p>CSR 104:3</p> <p>cumulative 12:15</p> <p>curious 74:5</p> <p>current 46:18 61:20 88:9 97:16</p> <p>currently 6:25 77:25</p> <p>curriculum 5:25 71:21 74:4, 10</p> <p>cutlery 46:1</p> <p>CV 5:16</p> <p>< D ></p> <p>dad 90:5</p> <p>daily 23:3 29:25</p> <p>dangerous 17:21 18:14 41:18 45:7</p>	<p>Daoust 3:10</p> <p>data 57:24</p> <p>date 104:6</p> <p>Dated 104:13</p> <p>day 1:16 9:25 16:1 19:20 23:21 24:10, 19 28:1, 2, 14 29:18 51:25 53:15 73:22, 24 96:8 97:17 104:13</p> <p>days 12:15 23:4, 5, 13, 16 29:10 53:16, 19 65:9 78:11 80:3, 5</p> <p>deal 9:23 77:7 100:20</p> <p>dealing 8:13 10:13 11:16, 17 65:23 87:14, 20 91:19</p> <p>dealt 13:18 39:20 93:8</p> <p>dear 68:20</p> <p>death 42:21 62:19</p> <p>deaths 12:10, 12 13:15 88:20 95:17</p> <p>debate 22:20 23:24 25:17</p> <p>debt 50:16</p> <p>December 41:1, 2</p> <p>decide 25:23</p> <p>decision 18:16 25:20 34:4</p> <p>decisionmaking 31:12</p> <p>decisions 25:6 30:15</p> <p>declining 77:3</p> <p>dedicated 8:22 68:3 70:23</p> <p>defend 66:16</p> <p>defending 38:2 44:23 45:3</p> <p>defensible 40:20</p> <p>defines 95:23</p> <p>definitely 92:6</p> <p>definitive 17:24 30:19, 22</p>
--	--	---	--	---

<p>degree 22:16 delivering 32:22 dementia 22:6 76:18, 20 77:11 demonstrate 9:15 department 5:22 69:12 85:9 depend 78:25 dependent 31:3 depending 56:21 depends 23:6 depressed 77:12 Deputy 3:2 Derek 3:6 description 10:17 deserve 8:24 desperation 41:24 despite 10:6 11:7 44:1 45:14 detail 71:12 85:8 details 80:10 deteriorated 14:23 detour 64:6 develop 71:20 developed 95:7 developing 30:7 diabetes 77:10 die 45:5 diem 50:7 difference 21:3 40:22 49:6 92:16 98:22 differences 11:9 56:15 68:7 different 15:12, 20 16:6 18:25 27:23 28:25 31:18, 21 33:13 40:13 48:3, 11 55:20, 25 66:8, 9, 10 79:23 80:6 87:3 89:2, 9 92:12 differential 24:7 differently 18:23 difficult 14:12 15:1 16:3 18:24 31:12 33:10, 25 38:7</p>	<p>43:24 62:23 73:23 90:8 91:1, 17 difficulties 43:5 70:9 difficulty 15:3 37:15 53:1 65:3, 11 dining 44:12 direct 60:9, 11, 12 83:1 directed 90:12 direction 5:8 79:3 88:10 92:7 directives 88:12 Director 3:6 6:1, 19 36:12, 13, 23 69:24 71:21 72:2 73:2 74:10, 11, 16, 19, 23 75:4, 13 76:11 directors 22:25 23:1 36:14 71:25 72:1, 9, 14 73:1 74:18 95:22 disappointed 10:19 discuss 64:9 discussing 23:16 discussion 12:7, 24 21:15 31:23 41:22 82:8 97:19 discussions 36:5 41:16 67:22 76:25 104:8 Disease 6:24 41:15 77:8 disinfect 16:23 17:11 disinfectant 21:2, 5 disinfectants 17:12 20:25 27:13 disinfection 17:3 18:4 43:21 disinfector 16:21 disposable 46:1</p>	<p>dispute 25:18 disrupt 45:24 distance 33:5 distinct 8:12 doc 73:18 Doctor 23:23 doing 9:20 11:6 15:18 16:14 18:3, 6 19:10, 19 20:10 25:2 27:13 31:17, 20 32:16 38:14 40:19 46:21 47:3 53:24 67:17 69:7 72:11, 16 80:20 81:20, 21 82:1 83:8, 11, 13, 23 85:14 86:8, 9, 11 91:12 96:1 99:18, 25 100:5, 20 102:4, 15, 17 downtown 8:2, 5 10:10 drive 44:21 driving 89:13 Drummond 3:2 duplicate 69:23 duration 12:14 duty 65:24 < E > each-bed 52:8 each-home 52:8 early 41:1 88:19 easier 41:7 easy 13:19 21:6 43:23 66:4 70:20 78:2 eat 44:12, 14 45:25 echo 68:9 economics 64:7 education 73:12 94:2 effect 42:7 97:19 effectively 34:12 effort 101:19 efforts 10:6 93:25 Eglinton 59:6</p>	<p>elderly 5:14, 25 elevate 73:20 eleven 79:23 Elizabeth 33:1 eloquently 82:14 emerg 73:17, 18 emergency 69:12 emotion 69:21 emphasize 20:11 employees 49:18 53:14 77:21 emptied 45:19 ended 102:25 end-of-life 76:24 77:6 engage 71:24 engagement 76:7 enormity 87:19 enormous 16:2 enormously 15:4 33:9 ensure 8:22 11:6 55:6 61:15 65:24 66:15 ensured 29:17 ensuring 93:20 94:1 enteric 31:8 entire 5:16, 24 39:24 89:20 entirely 33:22 envelope 50:3, 12, 18 51:2, 22 envelopes 46:19 50:2, 9, 22 environment 68:3 71:3 epidemiology 33:4 equation 57:11 equipment 46:24 64:20 88:13 escalate 35:3 escaped 13:13 especially 6:11 10:10 88:16 essence 95:7 essential 45:8 98:25</p>	<p>essentially 51:13 established 34:10 estimation 57:17 eventually 61:20 everybody 16:18 18:4 27:23 28:7 31:10 32:12 99:21 everybody's 16:2 19:6, 7 every-day 48:25 evidence 4:5 exactly 47:18 83:20 example 16:8 23:25 25:21 52:10 56:17 examples 79:18 excited 86:16 exclude 88:22 Executive 2:8 36:12, 23 69:24 72:1 exercise 78:15 97:1 exhausted 65:22 67:8 exhausting 68:18 expect 15:23 16:5 expectation 31:19 56:5 58:6 62:7 expectations 22:24 72:18 expecting 57:1 expense 52:4 expenses 50:11 51:6 experience 10:16 11:21 36:24 75:12 experienced 5:13 33:15 84:6 experiences 82:10 Expert 7:1 18:16, 19 38:1 39:16 40:17 46:8 49:20</p>
--	--	---	--	---

<p>expertise 5:6, 7, 9 6:19 38:19 40:7 46:25 49:12 73:19 80:22</p> <p>experts 15:20 27:15 89:11 95:21</p> <p>explain 7:19 69:22</p> <p>expose 26:22</p> <p>exposed 26:21</p> <p>express 28:19 69:23</p> <p>extended 43:10</p> <p>extra 27:2 46:23 67:13, 24 96:13</p> <p>extraordinarily 90:8</p> <p>extremely 63:8, 10, 12, 13 64:16 68:23</p> <p>< F ></p> <p>facing 98:12</p> <p>fact 8:9 10:5 12:9 20:12 34:9 38:13 41:14 43:6, 12 44:1 51:3 52:7 65:18 80:4 87:4 99:12, 22, 25 100:1 101:16</p> <p>factors 67:10</p> <p>failings 102:7</p> <p>failure 77:9</p> <p>fair 78:4</p> <p>fairness 78:5</p> <p>Faith 2:16, 17</p> <p>falls 86:12</p> <p>familiar 21:4 41:9</p> <p>families 9:9 43:8 55:4 66:24 67:20 68:8, 12 76:23 77:6</p> <p>Family 5:22 76:22 91:4, 7</p> <p>family-centred 76:21</p> <p>Fantastic 27:5</p> <p>fast 93:15</p>	<p>fear 82:4</p> <p>feedback 71:14</p> <p>feel 101:15</p> <p>feeling 19:13 23:20</p> <p>felt 23:9 24:20 29:2</p> <p>field 6:17</p> <p>fifty 89:16</p> <p>fight 5:2</p> <p>figure 44:3, 6</p> <p>figured 34:7 41:25</p> <p>fill 74:7 97:11</p> <p>filled 26:16</p> <p>financial 46:8 49:15 62:6</p> <p>financing 59:15</p> <p>find 5:10 48:19 63:4 69:3 80:6 88:16</p> <p>finding 19:12 26:13 61:3 84:1 93:1, 3 94:4</p> <p>fine 17:18</p> <p>five-day 23:9</p> <p>fix 13:20 102:6</p> <p>fixed 13:19 50:8</p> <p>flexibility 50:24</p> <p>floor 26:23</p> <p>flow 55:6</p> <p>flowed 43:6</p> <p>fluids 29:23</p> <p>focus 70:2, 3 80:9, 15, 16 85:19</p> <p>focused 68:15 80:14 102:12</p> <p>focusing 5:24</p> <p>follow 72:18 80:21 84:22</p> <p>following 83:20</p> <p>follow-through 81:12</p> <p>follow-up 43:4</p> <p>food 50:23 52:2</p> <p>foregoing 104:5, 11</p> <p>formed 93:5</p> <p>formula 47:14 52:12 57:8 58:25 59:4, 11 61:7</p>	<p>for-profit 54:4 90:18</p> <p>forth 104:7</p> <p>fortunate 90:2</p> <p>fortune 65:20</p> <p>forward 7:8 15:17 24:20 32:2 34:8 39:7 43:2 60:8 68:15 86:14, 17 101:14</p> <p>found 92:11</p> <p>four-hour 37:25 38:17 39:2, 8</p> <p>fourteen 53:16</p> <p>fourth 12:18 38:6 65:3, 11, 23</p> <p>frame 21:23 84:8</p> <p>framework 54:2 79:15 84:23</p> <p>Frank 2:2 23:22 24:13 25:12 28:22 34:1 38:20 43:3 52:25 55:10 57:13 58:11 84:19 94:6, 17 101:5, 8, 22 102:22</p> <p>Franklin 3:8</p> <p>frankly 50:4 59:23 64:25</p> <p>freedom 44:2</p> <p>freedoms 44:4</p> <p>frequency 22:21</p> <p>frequent 29:23</p> <p>frightening 26:8</p> <p>front 6:12 32:23 50:10 58:5 59:10 91:3 101:15</p> <p>front-line 19:16, 17</p> <p>frustrating 15:4</p> <p>full 10:19 65:25 79:2</p> <p>full-time 6:8 77:19 78:8, 13, 14, 17</p> <p>fully 46:11, 18 67:7</p> <p>funded 14:5 52:11</p>	<p>funding 39:11 46:19 47:13, 18 48:16 49:8 50:2, 3, 8 52:17, 22 53:2 55:13 56:20, 22 58:25 61:7 93:2, 7</p> <p>furniture 45:21</p> <p>future 77:25</p> <p>< G ></p> <p>gap 32:20 71:18</p> <p>gaps 74:6 97:11</p> <p>General 2:14 10:7 38:10</p> <p>generally 31:6 33:23 90:14, 18</p> <p>Genomics 7:3</p> <p>George 8:2, 10, 21 9:12 10:11, 14, 18, 20 11:16 13:22 17:19 18:10 20:18, 25 21:18, 24 22:13 34:23 35:19 36:25 40:25 53:9, 14 63:2 64:11, 18 66:1, 14, 20</p> <p>George's 12:23</p> <p>gestalt 13:23</p> <p>give 5:17 9:11 11:13 12:1 16:8 17:6 24:9 39:19 46:21 51:11, 21, 24 53:20 57:23 64:13 69:4 78:3, 24 79:9 87:19 88:22 90:9 96:24</p> <p>give-and-take 25:3</p> <p>given 4:5, 7 17:18 29:23 33:17 37:7 40:8 48:23 66:5 90:13</p> <p>global 9:24 50:6</p> <p>goal 9:10, 11 15:15 61:9, 21</p>	<p>63:14 91:2 93:14</p> <p>goals 76:25</p> <p>go-forward 13:4</p> <p>Good 4:2, 21 16:14 28:14 33:6 42:12 51:16 52:16 53:22 63:19 65:16, 19 76:17 81:13 100:11 101:19</p> <p>goodness 25:1</p> <p>government 42:25 46:13 47:1 50:1, 4, 14 51:4 54:5, 11 58:5, 16 59:23 61:21, 24 92:23</p> <p>governments 91:24</p> <p>Gowling 3:18, 19, 20, 21</p> <p>gracefully 102:21</p> <p>grant 58:5</p> <p>grateful 47:1</p> <p>gratefulness 92:3</p> <p>great 7:11 24:6 66:25 73:4 74:8 85:15</p> <p>ground 29:3 32:18, 19 33:9 35:1, 11 36:4 40:25 67:12, 17 69:9 70:18 95:8 96:7</p> <p>group 32:14 71:20 73:8</p> <p>groups 43:7</p> <p>growth 56:14</p> <p>GTA 59:2 61:11 62:25 89:19, 21, 22, 25 90:2</p> <p>guarantee 59:24</p> <p>Guardian 22:15</p> <p>guess 46:15</p> <p>guidance 18:22 68:25</p> <p>guide 95:19</p> <p>guideline 20:14</p> <p>guys 33:3</p>
---	--	--	--	--

<p>< H > half 59:17 62:15, 16 halls 91:2, 6 hallways 28:7 Hamilton 19:1 hand 4:20 40:21 98:11, 20 99:5 happen 37:10, 11, 12, 17 59:22 81:12 91:14 93:14 happened 13:2, 5 21:5 25:25 30:25 40:8 45:15 68:19 82:14 happening 19:12 25:17 26:10 30:17 31:16 32:21, 22 40:3 64:16 91:16 95:8 97:3 happens 27:22 47:19 happy 34:8 94:14 hard 11:5 18:16 28:18, 19 31:5 32:10 42:23 63:4 64:17 68:23 69:7 78:24 82:6 harder 32:4, 6 Hawthorn 3:12 head 60:17 headed 40:10 79:3 health 5:6 6:20 7:7, 10 8:7, 18 9:7, 8, 9 11:5 15:13 16:24 18:17, 19 21:3 22:21 24:8, 10 25:19 27:19, 20 30:14, 15, 20, 23 31:1, 14, 20 33:3, 14, 16 36:6 40:1 47:20 64:21 66:9 80:15 85:24 91:23 95:20 97:7</p>	<p>healthcare 27:22 42:21 47:17 hear 13:2 18:21 19:1 37:13 38:8 39:5 68:9 76:2 100:25 heard 12:25 20:6 43:7 46:8 47:6, 15 50:1 59:14 62:6, 20 70:16 71:22 72:12, 13, 25 75:23 79:7 81:10 86:25 89:11 90:17 91:8 97:23 hearing 15:19 20:3 23:3 39:6, 13 66:10 heart 68:20 77:9 heartbreaking 68:19 height 20:18 Held 1:15 HELEN 104:3, 17 help 6:15 27:7 33:12, 20 70:12 97:4, 15 helped 10:12 70:10 helpful 40:23 102:11 helping 27:8, 15 92:23 97:2 helps 96:5 hesitate 101:13 Hey 69:3 86:11 high 10:9 22:16 63:8, 10, 12, 13 80:16 higher 22:10 55:8 56:6 86:12 88:4 89:7 highest 12:17 87:16 88:25 highlight 20:2 21:1 high-risk 80:16 Hillmer 12:10 hired 41:5</p>	<p>48:21 hiring 49:19 hold 68:20 home 8:6, 23 17:6 20:21 22:6 27:18 28:6 29:6, 16, 22 35:12 36:12, 19, 23, 25 37:4 38:6 39:22 40:7 42:11 43:7, 13 45:23 46:15 48:7 52:19, 21 53:6, 10 54:24 56:4, 17 64:15 65:21 69:6, 19 71:2 72:3 73:4 76:8 78:25 79:1 80:2, 16 81:19 82:13, 21 83:1, 10, 25 85:13 91:11 92:9, 13 95:9 96:4, 12, 13, 17 97:3, 4 homes 4:6, 8 8:2 9:1 14:5, 7 17:10 18:15, 25 22:3 25:1 31:7 37:18 41:9 42:2 44:17, 21 45:13 46:4 48:4, 10 51:10 52:13 54:13, 15 62:8, 22, 24 63:11, 12 68:14 70:17 72:13, 20 79:10, 20, 22 80:1, 4 82:3 85:5, 17, 18, 22, 24 86:2 88:5, 20 89:16 93:22 95:23 97:25 honestly 14:17 33:13 99:4 Honourable 2:2 hoping 42:8 hospital 7:11 11:4 15:2, 4 17:1 24:21, 23 27:20 29:21 31:13 33:12 43:23 45:6 49:2 54:9 66:9</p>	<p>80:23 95:16 97:6 98:18, 20 hospitals 4:5 13:11 14:13, 16, 18, 24 16:24 21:17 24:16, 18 31:14 39:25 45:1, 2, 12 46:2 49:3, 7 69:11 81:1 98:1 Hota 37:6 Hota's 97:18 hour 73:11 hours 9:16 37:21 48:18 55:3 60:9, 11, 13 82:25 83:2 housed 22:13 housekeeping 18:4 52:2 housing 5:20 93:6 huge 33:16 50:17 54:19 human 67:7 hundred 64:19 65:8 80:5 90:23 hundreds 49:4 HVAC 20:5, 7, 10, 12 hygiene 97:21 98:11, 20 99:5</p>	<p>Immunization 6:22 impacted 10:11 impacts 76:19 implementing 7:15 36:10 implosion 28:4 67:4 important 8:4, 21 43:22 44:16 45:10 83:6 84:4 100:1 importantly 5:8 impose 45:11 imposed 45:16 imposing 45:11 impossible 34:11 63:5 improvement 77:20 84:24 improving 9:20 IMT 88:9 inadequate 39:8, 10 41:11 include 13:11 included 67:15 includes 50:22, 23 inconsistent 11:11 increase 36:20 67:5 increased 36:22 51:11 increasing 35:23 incredible 24:9 indefensible 44:5 index 47:20 indicator 52:16 85:14 indicators 6:18 85:12 86:2, 4 individual 28:16 40:7 55:17 85:13 individuals 8:1 industry 46:16 47:11 90:13 inexperienced 70:18 Infection 2:12 5:9 6:14, 19, 23 39:1 40:20 42:1, 12, 17</p>
---	---	--	---	--

<p>49:11 62:19 63:7, 10, 11, 13 83:10 infections 40:11 Infectious 6:24 41:15 influenza 31:9 39:21 40:3, 12 information 69:4 83:14 informed 11:22 infrastructure 55:24 56:24 60:2 infringement 44:9 infringements 43:10 in-house 69:15 initially 52:6 Initiative 85:23 input 95:21 inside 10:7 91:11 insight 7:21 79:11 inspected 81:2 inspecting 80:3 83:5 inspection 74:13 80:9 81:6 82:21 83:8, 15 84:1, 9 inspections 71:13 79:21, 23, 24 80:13, 25 81:9 82:7 83:4, 7 84:8 inspector 74:14 79:24 83:22 inspectors 4:6 20:11 80:5 82:4, 5, 20, 25 85:1 integrate 27:1 intelligence 33:4 interest 52:4 59:16 interested 57:18 60:5 interfere 44:24 interim 40:6 47:25 102:9 internal 38:25</p>	<p>interpreting 18:22 interrupting 23:23 interviews 4:7 in-the-moment 100:6 introduction 6:11 introductions 4:16 invest 42:23 51:1 55:24 56:1, 8, 12 57:7 58:8 60:1, 7 93:23 invested 52:20 investigation 19:9 investigator 33:2 investing 42:19 52:10 57:9 58:4 93:11 investment 55:6, 8 57:5 investors 52:6 55:19, 22 63:20, 22 invests 57:16 invited 4:8 75:25 76:1 involved 16:9 22:22 26:5 35:24 36:24 involvement 22:25 IPAC 6:16 13:1 14:6 15:5 18:19 24:22 27:6 35:17 37:8, 9, 16, 18, 21 38:1, 11, 12, 19 39:16 40:7, 24 41:5, 11 46:6, 9, 12, 14, 18, 25 48:13 49:19 83:8 100:17 isolation 96:23 issue 24:1 25:21 56:20 94:24 98:4 99:9 100:21, 25 issued 58:17</p>	<p>issues 8:11, 18 10:13 13:18 16:25 19:2 44:2 94:25 < J > Jack 2:5 Jain 2:8 4:20, 21 12:4 19:25 30:8 37:20 39:15 46:20 49:24 50:20 53:1, 4 55:21 57:21 58:23 60:25 62:11 64:8 78:1 79:6 84:18 86:19, 24 90:23 94:8, 10 101:6, 7, 9 102:19 Jessica 3:8 job 51:16 75:4, 21 88:9 Joe 7:6 John 3:17 4:2 12:5 34:20 37:6 39:4 46:5 49:22, 25 58:13 60:14 62:2 64:5 70:13 74:1 77:17 79:5 86:23 90:11 97:18 101:4 102:24 Johnston 46:10 join 48:25 joined 4:25 6:6 7:13 85:21 joining 7:18 journey 77:3 99:6 July 6:6 June 5:5 7:6 < K > Kate 3:4 Kavi 3:20 keeping 102:11 key 76:10, 16 89:12 99:19 kind 30:10 39:22 40:11 42:3 56:25 61:1 79:9</p>	<p>Kirkham 2:17 Kirkland 82:11 Kitts 2:5 49:1 knew 17:13 18:12 20:19 36:25 37:1 67:1 knowing 95:14 knowledge 73:9 75:21 knows 31:10 < L > lack 35:5 64:25 92:18 land 59:7 61:4, 18 63:4 large 8:17 22:12 30:6 34:10 larger 12:24 lastly 80:18 lawyer 3:16 Lead 3:8, 10 33:2 35:17 36:19 37:8, 18, 21 leader 6:17 65:24 leaders 8:13 27:6 70:6, 7, 15 71:24, 25 72:23 75:10 leadership 7:15 34:25 35:1, 6 36:11, 22 37:4 64:10 66:20 70:8, 17, 20 71:18 72:2, 4, 20 75:19 76:12 80:24 95:4 Leap 85:23 learn 33:10 80:12 83:14 86:13 learned 7:20 9:25 10:1, 12 39:3 learning 9:20 11:2, 3 71:9 73:3 leave 57:14 led 5:10 85:23 left 25:22 52:7</p>	<p>legislation 71:11, 12 74:12 83:9, 17, 18 lenders 63:19, 22 lessons 10:12 Lett 3:6 level 48:3 60:12 81:14 levels 85:13 LHIN 15:12 27:3 97:7 licences 61:12 license 51:17 life 15:15 76:19 102:1 lifetime 33:1 likes 55:22 limited 40:15 lines 56:2 lining 98:6 listen 16:18 19:23 27:14 31:25 33:6 66:7 listened 19:24 listening 16:15 19:6, 14 24:23 36:10 41:12 68:25 99:21 live 8:9 48:9 90:3 lively 22:19 lives 45:24 49:17 68:7 Living 2:9, 11, 13, 15 9:18 43:15 48:7 LLP 2:16, 17 local 30:14 location 62:21 89:17 lock 39:23 long 47:13 60:6 61:23 76:14 84:11 92:15 longest 12:12, 14 LONG-TERM 1:6 3:3, 5, 6, 8, 10, 13, 14 5:15 6:1, 3, 5 7:21 8:20, 25 11:15 13:11 14:8 17:8, 9 18:25</p>
--	--	--	--	--

24:22 29:6, 20 31:6 33:12 39:20 41:21 42:6, 25 43:24 45:9 47:5 48:1, 4, 10 49:7, 10 51:9, 15 53:6, 13, 22 55:1, 7, 23, 25 56:3, 8, 13, 19, 23 57:7, 10, 17, 25 58:8 59:16 68:2, 5, 13 70:6, 24 71:6, 17, 19 72:20 73:6, 7, 8, 15, 16, 21 74:15 75:11, 14, 15 76:10, 17 77:2, 4 80:7 81:1, 10 82:11 83:10 84:7 85:5, 21 87:1, 5 90:16, 18, 20, 21 91:22 92:19, 24, 25 93:22 95:9 99:9 100:9 102:16 looked 11:25 17:20 74:10 79:19 looking 5:16 48:20, 25 56:14 60:7 72:23 looks 4:18 74:13 lose 13:16 loss 43:8 lost 57:5 lot 7:9 11:10 15:13 26:9 29:12, 24 31:11 32:4, 10 33:20 42:17 43:21 44:2 52:7 56:17, 18 58:4, 6 59:25 65:2 79:11 90:17 102:15, 20 lots 12:7 35:11 loud 91:8 love 70:22 loved 71:3 90:3 91:12 low 58:9	lower 78:12 89:8 Lynn 3:19 < M > machine 19:1 made 26:1, 3 40:22 45:21 54:14 60:17 Mahoney 3:19 majority 28:5 making 17:16 25:10 29:5 34:4 67:19 68:16 81:25 male 22:10 manage 11:11 14:22 28:7, 19 31:10 33:20 37:1 41:25 52:18 67:25 70:12 77:12 90:8 97:15 managed 13:13 32:17 35:21 65:3 87:2 management 20:20 23:1, 2 24:17 35:3 36:5 75:23 76:6 77:8 84:10, 23 manager 32:21 97:15 managing 11:21 14:11 15:8, 21 22:18 33:2, 4, 16 55:4 mandatory 36:16 manner 86:6 Mapa 7:6 March 1:17 88:8 104:13 margin 47:9 57:24 58:1 marginally 22:13 Mark 2:16 4:18, 21 Marrocco 2:2 23:22 24:13 25:12 28:22 34:1 38:20 43:3 52:25 55:10 57:13	58:11 63:18 68:10 84:19 94:6, 17 101:5, 8, 22 102:22 Marrocco's 60:4 MARTINEAU 104:3, 17 mask 9:5 88:17 masking 83:24 masks 9:6 88:10 match 83:19 matches 83:18 matter 62:22 87:8, 9 90:6 McGeer 2:12 4:19 5:1, 11 6:10 7:17 11:20 12:1, 3, 6, 25 13:8, 9 19:25 20:22 23:25 30:8, 12, 13 34:5 37:13 38:9, 13 39:5, 9, 16, 21 40:16, 18 43:17 46:10 65:5 66:5, 19 69:2 92:8 94:15 98:17 101:20, 23 102:19 McGeer's 9:11 McGrann 3:4 meal 45:25 meant 10:24 55:24 measures 43:14 media 64:14 65:1 70:1 Medical 2:10 5:7, 15, 19 6:1, 8 22:24 23:1 29:16 36:13 37:3 67:16 69:5 71:1, 6, 21 72:1, 9, 14 73:1, 2 74:9, 11, 16, 17, 19, 23 75:3 76:11 95:21 medically 8:12 medication 84:10 Medicine 5:22 6:3, 5 40:2	MEETING 1:6 7:25 25:10 28:2 72:9 101:16 102:25 104:5 meetings 23:2 27:16, 17 28:1 member 6:2, 4, 25 11:19 41:23 members 9:2, 7, 22 46:23 48:22 53:8 63:17 64:22, 24 65:14, 22 66:15 78:19 91:4, 7 mental 8:7, 18 mentioned 7:24 11:1 74:3 merge 79:2 MEST 97:9 met 4:24 53:14 metrics 85:11 95:1, 2, 6 96:15, 25 97:17 98:5 mid-December 36:1 middle 5:5 9:18 18:2 38:5 41:2 85:4 mild 95:23 million 46:14, 22 47:2 52:11 54:14 93:11 millionaire 57:4 mind 23:23 42:3 minimal 92:12 Minister 3:2 ministries 15:12 93:13, 15 ministry 61:2, 15 71:7 84:2 minute 23:24 Minutes 82:12 missed 13:6 missing 96:17 100:14 Mississauga 63:9 88:24 mistaken 12:20 misunderstandin gs 32:11 mobile 8:16 model 79:11	moderate 95:24 96:21 modest 57:18 moment 89:23 money 47:7, 8, 23 50:25 51:5, 6 52:5, 6, 7 55:19 58:4 59:5, 10, 23, 25 92:22 94:2 month 65:19 months 9:16 16:1, 2 46:1 morning 4:2, 22 41:13 Morrison 58:21 mortality 87:11, 21 88:2 89:5 Moser 2:10 4:19 5:1, 11, 12 7:16 21:13, 19, 20 24:5, 15 26:2 29:2 34:20 35:14 38:13, 21, 23 66:18, 21 70:13, 21 74:8 79:11 81:5, 8 84:18 85:2 90:14 94:16, 21, 23 101:11 Moser's 9:10 motivated 55:18 move 23:20 45:23 80:19 86:14, 17 moved 6:7 8:9 48:6 movement 21:17 moving 15:17 23:15 26:9, 24 28:20 50:24 77:18 90:4 Mt 7:7 multiple 14:19, 20 48:2 86:25 87:2 municipal 52:13, 19, 21 61:3 municipalities 59:19 63:1 87:4 93:13, 15 municipality 54:7 92:21
---	--	---	--	--

<p>< N > N95 88:17 names 15:14 narrow 28:6 National 6:22 nationally 7:22 nature 30:23 34:3 near 68:20 nearly 6:21 14:7 needed 5:6, 7, 8 19:23 20:15 36:7 54:19 67:12, 16 68:22 69:16 74:22 96:7 97:3 needs 8:11 18:5 25:10 47:17 81:14, 16 82:2 96:12 99:21 negative 20:12, 17 negotiate 31:15 negotiation 71:8 Network 7:3 new 7:14, 15 22:24 26:25 28:15 33:20 41:4, 5, 6 46:12 47:21 48:23 54:11, 12 58:16, 17, 25 60:18 61:7 71:10, 12 75:1 83:12 85:3 86:16 newer 66:22 nimble 83:7 nimbleness 84:14 Nitin 2:8 4:20, 21 19:25 21:25 22:11 30:8 37:20 38:24 39:5, 15 46:20 49:24 50:20 53:4 55:21 57:21 58:23 60:25 62:11 64:8 72:13 77:17 78:1 79:6 84:18 85:7 86:19, 24</p>	<p>90:23 94:10 101:7 102:19 nonGTA 89:19 nonoutbreak 44:17 normal 39:24 84:5 North 63:11 85:25 northern 71:2 notes 104:12 not-for-profit 54:4, 8 59:19 62:25 not-for-profits 87:3 notwithstanding 28:24 34:2, 3 November 65:19 number 8:17 12:9, 13, 15 22:12 30:6 34:2 50:3 56:6 60:16 65:14 78:3, 24 79:4 87:12, 16 92:5 98:21 99:15, 16, 23 numbers 13:3 33:17 35:23 67:3, 5 87:7, 10 88:22, 23 89:2, 24 90:10, 13 96:10 97:5 99:10 nurse 29:18 37:24 95:22 nurses 48:15 75:10 97:10 nursing 22:3 29:13, 22 30:5 36:15 49:4 56:17 71:2 75:10 83:25 85:24 96:9</p> <p>< O > observational 99:1, 7, 16 100:3 occupational 16:24 18:17, 19 occurs 101:13 October 4:24 6:8 22:23</p>	<p>39:19 68:21 85:4 offer 4:11 offering 27:3 Office 22:15 50:11 62:7 Officer 2:9, 10 5:19 6:8 ones 70:18 one-time 93:7 ongoing 44:21 Ontario 6:1 7:22 8:20 10:8 11:15, 18 12:21 13:12 18:20 22:8, 15 48:17 49:3 59:21 71:5, 17 87:2, 21 91:22 Ontario's 6:23 7:4 operators 43:1 87:5 opinion 19:7 opinions 11:9 24:3 29:1 opportunities 60:1 opportunity 66:14 73:5 80:12 102:14 opposed 19:13, 22 101:2 order 26:1, 3 30:18 35:3, 10 36:5 orders 24:9 30:21 31:2 organism 42:6 organisms 41:21 organization 5:20 11:2 41:8 71:16 78:7, 15 86:1 organizations 19:18 organized 67:22 organizing 37:3 67:18 69:5 outbreak 11:12, 24 14:1, 2, 16, 25 15:9, 24 16:4, 10 18:2, 8 19:9 20:18</p>	<p>22:18, 25 23:2, 6, 11 25:8, 10 26:6, 8 27:11 30:9, 15, 17 32:17, 23 35:18, 24 36:9, 20 37:11 38:5, 6 40:23 44:14 49:14, 16, 19 64:18 65:3, 7, 12, 18 69:10, 20 70:12 75:23 76:2 79:19 82:11, 15, 23 87:10 88:7 89:3 92:14 95:8 outbreaks 11:17, 21 12:13, 14 13:14, 15 14:8, 11, 15, 19, 20, 22, 23 15:9, 10, 21, 22 16:19 19:6 22:22 23:3 30:11 31:2, 6, 13 33:2, 5, 17, 21 34:10, 18 35:19 37:1 39:20, 22 65:4, 7, 8, 10, 12, 16, 17 66:8 79:20 88:25 89:13 91:14 92:13 outcome 34:17, 18 40:23 65:16 80:13 92:12 99:19 outcome- focused 81:2 outcomes 80:17 outside 89:21, 25 overall 8:20 11:14 62:18 85:12 89:8, 9, 18 overhead 50:10 51:7 oversight 79:8, 14 81:15 84:14 overwhelmed 61:8 owners 4:8 87:5</p> <p>< P ></p>	<p>p.m 1:17 pages 84:11 pain 77:10 painful 99:7 palliative 76:24 pandemic 8:14 9:24 41:18 42:9 43:15 46:23 47:4 48:5, 20 61:8 83:13 panel's 10:22 Park 58:21 part 5:2 40:5 43:5 47:3 62:20 93:5 participants 1:16 104:9 particular 15:18 100:15, 20 particularly 13:12 84:7 partners 11:4 14:20 66:9 97:6, 7 part-time 77:18 78:8 79:2 party 56:21 pass 81:6 passed 87:24 passion 71:4 passionate 53:21 patients 19:20 75:18 Patricia 3:21 pause 17:14 pay 42:20 50:10 paying 52:1, 2, 3, 4, 5 pending 95:11 people 12:8 13:24 14:6 15:5, 11, 14, 19, 24 16:3, 5, 15, 16 17:24 18:5 19:5, 9, 13 22:16 24:2 25:13, 15 27:8 28:24 29:24 30:3, 6, 24 32:4, 6, 8, 14, 22, 25 33:5, 14, 16, 20 34:2, 15 35:11</p>
--	--	--	--	--

<p>38:3, 15 40:1, 10, 19, 25 41:5 42:2, 11, 12, 19, 23 43:9, 15, 24 44:11, 12, 13, 16, 22 45:5, 6, 15, 18, 23 47:7, 11, 15, 16 48:1, 8, 19, 21, 24, 25 49:9, 13, 17 51:10 53:22, 23 54:23 55:1, 15, 24 56:8, 12, 18, 23 57:7, 9 58:1, 8 60:6, 7 62:21 63:25 64:1 65:13 69:13, 21 70:10, 11 72:19 73:6 75:6, 20 77:1, 9 78:22 79:8, 25 80:20 90:19 92:17 93:8 94:4 95:4 96:10, 18 98:9, 23 99:17 100:17 people's 17:9 43:11 45:20 49:17 100:10 percent 22:4, 5, 7, 9 28:20 57:25 58:2 77:23 78:4 87:12, 22, 23, 25 88:3, 4 89:5, 6, 20, 21, 24, 25 90:23 91:21 97:21 98:8, 11, 19 99:1, 6, 12 percentage 22:10 62:24 89:18 performance 86:3 period 37:16 periods 43:10 102:2 peripherally 16:9 Perley 86:8 permanent 8:8 perplexing 70:14 person 28:12 37:23 38:10, 11,</p>	<p>18 55:20 57:16 87:23 personal 29:14 30:5 46:24 55:17 64:20 88:12 96:20 97:10 personally 102:3 personnel 20:4 person's 76:19 perspective 10:17 11:14 12:2 14:3 27:18, 19, 21 39:18 40:16 49:15 61:2, 3 66:6 79:10 90:9 93:17, 25 persuade 42:25 pervasive 37:17 Peterborough 90:5 ph 18:18 phone 18:18 91:9 physician 29:17 30:1 71:18, 20 73:14, 16, 17 75:2, 13, 17 physicians 5:1 71:7, 17 72:12 75:1, 22 picked 18:17 picking 91:9 picture 9:12 10:20 53:21 65:25 PIDAC 41:22 42:3 pie 53:5 piece 26:24 97:17 98:25 99:10 pieces 26:9, 25 28:20 57:6 pipeline 61:6 pitch 31:19 place 8:8 36:2 45:23 67:25 68:17, 24 69:17 96:2, 14 97:4 places 42:1 plan 27:1, 24, 25 92:2</p>	<p>planning 9:4 67:21 plays 8:3 plus 29:7 point 13:14 20:14 36:3 39:14 42:22 49:13 57:24 64:19 66:2, 3 82:15 84:22 88:9 98:15 pointed 30:16 points 10:21 policies 7:15 Policy 3:6, 8, 12, 14 83:11, 18, 19, 21, 25 Polley 2:16, 17 4:13, 16, 18 population 8:5, 16, 19, 21 21:24 22:2, 3, 4, 9 23:17 28:10 portion 56:23 posed 43:13 position 46:17 positive 26:14, 19 95:11, 12, 16 96:16, 22 possessions 43:25 possible 9:21 25:7 45:21 69:8 78:17 94:24 post 35:10 Post-Acute 6:5 potential 72:21 potentially 26:23 41:17 power 24:7 56:21 PPE 29:15 36:8 82:20 97:21 98:10 practical 97:10 practice 68:4 70:25 practices 11:10 36:9 80:21 practitioner 29:18 practitioners 5:14 95:22</p>	<p>pre 35:9 preCOVID 31:7 predict 67:7, 8, 9 predictable 58:10 preferred 16:11 prepare 10:13 present 21:22 presentation 58:14 101:10 presented 10:18 22:17 President 2:8, 11, 14 pretty 31:7 42:16 100:11 preventative 43:14 prevented 14:1 Prevention 2:12 5:9 6:14, 20 39:1 41:25 42:4, 12, 18, 24 49:12 previous 47:23 54:5 previously 7:7 36:24 59:3 62:12 71:22 pride 62:22 87:9, 10 89:23 90:6 primary 30:4 37:4 76:8 96:8 prior 22:13 priority 91:25 problem 18:10 33:8 39:7 54:22 59:3 100:14, 18 problems 70:19 98:13 procedures 83:19 process 11:25 29:1 31:4 34:4, 7, 14, 16 35:13 61:23 62:3, 4 74:13 83:16 84:25 product's 18:22 professional 24:2 Professor 5:21</p>	<p>profile 54:16 profit 50:11 program 54:12 58:16 59:20 71:21 102:11, 12 programs 36:17 50:23 progressing 27:11 project 97:15 projects 61:5, 10, 11, 12, 17 promise 7:14 prompted 7:25 proper 50:14 property 52:4 protect 9:21 25:14, 15 protective 46:24 64:20 88:12 protocol 83:8 84:10 protocols 17:15 84:10 proud 11:3 13:12 85:20 provide 7:20 8:22 11:22 30:24 42:3, 11 51:19 55:3 77:6 90:1, 2 provided 93:7 Providence 86:9 provider 19:18 76:8 93:10 providers 19:16 73:22 80:7 93:6 providing 8:4 14:14 22:14 36:15 51:13, 16 59:24 81:13 province 12:11 48:17 87:6 89:9, 20 provinces 59:15 provincial 6:24 20:13 41:15 85:15 prudent 23:9 PSW 96:9 PSWs 27:4 48:14 49:10 public 11:4 15:12 21:2</p>
---	--	--	---	--

<p>22:14, 20 24:8, 10 25:19 27:19, 20 30:14, 20, 23 31:14, 20 33:3, 14, 15, 16 36:6 40:1 66:9 90:21 95:20 97:6 publically 54:13 publically- reported 86:4 pull 77:13 pulled 82:6 put 9:7 14:13 17:7 24:19 31:19 61:25 67:12, 13 69:17 93:25 96:14 97:4 putting 65:25 68:24 94:1 96:2 puzzle 26:24, 25</p> <p>< Q > quality 81:14, 25 84:23, 25 85:8, 9, 22 86:3 question 24:6 34:13 41:11 46:15 49:23 53:7 60:4, 14 62:18 63:19 70:14, 22 74:3, 8 76:3 84:20 90:12 99:20 questioned 98:9 questions 6:16 16:17 57:15 86:20 91:4 94:15, 19, 21 quickly 29:25 67:9 84:15 96:20 quite 23:13, 19 62:9 76:15 79:8</p> <p>< R > raise 94:23 ran 88:15 ranked 12:10 rare 31:2 32:1 rarely 19:14 30:21, 22 74:14 75:13</p>	<p>rate 57:19 59:16 86:12 87:21, 24 88:3 89:5 rates 58:3 62:19 63:8, 10, 11, 13 87:11 ratio 78:9, 11 96:19 ratios 96:9 Rea 33:1 reach 25:1 32:15 read 10:17 71:11, 13 98:14 readers 13:7 reading 12:8 13:22 real 76:7 99:22, 23 realistically 50:12, 18 reality 91:18 realize 82:17 realized 65:22 66:3 67:11 71:16, 18 really 5:10 8:18 10:24 14:12, 13, 25 15:2 18:24 23:6, 12 24:5, 20 25:3 28:17, 18 31:2, 9 32:1, 24 33:6 34:24 42:8, 23 43:23 44:18 50:21, 25 51:20 64:9 65:21, 25 67:7, 25 68:5, 14 70:24 71:9 72:16 74:10 75:18, 19 81:13 82:6 84:3 86:11 87:13 90:4 92:2 94:13 97:12 98:7 102:7, 11, 17 reason 19:15 21:7 55:22 56:22 68:21 reasonable 23:14 44:24 reasons 31:22</p>	<p>rebuild 54:21 61:21 recalibrate 47:16 recall 4:4, 24 recognize 15:18 recognized 5:6 recommendation 25:24 54:18 recommendation s 31:18 69:1 102:9 recommended 23:21 46:11 reconfirm 9:14 reconfirmed 9:19 recorded 104:9 recording 53:9 64:24 recreation 36:18 50:23 recruit 78:21 redevelop 54:6 redeveloped 58:18 60:18 redeveloping 54:15 reduce 100:22 reduced 45:17 reducing 25:9 reduction 42:20 reference 20:24 referred 50:3 regarding 4:6 region 88:24 registered 37:24 49:11 97:9 regular 17:12 28:8 38:16 57:2 regulations 74:12 83:9 regulatory 79:8 reinstill 90:15, 20 related 27:12 88:17 relationships 28:11 31:15 67:1 relatively 57:18 58:9 relevant 82:8</p>	<p>remember 88:9 remotely 1:16 removing 44:4 renewing 7:16 rent 51:18 reorganize 18:3 repeatedly 37:10 39:10 replacing 48:22 report 40:6 47:25 94:25 Reporter 104:4, 18 REPORTER'S 104:1 reporting 98:19 99:20 representation 50:15 represents 50:5 reset 83:3 resident 12:19 23:16 28:16 51:4, 22, 25 52:14 96:13 resident-centred 76:21 81:20 residents 8:6, 11, 17 9:7, 21 12:11, 16 19:19 21:11, 16, 17 22:5, 10, 11, 12 23:8, 17 25:6, 11, 15 26:17, 18, 19 28:5, 10 29:7, 8, 9, 10, 24 30:2 43:8 46:13 48:6 50:6, 13 53:20 63:16 67:1, 2 68:8, 12 69:15 70:2 75:18 76:7, 22 77:5, 21 78:18 81:21, 22 91:21 95:10, 12, 15, 18 96:21 resistance 17:23 41:19 69:6 resistant 10:23, 25 16:11 20:8 42:5 66:2 resistive 23:18 resolved 24:4 resolves 24:1</p>	<p>resources 14:21 24:22 38:10 42:15, 18 78:21 82:19 90:1 96:7 respect 58:16 60:17, 21 respected 5:13 respectfully 37:25 79:16 respiratory 31:8 respond 84:15 94:11 responding 91:10 response 9:13 responsive 55:12 rest 46:16 51:23 60:15 restricted 44:18 restriction 43:13 restrictions 44:4 45:12, 16 results 26:11 95:13 98:5 101:3 retirement 56:3, 4 58:2 80:15 85:5 retiring 64:2 return 7:23 57:19 58:7, 9, 10 reversed 89:24 reviewed 95:1 revise 27:25 reward 57:11 rewarding 68:6 RHRA 80:14 Richards 34:21 35:8 Rideau 86:8 rightfully 91:8 rights 43:11, 16 44:9 rise 28:5 risk 51:11 54:2, 16 56:25 57:10 58:6 80:17 roadblocks 93:17 role 8:4 74:11, 20 75:7, 12, 19 roles 78:17 rolled 95:19</p>
--	---	--	--	--

<p>room 16:20 17:5 32:11 44:15 46:1 roommate 26:20 rooms 6:11 28:6 43:10 44:12 45:19 Rose 3:14 rounds 67:18 RPNs 27:4 rules 15:21 31:9 run 33:3 running 11:23 16:4, 18 19:5 29:20 39:24 49:2</p> <p>< S > Sabatino 18:18 safe 21:10 25:6, 7 safely 17:17 sat 71:7 satisfy 95:3 savings 42:21 Scarborough 63:7 89:1 90:4 scenario 52:23 54:10 68:2 school 71:1 75:11 schools 93:3 Science 7:2, 4 Sciences 85:24 scratches 63:24 se 90:13 secondly 35:9 seconds 12:20 Secretariat 3:3, 5, 7, 9, 11, 13, 15 Section 30:18 31:1 79:6 sector 7:21 10:6, 7 13:11 24:22 33:12 51:12 53:24 60:10 68:6, 7, 20 79:14 84:15 88:3 89:5 90:22 93:10 94:5 98:18, 20 self-assessing 97:25</p>	<p>send 97:8 sending 69:13 Senior 2:9, 11, 13, 14, 15 3:12, 14 5:19 9:18 35:4 93:6 95:3 Senior's 85:22 sense 34:7 51:11, 21, 24 55:14 61:15 64:13 72:15 96:3, 24 sensing 62:9 separately 28:2 seriously 42:4 serve 10:15 served 6:21 22:2 serves 8:16 service 33:4 services 8:4 36:17 69:5 servicing 50:16 52:2 set 9:23 58:3 72:18 76:25 104:6 setting 22:24 26:12 seventy-five 80:3 severe 8:10 30:7 95:25 share 79:18 80:21 86:11 shared 97:5 sharing 86:2, 5 shift 67:10 75:6 shifts 96:18 shirt 57:5 short 45:13 92:20 shortages 49:4 Shorthand 104:4, 12, 18 short-term 47:10 show 11:23 sick 30:3 53:16, 18 side 64:6 sides 18:20 Sienna 2:9, 11, 13, 15 4:3, 10, 13 5:3, 4 6:15 7:20 9:17 10:7,</p>	<p>22 11:14 12:9, 20 13:2, 14, 24 16:11, 20 17:13, 21, 22 18:9, 11 20:8 22:21 25:22 40:24 41:5 46:15, 22 55:15 58:19, 20 59:18 60:15 61:9 62:19, 23 66:13 68:21 70:16 72:22 85:3, 12, 20 86:16, 22 87:24 90:12 92:5, 20 93:24 97:13 Sienna's 37:18 63:21, 22 93:17 sight 25:5 significant 8:7 43:11 69:20 70:19 78:20 88:1, 6, 20 92:14 silence 94:7 Similar 8:25 9:1 20:22 simple 14:4 66:7 simplify 50:21 61:25 Sinai 6:20 7:7 single 9:6 45:6 78:3 sit 23:1 42:10 site 9:6 27:6, 7 29:4 35:25 38:12 78:3 85:1 96:8 sites 59:2 sitting 41:12 situation 13:17 14:10, 13, 24 15:2 25:20 38:2 situations 26:6 Sivasothy 3:20 sixteen 66:8 sixty 89:16 size 78:25 88:14 skill 33:9 skilled 56:17 76:21 skills 76:24 sleep 15:25 slightly 27:23</p>	<p>slower-moving 41:17 small 28:15 35:20 47:9 71:2 99:17 100:15 smoker 26:22 smokers 22:16 social 8:7 17:6 36:17 socially 8:12 Society 6:3 soft 16:23 17:2, 10 45:20 solution 19:12 47:5, 12 54:25 59:12 92:24 93:5, 10 solution-focused 81:3 solve 39:6 49:20 54:23 solves 54:22 somebody 17:4, 6 99:18 100:1, 5 102:15 someone's 43:6, 13 sooner 61:16 91:15 Sorry 64:5 73:25 76:11 sort 22:23 35:5 41:24 74:5 76:11 84:25 95:3 sorts 97:24 sought-after 5:13 sounded 17:17 96:10 south 76:15 space 7:10 speak 4:4, 9 7:23 26:4 85:7 92:8 speaking 31:6 33:23 80:23 specialist 46:7, 9, 18 specific 4:6 39:2 49:23 80:10 85:19 94:14</p>	<p>specifically 5:15 7:25 40:19 spend 54:14 spent 5:23 42:17 46:22 102:15 spite 89:10 spoke 7:13 60:24 82:14 spoken 22:12 spread 65:5 100:19 SQLI 85:23 St 8:2, 10, 21 9:12 10:11, 14, 18, 20 11:16 12:23 13:22 17:19 18:10 20:18, 25 21:18, 24 22:13 34:23 35:19 36:25 40:25 53:9, 14 63:2 64:11, 18 66:1, 14, 20 stability 60:8 stable 57:19 58:10 63:21 staff 12:12, 17 23:7 25:7 26:14 28:8, 11, 12 29:13 35:21 49:11 52:1, 3 64:17 73:20 76:9 82:18, 25 83:24 96:16, 17 staffed 9:2 staffing 26:16 48:1, 11, 18 49:4 92:19, 25 93:2, 23 96:6, 18 97:11 stage 39:12 77:1 stages 95:25 stake 63:22 standard 31:7 standardized 97:13 start 14:12 43:20 61:9, 10 62:16 started 35:22 36:20 48:5 71:20 72:10</p>
---	--	--	--	---

86:20 91:14, 17 95:9 99:4 starting 10:21 38:15 74:24 82:16 85:3 States 56:16, 18 79:12 statistics 22:1 stats 97:20 status 29:24, 25 stay 10:3 28:3 83:17 Steering 7:2 stenographically 104:9 step 99:2 stepped 37:2 steps 7:18 stick 49:18 stock 21:6 29:15 stop 44:7 73:25 stopped 17:24 54:7 strategy 23:10 93:18 streamline 61:25 stress 16:3 stretched 33:19 strong 79:15 stronger 24:21 struck 34:23 structure 35:9, 12 struggling 67:12 stuck 14:9 stuff 98:1 100:16, 19 subacute 29:21 Subcommittee 6:23 substantially 44:18 52:9 successfully 34:11 sufficient 58:15 suggest 79:16 suggesting 58:19 suggestion 80:18 suggestions 16:12 suited 5:19 summer 72:11	support 14:14 22:14 29:14 30:5, 6, 24 36:9, 15, 18, 22 37:2 41:11 55:1, 17 67:6 70:7 73:9, 12 77:1, 4, 5 82:25 96:20 97:10 supported 29:3 67:14 supporting 73:13 supports 27:2 29:16 36:4, 16 37:5 67:13, 24 68:16, 24 69:8, 14, 16 77:13 96:9, 13 97:3 supposed 18:15 42:2 surface 63:24 surfaces 16:23 17:2, 10 surprised 11:1 surrounding 13:18 surveillance 26:12 sustainable 52:12 Susy 100:25 swab 95:13 swabbed 96:16 swabs 95:11 switch 21:6 switchover 41:1 symptom 30:7 95:17 symptomatic 96:22 symptoms 76:20 95:24 syndrome 77:11 System 6:20 7:7, 11 20:8 42:22 46:12 systems 49:2 < T > tab 96:15 Table 7:4 tables 71:8 takes 51:4, 5 78:21 87:13	talk 20:2 21:13 42:19 64:1, 14 66:14 74:16 76:4, 5 80:7 81:20 86:13, 21 87:10 talked 8:1 17:15 20:22 35:10 37:14 39:21 49:5 51:8 60:18 63:22 67:3, 15 73:3 77:18 talking 25:8 48:2 83:7 task 9:23 taxes 52:4 Team 3:10 8:22 9:2, 7, 21 11:16, 19 20:20 27:4 28:1, 15 30:4, 5 35:4 36:15 37:3 46:23 48:22 53:8 63:16 64:22, 24 65:2, 11, 14, 22 66:15, 20, 22, 23 67:6, 11, 16, 24 68:22 69:7 70:3, 9 72:2 74:17 76:2 78:19 91:3 97:9 teams 22:20 29:3 36:2 72:17, 24 73:13 75:23 80:24 technically 15:8 30:14 31:18 tend 31:13 term 45:13 47:13 76:14 92:20 terms 21:24 35:22, 24 36:11 64:12 75:6 76:6 89:2, 4, 11, 18 93:24 94:8 terrible 44:9 terrified 82:17 test 20:13, 17, 19 tested 23:18 26:19	testified 34:21 37:6, 14 testimony 35:7 97:18 testing 21:15 22:21 23:4, 5, 7, 10, 13, 15, 18, 19 26:11, 13 76:5 thankful 91:23 Thanks 21:20 theme 21:12 theoretically 100:3 therapy 36:18 thing 15:22 16:9 18:1 19:3 24:15 25:2 34:22 53:25 63:15, 16 68:24 69:21, 22 78:18, 19 83:23 88:23 92:17 93:20 100:7 101:21 things 18:7 19:21 21:7 28:16 29:11 31:5 40:4 42:9 45:22 46:2 51:8 54:16 58:24 59:13 61:16 66:10 70:15 73:3 82:1 83:5, 15 84:15 89:12 90:7 94:14 100:2, 15 102:5 thinking 40:21 41:13 third 65:17 89:15 thirds 87:18 thirsty 73:9 thirty 68:4 Thou 24:11 thought 17:18 18:11, 13, 21 20:14 58:21 94:10 102:4 thousand 87:17 thrilled 72:25 Thunder 59:4, 8 ticking 72:6 84:11 ticking-the-box 97:1	time 14:17 15:13 23:12 26:6, 10, 11 27:22 28:14 33:17 38:7 39:22 42:13, 17 43:10 48:23 53:12 56:18 58:10 60:19, 24 61:6 64:4 67:5 71:17 77:3, 17 79:2 80:11 82:25 100:6 101:18 102:16 104:6 timeline 62:4, 9 timely 91:9 times 6:13 21:1 49:15 53:11 59:7 66:10, 16 84:5 86:25 timing 61:13 title 37:7 Today 4:3, 23, 25 6:13 7:19, 23 9:11 12:7 21:22 48:9 52:17 54:22 56:5, 9 78:2 92:4 told 12:10 13:25 39:9 49:3 77:19 91:15 toll 68:10, 11 top 23:11 60:16 topic 58:14 Toronto 5:23 8:2, 6 10:9 63:3 92:21 total 92:4 touched 64:12 tough 90:17 town 91:1, 6 tracing 33:18 track 97:14 train 33:20 78:22 trained 18:5 37:19 38:12 40:11 46:12, 18 75:8 training 37:9, 16 40:13 46:12
--	---	--	--	--

<p>71:21 74:25 75:15, 16 93:24 transaction 55:14 transcribed 104:10 transcript 12:23 13:7, 22 104:12 Transcripts 4:7 transfers 69:12 translate 99:2 transmission 25:9 41:20 42:1, 5 44:7, 25 45:17 100:9, 22 treatment 95:19 treatments 96:2 tremendous 11:21 triad 72:4 trivial 18:1 trouble 14:8 true 47:18 99:16 104:11 trully 53:23 Trustee 22:15 truth 100:8, 18 truthfully 70:24 trying 16:17 21:10 26:15 27:10 28:2, 7 32:12 33:12, 18 38:21 43:4, 12 59:21 67:25 68:23 69:14, 22 71:10, 14 74:7 82:18, 19 102:5 twelve 48:24 twenty 6:21 two-thirds 50:7 type 39:20 57:16 types 40:13</p> <p>< U > U.K 92:10 U.S 71:9 82:10 UHN 8:1 10:22 13:22, 24 16:13, 14, 15 17:19 18:13, 22 20:4, 7, 14 21:3, 15 22:20 23:8, 21 24:25 27:5</p>	<p>35:18 36:6 UHN's 16:12 ultimately 24:6 underserved 8:5 understand 7:8 11:8 20:9 27:10 28:12 32:7 33:8 40:2, 5 43:5, 12 55:11 61:14, 24 63:20 64:22 66:1 71:10 76:18, 19 80:24 84:4 87:22 96:5 97:2 understanding 5:17 21:9 38:24 75:6 96:11 understands 7:10 unfortunately 37:8 87:24 unique 8:15 28:10 68:5 unit 15:13 30:15 United 56:16, 18 79:12 units 30:21 31:1 universal 83:23 University 5:23 63:3 unscathed 10:4 update 60:21 83:21 updated 97:16 upgrade 54:20 upset 23:19 urgency 35:5 61:15 usual 29:19 31:21 75:16 utilities 52:3</p> <p>< V > vacancies 48:24 vaccinated 91:22 92:10 vaccination 102:10, 12 vaccine 91:20 92:3, 5, 6, 15</p>	<p>vaccines 93:21 Valley 92:9 valuable 73:14 value 73:17 101:1 102:3 variability 85:17 variant 92:11 variety 28:25 veer 83:20 versus 40:3 48:11 56:16 57:10 89:19 92:13 95:24 Vets 86:9 viable 52:22 54:10 Vice 2:11, 14 Vice-President 6:2 vicinity 92:14 Videoconferenci ng 1:15 view 11:23 20:15 25:24 27:23 38:9 39:19 40:15 46:21 49:1 58:15 66:2, 3 78:23 81:6 90:15 virtually 43:16 virus 83:12 visit 20:20 43:9 visitors 45:4 voluntary 24:17 35:2, 10</p> <p>< W > wage 49:6 wait 20:19 53:17 63:25 waiting 4:15 54:23, 24 95:13 walk 10:21 95:4 walked 42:4 Walsh 2:14 wanted 5:17 20:7, 10, 15 34:17, 19 42:14 54:5, 6 64:8 66:18 77:22 79:6, 9 81:5 84:20 90:9 94:9, 21, 24</p>	<p>96:24 101:12, 24 102:13 wants 49:14, 19 51:14 war 10:4 ward 28:6 Washington 82:12 watched 32:24 98:24 99:17 watching 41:16 100:2, 16 wave 5:5 9:3, 4, 13, 18 10:1, 2, 4 13:5, 13 14:10, 11, 18 35:20 65:18 66:23, 24 88:2 89:4, 7, 8 91:11 97:24 102:6 ways 8:15 34:6 90:24 weak 64:10 webinar 38:14 week 30:1 73:1 weekends 78:11 weeks 72:10 weigh 98:17 welcomed 48:17 wet 17:3 willing 45:22 49:14 78:10 willingness 49:9 WLG 3:18, 19, 20, 21 wondering 94:7 won't 45:5 Woodbridge 63:12 word 64:25 work 9:3 17:6 27:24 34:15 36:7 42:10 53:13 54:13 59:1 62:9 65:7 68:3, 6, 22 72:3 73:17, 22, 23 76:9, 15, 17 77:13 78:10 81:19 82:3 84:23 102:4, 14, 17 worked 34:4, 7, 14, 16 67:14</p>	<p>71:1, 5 worker 78:8 workers 29:14 30:5 55:17 77:19 96:20 97:10 workforce 77:23 working 11:6 19:21 25:4, 15 27:9, 21 29:1, 4 61:14, 24 67:23 68:13, 23 69:7 71:8 72:8, 22 81:21 85:4 95:23 works 73:14 world 39:24 worldwide 83:13 worried 13:21 49:17, 18 64:21 69:11 92:18 worry 49:16 worse 102:2 worst 46:3 write 30:18, 21 written 31:1</p> <p>< Y > yeah 13:10 14:4 30:13 40:18 70:5 85:2 year 4:24 48:9 56:5, 10, 11, 12 79:23 84:6, 17 years 6:21 37:24 47:13, 14 48:2, 8, 12 54:3, 5 57:9, 12 59:22 61:18 62:12, 15, 16 68:4 80:4 89:16 93:12 98:21 100:24 Yonge 59:6 York 63:11 younger 8:16 22:3, 8 Yup 18:24 100:6</p> <p>< Z > zone 95:14 zoning 61:4 Zoom 1:15 32:4</p>
---	--	--	--	--