Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System

The Honourable Eileen E. Gillese
Commissioner

Ontario

Commission d'enquête publique sur la sécurité des résidents des foyers de soins de longue durée

L'honorable Eileen E. Gillese
Commissaire

In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

Affidavit of Lisa Vink

I, Lisa Vink, of the County of Brant, MAKE OATH AND SAY:

1. I am a witness to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the "Inquiry"). I have firsthand knowledge of the matters to which I hereinafter depose. When I do not have firsthand knowledge, I have identified the source of my information and belief and believe it to be true.

2. I am a registered nurse (RN), having graduated from Fanshawe College in 1992. After graduation, I worked in municipal homes for the aged and a nursing home, as a RN. I also worked as an acting Director of Nursing (DON), and as a DON. I also taught the health care aide program for Fanshawe College for a class.

3. In 2000, I joined the Ministry of Health and Long-Term Care (MHLTC) as a Compliance Advisor, in the Central South Regional Office located in Hamilton. I was hired with about

10 other Compliance Advisors, in the province, as part of the MHLTC commitment to complete Annual Reviews in all long term care homes. I worked as a Compliance Advisor and then an Inspector in the Hamilton office since starting with the MHLTC.

4. When I first joined the MHLTC, there were three separate pieces of legislation that applied to the direct operation and obligations of homes that are now known as long-term care (LTC) homes: the *Nursing Homes Act* (*NHA*), the *Homes for the Aged and Rest Homes Act,* and the *Charitable Institutions Act*. Prior to July 1, 2010, Compliance Advisors would conduct Reviews in homes using the Long-Term Care Facilities Program Manual, which contained detailed standards and criteria with which the homes were required to comply.

5. I was working in the Hamilton Service Area Office (SAO), during the transition from the old legislative regime to the new regime, which culminated in the *Long-Term Care Homes Act, 2007* (*LTCHA*) and O. Reg. 79/10 ("the Regulation") coming into force on July 1, 2010.

6. In 2010, when the *LTCHA* and the Regulation came into force, I took on the role of Duty Inspector, triaging information that came into the Hamilton SAO. I was an informal lead in this area on and off until approximately late 2012, when the Centralized Intake Assessment and Triage Team (CIATT) took over responsibility for the triage process for the entire province.

ORGANIZATIONAL STRUCTURE OF THE HAMILTON SAO

7. The Central South Regional Office became the Hamilton SAO around 2007. At that time, I have been informed that there were approximately 18 full-time equivalent (FTE) Compliance Advisors working out of the Hamilton SAO. The number of Compliance Advisors or Inspectors in the office generally stayed the same until 2013. I have been informed that, in 2013, 17 new FTE Inspector positions were added to the Hamilton SAO.

8. Since I began working in the Hamilton SAO, there has always been at least one SAO Manager in the office. Karin Fairchild is the SAO Manager. She has been in this position since 2007.

9. Until recently, the SAO had two Inspector Team Leads (ITLs); they were Inspectors who took on leadership roles. ITLs provided support to Inspectors, including answering questions for Inspectors while conducting inspections, assigning work, providing guidance and reviewing Inspection Reports and Orders. ITLs in the Hamilton SAO have typically been RNs who previously conducted Inspections. However, more recently the Hamilton SAO also had an experienced Registered Dietitian ITL who was formerly an Inspector. Although I have acted as an ITL from time to time, I have never done so in an official capacity. My preference has been to inspect.

10. As of March of 2018, the ITLs no longer exist. They have been replaced by two Inspection Managers (IMs). While they continue to do much of the work previously done by ITLs, they are now managers and have taken over some of the responsibility for

human resource management and performance reviews, which had previously been the sole responsibility of the SAO manager.

11. The ITLs (now IMs) are responsible for assigning intakes for inspection. They email the administrative assistant, who then assigns the intake to a specific Inspector (or Inspectors).

12. Inspectors use their clinical judgement and experience in determining what action to take with respect to an intake that has been assigned to them. Inspectors are not required to obtain managerial approval to close an intake which has been assigned to them for the purpose of an Inquiry or Inspection. For example, a Critical Incident (CI) Report may have been amended by the LTC home after it was assigned for an Inspection or Inquiry. The assigned Inspector may determine that, based on new information provided by the LTC home, an Inspection or Inquiry is no longer necessary. An Inspector may decide to close the intake, as long as they document why they did so. An Inspector may also decide that an intake marked for an Inquiry should be inspected, or that an intake marked for Inspection may be completed as an Inquiry. An Inspector does not require approval from either an ITL (or IM) or from the SAO manager to make these decisions, but must document the decision that was made and why. In some cases, an Inspector may reach out to a manager for advice or a discussion before closing an intake. Changing the initial assigned action taken in relation to an intake is not a common practise with Inspectors; but, for example, may happen when additional information is provided related to the intake.

13. Although Inspectors have the discretion to use their clinical judgement and skills in conducting their tasks, Inspectors are required to notify their ITLs (now IMs) and/or seek approval for a number of different reasons, including, for example, if they are not able to submit their Inspection Reports in the required timeframe, if they receive a request from the home to extend the time period for a Compliance Order, or if they need to change the scheduled start date for an Inspection.

14. The ITLs (now IMs) review all Inspection Reports prior to the reports being sent to the long term care home and Licensee. All Resident Quality Inspection (RQI) Reports, and any potentially contentious Reports, as well as any Reports including an Order, are also reviewed by the SAO manager after the ITL (now IM) review.

15. The ITLs (now IMs) also review all Public Inspection Reports at least twice prior to the reports being posted on the MOHLTC public reporting website. This review is done to ensure that the Public Reports do not include personal information or personal health information. The SAO manager does not typically review Public Reports.

CHANGES FROM THE ROLE OF COMPLIANCE ADVISOR PRIOR TO JULY 1, 2010 TO THE ROLE OF INSPECTOR AFTER JULY 1, 2010

16. As a Compliance Advisor prior to July 1, 2010, I was assigned to specific LTC homes within the Hamilton SAO region. During this time, I was responsible, along with one other Compliance Advisor, for all of the homes in Niagara. I believe this was about 12 to 15 homes. Compliance Advisors were responsible for their own assignments and workload. They would manage and triage all information received in relation to these specific homes, including all complaints and Unusual Occurrence Reports submitted by homes to MHLTC (now known as Critical Incident Reports), and conduct Reviews at

those homes. When the *LTCHA* came into force on July 1, 2010, I became an Inspector. Inspectors are no longer assigned to specific homes and can be sent to any of the LTC homes within the catchment area of the SAO.

17. When I conducted a Review as a Compliance Advisor, I would use the LTC Facilities Program Manual and would determine whether the home was complying with the standards and criteria in that Manual. When I conducted a Review, typically I would review relevant records and make observations. Based on the record review and my observations, I may find that the home did not meet the standards and criteria in the Program Manual. I would discuss these findings with the Administrators and DOCs in the LTC home and may make some recommendations or provide the homes with advice on suggested or other successful practices for complying with the LTC Facilities Program Manual. I may then issue a Report of Unmet Standards or Criteria or complete an Observations and Discussion Summary. In determining whether to issue a Report of Unmet Standards or Criteria, I considered the four pillars; these were scope, severity, compliance history and the home's due diligence. If I issued a Report of Unmet Standards or Criteria, the home was required to respond with a Plan of Corrective Action. An Observation and Discussion Summary did not require the submission of a Plan of Corrective Action. This tool was a document to provide feedback to the home.

18. In the LTC Facilities Program Manual, homes were required to report "Unusual Occurrences", many of which are now known as CIs under the *LTCHA*. In my opinion, CIs are inspected now more than Unusual Occurrences were reviewed in the past. In the past, it was more an exception than the norm that MHLTC would review an Unusual

Occurrence. Since July 1, 2010, if there was potential at risk non-compliance arising from a CI, this would be inspected.

19. It was typical for Compliance Advisors to work on their own, whereas Inspectors often work in teams. Prior to July 1, 2010, an Annual Review could be completed by one Compliance Advisor in as little as 2-3 days in a smaller home. As an Inspector, I frequently work as part of a team, particularly since the rollout of Resident Quality Inspections (RQIs), which require a team and usually at least one week, depending on the RQI approach, the number of additional intakes being inspected upon, and the number of team members.

20. In the early months following the coming into force of the *LTCHA*, the majority of the Inspections completed were Complaint and CI Inspections. RQIs were initiated starting in 2011, and were rolled out to all homes later in 2013. Initially, there was a limited number of Follow Up Inspections, as there were few Orders that had been issued that required a follow up.

21. Inspections are conducted to ensure compliance with the requirements of the *LTCHA* and its Regulation. Inspectors have a number of tools to assist with Inspections, including the inspection powers in the *LTCHA*, the Inspector's Handbook with policies and procedures, and Inspection Protocols. During Inspections, we determine whether there is compliance with the legislation based on observations, interviews, and a review of the home's records. If it is determined that there has been non-compliance, the Judgement Matrix is used to help determine the action to take by considering the factors of scope, severity and compliance history. Inspectors no longer consider the home's

due diligence. The actions that an inspector may take pursuant to the *LTCHA* are to issue a written notification (WN), issue a voluntary plan of correction (VPC), issue a compliance order (CO), or make a Director referral (DR). At the end of each Inspection, an Inspection Report – one for the Licensee and one that will be made Public – is completed. The Public Inspection Report is the same as the Licensee Report, except it is edited to remove all personal information and personal health information. The Reports include non-compliance with the *LTCHA* or the Regulation and the findings to support those non compliances.

22. One of the changes associated with the implementation of the *LTCHA* was the elimination of the advisory role that Compliance Advisors had played. Prior to July 1, 2010, smaller homes, particularly standalone homes with 40-60 beds, would call the SAO or their assigned Compliance Advisor directly to ask for advice. For example, the smaller homes would call asking "Is there anyone with a good policy on this? If I have a challenging resident, what can I do?" Bigger homes, those belonging to corporations, would typically have nurse consultants to call for advice at the corporate level. Even when staff at the homes did call asking for advice, they did not always find the information that we shared with them helpful to their specific situation. The homes did not have to take our advice; I would not follow up on that.

23. With the implementation of the *LTCHA,* the role of Inspectors is to inspect and they do not provide advice to homes. When I get questions from a home, I often refer the home to the legislation or to available programs or organizations that can offer support, e.g., Behavioural Supports Ontario (BSO), or the Ontario Long-Term Care Homes

Association (OLTCA). Homes in the Hamilton area also hold quarterly meetings where the DONs and Administrators will get together to problem solve and share ideas around emerging issues.

24. When I am in a LTC home for an Inspection, I have found that frontline staff may ask for information about whether certain things are required by the Act or the Regulation. They will also sometimes ask me to confirm whether what their manager has directed them to do is a requirement in the *LTCHA* or the Regulation. If the question is about a specific issue under the *LTCHA* or the Regulation, I may direct them to the appropriate section in the *LTCHA* or Regulation that answers their questions and tells them what they are required to do. I also tell them they have to follow their managers' direction and the policies and procedures of the home.

25. To my recall I have not had staff ask me about their reporting obligations relating to abuse or neglect under the *LTCHA*. However, if I am conducting an Inspection about abuse or neglect, I will ask LTC home staff if they received training about mandatory reporting and if they are aware of their reporting responsibilities. If the answer that I get from the staff is not accurate then I will explain to them what the LTCHA actually requires in terms of reporting abuse or neglect.

26. After the *LTCHA* came into force, the inspection process went through a number of changes. Inspectors now interview frontline staff in addition to observing their work. The interviews are a significant change for the staff. As Inspectors, we consistently interview residents and families especially during stage 1 of the RQI. Previously, we

would speak with families during complaint Reviews, but now they are also formally interviewed during RQIs.

27. If someone wanted to raise a complaint while I was in the home conducting an Inspection, I would either take the complaint myself, if I was looking into a similar issue and could inspect the concern during my Inspection, or refer them to INFOline as appropriate to log and triage the complaint with the MHLTC depending on the issue, priority and risk.

28. Although much has changed with the inspection process since the *LTCHA* came into force, I am still familiar with many individuals in the Hamilton SAO homes. The amount of staff turnover depends on the home, community, and other factors. While staff turnover has been identified as a key risk indicator for the MHLTC, I would not inspect on staffing turnover if I felt the home was managing the turnover well, unless there was a specific complaint about it.

INITIAL AND ONGOING TRAINING OF INSPECTORS

29. When I started as a Compliance Advisor in 2000, training was quite informal. My training involved reading the LTC Facilities Program Manual, the applicable legislation and regulations, government policy, and audit tools. I then shadowed different Compliance Advisors until I was permitted to take on parts of Reviews on my own. I received more formal training in relation to topics such as writing briefing notes and file management.

30. The training relating to the transition to the *LTCHA* was more comprehensive and included:

    - Training on how to read the legislation and the Regulation, including terms, such as "clinically appropriate assessment instrument";
    - Training on report writing;
    - Training on the policies and procedures in the Inspector's Handbook, including the difference between Inspection and Inquiry, and how to use the Judgement Matrix; and
    - Interview skills and note-taking.

31. Since the transition to the *LTCHA,* ongoing training has been made available to me, as an Inspector. At times, this training is mandatory. We also have monthly staff meetings at the Hamilton SAO where we discuss issues and review policies and procedures and we may receive advice and guidance from ITLs (now IMs) and other Inspectors.

32. In RQI training, we participated in role-playing, which was geared towards interviewing residents in stage 1 of the RQI.

33. I do not recall receiving any specific training related to interviewing persons with dementia or cognitive decline. However, as a RN who has worked for years in LTC, I have spent much time speaking with elders and persons with cognitive decline. I have also completed certificate courses in gerontology studies, working with the aged and with persons with Alzheimer's, as part of my educational background.

34. As of March 7, 2018, Inspectors have been informed that all interview notes are to be verbatim. Before that time, it was only for contentious inspections that Inspectors were encouraged to consider having a second person present to take notes during interviews.

CONDUCTING INSPECTIONS UNDER THE *LTCHA*

35. Most Inspectors are RNs, but Inspectors also have other health care backgrounds, including, physiotherapists, Registered Dietitians and public health (environmental health inspectors).

36. Inspections are conducted more frequently by teams of Inspectors. All RQIs are completed by teams. We may also have teams conduct Complaint, Critical Incident and Follow-up (CCF) Inspections if the issues involve more than one discipline or if there are multiple CCF intakes to be completed during one Inspection.

37. All Inspections under the *LTCHA,* with the exception of Pre-Occupancy Inspections, are required to be unannounced.

38. Anyone can make a complaint about a LTC home and it is the role of Inspectors to do an inspection or inquiry into the issue, if the concern is related to the *LTCHA* or Regulation. CI reports are triaged for risk to determine if an inquiry or inspection is warranted. It is the MHLTC's policy to inspect or complete an Inquiry on all complaints that are relevant to the legislation and we have sufficient information to inspect upon. The only exception is when a person has repeatedly complained about the same issue, which has already been subject to inspections and no new information is provided. In those cases, we would communicate to the complainant that we are unable to inspect

the same concern, which has already been found to be compliant, if there is no new information.

39. The Inspector's role during an inspection of a complaint or a CI is to inspect on the specific issues identified in the intake and to determine whether the home is compliant with the requirements of the *LTCHA* and the Regulation. If, during the course of an Inspection, other concerns are raised with me or I observe potential risk situations, then I would inspect those issues. Generally, if the intake is a CI, I would be aware of the staff member involved. If the intake is generated from a complaint, I would not be aware of the staff involved, in most cases. If I believed this was relevant, I would make inquiries to determine who the staff member is in order to conduct my inspection and ensure that the home is compliant.

40. With respect to RQIs, Inspectors in the Hamilton SAO are placed in teams and each team is assigned approximately 18 LTC homes. At the beginning of the year, the teams are assigned to determine who will be the primary Inspector for each RQI, and when they will go into the homes to conduct the Inspections. This is done according to (a) when the last RQI was completed; (b) the home's risk level; and (c) the pending intakes for the home.

41. As Inspectors, we will review the risk level assigned to each LTC home to assess how quickly a RQI should be completed. Higher risk homes ideally have their RQIs completed earlier in the year.

42. The practice in the Hamilton SAO is for Inspectors to take along any intakes for CCF Inspections when going to conduct a RQI at a LTC home.

MAKING FINDINGS OF NON-COMPLIANCE

43. Before finding that a LTC home has failed to comply with either the *LTCHA* or the Regulation, Inspectors aim to have at least two sources of evidence to support a finding although that is not required and may not be possible in all circumstances.

44. Inspections are conducted on-site in the homes with very rare exceptions. Inspectors will talk to staff (e.g. Personal Support Workers, registered staff, management, staff from other non-clinical departments). Inspectors will make observations and interview staff about what was observed. Inspectors also interview residents/their representatives. Inspections also include observations and record reviews (clinical health records and other records such as meeting minutes or policies and procedures).

45. Commission Counsel asked me if there is a clear "standard of proof" to find non-compliance. That is not language that I use. My findings of non-compliance are based on the information I gathered (either through observations, interviews, or record reviews), and the exercise of my clinical judgement.

46. There are times when I cannot make a finding of non-compliance in an Inspection because I have two credible versions of what occurred, and I cannot verify that the incident occurred. In these situations, I may not be able to determine whether the incident happened that could lead to a finding that the home did not comply with the LTCHA or the Regulation.

47. When deciding where findings of non-compliance should be identified within the *LTCHA* or the Regulation, Inspectors are instructed to find the most appropriate "fit" with respect to classifying the non-compliance in the legislation although a single issue may result in findings of non-compliance with more than one requirement.

48. Once an Inspector has found that there has been non-compliance with either the *LTCHA* or the Regulation, the Judgement Matrix is the tool used to help determine the type of action (WN, VPC, CO or DR) to take. The Judgement Matrix is a tool for applying section 299 of the Regulation, which requires Inspectors to consider (and only consider) the severity of the non-compliance, the scope of the non-compliance, and the compliance history of the home when determining the action to take where non-compliance is found. When an Inspector applies the Judgement Matrix it will lead to a suggested action. Inspectors may depart from the suggested action in accordance with the Judgment Matrix Policy. Attached as Exhibit "A" to my affidavit is the Judgement Matrix Policy version dated January 16, 2018 [LTCI00071495] and the Judgement Matrix and Compliance Due Date Decision Tool [LTCI00046896].

49. If there has been non-compliance involving one resident, I will identify two other residents, with similar and like needs, to also inspect upon for the same issue. To determine the scope of non-compliance in relation to residents, if one resident is affected by the non-compliance identified, the scope is isolated, if two residents are affected, it is a pattern, and if three are affected, the scope is widespread. In assessing the scope of failing to comply in relation to policies or procedures, I may also consider whether different areas of the home, or other staff, are following the policy.

50. In terms of reviewing the home's compliance history while completing the Judgement Matrix, Inspectors review the specifics of prior non-compliances, not only the broad legislative heading listed on the compliance history print-out under which a past finding of non-compliance was made. As such, when the non-compliance relates to a broad obligation, (e.g., plan of care), we are instructed to consult past Inspection Reports.

51. The Judgement Matrix Policy gives some direction of when it is acceptable for an Inspector to depart from the suggested action of the Judgement Matrix. For instance, when the finding of non-compliance does not involve a key risk indicator, the Inspector may move down one quadrant in the matrix (but does not have to do so). Inspectors do not have discretion to vary the scope of non-compliance. Inspectors may adjust the compliance history level down if it is a level 1 or 2, or adjust it up if it is a level 5 or 6. Common sense and clinical judgement can also guide Inspectors' decisions about whether to adjust up or down as well. While Inspectors need to document if they depart from the suggested action of the Judgement Matrix, they do not require managerial approval to do so. Inspectors may be asked to justify that departure on review of the Inspection Report by the IM or SAO Manager.

THE ELIZABETH WETTLAUFER (EW) INSPECTIONS

(A) Assignment to the Hamilton SAO EW Inspections

52. I was assigned to the Telfer Place (TP) EW Inspection by my SAO manager, Karin Fairchild, along with another Inspector. I was in the office when Karin Fairchild was sent a copy of an email that the Director, Karen Simpson, had received regarding EW's confessions made to the Toronto Police. The email had originally come to the MHLTC

from the OLTCA. This was on October 5, 2016. The email indicated that a former staff member had admitted herself to a mental health facility and had confessed to murdering or attempting to murder people in different LTC homes, one of which was TP. Attached as Exhibit "B" to my affidavit is a copy of the email that I understand Karin Fairchild had received from Karen Simpson on October 5, 2016 [LTCI00041459].

53. The MHLTC received a CI on October 5, 2016, from TP after the email had come in from the OLTCA. The CI said that the home had been informed by the police that they were investigating a registered nurse – EW – who had checked herself into a health care facility, had admitted to attempting to kill LTC residents, and had specifically attempted to kill TP resident Sandra Towler, by giving her 60 units of fasting acting insulin and 80 units of long acting insulin in the winter of 2016. The CI noted that she was an employee of Lifeguard Homecare Staffing Services. TP did acknowledge that EW had worked for the home over 2015 and 2016. The CI noted that Sandra Towler was still a resident of the home. Attached as Exhibit "C" to my affidavit is a copy of the CI submitted by TP on October 5, 2016 [LTCI00041443]

54. Additional information was provided by TP on October 7, 2016. This additional information included that EW had identified that RN Diane Beauregard had "corrected" what she had done. The home reported they had located a documented change in the resident's clinical status, in the resident's health record, in September 2015. Attached as Exhibit "D" to my affidavit is a copy of the Amended CI Report that TP submitted to the Ministry [LTCI00068827].

55. On October 5, 2016, the team who was assigned to this inspection was instructed not to discuss this information with anyone, including colleagues or anyone in TP other than the homes' management. The information about the offence relating to Sandra Towler did not become public until January 13, 2017, when a charge was laid.

56. When my SAO manager first learned that EW had confessed to attempting to overdose a TP resident with insulin, we reviewed all available documents on our internal shared drive with the ITL, to determine if we had received a CI or complaint about the incident at TP. CIATT also searched the intake system in an attempt to determine if they had received any information about this incident. We could not find anything.

(B) Off-Site Preparation for the Inspection

57. On October 5, 2016, another Hamilton SAO inspector, Lesley Edwards, was asked to go to TP to gather the home's documentation regarding resident hospital transfers, shifts worked by EW, and discharges and deaths from the home.

58. The Hamilton SAO learned that EW had also worked as an agency RN in several other homes, including Anson Place, Dover Cliffs, Park Lane Terrace and Brierwood Gardens. As a result, the Hamilton SAO initiated inspections in these homes and obtained some preliminary "high level information" from these homes, such as when EW worked in the homes. All of this was completed in October. We also requested that the identified homes review their records involving medication errors.

59. Shortly after being assigned to the TP EW Inspection, I met with London SAO Inspector Rhonda Kukoly, the lead Inspector assigned to the Caressant Care Woodstock (CCW)

EW Inspection. We worked together to create an Inspection Plan for the EW Inspections. We quickly realized, however, that while the approaches to the Inspections were to be consistent, the CCW Inspection was rather different from those involving LTC homes in the Hamilton SAO, where EW had been placed as an agency RN (and was not an actual employee of the home). In other words, while our approach to the Inspections would be similar, we were both dealing with different aspects of the *LTCHA*. For instance, in the TP inspection we planned to look at whether the *LTCHA* requirement that a home have a RN who is a member of the home's regular nursing staff to be on-site 24/7 (this would not include an agency nurse except in limited circumstances) had been complied with. TP, which we knew to be a small home, may not have complied with this requirement if EW was the only RN on-site. The *LTCHA* also has training requirements for agency staff. For the agency staff, we included in our inspection planning to review the contracts between the licensee and agency that provided EW to the home.

60. We were directed not to go to the home initially to conduct the on-site portion of the Inspection except for Lesley collecting documents on October 5, 2016. I do not recall who provided this direction or the reason for it. After the plan was prepared, it was forwarded to Karin Fairchild (the manager of the Hamilton SAO), Karen Simpson (the Director) and Peggy Skipper (the manager of the London SAO). Attached as Exhibit "E" to my affidavit is my Inspection Plan for the EW Inspection at TP [LTCI00041559].

61. The TP Inspection team was comprised of Lesley, Phyllis Hiltz-Bontje and myself. All three of us are RNs and Inspectors out of the Hamilton SAO.

62. We completed an initial review of the documents received from TP and the other Hamilton SAO homes in preparation for the Inspections, but nothing stood out as alarming. We requested and received a few documents from TP initially, including the shifts worked by EW and hospital transfers during that time. The most helpful information was the CI report submitted by TP that provided the name of the resident who was the alleged victim, the relevant timeframe of the alleged incident, and once amended, it also had the name of the nurse who "corrected what she [EW] had done."

63. Prior to starting the Inspection, I briefly reviewed the previous 36 months of compliance history from TP, which is typically part of the inspection preparation process. I recall TP's compliance history included some issues regarding medication administration and sufficient staffing. There were also some plan of care issues that may be relevant.

64. I did not review the Long-Term Care Home Risk & Performance Assessment (LRPA) risk level that had been assigned to TP prior to the Inspection. While we review a home's assigned LRPA (now LPA) risk level at the beginning of the year for the purpose of scheduling RQIs in order to determine how quickly the Inspections should be completed, it is not part of the inspection planning process to check the home's LRPA level in preparation for a CCF Inspection.

(C) The On-Site Inspection Process

65. Once on-site for the TP Inspection, Lesley and Phyllis requested the available health records for Sandra Towler and some of the home's policies and procedures and training records.

66. When I returned to work on November 9, 2016, Lesley updated me on the progress of the Inspection at TP. She and Phyllis had already completed observations of medication passes (including for residents with insulin); observed agency staff involved in medication administration; interviewed the Acting Director of Care (ADOC) regarding the Medication Inspection Protocol; and collected other data.

67. As in any other inspection, we conducted interviews, made observations and reviewed the home's policies and other relevant documents, such as meeting minutes, health records (resident charts and progress notes), and the home's internal incident and investigation reports. We were inspecting to determine whether there had been complaints about EW, what training she received, and for medication errors.

68. Lesley and I reviewed portions of the clinical health records for Sandra Towler and other identified residents who had passed away around the time that EW had worked in the home. We reviewed diagnoses, cause of death and progress notes. The chart reviews of these former residents did not result in any findings of non-compliance.

69. There were some unique aspects to the EW Inspection. We were limited with respect to whom we were permitted to interview and the questions that we were able to ask based on the ongoing police investigation and the fact that charges had not been laid in relation to the victim Sandra Towler when the Inspection was being conducted. As noted above, we could not reveal what we knew about the allegations or the offence against Sandra Towler during the interviews of staff. As a result, we started our interviews with management rather than frontline staff. Also, the entire Medication

Inspection Protocol was completed including interviewing the pharmacist – a person that I would not typically interview, unless an issue arose during the Inspection. We also were not able to interview EW as part of the Inspection and we were directed that we could not use the information TP had received from the police about EW's confession as evidence to support any findings of non-compliance in the Inspection.

70. I do not know who made the decisions about when we could interview staff in the home. I understand that, while I was away, Lesley and Phyllis were vetting the list of who to interview with the SAO manager Karin Fairchild. They would send a list of who they wanted to interview to the SAO manager and then would be told when we could do the interview.

71. We attempted to interview Ms. Towler but she was not interviewable due to her health status. We spoke with Sandra Towler's family in March, 2017.

(D) Inspection Findings

72. As a result of the TP Inspection, we issued six Written Notifications (WNs), all of which were accompanied by Voluntary Plans of Correction (VPCs). Attached as Exhibit "F" to my affidavit is the Licensee Copy of the Inspection report [LTCI00041487]. This Report, as well as the other EW Inspection Reports prepared by Inspectors in the Hamilton SAO were reviewed multiple times before their release. They were all reviewed by both the ITL and SAO manager.

73. We made the following specific findings of non-compliance during the TP EW Inspection:

a) Failing to comply with s. 8(3) *LTCHA,* which requires the licensee to ensure that there is at least one RN who is both an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

b) Failing to comply with s. 75(2) *LTCHA,* which requires the licensee to ensure that screening measures, which include criminal reference checks, are conducted in accordance with the Regulation (s. 215(1) and (2)) before they hire staff.

c) Failing to comply with s. 76(1) and (2) *LTCHA,* which requires the licensee to ensure that all staff receive training as required before working in the home.

d) Failing to comply with s. 101(2) and (3) O. Reg. 79/10, which requires the licensee to ensure that a documented record is kept in the home that includes the date complaints were received, the action taken to resolve the complaint, and the final resolution, if any, as well as the date the response was given to the complainant.

e) Failing to comply with s. 135(1) O. Reg. 79/10, which requires the licensee to ensure that every medication incident involving a resident is reported to the resident's substitute decision maker and the pharmacy service provider.

f) Failing to comply with s. 234(1) O. Reg. 79/10, which requires the licensee to ensure that a record is kept for each staff member that includes, where applicable, verification of the staff member's current certificate of registration with the College or regulated health profession of which he or she is a member or

verification of the staff member's current registration with the regulatory body governing his or her profession.

74. In making these findings, we used the Judgement Matrix to guide our decisions. Attached as Exhibit "G" to my affidavit is a copy of the Judgement Matrix completed as part of the TP EW Inspection [LTCI00041509].

75. As explained in paragraphs 48 to 51 above, the Judgement Matrix policy allows for decisions to be made to vary what the Judgement Matrix suggests as the appropriate action provided that variance is documented. When Lesley and I did the Judgement Matrix, we varied what the Judgement Matrix suggested for two of the findings of non-compliance in the EW inspection:

- With respect to the finding concerning s. 75(2) *LTCHA* and criminal reference screening checks, it was identified that TP did not have the criminal reference checks completed for all three of the agency staff whose records were reviewed. The home was under the impression that Lifeguard Homecare Inc. (which employed these three agency staff) had completed these checks, although the home did not have any record to confirm this. TP had criminal reference checks completed for its regular staff. As a result, the severity of this non-compliance was 1 – minimum risk. We reduced the suggested action taken from a CO to a VPC as the problem was limited to agency staff in the home.

- With respect to the finding concerning s. 76(1) and (2) *LTCHA,* and the required training for staff, it was identified during the Inspection that two of the three

agency staff members reviewed had not completed the required training in 2015 when EW was working there. The decision was made to reduce the action taken from a CO to a VPC as during the Inspection it was identified that in the summer of 2016, the staff at the home had identified the need to educate agency staff through their own internal process and changed their policies and procedures.

76. During the Inspection, as part of the review of the records provided by TP, we reviewed an email that Michelle Cornelissen, the former Director of Care (DOC) at TP, had sent to Heidi Wilmot-Smith, the owner of Lifeguard Homecare Inc., summarizing some issues that had arisen with EW. In the email, Michelle Cornelissen identified a complaint made by a Personal Support Worker (PSW) about EW's failure to adequately assess or check a resident who exhibited a responsive behaviour, and a concern raised by a physician about EW's ability to "assess our Residents and carry out basic nursing duties." Attached as Exhibit "H" to my affidavit is a copy of the email collected during the EW Inspection between Michelle Cornelissen and Heidi Wilmot-Smith that includes the email Michelle Cornelissen sent to Heidi Wilmot-Smith raising issues about EW's care of residents [LTCI00041461].

77. After reviewing the email, we interviewed the PSW who made the complaint, Michelle Cornelissen and two physicians, Dr. McDonald and Dr. Williams (who Michelle Cornelissen identified may have expressed concerns to her about EW, and the Administrator, Jim Eagleton). Attached as Exhibit "I" to my affidavit are my Ad Hoc notes documenting these interviews. The most relevant passages can be found at pages 11, 16-19 and 34-36 [LTCI00041407]. Attached as Exhibit "J" to my affidavit are

Lesley's Ad Hoc notes documenting these interviews. The most relevant passages can be found on page 10, page 13, page 15, and page 22 [LTCI00041409].

78. We interviewed the PSW and who identified that a resident had roused in the middle of the night and grabbed the PSW's wrist. EW came to assist and the resident released the PSW's wrist and then the PSW suggested to EW that the resident be given Ativan (a medication to help calm the resident down). The PSW told us that, at that point, EW said the resident is not worked up enough to give Ativan yet.

79. We also followed up on the statement in the email concerning the physician's comments about lack of confidence in EW's abilities to assess residents and carry out nursing duties. We initially spoke with Michelle Cornelissen about what the physician had told her. She was not able to recall much of the initial conversation. She was not able to recall which physician had made the comment but identified two physicians that she felt might have made the comment: Dr. McDonald or Dr. Williams. Both physicians were interviewed. During my discussion with Dr. McDonald, he told me that he did not report any concerns to Michelle Cornelissen regarding a particular agency nurse. In my discussion with Dr. Williams, he told me that he did not recall EW at all, but he observed a nurse one night swearing and being verbally abusive to some residents but he did not know the nurse. He did not give me any specific examples about to who or what was said. He did not witness any physical abuse. I was shocked by this new allegation which I considered to be an allegation of abuse. I reported this allegation to Michelle Cornelissen and Jim Eagleton the same day so that the home could investigate. Michelle Cornelissen said she did not recall Dr. Williams making this allegation of abuse

to her. Jim Eagleton told Lesley a week later that he spoke to Dr. Williams who told him that he could not recall either the resident or the nurse, but assumes it was the agency nurse.

80. In order to make a finding against the home, that the home did not report Dr. Williams' allegation of abuse to the MHLTC as per s. 24 *LTCHA*, I would have needed more information, such as what was the alleged abuse, who the resident was, when the alleged abuse occurred, and who the nurse was. Given Dr. Williams' limited recollection of what he had seen, and the fact that there was no record of any such event from the time, the information we needed was not available. In addition, we had no information to indicate that the home had been aware of Dr. Williams' allegation until after I told Michelle Cornelissen and Jim Eagleton what Dr. Williams had told me.

81. During a review of the clinical record it was initially identified that EW's monitoring and recording of Sandra Towler's blood glucose levels, were not consistently completed or recorded as per the doctor's orders and that this would be the subject of a finding of non-compliance. Based on an initial review of documents and records, I had identified apparent non-compliance in relation to s. 30(2) O. Reg. 79/10 and s. 6(7) *LTCHA,* requiring staff to document all assessments, reassessments and interventions taken with respect to a resident and to provide care as per the plan of care. My initial findings based on my review of records was not supported by the interviews that I conducted with the staff who were able to provide me with medical records that EW had in fact recorded the required information in relation to the glucose readings, but had recorded

the information in the wrong location in the clinical record. There was thus no non-compliance identified related to this area.

PERSONAL IMPACT

82. When I learned that EW had confessed to the police that she had murdered residents, I was angry and upset that she chose this population who are vulnerable and at risk. It is my community. I am familiar with TP and I had met a number of the residents and frontline staff who worked there. I was shocked that someone had done this.

SWORN BEFORE ME at the City of Hamilton,)
in the ~~County of~~ Regional Municipality of Hamilton-Wentworth, on July 24, 2018)
)
)
)
)
)

Commissioner for Taking Affidavits

Lisa Vink

This is Exhibit "A"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

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JUDGEMENT MATRIX

Policy

PURPOSE

The purpose of the Judgement Matrix (JM) policy is to provide inspectors in the Long-Term Care Homes Quality Inspection Program (LQIP) of the Long-Term Care Inspections Branch, Ministry of Health and Long-Term Care (MOHLTC), with the following:

- the use of a standardized, consistent, and evidence-based tool to determine the most appropriate action to take and or order to make, based on the factors to be taken into account when non-compliance with a requirement under the *Long-Term Care Homes Act, 2007* (LTCHA), is in issue;
- the definition of JM and additional definitions relevant to JM from the *LQIP Glossary of Terms*;
- applicable legislative references which provide the authority, mandate, and requirements relative to factors to be taken into account, when non-compliance with a requirement in the LTCHA is identified; and
- procedures and relevant resources.

DEFINITIONS

Judgement Matrix (JM): The JM is a grid-like tool that plots the ***scope*** of non-compliance of harm or risk of harm arising from the non-compliance on one axis, the ***severity*** of the non-compliance of harm or risk of harm arising from the non-compliance on the other axis, and with consideration of the non-compliance as a key risk indicator.

Each grid (quadrant) will identify potential action(s) to take and or order(s) to make based on the non-compliance. The inspector uses the licensee's compliance history to assist in choosing the best option(s).

Compliance History (CH): The licensee's history of compliance with the legislative requirements, in an applicable LTCH, as accumulated within the last 36 months, e.g., if the current inspection is May 31, 2014, the CH would be from June 1, 2011 to May 31, 2014. An exception for extending the scope of the licensee's CH to more than one home owned by the licensee and for a greater time period, may be considered at the discretion of the inspector in consultation with the SAO Manager, where it is warranted.

Compliance Order (CO): This is an order that can be made by an inspector or Director on the licensee of a LTCH, if the licensee has failed to comply with a requirement under the LTCHA. The inspector may order the licensee of a LTCH to:

- do anything or refrain from doing anything, to achieve compliance with a requirement under the LTCHA; or
- prepare, submit and implement a written plan for achieving compliance with a requirement under the LTCHA.

Director Referral (DR): Action taken along with a Written Notification (WN) is one action that an inspector may take to address the non-compliance with a requirement in the LTCHA. This would be when the best action to take/order to make, as determined through the use of the Judgement Matrix (JM) and in consideration of the licensee's compliance history (CH), is beyond the authority of the inspector and requires the Director to examine the findings and take the appropriate action/order. In addition there are three other situations when a Director Referral is or may be required:

a) In cases of repeated non-compliance, e.g., when an order has been issued and subsequently the licensee has been found to be in non-compliance with the order twice through two follow up inspections, there is a policy requirement for the inspector to issue a Director's Referral;
b) In cases when the inspector suspects that there is a high risk situation, e.g., multiple orders issued, the inspector may also make a referral to the Director after consulting with their manager;
c) The appropriate response to a finding of non-compliance is beyond the authority of the inspector.

Financial Sanction (FS): A Director's order made on the licensee of a LTCH requesting that funding be returned or withheld as per section 155 of the LTCHA.

Interim Manager (IM): If the Director makes an order revoking the LTCH's licence, the Director may also make an order for the LTCH to be occupied and operated by an IM until the revocation of the licence becomes effective, and the residents of the home are relocated as per the requirements in section 157(4) of the LTCHA.

Key Risk Indicator (KRI): A KRI is a measurement used by the Ministry to assess the licensee's performance, based on the nature and extent of potential harm that may affect the well-being of residents (clinical), or the associated risk of the situation (non-clinical).

Mandatory Management Order (MMO): This is a Director's order made on the licensee of a LTCH to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the LTCH, as per the requirements outlined in section 156 of the LTCHA, if the following grounds are met:

a) the licensee has not complied with a requirement under the LTCHA, **and**
b) there are reasonable grounds to believe that the licensee cannot or will not properly manage the LTCH, or cannot do so without assistance.

Revocation of Licence (RL): This is a Director's order made on the licensee of a LTCH to revoke their licence, as per the grounds outlined in section 157 of the LTCHA. This may also include an

order providing that the home be occupied and operated by an interim manager until the revocation is effective and the residents are relocated.

Scope: This means pervasiveness throughout the home *(O.Reg. 79/10 ss. 299(3).* Scope refers to the extent of the effect on residents' health and/or safety, or area covered by a given activity, concern, or problem, and can be described at three levels: isolated, pattern, or widespread.

Severity: This refers to the degree of negative impact on residents' health and/or safety of a given activity, concern, or problem, and can be described at four levels: minimum risk, minimal harm or potential for actual harm, actual harm/risk, or immediate jeopardy/risk. The severity level may be affected by whether the provision in non-compliance is or is not a KRI.

Suspension of Licence:

Voluntary Plan of Correction (VPC): If an inspector finds that a licensee has not complied with a requirement under the LTCHA, a VPC is an action taken by an inspector on the licensee, whereby the licensee is requested to prepare a written plan of correction for achieving compliance and to be implemented voluntarily. There is no requirement for the licensee to submit the plan to the inspector or to produce the VPC on subsequent inspection.

Work and Activity Order (WAO): This is an order made by an inspector or Director on the licensee of a LTCH, directing the licensee to:

- allow employees of the Ministry, or agents or contractors acting under the authority of the Ministry, to perform any work or activity at the LTCH that is necessary, in the opinion of the person making the order, to achieve compliance with a requirement under the LTCHA; and
- pay the reasonable costs of the work or activity.

Grounds: *(as outlined in section 154 of the LTCHA)*

The WAO may be made and served if:

- the licensee has not complied with a requirement under the LTCHA; and
- there are reasonable grounds to believe that the licensee will not or cannot perform the work or activity necessary to achieve compliance.

Written Notification (WN): This is the minimum action taken by an inspector for every provision where the licensee has not complied with a requirement under the LTCHA. The WN identifies the legislative reference and finding(s) (the facts that support the finding of non-compliance with the legislative provision).

Additional definitions relevant to the JM can be found in the LQIP Glossary of Terms.

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LEGISLATIVE REFERENCES

LTCHA PART IX	COMPLIANCE AND ENFORCEMENT
LTCHA s. 142	Purpose of inspection
LTCHA s. 149	Inspection report
LTCHA s.152	Actions by inspector if non-compliance found
LTCHA s. 153	Compliance orders
LTCHA s. 154	Work and activity orders
LTCHA s. 155	Order that funding be returned or withheld
LTCHA s. 156	Mandatory management orders
LTCHA ss. 157(1)	Revocation
LTCHA ss. 157(4)	Interim management
LTCHA s. 158.1 (1)	Minister's suspension
LTCHA s. 159	No due diligence or mistake of fact
LTCHA s. 160	More than one order
O. Reg. 79/10 PART IX	COMPLIANCE AND ENFORCEMENT
O. Reg. 79/10 s. 299	Factors to be taken into account

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POLICY

Within the LQIP, there is a standardized, consistent approach, which all inspectors must follow when deciding the action to take if a LTCH has not complied with a requirement under the LTCHA. This policy will direct inspectors on using the Judgement Matrix (JM) (severity, scope, and compliance history) for the decision-making process.

The JM process includes the following elements:

- The **mandatory use** of the Judgement Matrix/Compliance Due Date (JM/CDD) Decision tool by an inspector, when non-compliance with a requirement under the LTCHA has been found during an inspection, to assist in determining as per section152 of the LTCHA, what action to take or order to make.
- A prescribed approach for using the factors to be taken into account if non-compliance is found, e.g., the JM/CDD Decision tool (severity and scope of the non-compliance) and the licensee's compliance history (CH) of non-compliance (NC).
- A means to support the decision-making process on the most appropriate action to make, and a consistent application of compliance due dates for orders (refer also to the Orders Policy for more detail).
- **Mandatory** documentation to support the decision-making process.

OUTCOMES

The following outcomes are expected to be achieved with the application of the JM as described in this policy and procedure:

- The inspector applies a written notification (WN) for each provision under the LTCHA found to be in NC.
- The inspector and the Director consistently apply all the factors to be taken into account, and only those factors as per O. Reg. 79/10 subsection 299 (1) for each NC under the LTCHA.
- The findings and grounds support the decision(s) for action taken/order made for each provision under the LTCHA found in NC.
- Documentation supports the decision-making process.

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JUDGEMENT MATRIX

Procedure

HOW TO USE THIS DOCUMENT

The procedure describing the JM includes the following elements:

- detailed direction for the inspector on how to use the JM;
- guidance on the use of tools and applicable reference documents; and
- description of the role and responsibility of the Primary Inspector for the use of the JM when more than one inspector conducts the same inspection.

PROCESS FLOW

See following page for the Process Flow.

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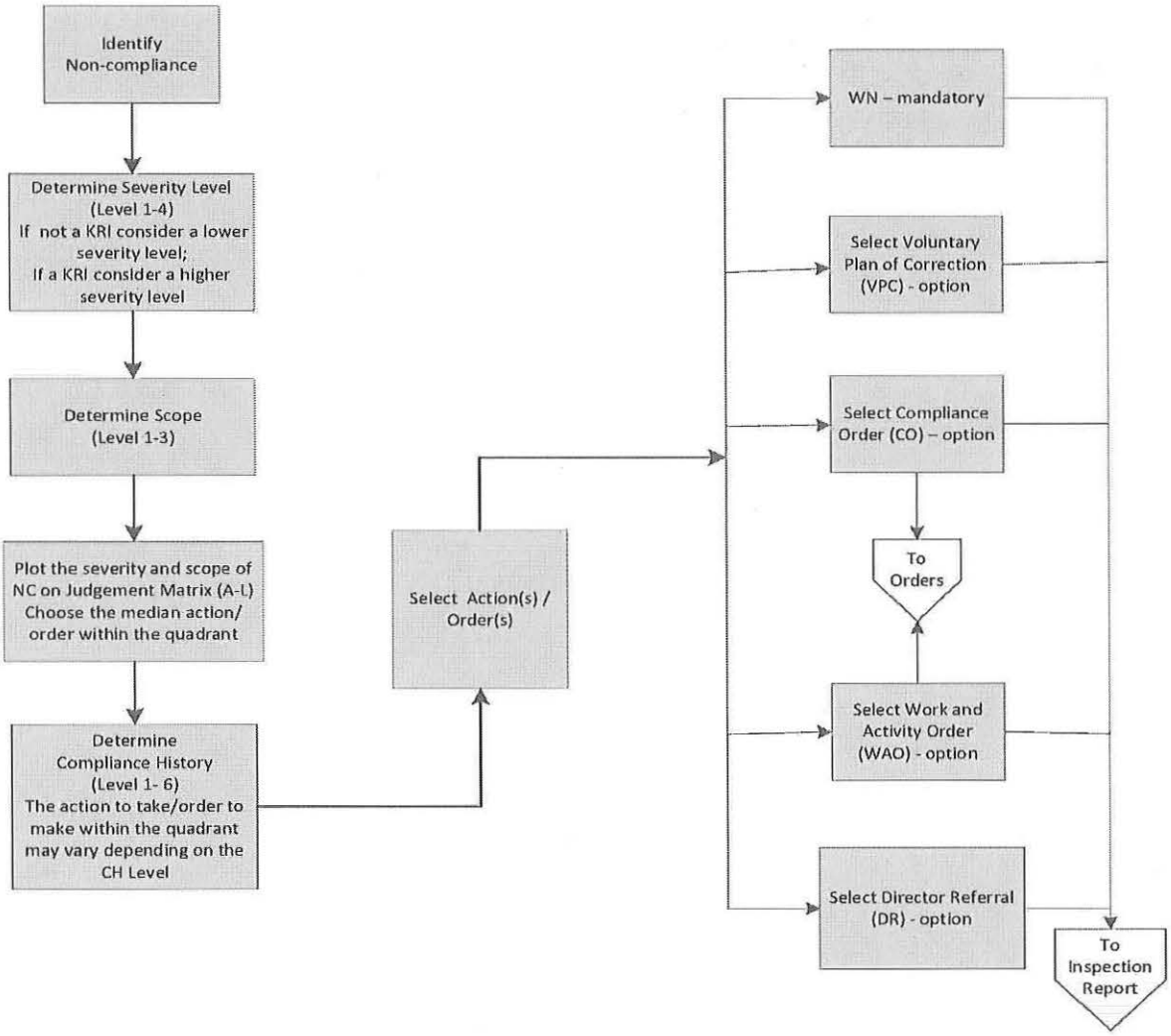
Judgement Matrix



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JUDGEMENT MATRIX PROCESS

Introduction

The following activities precede the use of the JM:

- The inspector(s) conducted the inspection and determined that there was NC with one or more requirements under the LTCHA.
- The Primary Inspector gathered the licensee's CH for the applicable LTCH, for the last 36 months, including NC with the legislation and any LTCH Service Accountability Agreement (L-SAA) requirements provided for, by the legislation and the associated action taken/order.
- The inspector(s) who identified the NC has sufficient relevant information to explain why the specific requirement under the legislation is found to be non-compliant, including the scope and severity of the provision found in NC.

Primary Inspector Roles and Responsibilities

When multiple inspectors conduct the same inspection, all secondary inspectors merge their data with the Primary Inspector's data to produce a comprehensive summary of all the facts prior to applying the JM process to any provision found in NC.

Where NC is found with one or more legislative provisions, the JM is applied to each provision found in NC. Where more than one inspector provided information to support the finding of NC with the exact same requirement under the LTCHA, the Primary Inspector facilitates discussion (for determining action to take/order to make) utilizing the JM process.

Judgement Matrix Procedure

The chart below outlines the procedural steps for conducting the JM process.

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
Analysis & Decision-Making		
1. Multiple inspectors conducting the same inspection should follow the steps starting at Step 1. An inspector who conducts an inspection on their own should skip to Step **4**.	Inspector	*IQS Stage 2 Application Inspector Manual*
2. In preparation for the group discussion, each inspector pre-determines the compliance action to take/order to make for each of their specific provisions found in NC with consideration of the 3 factors: scope, severity, (including KRI), and the licensee's CH).	Inspector	*IQS Stage 2 Application Inspector Manual* *RQI Policy, as applicable* *LTCHA & O Reg 79/10*
3. All secondary inspectors transfer the IQS information via their encrypted USB to the Primary Inspector's tablet.	Inspector	*IQS Stage 2 Application Inspector Manual* *RQI Policy, as applicable*
4. As applicable, the Primary Inspector reviews with the secondary inspector(s), the identified provisions found in NC *(one at a time)* and the supportive findings.	Inspector	*IQS Stage 2 Application Inspector Manual* *RQI Policy, as applicable* *LTCHA & O Reg 79/10*
5. For each provision found in NC, analyze the summarized information to ensure it is sufficient and supports the identified LTCHA provision. The findings are documented in a manner consistent with LQIP documentation principles. (The JM/CDD Decision Tool was developed to assist inspectors with documentation of all decisions related to the	Inspector	*Documentation Policy* *Resident Quality Inspection (RQI) Policy, as applicable* *JM Policy: Appendix H: JM/CDD Decision Tool*

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
JM and if applicable, any decisions related to compliance due dates for orders).		
6. For each requirement under the LTCHA found in NC, the inspector(s) must consider the three factors to be taken into account and only these factors when determining action to take or order to make. The 3 factors to be taken into account are: i. **Severity** of the NC and when there is harm/risk of harm arising from the NC, the severity of the harm or risk of harm, including consideration of whether the NC is a KRI. ii. **Scope** of the NC (isolated, pattern, widespread) and where there is harm or risk of harm arising from the NC, the scope of harm or risk of harm. iii. The licensee's **Compliance History (CH)** for the past 36 months. ***Notes:*** • ***Exception:*** *In determining whether to make an order under s.157 (Revocation) of the LTCHA, the Director may take into account the severity, scope, and CH as above, and any other factors considered relevant.* • *Based on the risk of the NC, the Director may consider the licensee's CH for a greater period of time and scope.*	Inspector	*IQS Stage 2 Application Inspector Manual* *RQI Policy, as applicable* *LTCHA & O Reg 79/10* *JM P&P* . *Appendix A: Levels of Risk* . *Appendix B Legend* . *Appendix C: JM* . *Appendix D: Levels of Severity of NC* . *Appendix E: Key Risk Indicators* . *Appendix F: Levels of Scope of NC* . *Appendix G: Levels of CH* . *Appendix H: JM/CDD Decision Tool*
7. Determine the severity level of the NC (Level 1-4): **Level 1 - Minimum Risk:** is non-compliance that has the potential for causing no more than minor negative impact on the resident(s).	Inspector	*Appendix A: Levels of Risk* *Appendix D: Levels of Severity of NC*

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Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
Level 2 - Minimal Harm or Potential for Actual Harm: is non-compliance that results in minimal discomfort to the resident and/or has the potential (not yet realized) to negatively affect the resident's ability to achieve their highest functional status. **Level 3 - Actual Harm/Risk:** is non-compliance that results in an outcome that has negatively affected the resident's ability to achieve their highest practical functional status. **Level 4 - Immediate Jeopardy/Risk:** is non-compliance that places the resident in immediate jeopardy as it caused (or is likely to cause) serious injury, harm, impairment, or death to a resident receiving care in the LTCH. *Note: When viewing Appendix A, please note that there are 5 levels of risk for the purpose of triaging of intakes. Level 3+ was identified for **Significant Actual Harm/Risk** and is a situation that results in an outcome that had a serious negative impact on one or more residents' health, quality of life and/or safety, or that is creating a serious risk of significant actual harm/risk related to one or more residents' health, quality of life and/or safety. When utilizing the JM, the severity level chosen should be proportionate to the level of risk. If the severity level is considered to be **significant actual harm/risk (3+)**, it should be considered to be a severity risk level 3 but the actions taken by the inspector could be adjusted, as appropriate.* *For assessment of all severity levels, consider the following:*		*Appendix E: Key Risk Indicators* *Appendix H: JM/CDD Decision Tool*

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Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
• Where the resident is unable to express the risk or harm, e.g., a resident with cognitive impairment may not be able to express how emotional abuse from a staff member affected them, the inspector may contact the resident's Substitute Decision Maker (SDM) for assistance in determining the severity level. • Determine whether the provision found in NC is a KRI. • If the provision found in NC is not a KRI, the inspector may consider a lower severity level. For example: if the NC is related to a resident who did not receive restorative care interventions as ordered and the NC with the provision did not result in the resident having a decline in functional capacity, the severity level may be Level 2 "potential for actual harm". This NC is not a KRI and thus the inspector has the choice to lower the severity level to Level 1 (Minimum Risk), as appropriate. • If the provision found in NC is a KRI, the inspector may consider a higher severity level. For example: if the provision in NC is related to the registered nursing staff not reassessing an infected sacral wound for 3 weeks (skin and wound is a clinical KRI), the inspector has the choice to raise the severity Level from, e.g., Level 2 (minimal harm or potential for actual harm); to Level 3 (actual harm), as appropriate. • Determine the final severity level. • If the severity level was altered based on whether the requirement found in NC was a KRI or not, record the variance on the JM/CDD Decision Tool.		

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
Notes: • *It is mandatory to complete the JM/CDD tool even if there is no variance.* • *Based on the KRI, the severity level may only be raised or lowered one level.*		
8. Determine (and *record as appropriate)* the level of the **scope**/pervasiveness of the provision found in NC, i.e., Level 1-3 (isolated, pattern or widespread).	Inspector	*Appendix F – Levels of Scope of NC* *Appendix H: JM/CDD Decision Tool*
9. Plot the final severity level and the scope level of the provision found in NC on the JM to identify the quadrant to be used, i.e., quadrant A to L. • Identify the median (or default) action/order within the quadrant. • Each quadrant identifies the available options to take/make. The JM was designed such that the median action/order increase within the quadrant from the lower left quadrant to the upper right quadrant. You will note that the WAO is not a median in any quadrant, although the option to make a WAO continues to exist. Based on only the scope and severity of the NC, the *median* action to take/order to make is the following: ▪ A – Written Notification (WN) ▪ B, D – Voluntary Plan of Correction (VPC) ▪ C, E, F, G, H, J – Compliance Order (CO) ▪ I, K – Director Referral (DR) ▪ L – Revocation of Licence with or without an Interim Manager (RL/IM).	Inspector	*Appendix C – Judgement Matrix* *Appendix H: JM/CDD Decision Tool*

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Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
Note: *The median action in each quadrant is underlined. When viewing the JM in colour the median action is also the coloured action to take/make.* ***Inspectors must not consider due diligence by the LTCH when determining actions in the JM.***		
10. Determine the licensee's **Compliance History** level of the NC (Level 1-6). ▪ Depending on the level of CH, the identified median action may be altered. If the CH was level 1 or 2, the action to take may be reduced, e.g., CO to a VPC. If the CH was level 5 or 6, the action to take may be increased, e.g., VPC to a CO. This adjustment is made **within the quadrant**. ▪ If the median default action was altered based on the CH, record the variance on the JM/CDD Decision Tool and document the reason for the variance. ***Note:*** *The CH refers specifically to the licensee's CH.* ▪ *If the LTCH is sold there would be a new licensee. As such the new licensee would have a new CH.*	Inspector	*Appendix G– Compliance History* *Appendix H: JM/CDD Decision Tool*
11. The inspector selects the most appropriate action/order from the available options within the quadrant in the IQS Staging Form. • The inspector must choose a WN for every requirement under the LTCHA found in NC. This may be the only action taken, or may be in addition to other action taken or order made. Note: A WN is a default action in IQS and is left for every non-compliance.	Inspector	*Inspection Reports Policy* *Orders Policy* *Appendix B: Legend* *Appendix H: JM/CDD Decision Tool*

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Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
• If any action/order is made in addition to the WN, the inspector must ensure that the action/order to be taken meets the legislative grounds: • Voluntary Plan of Correction *(Grounds – NC)* • Compliance Order *(Grounds – NC)* • Work and Activity Order (Grounds – NC and inspector has reasonable grounds to believe that the licensee will not or cannot perform the work or activity to achieve compliance.) If the action chosen within the quadrant for the NC is a WAO, the inspector must have reasonable grounds to believe that the licensee will not or cannot perform the work or activity to achieve compliance. If these legislative grounds are not met, the inspector must consider an alternate action, e.g., a CO. • Director Referral (DR) (Legislation – A DR is typically made if the inspector is making a recommendation beyond the authority of the inspector and in the following circumstances: **a.** In cases of repeated NC, e.g., when an order has been issued, and subsequently the licensee has been found to be in NC with the order twice through two follow up inspections, **there is a policy requirement for the inspector to issue a CO and a Director's Referral;** b. In cases when the inspector suspects that there is a **high risk situation**, e.g.,		

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
multiple orders issued, the inspector may also make a referral to the Director after consulting with their manager; c. The appropriate response to a finding of NC is beyond the authority of the inspector, e.g., cease admissions, withhold funding, etc. A DR requires discussion with the SAO Manager. Where multiple subsections of the same provision are found in NC, the action taken may relate to one or all of the subsections. For example, if subsections 1, 7, 8 and 10 under section 6 of the LTCHA were found to be in NC, the inspector would issue a WN and if a CO was also identified as the appropriate action to take, the inspector may choose to make the order under s. 6. **Note:** This would require the Primary Inspector to remove all the findings related to the subsections of 6 and issue all of them to the section. **If an inspector is issuing three or more subsections, as an order, consult with your SAO Manager to determine if it is more appropriate to issue an order to the section.** • Orders may be made to the subsection with the most significant findings of NC, e.g., s. 6(8) of the LTCHA. Depending on the circumstances, exceptions to this may occur. Other additional action(s) may be taken for any of the identified subsections under s.6 of the LTCHA, e.g., VPC, as appropriate. • More than one order may be made for the same legislative requirement, as applicable, e.g., an immediate order could be left for s.		

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
6(8) and a CO requesting a plan could also be left to the same subsection, if deemed appropriate. In multiple inspector inspections: • The inspector(s) who provided the findings supporting NC with the requirement under the LTCHA, should describe the JM process taken and final decision to the team. • If more than one inspector found the same requirement under the LTCHA in NC, the collective findings should be described to the team and the JM process is used on the collective findings. The final decision re the action/order should be made by the inspectors who provided the supportive findings. • Although the team members provide guidance through discussion, the inspector(s) who provided the findings to support the NC have the final decision on the appropriate action to take/order to make based on the factors to be taken into account. • Where consensus cannot be found with the NC involving more than one inspector, the SAO Manager/Inspection Manager/ITL will be consulted for facilitation purposes. • Team discussions related to using the JM process and deciding the final action/order for each requirement under the LTCHA found in NC, can be conducted off the site of the LTCH, either in person or by teleconference. ***Notes:*** • The Primary Inspector has the ability to change the evidence of secondary inspector(s) should		

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
this be required to reach consensus with the JM. The permission from the secondary inspector must be documented in writing. **This permission must be given for each specific change.** There cannot be a blanket statement that any findings may be changed in this inspection. **A confirmation email must be saved as part of the inspection package <u>for each change</u>.** • If an inspector is conducting an inspection for a reason other than to follow-up on an existing order '**not past-due**', and identifies additional evidence that supports non-compliance with that existing order '**not past-due**', the inspector should take the following action: o Issue a Written Notification (WN) with the new evidence that supports the existing order not past-due. **If the issue is about the exact same thing, <u>do not make an additional order</u>** (even if the recommended action after completing the JM and applying the Compliance History (CH) is to make an order. An example of the issue being the exact same thing is 24/7 nursing was not in place and there are an additional four shifts not covered by a registered nurse. o In the inspection reports (Licensee and Public), reference the original order, including the date, number and compliance due date of the original order, e.g., the following is further evidence to support the order issued on August 22, 2017, during complaint		

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
inspection 2017_536171_0023 to be complied January 1, 2018. o However, there may be times when an inspector needs to issue a **new order** to the same leg/reference for an order that is **not past due,** because there is a high risk issue that needs to be addressed that is **not related to the existing order**. An example of this would be that O. Reg., 79/10, s. 8(1)(a) has a "not past due" order related to the LTCH's policy does not include taking heights of residents upon admission and annually thereafter. *Note: the order was issued to s. 8, subsection 1.* During the current inspection, a resident is in excruciating pain. An order is made telling the LTCH to address the resident's pain immediately, noting that the pain policy was not followed. A closer due date than what was left for the height issue is required. In this case, a new order could be made to O. Reg., 79/10, s. 8(1)(b) with a closer compliance date. *Note: the order was made to s. 8, sub-section 1 – **orders are made at the section or subsection level.** If there are any concerns, discuss with your SAO Manager.* o When completing the JM/CDD Decision tool, identify the WN that is issued and document the reason for the variance, e.g., additional evidence for existing order not past-due. o When conducting the post-inspection activities add the new evidence (from		

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
the findings in the WN) on the Intake that was prepared for the Follow- up inspection to the original order. This will ensure that the follow-up inspection includes action taken on both the original order 'not past-due' and the additional evidence related to the order.		
12. Repeat Steps 6-10 for every requirement under the LTCHA found to be in NC. **Document all decisions on the JM/CDD Decision Tool** and note any variances.	Inspector	*Appendix H: JM/CDD Decision Tool*

See Watchpoints on next page

Watchpoints:

- Only three factors can be considered when determining the JM decision – severity, scope and compliance history (CH). Due diligence by the LTCH must not be factored into the JM decision.
- Depending on whether the requirement found in NC is a KRI, the severity level may only be raised or lowered one level after consideration by the inspector.
- After the quadrant is chosen and the median identified, the CH is the factor used to determine if the median action/order is appropriate. Based on the CH, the most appropriate action to take/order to make may be one or more alternate actions/orders within that quadrant.
- Where the resident is unable to express the risk or harm, e.g., a resident with cognitive impairment may not be able to express how emotional abuse from a staff member affected them, the inspector may contact the resident's substitute decision maker (SDM) for assistance in determining the severity level.
- Any WAO made must meet the legislative grounds, i.e., in addition to finding non-compliance (NC) with the legislative requirement, the inspector must believe that the licensee will not or cannot perform the work or activity to achieve compliance. Any WAO requires discussion with the SAO Manager.
- A DR is typically made if the inspector is making a recommendation beyond the authority of the inspector and in the following circumstances:
    a. In cases of repeated NCs, e.g., when an order has been issued and subsequently the licensee has been found to be in NC with the order twice through two follow up inspections, there is a policy requirement for the inspector to issue a Director's Referral;
    b. In cases when the inspector suspects that there is a high risk situation, e.g.., multiple orders issued, the inspector may also make a referral to the Director after consulting with their manager;
    c. The appropriate response to a finding of NC is beyond the authority of the inspector, e.g., cease admissions, withhold funding, etc.
- Any DR requires discussion with the SAO Manager.

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COMMUNICATION STANDARDS

Code of Professionalism, 2006

Inspector Etiquette

PRIVACY REQUIREMENTS

Obligations under *Personal Health Information Protection Act, 2004 (PHIPA), Freedom of Information and Protection of Privacy Act, 1990* (FIPPA), *Long-Term Care Home's Act, 2007* (LTCHA) and its Regulation re:

a) taking all reasonable steps to respect the **privacy** of individuals, by protecting against the unauthorized disclosure of their personal information (PI) and personal health information (PHI);

b) not disclosing PI and PHI in Public Inspection and/or Order Reports (see also O Reg. 79/10, s. 301);

c) Tip Sheet: Protect PI & PHI in Public Reports

LQIP Privacy Policy

SECURITY REQUIREMENTS

Security Requirements

SUPPORT AND REFERENCE DOCUMENTS

LHIN – Service Accountability Agreement (L-SAA) – Article 10 s.10.1 (vi) General.

Judgement Matrix Appendices

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QUALITY MANAGEMENT ACTIVITIES (Implementation date to be determined)

Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
Quality Management Activities		
Perform reviews of JM/CDD tools to confirm that the Compliance Due Date (CDD) was established using CDD process and that the JM was used to determine the appropriate actions to take/orders to make. Each SAO will conduct audits of 5% of high risk orders to confirm that the high risk orders had appropriate CDD assigned. Each SAO will conduct audits of 5% of JM.CDD tools to compare it with the IQS JM tool to determine if decisions made on the JM/CDD tool were the same as IQS. Audit the time frames through the process of data monitoring/analysis. The audit cycle is based on a calendar year. Determine whether the compliance due dates were determined as per established process using SAO Audit of JM/CDD. Document the log number/LTCH name, identification (ID) number (#) and record any notes for variances. **Use the *'SAO Audit of Judgement Matrix/CDD Decision Tool'*** to record the responses. Audit questions are based on established requirements. Responses may be 'yes', 'no' or not applicable (N/A), as appropriate. The following questions will be asked:	SAO Manager/ QM person	*SAO Audit of Orders* *Data monitoring/analysis*

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Steps / Description	Co-ordination / Responsibility	Supportive Documents / Key Elements
✓ If there was non-compliance, was the Judgement Matrix/Compliance Due Date Decision Tool used to record the decisions? ✓ Was the JM in IQS the same as what was recorded on the JM/CDD tool? ✓ Was the appropriate compliance area and associated risk level time frame used to establish the CDD? ✓ Were the "additional aspects to consider" taken into consideration? ✓ Was the JM/CDD tool posted on the Y: drive?		

APPENDICES

Appendix A: Levels of Risk

Appendix B: Legend

Appendix C: Judgement Matrix

Appendix D: Levels of Severity of Non-Compliance

Appendix E: Key Risk Indicators

Appendix F: Levels of Scope of Non-Compliance

Appendix G: Levels of Compliance History; Compliance History Clarification

Appendix H: Judgement Matrix/Compliance Due Date Decision Tool

APPENDIX A: LEVELS OF RISK

For each overall intake and each inspection item, the Level of Risk must be identified:

Level 1 **Minimum Risk:** A situation that has the potential for causing no more than minor negative impact on the resident(s) and poses no/nominal threat of on-going risk of harm. An inquiry within 90 business days is considered reasonable.

Level 2 **Minimal Harm or Potential for Actual Harm:** A situation that results in minimal discomfort to the resident and/or has the potential (not yet realized) to negatively affect the resident's ability to achieve their highest functional status and poses minimal threat of on-going risk of harm. An inquiry within 90 business days is considered reasonable.

Level 3 **Actual Harm/Risk:** A situation that results in an outcome that has negatively affected one or more resident's health, safety or well-being, including the resident's ability to achieve their highest practical functional status, or where there is a pattern of incidents contributing to the harm/risk. This may include a situation involving actual harm/risk where action was taken by the licensee/LTCH staff to minimize the risk or prevent the situation from recurring or escalating. An inspection within 60 business days is considered reasonable.

Level 3+ **Significant Actual Harm/Risk:** A situation that results in an outcome that had a serious negative impact on one or more residents' health, quality of life and/or safety, or that is creating a serious risk of significant actual harm/risk related to one or more residents' health, quality of life and/or safety. An inspection within 30 business days is required. The situation does not require an "immediate inspection" as outlined in s. 25(2) of the LTCHA (refer to "Immediate inspection" below).

Level 4 **Immediate Jeopardy / Risk:**
A situation that places a resident or group of residents in immediate jeopardy as it has caused serious injury, harm, impairment, or death to a resident receiving care in the LTCH. This also includes a situation that is highly likely to place a resident or a group of residents in immediate jeopardy where it would cause serious injury, harm, impairment or death, and the licensee is not taking immediate action to appropriately rectify the issue or has failed to intervene, to prevent the situation from unfolding. This level includes situations that require an immediate visit to the LTCH.

An "immediate inspection" (as per the LTCHA s. 25(2) is required for the following that resulted in serious harm or a significant risk of serious harm to the resident:

- improper or incompetent treatment or care of a resident;
- abuse of a resident by anyone, or neglect of a resident by the licensee or staff;
- unlawful conduct; and
- a violation of section 26 (whistle-blowing protection).

***Note:** It may be necessary to substitute 'resident' with 'operations of the home' as applicable.*

APPENDIX B: LEGEND

Legend		
WN	Written Notification	s.152. 1.
VPC	Voluntary plan of correction (licensee to prepare a written plan of correction for achieving compliance, to be implemented voluntarily).	s.152. 2.
DR	Director Referral – inspector to issue a WN and make a referral to the Director	s.152. 4.
CO	Compliance Order	s.153
WAO	Work & Activity Order	s.154
FS	Financial Sanction (Order that funding be returned or withheld)	s.155
MMO	Mandatory Management Order	s.156
RL	Revocation of License	s.157(2)(a)
IM	Interim Manager	s.157 (4-6)
SL	Suspension of Licence	s. 158.41 (1)

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APPENDIX C: JUDGEMENT MATRIX

Severity of Non-Compliance				
	Level 4 **Immediate Jeopardy/Risk**	**J** **WN**. VPC. CO. WAO. DR.	**K** **WN**. VPC. CO. WAO. **DR**. FS. MMO	**L** **WN**. VPC. CO. WAO. DR. FS. MMO. **RL/IM**
	Level 3 **Actual Harm/Risk**	**G** **WN**. VPC. CO. WAO. DR.	**H** **WN**. VPC. CO. WAO. DR.	**I** **WN**. VPC. CO. WAO. **DR**. FS. MMO
	Level 2 **Minimal Harm or Potential for Actual Harm**	**D** **WN**. VPC. CO. DR.	**E** **WN**. VPC. CO. WAO. DR.	**F** **WN**. VPC. CO. WAO. DR.
	Level 1 **Minimum Risk**	**A** WN. VPC. DR.	**B** **WN**. VPC. CO. DR.	**C** **WN**. VPC. CO. WAO. DR.
		Level 1 **Isolated**	**Level 2** **Pattern**	**Level 3** **Widespread**
		Scope of Non-Compliance		

APPENDIX D: LEVELS OF SEVERITY OF NON-COMPLIANCE

Severity is one of three factors that an inspector or the Director takes into account in determining the most appropriate action(s) to take/order(s) to make where there has been a finding of non-compliance with a requirement under the Act. "The severity of the non-compliance and, in cases where there has been harm or risk of harm to one or more residents arising from the non-compliance, the severity of the harm or risk of harm" *(O.Reg. 79/10 s. 299(1)1).*

The severity can be described at four levels on the Judgement Matrix:

Level 1 **Minimum Risk:** is non-compliance that has the potential for causing no more than minor negative impact on the resident(s).

Level 2 **Minimal Harm or Potential for Actual Harm:** is non-compliance that results in minimal discomfort to the resident and/or has the potential (not yet realized) to negatively affect the resident's ability to achieve their highest functional status.

Level 3 **Actual Harm/Risk:** is non-compliance that results in an outcome that has negatively affected the resident's ability to achieve their highest practical functional status.

Level 4 **Immediate Jeopardy/Risk:** is non-compliance that places the resident in immediate jeopardy as it caused (or is likely to cause) serious injury, harm, impairment, or death to a resident receiving care in the LTCH.

Notes:

1. When viewing Appendix A, please note that there are 5 levels of risk for the purpose of triaging of intakes. Level 3+ was identified as **Significant Actual Harm/Risk** and is a situation that results in an outcome that had a serious negative impact on one or more residents' health, quality of life and/or safety, or that is creating a serious risk of significant actual harm/risk related to one or more resident's health, quality of life and/or safety.

   When utilizing the JM, the severity level chosen should be proportionate to the level of risk. If the severity level is considered to be **significant actual harm/risk (3+),** it should be considered to be a severity risk level 3, but the actions taken by the inspector could be adjusted, as appropriate.

2. The inspector may need to substitute the reference to 'resident' with 'the situation'.

3. Where the resident is unable to express the risk or harm, e.g., a resident with cognitive impairment may not be able to express how emotional abuse from a staff member affected them, the inspector should contact the resident's SDM for assistance in determining the severity level.

Consider whether the NC is a Key Risk Indicator (KRI).

- If the NC is not a KRI, the inspector may consider a lower severity level. For example: if the NC is related to a resident who did not receive restorative care interventions as ordered, and the NC did not result in the resident having a decline in functional capacity, the severity level may be Level 2 "potential for actual harm". This NC is not a KRI and thus the inspector has the choice to lower the severity level to Level 1 (Minimum Risk), as appropriate.
- If the NC is a KRI, the inspector may consider a higher severity level. For example: if the NC related to the registered nursing staff not reassessing an infected sacral wound for 3 weeks (skin and wound is a clinical KRI), the inspector has the choice to raise the severity Level from, e.g., Level 2 (minimal harm or potential for actual harm) to Level 3 (actual harm), as appropriate.

APPENDIX E: KEY RISK INDICATORS

Key Risk Indicators

Clinical	Non-clinical
Required Programs (including policy & plan of care concerns) - falls prevention and management - skin and wound - continence care and bowel management - pain Responsive Behaviours (including policy & plan of care concerns) Minimizing of Restraining (including policy & plan of care concerns) Nutrition Care and Hydration (including policy & plan of care concerns) - nutrition care - hydration - weight loss management - safe positioning Medications - safe storage - medication administration - medication incidents - medication misappropriation	Safe and Secure (including policy related concerns) - doors - bed rails - windows - communication and response systems - hazardous chemicals - emergencies/disasters including emergency plans Reporting (including all issues contained in MR or CI) - complaints - making mandatory reports - reporting critical incidents Infection control (including program and policy related concerns) - hand hygiene - outbreaks Alleged/actual abuse &/or neglect – verbal, physical, emotional, sexual, financial (including policy related concerns) Staffing (includes hours and qualifications) - Administrator - Director of Nursing and Personal Care - 24/7 Registered Nurse - Staffing plan to meet needs of residents - Nutrition Manager - Registered Dietitian - Housekeeping, Laundry and Maintenance services lead(s)

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APPENDIX F: LEVELS OF SCOPE OF NON-COMPLIANCE

'Scope' means pervasiveness throughout the home *(O.Reg. 79/10 ss. 299(3).*

Scope is one of three factors that an inspector takes into account in determining the most appropriate action to take and/or orders to make where there has been a finding of non-compliance with a requirement under the Act.

The scope can be described at three levels on the Judgement Matrix: isolated, pattern, or widespread.

Level 1 - Isolated	**Isolated** is when: • one or the fewest number of the affected population that were inspected, and/or • one or the fewest number of staff involved, and/or • the situation has occurred only occasionally or in a very limited number of locations (or units) in the LTCH. *NC found in thirty-three percent (33%) or less of the affected population that were inspected; for example: • 1 out of 3 = 33% • 1 out of 4 = 25% • 1 out of 5 = 20% • 1, or 2 out of 6 = 17% (1 out of 6) or 33% (2 out of 6) ***Example:*** *After the day the LTCHA came into force, one food service worker (FSW) was hired and had not successfully completed nor was enrolled in a FSW training program at an established college (*O. Reg. 79/10 *s.78(1).*
Level 2 - Pattern	**Pattern** is when: • more than the fewest number of residents are affected, and/or • more than the fewest number of staff involved, and/or • the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. NC found in 34% to 67% of the affected population that were inspected; for example: • 2 out of 3 = 67% of the affected residents who were inspected • 2 out of 4 = 50% • 2, or 3 out of 5 = 40% (2 out of 5) or 60% (3 out of 5) • 3, or 4 out of 6 = 50% (3 out of 6) or 67% (4 out of 6)

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	***Example**: Three (3) of the five (5) bedrooms surveyed in the Main Wing had air temperatures ranging from 18 – 21 degrees, and the three corresponding residents complained of the air temperature being too cold (O. Reg. 79/10 s.21).*
Level 3 - Widespread	**Widespread** is when: • The problems causing the deficiency are pervasive in the LTCH and/or represent systemic failure that affected or has the potential to affect a large number of LTCH's residents. • Widespread scope refers to the entire population at the home that were surveyed, not a subset of residents or one unit or location that was surveyed. NC found in more than 67% of the affected surveyed population, for example: • 3 out of 3 or 100% of the residents were affected. • 3 or 4 residents out of 4 residents; 3 out of 4=75%, or 4 out of 4 = 100% of the affected residents who were inspected. • 4 or 5 residents out of 5 residents; 4 out of 5 residents = 80%, or 5 out of 5 residents = 100% • 5 or 6 residents out of 6 residents; 5 out of 6 residents = 83%, 6 out of 6 residents = 100% **Example**: *Four of the last five(5) residents who were admitted with altered skin integrity did not receive a skin assessment by a member of the registered nursing staff within 24 hours of their admission (O. Reg. 79/10 s.50(2)(a)(i).*

APPENDIX G: COMPLIANCE HISTORY LEVELS

Level 1 No previous non-compliance	No previous non-compliance within the last 36 months from the date of the current inspection.
Level 2 Previous unrelated non-compliance	One or more **unrelated** non-compliance in the last 36 months.
Level 3 Previous related non-compliance	One or more **related** non-compliance in the last 36 months.
Level 4 Ongoing non-compliance despite previous action taken by Ministry	Despite Ministry action, e.g., VPC (written plan of correction to be implemented voluntarily) or issuance of an order, the licensee continues to be in non-compliance with the original area of non-compliance on the third or more inspection.
Level 5 Multiple non-compliances related and unrelated	Multiple non-compliances, with at least one related order to the current area of concern.
Level 6 Obstruction	• Person(s) who provided false or misleading information, (including, false or misleading information in any required document); • Refusing to provide required information; • Hindering or obstructing a Ministry employee from conducting an inspection; and • Includes situations in the last 36 months where a responsible person prevented an inspector from conducting inspections for the administration of Ministry legislation, requiring an inspector to obtain a judicial order to carry out the inspection.

Compliance History (CH) Clarification

Definitions:

Related non-compliance: A previous legislative requirement found to be in issue (non-compliance) that is exactly the same or associated with the same legislative requirement also found to be in non-compliance, to which it is being compared.

For example: non-compliance (NC) was found with LTCHA s. 31(2). "The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained."

A related non-compliance would either be NC with LTCHA s. 31(2)1. (exactly the same) or NC with a legislative requirement that relates to restraining a resident.

Unrelated non-compliance: A previous legislative requirement found to be in issue (non-compliance) that is neither exactly the same, nor is associated with the same legislative requirement to which it is being compared.

For example, non-compliance was found with the LTCHA s. 31(2)1 related to restraining a resident. Unrelated non-compliance would be any non-compliance with legislative requirements that do not relate to restraining a resident.

Scenario:

The following scenario was developed to give some context to the legislative requirement found in NC and to ensure that the other 2 factors - severity and scope, were included when factoring in the licensee's compliance history (CH) – to determine the action to take/order to make in response to the NC (O. Reg. 79/10 s.299).

Each of the 6 levels of CH is applied to the same legislative requirement found in NC and the same scope and severity level to demonstrate the effect of the *licensee's* history of compliance when determining what actions to take/orders to make.

January 15th, 2012

NC with LTCHA s. 31(2)1. "The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained."

A resident was found restrained with a lap belt. The resident had been using the lap belt daily for 2 weeks. There was no indication in the resident's plan of care indicating the risk of harm that the resident would suffer without the restraint.

Severity – KRI Minimizing of Restraining

Level 2 – "Minimal Harm or Potential for Actual Harm" is NC that results in minimal discomfort to the resident and/or has the potential (not yet realized) to negatively affect the resident's ability to achieve their highest functional status.

Based on the inspector's professional judgement, the severity level was not increased to actual harm/risk.

Scope:

Level 1 - Isolated;

NC to this legislative requirement affected only 1 of the 3 residents using restraints in the LTCH, who were audited.

Severity Level 2 and Scope Level 1 = Quadrant D

Quadrant D = potential action includes WN, **VPC**, CO, DR; median default is **VPC**

Understanding the Levels of Compliance History (CH)

Example #1: Scenario with Level 1 CH
Scenario: NC with LTCHA s. 31(2)1; Quadrant D, median default VPC

CH – Level 1 No previous non-compliance within the last 36 months.

Decision: WN

The identified median action was lowered to a WN because there was no history of any NC in the past 36 months.

***Note**: Since the decision is affected by the 3 factors (severity, scope and CH), one may argue that a VPC should also be issued because of the severity (including the KRI) of the NC. That is acceptable.*

Example #2: Scenario with Level 2 CH
Scenario: NC with LTCHA s. 31(2)1; Quadrant D, median default VPC

CH - Level 2: One or more unrelated NC in the last 36 months

Compliance History:

September 12, 2011

NC with LTCHA s.8. (1)(a) "Every licensee of a LTCH shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents", e.g., *the nursing staff on nights was not able to manage a resident with a tracheotomy who required care.) – (WN, VPC)*

NC with O. Reg. 79/10 s.26. (3)13. "A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 13. Nutritional status, including height, weight and any risks related to nutrition care", e.g., *the resident's plan of care did not include the dietary assessment related to weight-loss risk to the resident. – (WN)*

NC with O. Reg. 79/10 s.13. "Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy", e.g., *a semi-private room for a couple did not include a privacy curtain between the beds.) – (WN)*

Decision: WN and VPC

The identified median action is appropriate given the CH of multiple NCs. It was not increased because the CH of NC was unrelated. The action was not decreased to a WN to ensure the licensee gives the issue of restraints attention in lieu of other, albeit unrelated NC issues, in the home.

Note: *The inspector may choose to only issue a WN, based on enhanced supportive evidence concerning the three factors.*

Example #3: Scenario with Level 3 CH

Scenario: NC with LTCHA s. 3. (2)1; Quadrant D, median default VPC

CH - Level 3 - One or more **related** non-compliance in the last 36 months.

Compliance History:

July 6, 2011

NC with LTCHA s.30. (1)1. Every licensee of a LTCH shall ensure that no resident of the home is: 1. Restrained, in any way, for the convenience of the licensee or staff. – *(WN & VPC)*

NC with O. Reg. 79/10 s.26. (3)19. A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks *(Plan of care did not include the assessment of any discipline except nursing related to the use of restraint for the resident) – (WN)*

Decision: WN and CO

The median action is increased to a CO because there was related NC (restraints) identified within the last year, including an issuance of a VPC as action to be taken. Previous action taken to correct the related NCs was not effective in ensuring compliance with this related legislative requirement.

Note: In a different scenario, if the current NC and the previously issued related NC was not risk-related, the inspector may choose to leave a WN and VPC. The decision is affected by the 3 factors (severity, scope, and CH).

Example #4: Scenario with Level 4 CH

Scenario: NC with LTCHA s. 31(2)1; Quadrant D, median default VPC

CH - Level 4 - Despite Ministry action (written plan of correction to be implemented voluntarily) or issuance of a CO, the licensee continues to be in non-compliance with the original area of non-compliance on the third (or more) inspection.

Compliance History:

August 3, 2011
NC with LTCHA s. 31. (2)1 – *(WN & VPC)*
Sept. 12, 2011
NC with LTCHA s. 31. (2)1 – *(WN & CO)*

Decision: WN and CO

The identified median action (VPC) had already been issued and later increased to a CO. The licensee had not corrected the VPC or CO related to the same NC (restraints). The inspector would link the previous order to a new order with the additional evidence.

In addition, depending on the scope and severity, the inspector should speak with their SAO Manager about the consideration for a Director Referral, since this represents the third time the same NC was found including a previous Order not corrected.

Example #5: Scenario with Level 5 CH

Scenario: NC with LTCHA s. 31(2)1; Quadrant D, median default VPC

CH - Level 5 - Multiple non-compliances, with at least one related order to the current area of concern.

Compliance History:

July 6, 2011

NC with LTCHA s. 30(1)1. Every licensee of a LTCH shall ensure that no resident of the home is: 1. Restrained, in any way, for the convenience of the licensee or staff. *(WN, CO)*

NC with O. Reg. 79/10 s.26. (3)19. A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 19. Safety risks *(Plan of care did not include the assessment of any discipline except nursing related to the use of restraint for the resident). (WN)*

September 12, 2011

NC with LTCHA s.8. (1)(a) Every licensee of a LTCH shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents, e.g., *the nursing staff on nights was not able to manage a resident with a tracheotomy who required care. (WN, VPC)*

NC with O. Reg. 79/10 s.26. (3)13. A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 13. Nutritional status, including height, weight and any risks related to nutrition care, e.g., *the resident's plan of care did not include the dietary assessment related to weight-loss risk to the resident. (WN)*

NC with O. Reg. 79/10 s.13. Every licensee of a long-term care home shall ensure that every resident's bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, e.g., *a semi-private room for a couple did not include a privacy curtain between the beds. (WN)*

Decision: WN and CO

The median action is increased because there were multiple non-compliances, two of which were related:

- LTCHA s.30. (1)1. - (WN & CO)
- NC with O. Reg. 79/10 s.26. (3)19.

Example #6: Scenario with Level 6 CH

Scenario: NC with LTCHA s. 31. (2)1; Quadrant D, median default VPC

CH - Obstruction

Person(s) who provided false or misleading information (including, false or misleading information in any required document); or

Refusing to provide required information; or

Hindering or obstructing a Ministry employee from conducting an inspection;

This also includes situations in the last three years where a responsible person prevented an inspector from conducting inspections for the administration of Ministry legislation, requiring an inspector to obtain a judicial order to carry out the inspection.

Note: *For CH Level 6, the obstruction would need to have occurred prior to the inspection (within the past 36 months) whereby the licensee, (as an individual) was convicted of a related obstruction or has a finding of NC with a related obstruction provision in the LTCHA (e.g., LTCHA s.151).*

Compliance History:
July 1, 2011
The licensee (as a person) was convicted of a related (restraint) obstruction offence.

Note *- This scenario has never happened yet.*

Decision: WN and *call the SAO Manager for direction re additional action, e.g., DR.*

Obstruction During the Inspection:
If the inspector believes that obstruction is occurring during the inspection, the inspector would deal with the obstruction separately after consultation with their SAO Manager. During an inspection the goal is to overcome any obstruction at the time to obtain the required information.

An example of potential obstruction occurring during the inspection, e.g., the inspector made a written demand (LTCHA s.151.(b) for the plan of care concerning this particular legislative requirement and once received, noted that there was falsification of the document.

APPENDIX H: JUDGEMENT MATRIX/COMPLIANCE DUE DATE DECISION TOOL

Sample on next page

- Refer also to the Inspector's Handbook for the JM/CDD Decision Tool template in Section 4 – Templates – B. Other

Judgement Matrix and Compliance Due Date Decision Tool

Key Risk Indicators	Severity	Scope	Compliance History
CLINICAL *(including policy & plan of care concerns)*: **Required Programs** – falls prevention & management, skin & wound, continence care & bowel management, pain; **responsive behaviours; minimizing of restraining**; **nutrition care & hydration** – nutrition, hydration, weight loss management, safe positioning; **medications** – safe storage, medication administration, medication incidents, & medication misappropriation. **NON-CLINICAL** *(including program & policy related concerns)*: **Safe & secure** – doors, bed rails, windows, communication & response systems, hazardous chemicals, emergencies/disaster including emergency plans; **reporting** –complaints, making mandatory reports & reporting critical incidents; **infection control** – hand hygiene & outbreaks; **alleged/actual abuse &/or neglect** – verbal, physical, emotional, sexual, financial; **staffing** – administrator, director of nursing & personal care, 24/7 registered nursing, staffing plan to meet needs of residents, nutrition manager, registered dietitian, housekeeping, laundry & maintenance services lead(s).	1. Minimum Risk 2. Minimal Harm or Potential for Actual Harm 3. Actual Harm/Risk 4. Immediate Jeopardy	1. Isolated 2. Pattern 3. Widespread	1. No previous NC within last 36 months 2. 1 or more unrelated NC in last 36 months 3. 1 or more related NC in last 36 months 4. Despite MOH action (VPC, order), NC continues with original area of NC 5. Multiple NC with at least one related order to the current area of concern 6. Obstruction

**Refer to the Judgement Matrix and Orders P&Ps for complete definitions to assist in decision making*

Home Name: SAMPLE used for Training **Date:** December 7 & 8, 2017

												Compliance Due Date (CDD) for CO		
Act (s) or Reg (r)		Section related to NC (brief)	Initial Sev. Level	KRI (Y/N)	Final Sev. Level	Scope	JM Quadrant	JM Median Action	Compliance Hx	Action/ Order Decision	Reason for Variance	High Risk (Y/N)	CDD Within Max Time Frame	Reason for CDD Variance
e.g.	*r. 129(1)*	*Safe storage of drugs – med cart unattended and not locked; controlled substances not double-locked*	*2*	*Y*	*2*	*1*	*D*	*VPC*	*3*	*VPC*	*Location on a unit with no wandering residents. CH indicates this provision was previously identified in an inspection a year ago.*			
e.g.	*s. 6(7)*	*Plan of Care~ Care not provided related to continence as specified in plan*	*2*	*Y*	*2*	*2*	*E*	*CO*	*2*	*VPC*	*NC is a KRI. CH is a Level 2 with only 4 NCs in the last 36 months and none of the NC are related to continence. Decreased to a VPC.*			
e.g.	*s. 6(7)*	*Plan of Care~ Care not provided related to restorative care as specified in plan*	*2*	*N*	*1*	*2*	*B*	*VPC*	*2*	*VPC*	*NC is not a KRI. Risk was minimal harm with no negative outcome, therefore, severity was decreased to Level 1.*			

e.g.	s.19	Duty to protect	3	Y	3	1	G	CO	5	CO	Significant actual harm (abuse), severity level not at IJ level, stayed at level 3; CH showed multiple NCs and s.19 previously issued as CO x1.	Y	Y	
e.g.	s. 76(2)3	Training prior to performing duties	3	N	3	1	G	CO	5	CO	Immediate order left to ensure PSW is trained prior to performing any more duties in the home. CH showed multiple NCs.	Y	Y	
e.g.	s. 76(7)1.	Training – direct care staff – abuse recognition and prevention	2	N	2	3	F	CO	5	CO	Recurring order related to abuse training, therefore, high risk. CH showed multiple NCs.	Y	N	Large home requires additional time to train staff No corporate resources to support the home/training 30 days for CDD(approved by SAO manager)
6.														
7.														
8.														
9.														
10.														

	CDD for High Risk CO up to 7 days	CDD for Not High Risk CO up to 90 days
Abuse /Neglect / *Retaliation (Duty to protect; * For Abuse policy see 'Policy' below; For training see 'Training' below)*	7 days	90 days
Drugs *(safe storage; administration)*	7 days	90 days
Residents' Rights	7 days	90 days
Responsive Behaviours	7 days	90 days
Restraints	7 days	90 days
Safe and Secure *(bed rails; communication and response system doors, elevators, emergency plan, generators, hazardous substances, windows)*	7 days	90 days
	CDD for High Risk CO up to 21 days	**CDD for Not High Risk CO up to 120 days**
Accommodation Services *(Maintenance, Laundry and Housekeeping)*	21 days	120 days
Admission authorization *(Licensee's admission consideration & approval)*	21 days	120 days
Complaints	21 days	120 days
Continuous Quality Improvement / Quality Management	21 days	120 days
Dietary Services & Hydration *(wt. changes; menu planning; food production; dining & snack service)*	21 days	120days
General Programs *(other than those already identified) Restorative Care; Recreation/Social; Medical; Information & referral assistance; Religious & spiritual; Volunteer)*	21 days	120 days
Infection Prevention and Control Program *(staff participation, implementation of program; immunization & screening)*	21 days	120 days
Mandatory Reporting	21 days	120 days
Nursing & PSS *(ADLs including bathing)*	21 days	120 days
Policy *(developed; communicated, implemented; complied with)*	21 days	120 days
Plan of Care *(assessment/re-assessment, plan, goal; clear direction; complete; comply; provision; revision)*	21 days	120 days
Required Programs *(continence care and bowel management, falls, pain management, skin & wound)*	21 days	120 days
Staffing *(Qualifications & Hours - Administrator; DONPC, 24/7 RN; nursing PSS staffing plan; RD, NM, Cook; FSW; Designated Leads)*	21 days	120 days
Training staff *(includes orientation, training and re-training)*	21 days	120 days
Transferring and Positioning	21 days	120 days

Judgement Matrix

Severity of Non-Compliance	Scope of Non-Compliance: Level 1 Isolated	Level 2 Pattern	Level 3 Widespread
Level 4 Immediate Jeopardy/Risk	J WN, VPC, CO, WAO, DR,	K WN, VPC, CO, WAO, DR, FS, MMO	L WN, VPC, CO, WAO, DR, FS, MMO, RL/IM
Level 3 Actual Harm/Risk	G WN, VPC, CO, WAO, DR,	H WN, VPC, CO, WAO, DR,	I WN, VPC, CO, WAO, DR, FS, MMO
Level 2 Minimal Harm or Potential for Actual	D WN, VPC, CO, DR,	E WN, VPC, CO, WAO, DR,	F WN, VPC, CO, WAO, DR
Level 1 Minimum Risk	A WN, VPC, DR,	B WN, VPC, CO, DR,	C WN, VPC, CO, WAO, DR,

Additional Aspects to Consider

The inspector must also consider the following when determining the appropriate CDD	Yes / True (Consider a shorter CDD)	No / False (Consider a longer CDD)
The Order is a recurring order.		
There is reason to believe that there are sufficient internal/corporate (financial or human) resources to support the home in returning the Order to compliance.		
The size of the home is less than 192 beds		

KEY RISK INDICATORS:
RAI-MDS related:
new or worsening pressure ulcers; daily physical restraint; weight loss; falls; new fracture; indwelling catheter; prevalence or worsening bladder or bowel incontinence; fecal impaction; mod/severe or worsening pain; pneumonia; wound infection; UTIs; worsening function in ADLs; depression without anti-depressant therapy; worsening depression or anxiety; behavioural symptoms affecting others; worsening behaviour; anti-anxiety/hypnotic drug use; antipsychotic drug use in absence of psychotic/related condition;
Non-RAI-MDS related:
verified complaints; offensive odour; poor grooming & hygiene; staff or leadership turnover; financial concerns; alleged/actual financial abuse to resident; availability of meaningful activity; use of agencies; poor oral health; nourishment/supplement not consumed by resident at nutritional risk; environmental hazards/system breakdown; accidental/unexpected death; missing resident; emergencies; equipment related injuries; alleged/actual abuse/assault; medication misappropriation; injuries resulting in transfer/admission to hospital; outbreaks

SCOPE:
1 – *Isolated*
2 – *Pattern*
3 – *Widespread*

SEVERITY:
1 – *Minimum Risk*
2 – *Minimal harm or Potential for Actual Harm*
3 – *Actual Harm/Risk*
4 – *Immediate Jeopardy*

COMPLIANCE HISTORY:
1) *No previous NC within last 3 yrs.*
2) *1 or more unrelated NC in last 3 yrs.*
3) *1 or more related NC in last 3 yrs.*
4) *Despite MOH action (VPC, order), NC continues with original area of NC*
5) *Multiple NC with at least one related to the current area of concern*
6) *Obstruction*

Judgement Matrix and Compliance Due Date Decision Tool

Home Name: _____ **Date:** _____

**Refer to the Judgement Matrix and Orders P&Ps for complete definitions to assist in decision making.*

												Compliance Due Date (CDD) for CO		
	Act (s) or Reg (r)	Section related to NC (brief)	Initial Sev. Level	KRI (Y/N)	Final Sev. Level	Scope	JM Quadrant	JM Median Action	Compliance Hx	Action/ Order Decision	Reason for Variance	High Risk (Y/N)	CDD Within Max Time Frame	Reason for CDD Variance
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														

												Compliance Due Date (CDD) for CO		
	Act (s) or Reg (r)	Section related to NC (brief)	Initial Sev. Level	KRI (Y/N)	Final Sev. Level	Scope	JM Quadrant	JM Median Action	Compliance Hx	Action/ Order Decision	Reason for Variance	High Risk (Y/N)	CDD Within Max Time Frame	Reason for CDD Variance
13														
14														
15														
16														
17														
18														
19														
20														
21														
22														
23														
24														
25														
26														
27														
28														
29														
30														

Description of Non-Compliance Areas	CDD for High Risk CO up to 7 days	CDD for Not High Risk CO up to 90 days
Abuse /Neglect / *Retaliation (Duty to protect;* * *For Abuse policy see 'Policy' below; For training see 'Training' below)*	7 days	90 days
Drugs *(safe storage; administration)*	7 days	90 days
Residents' Rights	7 days	90 days
Responsive Behaviours	7 days	90 days
Restraints	7 days	90 days
Safe and Secure *(bed rails, communication and response system doors, elevators, emergency plan, generators, hazardous substances, windows)*	7 days	90 days
	CDD for High Risk CO up to 21 days	**CDD for Not High Risk CO up to 120 days**
Accommodation Services *(Maintenance, Laundry and Housekeeping)*	21 days	120 days
Admission authorization *(Licensee's admission consideration & approval)*	21 days	120 days
Complaints	21 days	120 days
Continuous Quality Improvement / Quality Management	21 days	120 days
Dietary Services & Hydration *(wt. changes; menu planning; food production; dining & snack service)*	21 days	120days
General Programs *(other than those already identified) Restorative Care; Recreation/Social; Medical; Information & referral assistance; Religious & spiritual; Volunteer)*	21 days	120 days
Infection Prevention and Control Program *(staff participation; implementation of program; immunization & screening)*	21 days	120 days
Mandatory Reporting	21 days	120 days
Nursing & PSS *(ADLs including bathing)*	21 days	120 days
Policy *(developed; communicated; implemented; complied with)*	21 days	120 days
Plan of Care *(assessment/re-assessment, plan, goal; clear direction; complete; comply; provision; revision)*	21 days	120 days
Required Programs *(continence care and bowel management, falls, pain management, skin & wound)*	21 days	120 days
Staffing *(Qualifications & Hours - Administrator; DONPC; 24/7 RN; nursing PSS staffing plan; RD, NM; Cook; FSW; Designated Leads)*	21 days	120 days
Training staff *(includes orientation, training and re-training)*	21 days	120 days
Transferring and Positioning	21 days	120 days

Judgement Matrix

Severity of Non-Compliance	Scope of Non-Compliance: Level 1 Isolated	Level 2 Pattern	Level 3 Widespread
Level 4 Immediate Jeopardy/Risk	J WN. VPC. CO. WAO. DR.	K WN. VPC. CO. WAO. DR. FS. MMO	L WN. VPC. CO. WAO. DR. FS. MMO. RL/IM
Level 3 Actual Harm / Risk	G WN. VPC. CO. WAO. DR.	H WN. VPC. CO. WAO. DR.	I WN. VPC. CO. WAO. DR. FS. MMO
Level 2 Minimal harm or potential for actual harm	D WN. VPC. CO. DR.	E WN. VPC. CO. WAO. DR.	F WN. VPC. CO. WAO. DR.
Level 1 Minimum risk	A WN. VPC. DR.	B WN. VPC. CO. DR.	C WN. VPC. CO. WAO. DR.

Additional Aspects to Consider The inspector must also consider the following when determining the appropriate CDD	Yes / True (Consider a shorter CDD)	No / False (Consider a longer CDD)
The Order is a recurring order.		
There is reason to believe that there are sufficient internal/corporate (financial or human) resources to support the home in returning the Order to compliance.		
The size of the home is less than 192 beds		

This is Exhibit "B"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

Vink, Lisa (MOHLTC)

From: Fairchild, Karin (MOHLTC)
Sent: October 5, 2016 3:09 PM
To: McNally, Aislinn (MOHLTC); Vink, Lisa (MOHLTC)
Subject: FW: Urgent

See below

Thanks, Karin

From: Colameco, Stacey (MOHLTC)
Sent: October 5, 2016 11:29 AM
To: Fairchild, Karin (MOHLTC)
Subject: FW: Urgent

Stacey Colameco
Sr. Manager –Compliance and Enforcement
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
Phone: 416-325-8770
Stacey.colameco@ontario.ca
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5

From: Simpson, Karen (MOHLTC)
Sent: October 5, 2016 11:27 AM
To: Nestor, Mary (MOHLTC); Colameco, Stacey (MOHLTC)
Subject: Fw: Urgent

Karen Simpson
Director
LTC Inspections Branch
LTC Homes Division

From: Smith, Sharon Lee (MOHLTC) <SharonLee.Smith@ontario.ca>
Sent: Wednesday, October 5, 2016 11:10 AM
To: Candace Chartier
Cc: Lytle, Nancy (MOHLTC); Pollard, Brian (MOHLTC); Simpson, Karen (MOHLTC); McNally, Sarah (MOHLTC)
Subject: Re: Urgent

Thank you. Will follow up asap
Brian pls call me on cell 6475443300
SL

Sent from my iPhone

On Oct 5, 2016, at 10:46 AM, Candace Chartier <CChartier@oltca.com> wrote:

Please see below. You may have already been notified.
It was easier to just forward what I sent my team.
Best
Candace

Sent from my iPhone

Begin forwarded message:

From: <CChartier@oltca.com>
Date: October 5, 2016 at 10:44:48 AM GMT-4
To: Senior Staff <SeniorStaff@OLTCA.local>, Bill O'Neill <Boneill@KensingtonHealth.org>
Subject: Urgent

Hi everyone

You may want to sit down for this....

Jim Lavelle just called me. A nurse that worked for him from 2007-2014 (she was fired in 2014 due to medication errors) walked into a Toronto Police station and has admitted to murdering seven residents with insulin injections. She admitted to trying to kill four additional residents but they apparently lived. She admitted to working at another home called Telford Place (can we check and see if a member?) and murdered a resident there with insulin as well and finally, then went on to admit she worked for Life Care Agency and murdered another resident. At first police thought there was mental illness issues around this confession but apparently was assessed by a psychologist and they believe it is true. Caressant Care has hired David Golden and a PR firm to help them get through this. They will be notifying ministry as well. We need to be prepared for a lot of media as bodies will have to be exhumed, families notified and a full scale investigation. I am literally sick to my stomach and can't even imagine this horror. On top of it all she has only given police the first names of residents.

Candace

Sent from my iPhone

This is Exhibit "C"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

2742-000013-16

TELFER PLACE
245 GRAND RIVER STREET NORTH
PARIS

CI Date and Time	Date and Time CI first Submitted to MOH	Current Status CHANGED ON 5-Oct-2016 15:51
4-Oct-2016 12:45	5-Oct-2016 15:50	SUBMITTED

Mandatory/Critical Incident Description

Please identify whether you are reporting a Mandatory Report or a Critical Incident:

Mandatory Report [LTCHA, 2007]

Which Mandatory Report category best applies?

Abuse/Neglect [24(1)(2)]

Area/Location of incident:

Other (please specify)

Please specify (Area/Location)

Location is unknown at this point.

Select relevant sub-category as applies to Abuse/Neglect:

Staff to resident

Select relevant sub-type(s) as applies to Abuse/Neglect:

Physical

Description of the Incident, including events leading up to the occurrence

On Monday Oct 5th,Officer In the lead Karen Overbaugh #108 and Officer Phyllis Eastalake #9910. into Telfer Place asking to speak to ED. ED was out of building at meeting. Officer Phyllis Eastalake spoke with Director of Care Michelle Cornelissen and Regional Director clinical Services Cheryl Muise.
She stated she was investigating an allegation that had been made. Overview of Discussion with Police Officer: She stated a registered nurse by the name of Elizabeth Wettlaufer who had checked herself into a health care facility had admitted to attempting to kill long term care residents. Elizabeth had stated that she attempted to kill the resident Sandra Tower at Telfer Place by giving her 60 units of fast acting insulin and 80 units of long acting insulin but she survived sometime in the Winter of 2016.
No further information was given or available. Police questioned whether she was an employee, and it was noted that she is not an employee of Telfer Place but an employee of Lifeguard HomeCare (Staffing Services).
Telfer Place did acknowledge that she has worked for the Home over 2015 and 2016.

Identifying information

Name of home staff RESPONDING to Incident

Michelle Cornelissen DOC

Actions taken

What care was given or action taken as a result of the Incident?

At this point this is an allegation and the Home has begun an internal investigation.
Starting with reviewing the Resident Sandra Tower's medical condition past and current.(Note that Sandra is still a resident of Telfer Place)Sandra's medical condition during shifts when the RN Elizabeth Wettlaufer worked.
Identifying all shifts worked by the "agency" RN Elizabeth Wettlaufer in 2015/2016.
Reviewing medical condition of residents during her worked shifts and post.

By whom?

DOC Michelle Cornelissen
ED/Regional Manager Ruthanne Foltz
Regional Manager Clinical Services Cheryl Muise

2742-000013-16

TELFER PLACE
245 GRAND RIVER STREET NORTH
PARIS

CI Date and Time	Date and Time CI first Submitted to MOH	Current Status
4-Oct-2016 12:45	5-Oct-2016 15:50	CHANGED ON 5-Oct-2016 15:51 SUBMITTED

Was physician called?

No

What other authorities were contacted about this Incident?

Police

Was the MOHLTC after hours pager contacted about this Incident?

No

What other additional authorities were contacted? (e.g. First Nations Band Council, Veterans Affairs Canada, Ministry of Labour, etc.)

Mary Brazier VP of Quality and Support Verbally/Phone contacted MOHLTC

For resident-related occurrences

Were relative(s), friend(s), designated contact(s) and/or substitute decision maker(s) contacted?

No

If No, why not?

Police Officer had noted that they were not contacting any family at this point as there is currently no proof of this allegation and the mental health status of the alleged.
Revera VP Mary Brazier has been in contact with MOHLTC to seek guidance with family disclosure.

What is the outcome/current status of the individual(s) who was/were involved in this occurrence?

Sandra Tower continues to be a resident here at Telfer Place. Our preliminary reviews are showing no significant medical issues or occurrences during the broad time frames given in the allegation. More information will be provided as reviews are currently being conducted.

What was the family members' response?

Will update as disclosure is provided.

Analysis and follow-up

What immediate actions have been taken to prevent recurrence?

Will update as review is currently being conducted.

What long-term actions are planned to correct this situation and prevent recurrence?

Will update as review is currently being conducted.

Name of person initiating report

Ruthanne Foltz

2742-000013-16

TELFER PLACE
245 GRAND RIVER STREET NORTH
PARIS

CI Date and Time	Date and Time CI first Submitted to MOH	Current Status CHANGED ON 5-Oct-2016 15:51
4-Oct-2016 12:45	5-Oct-2016 15:50	SUBMITTED

Category of person initiating report
Administrator

Date of report (MM/DD/YYYY)
10/05/2016

Please check to confirm the Administrator or Designate has signed the original of this form
Yes

This is Exhibit "D"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

2742-000013-16

TELFER PLACE
245 GRAND RIVER STREET NORTH
PARIS

CI Date and Time	Date and Time CI first Submitted to MOH	Current Status
4-Oct-2016 12:45	5-Oct-2016 15:50	CHANGED ON 7-Oct-2016 09:02 **AMENDED**
		Previous Status ~~SUBMITTED~~

Mandatory/Critical Incident Description

Please identify whether you are reporting a Mandatory Report or a Critical Incident:

Mandatory Report [LTCHA, 2007]

Which Mandatory Report category best applies?

Abuse/Neglect [24(1)(2)]

Area/Location of incident:

Other (please specify)

Please specify (Area/Location)

Location is unknown at this point.

Select relevant sub-category as applies to Abuse/Neglect:

Staff to resident

Select relevant sub-type(s) as applies to Abuse/Neglect:

Physical

Description of the Incident, including events leading up to the occurrence

On Monday Oct 5th,Officer in the lead Karen Overbaugh #108 and Officer Phyllis Eastalake #9910. into Telfer Place asking to speak to ED. ED was out of building at meeting. Officer Phyllis Eastalake spoke with Director of Care Michelle Cornelissen and Regional Director clinical Services Cheryl Muise.
She stated she was investigating an allegation that had been made. Overview of Discussion with Police Officer: She stated a registered nurse by the name of Elizabeth Wettlaufer who had checked herself into a health care facility had admitted to attempting to kill long term care residents. Elizabeth had stated that she attempted to kill the resident Sandra Tower at Telfer Place by giving her 60 units of fast acting insulin and 80 units of long acting insulin but she survived sometime in the Winter of 2016.
No further information was given or available. Police questioned whether she was an employee, and it was noted that she is not an employee of Telfer Place but an employee of Lifeguard HomeCare (Staffing Services).
Telfer Place did acknowledge that she has worked for the Home over 2015 and 2016.

Identifying information

Name of home staff RESPONDING to Incident

Michelle Cornelissen DOC

2742-000013-16

TELFER PLACE
245 GRAND RIVER STREET NORTH
PARIS

CI Date and Time
4-Oct-2016 12:45

Date and Time CI first Submitted to MOH
5-Oct-2016 15:50

Current Status
CHANGED ON
7-Oct-2016
09:02
AMENDED

Previous Status
~~**SUBMITTED**~~

Actions taken

What care was given or action taken as a result of the Incident?

7-Oct-2016 8:58 : Update: Oct 7, 2016
Home was contacted by Const. Phyllis Eastlake with some additional information to follow up in our investigation of the allegation.
She stated that the Nurse Elizabeth had now given them more information and had named the nurse who had "corrected" what she had done as Dianne Beauregard RN. The Regional Manager of Clinical Services for Revera began review and was able to find a documented change in resident clinical status as follows:
On September 6th, 2015 the Nurse Elizabeth W. worked on the evening shift. 2pm to 10pm. During her shift she documents in resident Sandra. T. chart that resident refused her bath. During the previous 24 hours of charting there is no noted issues with her blood sugar but there is noted decrease in fluid intake.
On September 7th, at 0120am the shift following the evening shift Elizabeth W. worked, on care rounds it is noted that the Resident in question Sandra T. was unresponsive and would not arouse with various stimuli provided. Her blood sugar was taken and noted at 2.2. 911 was called at 0130am and arrived on at the Home. An IV was started by the paramedics and she was given IV dextrose. Within 20 minutes time the resident's condition improved she was responsive and it is noted at 0220am that her blood sugar was 6.7. She was not taken to Hospital by paramedics and remained at the Home. She was put on every hour blood glucose checks and was monitored. Over the next several shifts/days there is documentation that notes difficulty with maintaining blood sugars and resident was sent to hospital and returned.
With the finding of this new information in our investigation the Police Officer Phyllis E. was contacted and information was provided. The Officer took all available verbal information and noted that she would be interviewing the Nurse Dianne B. (a employee of Telfer Place).
At this point this is an allegation and the Home has begun an internal investigation.
Starting with reviewing the Resident Sandra Tower's medical condition past and current.(Note that Sandra is still a resident of Telfer Place)Sandra's medical condition during shifts when the RN Elizabeth Wettlaufer worked.
Identifying all shifts worked by the "agency" RN Elizabeth Wettlaufer in 2015/2016.
Reviewing medical condition of residents during her worked shifts and post.

By whom?

DOC Michelle Cornelissen
ED/Regional Manager Ruthanne Foltz
Regional Manager Clinical Services Cheryl Muise

Was physician called?

No

What other authorities were contacted about this Incident?

Police

Was the MOHLTC after hours pager contacted about this Incident?

No

What other additional authorities were contacted? (e.g. First Nations Band Council, Veterans Affairs Canada, Ministry of Labour, etc.)

Mary Brazier VP of Quality and Support Verbally/Phone contacted MOHLTC

For resident-related occurrences

Were relative(s), friend(s), designated contact(s) and/or substitute decision maker(s) contacted?

No

2742-000013-16

TELFER PLACE
245 GRAND RIVER STREET NORTH
PARIS

CI Date and Time
4-Oct-2016 12:45

Date and Time CI first Submitted to MOH
5-Oct-2016 15:50

Current Status
CHANGED ON
7-Oct-2016
09:02
AMENDED

Previous Status
~~SUBMITTED~~

If No, why not?

7-Oct-2016 9:02 : Update September 7 2016- Home and Region Director of Operations Trish Nolan spoke with Const. Phyllis Eastlake and she noted that she would be contacting family within the next 24hours. The Officer will be informing Trish Nolan when that contact has been made.
Regional Director of Operations (RDO) Trish Nolan will be contacting resident's POA once police contact has been made.
Police Officer had noted that they were not contacting any family at this point as there is currently no proof of this allegation and the mental health status of the alleged.
Revera VP Mary Brazier has been in contact with MOHLTC to seek guidance with family disclosure.

What is the outcome/current status of the individual(s) who was/were involved in this occurrence?

Sandra Tower continues to be a resident here at Telfer Place. Our preliminary reviews are showing no significant medical issues or occurrences during the broad time frames given in the allegation. More information will be provided as reviews are currently being conducted.

What was the family members' response?

Will update as disclosure is provided.

Analysis and follow-up

What immediate actions have been taken to prevent recurrence?

Will update as review is currently being conducted.

What long-term actions are planned to correct this situation and prevent recurrence?

Will update as review is currently being conducted.

Name of person initiating report

Ruthanne Foltz

Category of person initiating report

Administrator

Date of report (MM/DD/YYYY)

10/05/2016

Please check to confirm the Administrator or Designate has signed the original of this form

Yes

Case Notes

Most Recent Note : Assessed as per current process; level of risk is 3. Inspection required. ANM

This is Exhibit "E"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

Ontario Ministry of Health and Long-Term Care

Off-site Preparation for On-site Inquiry / Inspection Plan

Log # (s): 295783-16	Home ID: 2742
Licensee Official Name:	Telfer Place
LTCH Name & Address (if different from above):	Telfer Place 245 Grand River Street North Paris Ontario
Administrator Name:	Jim Eagleton
Off-Site Preparation Date:	October 17, 2016
Inspector(s) Name & ID # (Identify Team Lead if more than one Inspector:	Lisa Vink -168 Lesley Edwards - 506 Phyllis Hiltz-Bontje - 129
Inspection Date: October 28, 2016	Most Recent Inspection Date: please see compliance Hx
Meeting Date, Time, & Place (prior to entry):	To be determined

Inspection Type:

☐ On-Site Inquiry x Complaint ☐ Critical Incident System (CIS) ☐ Follow-up

☐ Other

☐ Concurrent Inspection(s)

Gather Supplies:

☐ Tablet, air card, VPN token, encrypted USB key, power cord, and power bar, extra battery as needed
☐ Inspector Certificate of Appointment and name tag
☐ Business cards
☐ Blackberry
☐ Portable printer, paper (optional)
☐ Other relevant supplies (e.g., emergency back-up paper copies, legislation, thermometer)

Inspection Plan Guidance

Complete an inspection plan below, in as much detail as possible, using the questions below as a guide.

How?
- How will the information be gathered, e.g., through interviews, observations, record reviews?

Notes:

Who?
- Who can provide the information – resident, SDM, staff (encourage to interview from unregulated care providers, then registered staff then manager etc.)?

- Who are the most appropriate inspectors to conduct the inspection and how many?
Notes:

What?
What potential questions need to be developed to clarify what happened and when? What IP(s) should be used or legislation referenced?
Notes:

Where?
Where can the information be found, e.g., resident room, specific unit, records?
Notes:

When?
When is the most appropriate time to gather the information e.g., on a weekend, on a specific shift, or during regular business hours?
Notes:

CIS – cut and below

2742-000013-16	CI Date and Time	Date and Time CI first Submitted to MOH	Current Status CHANGED ON 7-Oct-2016 09:02		
	TELFER PLACE 245 GRAND RIVER STREET NORTH PARIS		4-Oct-2016 12:45	5-Oct-2016 15:50	AMENDED Previous Status ~~SUBMITTED~~

Mandatory/Critical Incident Description

Please identify whether you are reporting a Mandatory Report or a Critical Incident:

Mandatory Report [LTCHA, 2007]

Which Mandatory Report category best applies?

Abuse/Neglect [24(1)(2)]

Area/Location of incident:

Other (please specify)

Please specify (Area/Location)

Location is unknown at this point.

Select relevant sub-category as applies to Abuse/Neglect:

Staff to resident

Select relevant sub-type(s) as applies to Abuse/Neglect:

Physical

Description of the Incident, including events leading up to the occurrence

On Monday Oct 5th,Officer in the lead Karen Overbaugh #108 and Officer Phyllis Eastalake #9910. into Telfer Place asking to speak to ED. ED was out of building at meeting. Officer Phyllis Eastalake spoke with Director of Care Michelle Cornelissen and Regional Director clinical Services Cheryl Mulse.
She stated she was investigating an allegation that had been made.
Overview of Discussion with Police Officer: She stated a registered nurse by the name of Elizabeth Wettlaufer who had checked herself into a health care facility had admitted to attempting to kill long term care residents. Elizabeth had stated that she attempted to kill the resident Sandra Tower at Telfer Place by giving her 60 units of fast acting insulin and 80 units of long acting insulin but she survived sometime in the Winter of 2016.
No further information was given or available. Police questioned whether she was an employee, and it was noted that she is not an employee of Telfer Place but an employee of Lifeguard HomeCare (Staffing Services). Telfer Place did acknowledge that she has worked for the Home over 2015 and 2016.

Identifying information

Name of home staff RESPONDING to Incident

Michelle Cornelissen DOC

Actions taken

What care was given or action taken as a result of the Incident?

7-Oct-2016 8:58 : Update: Oct 7, 2016
Home was contacted by Const. Phyllis Eastlake with some additional information to follow up in our investigation of the allegation.
She stated that the Nurse Elizabeth had now given them more information and had named the nurse who had "corrected" what she had done as Dianne Beauregard RN. The Regional Manager of Clinical Services for Revera began review and was able to find a documented change in resident clinical status as follows:
On September 6th, 2015 the Nurse Elizabeth W. worked on the evening shift. 2pm to 10pm. During her shift she documents in resident Sandra. T. chart that resident refused her bath. During the previous 24 hours of charting there is no noted issues with her blood sugar but there is noted decrease in fluid intake.
On September 7th, at 0120am the shift following the evening shift Elizabeth W. worked, on care rounds it is noted that the Resident in question Sandra T. was unresponsive and would not arouse with various stimuli provided. Her blood sugar was taken and noted at 2.2. 911 was called at 0130am and arrived on at the Home. An IV was started by the paramedics and she was given IV dextrose. Within 20 minutes time the resident's condition improved she was responsive and it is noted at 0220am that her blood sugar was 6.7. She was not taken to Hospital by paramedics and remained at the Home. She was put on every hour blood glucose checks and was monitored. Over the next several shifts/days there is documentation that notes difficulty with maintaining blood sugars and resident was sent to hospital and returned.
With the finding of this new information in our investigation the Police Officer Phyllis E. was contacted and information was provided. The Officer took all available verbal information and noted that she would be interviewing the Nurse Dianne B. (a employee of Telfer Place).
At this point this is an allegation and the Home has begun an internal investigation.

Starting with reviewing the Resident Sandra Tower's medical condition past and current.(Note that Sandra is still a resident of Telfer Place)Sandra's medical condition during shifts when the RN Elizabeth Wettlaufer worked.
Identifying all shifts worked by the "agency" RN Elizabeth Wettlaufer in 2015/2016.
Reviewing medical condition of residents during her worked shifts and post.

By whom?

DOC Michelle Cornelissen
ED/Regional Manager Ruthanne Foltz
Regional Manager Clinical Services Cheryl Muise

Was physician called?

No

What other authorities were contacted about this Incident?

Police

Was the MOHLTC after hours pager contacted about this Incident?

No

What other additional authorities were contacted? (e.g. First Nations Band Council, Veterans Affairs Canada, Ministry of Labour, etc.)

Mary Brazier VP of Quality and Support Verbally/Phone contacted MOHLTC

For resident-related occurrences

Were relative(s), friend(s), designated contact(s) and/or substitute decision maker(s) contacted?

No

If No, why not?

7-Oct-2016 9:02 : Update September 7 2016- Home and Region Director of Operations Trish Nolan spoke with Const. Phyllis Eastlake and she noted that she would be contacting family within the next 24hours. The Officer will be informing Trish Nolan when that contact has been made.
Regional Director of Operations (RDO) Trish Nolan will be contacting resident's POA once police contact has been made.
Police Officer had noted that they were not contacting any family at this point as there is currently no proof of this allegation and the mental health status of the alleged.
Revera VP Mary Brazier has been in contact with MOHLTC to seek guidance with family disclosure.

What is the outcome/current status of the individual(s) who was/were involved in this occurrence?

Sandra Tower continues to be a resident here at Telfer Place. Our preliminary reviews are showing no significant medical issues or occurrences during the broad time frames given in the allegation. More information will be provided as reviews are currently being conducted.

What was the family members' response?

Will update as disclosure is provided.

Analysis and follow-up

What immediate actions have been taken to prevent recurrence?

Will update as review is currently being conducted.

What long-term actions are planned to correct this situation and prevent recurrence?

Will update as review is currently being conducted.

Name of person initiating report

Ruthanne Foltz

Category of person initiating report

Administrator

Date of report (MM/DD/YYYY)

10/05/2016

Please check to confirm the Administrator or Designate has signed the original of this form

Yes

Case Notes

Most Recent Note : Assessed as per current process; level of risk is 3. Inspection required. ANM

PHASE 1 – to be initiated Oct 28, 2016

It was been identified during the initial visit to the LTCH that the identified individual was not an employee of the home – however worked at the home, thru a contract agency, Lifeguard Homecare.

This phase of the inspection will be conducted to gather information and begin the process of inspection for a review of:

1. the following IP's, in whole or part: Medication, Training and Orientation, Reporting and Complaints, Sufficient Staffing and Critical Incident Response

2. an initial review of any medication errors/incidents made or identified by the identified nurse (RN EW) – did any incidents require reporting to the Director and if so were they reported to the Director as required in the legislation
3. a review of the identified nurses (RN EW) personal file maintained by the home, if available, including: orientation and training records, any performance issues or concerns, dates/shifts worked (it is noted that the records previously provided are unclear for certain dates regarding the shift worked), position worked in the home, reason no longer at the home and any other relevant information
4. to obtain contact information, as available, for any management staff no longer with the organization who was employed at the time home, at the time that the nurse (RN EW) was at the home
5. to obtain a copy of the contract signed by the licensee and the agency (Lifeguard Homecare) that the identified nurse (RN EW) worked for while at the home
6. to obtain a copy of the copy of the contract with the Pharmacy Service Provider who was in place at the time that the nurse was at the home (RN EW)

Who?

-Administrator
-DOC
-Registered staff – 3 in total who are responsible for all or a portion of the medication management system, include agency staff if available
-Pharmacy service provider, if needed to collect further information necessary to complete the Medication IP
-Lifeguard Homecare Agency management staff responsible for the nurse

Inspection to be completed by 2 nursing inspectors

What?

*****Home IP's only to be used – due to phase 1 being a review of systems and process in place in the home**

Medication Inspection Protocol
Completed the Medication IP, in its entirety according to the procedure as outlined
Include an initial review of any medication errors/incidents made or identified by the identified nurse (RN EW) or for the identified resident (ST)

Training and Orientation Inspection Protocol
Complete relevant sections of this IP with the DOC and/or staff educator and 3 registered staff in the home - including agency staff in available

Part A according to the procedure as outlined for the questions below:
Question #12 – regarding agency staff – receive training
If ANC is identified in Part A – move to the appropriate questions in Part B

Critical Incidence Response IP
Complete relevant sections of this IP with the Administrator and DOC and a during a review of all home identified incidents involved the identified nurse (RN EW) and any home identified medication incidences for the identified resident (ST)

Complete this IP according to the procedure outlined specifically for:
Part B
Question #3, parts 3 and 5 – reporting of missing or unaccounted for controlled substances and medication incident for which resident was taken to hospital

Part C (if appropriate)
Question #5 – follow up report to the Director within 10 d
Question #6 – report to be completed for those involved
Question #7 – report to include actions taken by the home
Question #8 - report to include analysis and FU action
Question #9 – report to include information regarding author of report and if inspector notified and when
Question #10 – if serious incident/injury was SDM notified

Sufficient Staffing IP
Complete with the DOC and/or staff educator in the LTCH
Complete according to the procedure as outlined for the questions below:
Complete Part A
Question #1 - Certification of Nurses
Question # 30 – Staff Qualifications (General)
40

Reporting and Complaints IP
Complete with the Administrator and DOC and 3 registered staff in the home (include agency staff if available)
Complete entire IP according to the procedure as outlined for any complaints the home received regarding the identified nurse (RN EW) or 3 complaints received regarding medications or the care of residents

Where?

In clinical records of identified records related to home identified medication incidents only
Interviewed to be conducted via telephone and face to face
Training records
Nurses (RN EW) file (if available)
CIS system
Meeting Minutes
Medication Error Forms
Risk Management forms
Policies and Procedures
Medication room
Internal investigation files and notes
Complaints log and files and records

When?

Regular business hours.

Review the Licensee's Compliance History in the LTCH
(If not in IQS, refer to Compliance History working document)

This is Exhibit "F"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Licensee Copy/Copie du titulaire de permis

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
May 24, 2017	2016_188168_0020	029573-16	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA VINK (168), LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 5, 28, 2016, November 1, 3, 4, 9, 10, 14, 2016, December 12, 13, 14, 22, 2016, January 3, 2017, February 13, 17, 2017 and March 21, 2017.

This complaint inspection was conducted related to medication incidents and adverse drug reactions, administration of drugs, duty to protect and reporting certain matters to the Director.

During the course of the inspection, the inspector(s) spoke with former and current Executive Directors (ED), former Directors of Care (DOC), the Assistant Director of Care (ADOC), the Medical Director, an attending physician, the restorative care coordinator, pharmacist, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), the Director of Health and Wellness (retirement home), Regional Manager of Education and Resident Services, Retirement Coordinator, Food Service Manager (FSM), Regional Manager of Clinical Services, an external vendor, family members and residents.

During the course of this inspection the inspectors: observed the provision of care and services including medication administration, reviewed clinical health records and other records including but not limited to: relevant policies and procedures, employee files, staff training and orientation records, staffing schedules, meeting minutes, complaints and medication incidents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found, (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté, (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Telfer Place is a long term care home with a licensed capacity of 45 beds.
Executive Director #618 verified the staffing pattern for the home included at least one RN (not including the Director of Care) on duty and present at all times, in addition to a mix of RPNs and PSWs to meet the nursing and personal care needs of residents.

Interview with ED #618 identified that currently the home has a sufficient number of RNs on staff to fill all RN positions according to the staffing plan; however, that there were occasions when due to vacation coverage or illness the home has vacant shifts which needed to be filled.
It was identified that the home consistently offers additional shifts and overtime to their RNs to fill these vacant shifts; however, when the RNs employed by the home are unwilling or unable to work the vacant shifts the home may fill the shifts with RPNs employed by the home with a RN on call, or with RNs employed by an employment agency, in an effort to provide RN coverage 24 hours a day seven days a week.
The Registered Nurses Staffing Schedules were provided from June 25, 2016 until December 9, 2016, on request.
It was identified that the home was able to supplement their staffing levels with the new graduate initiative program.
A review of the schedules, by scheduler #616, confirmed that over the identified time period there were over 25 occasions when the only RN in the home was an agency RN and seven occasions when there was only an RPN, employed by the home, in the building with a RN, on call.
It was verified by ED #618 that the agency RNs were not members of the regular nursing staff and that no circumstances were present, to their knowledge, which permitted an exception to the requirements of section 8(3), by virtue of section 45 of the Regulation.

The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. [s. 8. (3)] (168)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is at least one registered nurse who is an employee of the licensee and is a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that screening measures, including criminal reference checks, were conducted in accordance with the regulations before they hired staff.

Ontario Regulation 79/10 section 215(1)(2) identifies that the section applies where a criminal reference check is required before a licensee hires a staff member, as set out in subsection 75(2) of the Act and that the criminal reference check must be conducted by a police force and conducted within six months before the staff member is hired by the licensee. Subsection 75(3) of the Act identifies that a staff member who is agency staff is considered hired when he or she first works in the home.

RN's #610, #609 and #605 worked at the long term care home, as agency registered nurses, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
RN #610 worked occasionally at the home from February 2015 until the spring of 2016.
RN #609 worked occasionally at the home from 2014 until the fall of 2016.
RN #605 worked only one shift, independently at the home in October 2016.
Interview with the ADOC identified that the RNs provided direct care to residents as part of their duties during the shifts they worked at the home.
Former DOC #620 identified that it was the expectation that the employment agency completed all of the required screening, for any staff they arranged to work at the home.
The ADOC verified that they had not obtained criminal reference checks from the employment agency that employed the RNs nor had they requested that the staff provide verification of a completed criminal reference check before they performed their responsibilities.

Ontario Regulation 79/10 section 234(1)3 identifies that the licensee is required to ensure that a record is maintained for each staff member of the home that includes the staff member's criminal reference check, as required under subsection 75(2) of the Act.

Screening measures, including criminal reference checks, were not conducted as required. [s. 75. (2)] (168)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that screening measures are conducted in accordance with the regulations before they hired staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training
Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home received training as required. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before they received training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

RNs #610 and #607 were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the licensee and an employment agency or other third party.

Executive Director #618 identified that to their knowledge the home utilized the services of employment agencies to fill vacant shifts including coverage of vacation time of regular employees of the home and/or to cover sick calls.

A. RN #610 worked at the home, beginning in February 2015, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
A review of orientation and training records, provided by the home, for RN #610 identified that they did not receive training in the areas of: Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control.
Interview with RN #607, who completed the orientation with RN #610, was shown a copy of the agency RN's "Orientation Checklist" and identified that they could not specifically recall the orientation. It was verified that during the orientation process RN #607 would have followed the checklist and that the specific items identified were not recorded as being completed according to the document provided. To the recall of RN #607, they were not aware of any additional handouts or information provided to agency staff as part of the orientation process, in 2015.
The ADOC reviewed the employee records for RN #610 and verified that the orientation and training records available did not include that all of the mandatory training was completed.

Orientation and training was not provided as required for RN #610 in the area of Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services.

B. According to orientation records RN #609 worked at the home, beginning in May 2014, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.
The ADOC identified that the home continued to utilize the services of the RN intermittently, as required until approximately the fall of 2016.
A review of the initial orientation, from 2014, provided by the home, for RN #609 identified that they did not receive training in the areas of: Residents' Bill of Rights, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control.
The ADOC reviewed the employee records for RN #609 and verified that the orientation records available did not include that all of the mandatory training was completed in 2014.
Interview with the ADOC identified that in the summer of 2016, the role of staff development was added to their position. At this time they implemented an agency staff training booklet, in addition efforts were made to provide retraining to all regular agency staff for the mandatory training.
Training records, identified that RN #609 was retrained and provided with a hard copy of the required training on August 22, 2016.
This training was completed with the support of DOC #620.
A review of the sign off records, training materials and interview with the ADOC identified that the

RN was provided with all required training, when they were retrained in August 2016.

Orientation was not initially provided as required for RN #609 in the area of Residents' Bill of Rights, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services.

Interview with former DOC #619 who was responsible for staff development, identified that in 2015, agency staff would have received a minimum of a four hour orientation, with a RN from the home, to complete an orientation checklist. DOC #619 also indicated that the home implemented a "booklet" for agency staff, which included all mandatory training to be completed, along with a sign back form for the agency staff to complete and return to the home, for retention as a record that the training was complete; however, the exact time of this implementation was unknown.

The training was not completed as required. [s. 76. (1)] (168)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff at the home receive training as required and that no person mentioned in subsection (1) performs their responsibilities before they receive training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 24 to make mandatory reports. 5. The protections afforded by section 26. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that included: the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

A. Review of the home's complaint logs identified that there was a complaint made by resident [redacted] substitute decision maker (SDM).
The Client Service Response (CSR) form did not include the date which the complaint was received.

The CSR form did include the nature of the complaint and indicated that the form would be forwarded to the ADOC for follow-up.
The CSR form did not include a record of the action taken to resolve the complaint, including dates, time frames for actions or the final resolution for the complaint, nor dates on which a response was made to the complainant.
Interview with the ADOC on December 13, 2016, confirmed that they did not recall the complaint being forwarded to them and did not complete the CSR form.
Interview with the Regional Manager of Education and Resident Services, who was the acting ED at the time of the complaint, confirmed that they forwarded this complaint to the ADOC for completion and that it was the expectation that the relevant manager would complete the form before returning it to the ED.

B. A complaint was made by resident [redacted] SDM.

The CSR form did include the nature of the complaint; however, there was no mention of the actions taken to resolve the complaint, including dates, time frames for actions and the final resolution for the complaint, nor did not include dates on which a response was made to the complainant.
Interview with the Regional Manager of Education and Resident Services, who was the acting ED at the time of the complaint, confirmed that they forwarded this complaint to the ADOC and the FSM for follow-up and completion.
Interview with the ADOC on December 13, 2016, revealed that they could not recall the CSR form.
Interview with the FSM on December 14, 2016, verified that they recalled a discussion regarding the concern at the management meeting; however, could not recall a CSR form for the issue.

C. An email complaint was sent to the ADOC on February 7, 2016, from staff regarding the care and services provided to residents by agency staff at the home.
The ADOC received the complaint and responded to RN #612, the following day, by email indicating that the concern would be forwarded to DOC #103.
A review of the home's complaints log did not include a CSR form regarding the concerns identified.

Interview with DOC #103 confirmed that they did not recall any concerns regarding care and services provided to the residents by agency staff at the home.
Interview with the ADOC on February 18, 2017, confirmed that they did not complete a CSR form for the concerns identified in the email and confirmed that the home did not follow the complaints process.

The home did not comply with the requirements for the management of complaints. [s. 101. (2)] (506)

2. The licensee failed to ensure that documented complaints were reviewed and analyzed for trends at least quarterly.

A review of the home's Professional Advisory Committee meeting minutes for April and July 2016, were completed.
Client Service Response (CSR) forms were identified in the meeting minutes; however, the meeting minutes did not include a review of the complaints nor were the complaints analyzed for trends.
Interview with the Regional Manager of Education and Resident Services, who was the acting ED in July 2016, confirmed that the complaints were not reviewed and analyzed for trends at the Professional Advisory Committee meeting as per the process in the home.

The complaints were not reviewed and analyzed for trends as required. [s. 101. (3)] (506)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes: the date the complaint is received;
the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response is provided to the complainant and a description of the response; and any response made in turn by the complainant and to ensure that documented complaints are reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident was reported to the resident's substitute decision maker (SDM) and the pharmacy service provider.

Review of the home's medication incidents identified five medication incidents, involving residents [redacted] that took place on an identified date in February 2016, were documented as medication omissions by RN #631.
The medication incidents were discovered by the following shift and medication incident reports were completed.
The medication incident reports did not include information that the residents' SDMs were notified of the incidents nor that the pharmacy was informed of the omissions.
Interview with the home's pharmacist, who regularly visits the home, verified they did not always receive medication incidents from the home. Medication incidents were identified to be consistently reported when they were a pharmacy error or an adverse event. The pharmacist identified that to their knowledge the home managed medication errors, by the nursing staff internally.
Interview with the ADOC on December 12, 2016, confirmed that the five identified medication incidents were not reported to the residents' SDMs or pharmacy as required. [s. 135. (1)] (506)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident which involves a residents is reported to the resident's substitute decision maker (SDM) and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 234. Staff records
Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience. O. Reg. 79/10, s. 234 (1).
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. O. Reg. 79/10, s. 234 (1).
3. Where applicable, the results of the staff member's criminal reference check under subsection 75 (2) of the Act. O. Reg. 79/10, s. 234 (1).
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: where applicable, verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she was a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.

It was identified by ED #618 that the home had a staffing plan and a minimum staffing level that they would maintain to provide care and services to the residents. When the home was unable to achieve this level, with staff employed by the home, they utilized the services of employment agencies, who held contracts with the home, to provide professional nursing services on request.

There was a contract between the home and an agency which identified that all staff provided would be in good standing with the College of Nurses (CNO) and that the company would endeavor to provide proof of insurance, WSIB (Workplace Safety and Insurance Board) and proof of registration/license upon request.

A. Agency RN #610 worked at the home and was responsible to provide direct care to residents intermittently from February 2015, until April 2016. The home had not requested proof of registration/license, from the agency or the staff member, nor had they verified the nurse's standing with the CNO by other means such as the CNO "Find a Nurse" website as identified by the ADOC. The home did not maintain a record of the RNs verification of current registration with the CNO.
B. Agency RN #609 worked at the home and was responsible to provide direct care to residents intermittently from 2014, until the fall of 2016. The home had not requested proof of registration/license, from the agency or staff member, nor had they verified the nurses standing with the CNO by other means such as the CNO "Find a Nurse" website as identified by the ADOC. The home verified the nurse's status with the CNO, on August 22, 2016 and at that time maintained documentation to support that the nurse was "entitled to practise with no restrictions".

Interview with the ADOC verified the past practice, when they utilized the services of the agencies to provide registered nursing staff, that they had not requested proof of registration/license with the CNO nor checked the status for the specific registered nursing staff who worked in the home as placed by the employment agency, as it was assumed that the agency screened staff as outlined in their contact. [s. 234. (1) 2.] (168)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member: where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession, to be implemented voluntarily.

Issued on this 24th day of May, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

This is Exhibit "G"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

Legend:

Refer to policy for Judgment Matrix for complete definitions to assist in decision-making.

SEVERITY:
1 – *Minimum Risk*
2 – *Minimal harm or Potential for Actual Harm*
3 – *Actual Harm/Risk*
4 – *Immediate Jeopardy*

SCOPE:
1 – *Isolated – Five (5%) or less of the affected surveyed population.*
2 – *Pattern – Greater than 5%or fewer than 33% of the affected surveyed population.*
3 – *Widespread – Greater than 33% of the affected surveyed population*

Compliance History:
1) no previous non-compliance within last 3 years (2 full+current)
2) 1 or more unrelated non-compliance in last 3 years
3) 1 or more related non-compliance in last 3 years
4) despite MOH action (VPC, order), non-compliance continues with original area of N/C
5) Multiple n?c with at least one related to the current area of concern
6) Obstruction

Home Name: Telfer Place **Date: March 2017 – 29573-16**

	Act or Reg	Evidence/related to area of non-compliance	KRI	Sev	Scope	Comp Hist	Judgment Matrix Decision	History/Justification for Decision
E.g	O.Reg.r8(1)	r/t Quality Improvement – policies not followed for minimizing of restraining, skin & wound		2	2	3	VPC	Previously issued in April 2003 as a WN & VPC and still occurring – four areas not following policy
	Act 8(3)	24/7 RN		1	2	3	(B) VPC	
	Act 75(2)	Screening – police check		1	3	2	(C) CO	Change/reduce to a VPC as the agency who employed the staff were to have completed the required screening - the home did not verify that this had been completed but it was the expectation – no HX
	Act 76(1)(2)	Training – orientation		2	2	2	(E) CO	Change/reduce to a VPC as concerns had been identified by home, prior to the inspection and a change in practise since the time of the findings
	Reg 101	Dealing with complaints		1	2	3	(B) VPC	
	Reg 135	Medication incidents		1	2	3	(B) VPC	
	Reg 234	Staff records – of CNO verification		1	2	2	(B) VPC	

This is Exhibit "H"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

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5 Grand River St N, Paris ON N3L 3V8
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www.reveraliving.com

Respect | Integrity | Compassion | Excellence

I R Hunter an inspector appointed under the Act, certify this to be a true copy of the original, dated Oct 31/16
Signed: R Hunter

From: Heidi Wilmot Smith [mailto:heidiws@lifeguardhomecare.com]
Sent: Wednesday, May 04, 2016 3:56 PM
To: Michelle Cornelissen
Cc: Taryn Smith
Subject: RE: Reported RN Incident

Michelle:

Taryn and I have met with Bethe.

Would it be possible to meet one day next week?

May 10 is not possible for me.

Best regards,

Heidi Smith

From: Michelle Cornelissen [mailto:Michelle.Cornelissen@reveraliving.com]
Sent: Wednesday, April 20, 2016 3:38 PM
To: heidiws@lifeguardhomecare.com
Subject: Reported RN Incident

Hello Heidi,

As discussed today on the phone we have had reported issues with the RN Beth.

1. An incident was reported this morning by our PSW who worked with Beth last night. This PSW reported a workplace injury to Beth; there was no incident report completed. Also the injury was a result of a Resident to which I could find no documentation at all related to Residents identified behaviors in his chart. The PSW identified to the Beth that she was concerned for the safety of the Resident and of other Residents due to demonstrated behaviors and requested that Beth check on him frequently but noted that in fact Beth did not and failed to further inform oncoming staff of the issues experienced throughout the night?
2. Further the physician was in today and brought up concerns related to Beth as well and did not feel confident in her abilities to assess our Residents and carry out basic nursing duties. The physician also mentioned that he felt she lacked accountability as a nurse and to the Residents of the home.

As you mentioned Heidi it has been brought to your attention regarding the vulgar and inappropriate comments made by Beth when speaking with our staff.
From this point forward Telfer Place would no longer be comfortable utilizing Beth as a Registered Nurse in our Home.

This is Exhibit "I"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

Resident #	Risk Name	Criteria Name	Notes
			1. THIS WAS ENTERED INTO THE WRONG HOME _ DELETE NOTES BELOW (12/19/2016 12:32:00 PM) 2. this is a late entry from FRIDAY -issues identified during stage 1 1. 2 pills found on floor one in room 419 and the other 204 will do med observation (for RQI and complaint inspection on both the 4th and 2nd floor) 2. issues with tub rooms on the 4th and 3rd floor - the tubs are stained and discoloured 3. during initial tour 2nd floor malodourous - but no issues later in the day or today (MONDAY) 4. as part of complaint - additional screening questions were asked of some residents r/t privacy with mail rough care with transfers specifically when being put to bed cleaning of floors staffing on nights assistance with toileting decision making ie getting to see MD when they want to and being informed of what meds they are on frequency be beds changed and if allowed to have their window open please refer to ABAQIS for these comments also paper towel balls were left behind doors in rooms 419, 416 405 to determine cleaning of floors trends -LE - still had 1 resident to interview no families as of yet no trends LV - no families yet 1 residents allegation of abuse - but could not give specific info no trends call bell issues identified in rooms 419 and 219 main staff alerted immediately and a repair man was in the home prior to the insepctors leaving and resolved the issue --- only able to get 2 family interviews - despite attempting to contact all residents who were not interviewed --- will inspector initiate heights --- total of 6 IP's trigged from this RQI

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			---------- due to complaints (anon) will increase sample size where approrpaite to 3 additional residents ---------- (12/19/2016 11:14:12 AM)
			1. THIS WAS ENTERED INTO THE WRONG HOME _ PLEASE IGNORE NOTE (12/19/2016 12:33:05 PM) 2. NOTES FROM ABAQIS r/t complaints 11826-16 and 14700-16 Resident [redacted] Building and Environment (133501, 101500) 1. Is this a comfortable building in which to live? (Comfortable includes appropriate temperature and lighting.) Comment History: o window is on the roomates side of bed - has never asked (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:28:36) o o Yes 2. Is the home clean? Comment History: o floors too (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:28:36) o o Yes Participation in Care Decisions (107210) 1. Are you involved in decisions about the care you receive, such as accepting or refusing treatment as appropriate? Comment History: o never asked to see the md staff tell her about her pills (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:28:36) o o Yes Sufficient Staff (136232) 1. Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time? Comment History: o no problems on nights either (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:28:36) o o Yes Privacy (107204) 1. Do you have privacy when on the telephone? Comment History: o phone at desk - no concerns with privacy mail from church only - it is not opened (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:28:36) o Yes o o ---------- ---------- Resident # [redacted] Building and Environment (133501, 101500) 1. Is this a comfortable building in which to live? (Comfortable includes

appropriate temperature and lighting.)
Comment History:
o no issues with window (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:54:13)
o
o Yes
2. Is the home clean?
Comment History:
o floors too (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:54:13)
o Yes
Participation in Care Decisions (107210)
1. Are you involved in decisions about the care you receive, such as accepting or refusing treatment as appropriate?
Comment History:
o is aware of what meds taking - sees MD on reqest (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:54:13)
o Yes
Abuse (125253)
1. Have you ever been treated roughly by staff?
Comment History:
o no problems with transfers either - is quite ind (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:54:13)
If the resident answers "Yes", ask who, what, when, where, how often?
o No
Sufficient Staff (136232)
1. Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?
Comment History:
o night shift ok too (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:54:13)
o Yes

Privacy (107204)
1. Do you have privacy when on the telephone?
Comment History:
o own phone in room - has privacy - mail is open when she gets it - she wants it like this (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:54:13)
o Yes
o
o

Resident - [redacted]
Building and Environment (133501, 101500)
1. Is this a comfortable building in which to live? (Comfortable includes appropriate temperature and lighting.)
Comment History:
o can use window with no concerns (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:11:01)
o Yes
2. Is the home clean?
Comment History:
o floors too (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:11:01)
o Yes
F. Participation in Care Decisions (107210)
1. Are you involved in decisions about the care you receive, such as accepting or refusing treatment as appropriate?
Comment History:

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

o can see DR when he asks on weds he comes - can not recall what his meds are - had not asked (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:11:01)
o Yes
G. Abuse (125253)
1. Have you ever been treated roughly by staff?
Comment History:
o not rought with transfers either (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:11:01)
If the resident answers "Yes", ask who, what, when, where, how often?
o No
Sufficient Staff (136232)
1. Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?
Comment History:
o sometimes they are short handed - then a longer wait no problems on the night shift (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:11:01)
o Yes
Privacy (107204)
1. Do you have privacy when on the telephone?
Comment History:
o almost never uses the phone - does not get mail - (Lisa.Vink@ontario.ca @ Dec 16, 2016 15:11:01)
o Yes

----------Resident Interview: [redacted]
Building and Environment (133501, 101500)
1. Is this a comfortable building in which to live? (Comfortable includes appropriate temperature and lighting.)
Comment History:
o can open window - if wants it open - but not a issue for her to have open (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:27:49)
o Yes
2. Is the home clean?
Comment History:
o floors too (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:27:49)
o Yes
F. Participation in Care Decisions (107210)
1. Are you involved in decisions about the care you receive, such as accepting or refusing treatment as appropriate?
Comment History:
o is aware of her meds - is also good about getting her to see her MD - including the foot MD - just 1-2 weeks got a new MD - Dr Yanover - she got an introduction and a hug (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:27:49)
o Yes
G. Abuse (125253)
1. Have you ever been treated roughly by staff?
Comment History:
o including lifts/transfers - although needs minor assistance only with transfers - although needs help with compression stockings and they are gentle (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:27:49)
If the resident answers "Yes", ask who, what, when, where, how often?
o No
Sufficient Staff (136232)
1. Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

Comment History:
o no issues on d, e, or n shift (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:27:49)
o Yes
Privacy (107204)
1. Do you have privacy when on the telephone?
Comment History:
o privacy with mail as well - not opened when delivered has own phone in room has privacy (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:27:49)
o Yes
o

Resident Interview: [redacted]
Building and Environment (133501, 101500)
1. Is this a comfortable building in which to live? (Comfortable includes appropriate temperature and lighting.)
Comment History:
o window open when she wants (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:06:58)
o Yes
2. Is the home clean?
Comment History:
o floors too (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:06:58)
o Yes
F. Participation in Care Decisions (107210)
1. Are you involved in decisions about the care you receive, such as accepting or refusing treatment as appropriate?
Comment History:
o not asked to see doctor - - knows her meds (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:06:58)
o Yes
G. Abuse (125253)
1. Have you ever been treated roughly by staff?
Comment History:
o not rough with transfers in a w/c - 2 staff (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:06:58)
If the resident answers "Yes", ask who, what, when, where, how often?
o No
Sufficient Staff (136232)
1. Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?
Comment History:
o nights are ok too (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:06:58)
o Yes
Privacy (107204)
1. Does staff provide you privacy when they work with you, changing your clothes, providing treatment?
o Yes
2. Do you have privacy when on the telephone?
Comment History:
o privacy on phone and gets mail it is not opened (Lisa.Vink@ontario.ca @ Dec 16, 2016 14:06:58)
o Yes
Resident Interview: [redacted]

Building and Environment (133501, 101500)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. Is this a comfortable building in which to live? (Comfortable includes appropriate temperature and lighting.) Comment History: o opens and closes on own - her windows (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:56:31) o Yes 2. Is the home clean? Comment History: o including floors (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:56:31) o Yes F. Participation in Care Decisions (107210) 1. Are you involved in decisions about the care you receive, such as accepting or refusing treatment as appropriate? Comment History: o refuses meds when she wants to - sees to MD when she has to - they once said no - does not remember when or why wanted to see him (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:56:31) o No G. Abuse (125253) 1. Have you ever been treated roughly by staff? Comment History: o 1 PSW WHEN SHE DOES NOT GET DRESSED BY HERSELF SHE IS ROUGH WITH HER - DOES NOT KNOW HER NAME - SHE WAS HERE TODAY - CAN NOT DESCRIBE HER (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:56:31) If the resident answers "Yes", ask who, what, when, where, how often? o Yes Sufficient Staff (136232) 1. Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time? Comment History: o at night wait for them to answer the bell (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:56:31) o No Privacy (107204) 1. Do you have privacy when on the telephone? Comment History: o does not get any mail it goes to her brother has to use the phone at the desk lots of people there (Lisa.Vink@ontario.ca @ Dec 16, 2016 13:56:31) o No (12/19/2016 12:04:39 PM)
			1. arrived onsite at 0855 and met with admin JIM and reinforced purpose of visit (11/9/2016 9:08:28 AM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. former DOC MIchelle returned by call - she identified that she was at Paris at the police station today and also at Telfer place she had agreed to be interviewed on MON afternoon at [redacted] (11/10/2016 3:28:37 PM) 2. return call received from former DOC SHerri - she agreed to be interviewed at her LTCH on MOnday at approx 10-1015 for approx 1 hour -she questioned the nature of the visit - I explained it was related to Telfer place - she seemed surprised however agreed to meet MONDAY at 10-1015 ish (11/10/2016 10:36:54 AM) 3. just arranged a meeting with current ADOC Lindsay for 900 MONDAY am (11/10/2016 1:39:08 PM) 4. again call placed to former DOC MICHELLE C again pick up by answering machine - - transferred to reception who identified that she was again not in the home today - but was expected on Friday of this week will call back on friday (11/10/2016 1:33:09 PM) 5. again call placed to former DOC Sherri T - message left this am at approx 0955 requesting a return call to set up an appointment for MONDAY am awaiting return call ---------- again call placed to former DOC Michelle Cornelissen - message left this am at approx 0958 requesting a return call to set up an appointment for MONDAY afternoon - awaiting a return call (11/10/2016 9:57:05 AM) 6. second call placed to former DOC MC - - it was identified by office staff that she was off site at a DOC meeting today - - will attempt to book a meeting for MONDAY (11/9/2016 3:57:42 PM) 7. error below phone # is 519 area code not 905 call placed back to LTCH at 1340 it was identified that the DOC does not work on WED - therefore not able to set up an interview call placed to former DOC Michelle Cornelissen currently working at [redacted] called [redacted] voice mail recording - message left requesting return call awaiting return call (11/9/2016 1:40:57 PM) 8. call placed to former DOC Sherri Toleff at her current home [redacted] - message left requesting a return call on my cell to hopefully set up a meeting with her for Thursday at 1100 (11/9/2016 11:21:32 AM)
			1. attempted to interview ADOC Lindsay Astley today - she is off ill and will not be interviewed today (11/9/2016 11:29:57 AM)
			1. First draft of interview questions - additional specific questions r/t medication errors and written complaints will be added by inspector LE Interview: Associate DOC Lindsay Astley Interview Date and Time: Interviewer: Recorder:

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

1. What is your position at Telfer Place and how long have you been in this role?

2. What are responsibilities in your position - have these responsibilities changed since February 15, 2015? If yes please describe how.

3. Does this position require you to orientate, train or organize staff education - specifically for nurses, if yes please explain.

4. Are you aware of the home has ever had the opportunity/need to utilize agency registered staff in the LTCH

5. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found?

6. Is there any training or orientation provided to agency registered staff prior to them preforming duties in the LTCH.

7. Are you aware of there is a different process or procedure for the orientation/training of regular registered staff employees of the home or of agency registered staff. If yes please describe.

8. As the ADOC, what was/is your role related to the orientation process for agency registered staff?

9. Will you please describe the current process in place for the orientation and training of agency registered staff, including providing us a copy of any documents/checklists used in this process.

10. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?

11. Previously, during this inspection, you indicated to inspector PHB that there was a change in the orientation process in the Summer of 2016 for agency registered staff - will you please confirm this and detail what was the process prior to the Summer of 2016.

12. Do you recall if you provided or organized orientation or training for agency registered staff RN BW. Please describe the training/orientation she received.

13. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail and actions taken as result.

14. Are you aware or did you receive any verbal complaints, which could not be resolved within 24 hours, or any written complaints in 2015? Is yes please describe and actions taken. Would there be a record related to these complaints or concerns? If yes where.

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

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Inspection Type: Complaint

			We may need to contact you again at a later date if we have further questions. Comments made during interview were reviewed by the interviewee: Interviewee made following comments: (additional comments/corrections) Interviewee verified, the information provided as accurate: information provided: Added to Ad Hoc notes in IQS: (11/9/2016 11:32:12 AM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. PSW returned call Dec 16, 2016 – at approx. 0910 (message previously left by inspector LE) Telephone interview conducted this am, by inspector L Edwards with L Vink present as well - with PSW and union steward Lynn Jackson from Telfer place. Telephone interview conducted as PSW was not working when we previously were at the home, after she was identified to me someone who may have knowledge of this situation, and was not available at the home on the next scheduled visit. Lynn was informed of the purpose of our call and identified the agency staff member by name (BW) She was informed that her name had come up as a person who may have knowledge about the RN during the course of other interviews She identified that this would be the 3rd time telling this story She identified that she worked with the agency RN a number of times, and always ate lunch with her and had breaks – she was unusual with the things that she would say to staff but nothing to say that she was "crazy" She identified that there was an evening that she was working with resident Sandy Towler (ST) – she had put her to bed – later in the shift her roommate D.C. who no longer resides at the home was calling out so she entered the room again - - it was her routine to always check the resident (ST) in the first bed when walking by - - as she did this she noted that ST was not her usual self. She tried to talk to her and see if she was ok but as usual she really did not respond – but she did not look like herself – she reassured ST. When leaving the room – the RN (BW) was outside of the door with her pill cart – she asked her to check on the resident as she was not herself – she went into the room and identified that her vitals were ok. About 10-15 minutes later the roommate was calling out again so again the PSW entered the room and noted the resident still not to be her usual self – just how she looked. This time when she left the room the RN was up at the nsg station with her med cart. So the PSW asked her if she checked her sugar as she was diabetic – the RN responded that she did not - - there was another nurse at the desk Tracey Raney she heard this conversation and responded with "you better get on that". She (the PSW) then saw the RN going down the hall with the glucometer in her hand - - she did not follow the RN in the room, nor did she watch her. There was really nothing else about this shift – but she thinks that this is the night that resident ST was sent out to the hospital. She (the PSW) was asked about other description of the shift to get a time line - but could not give any as it was over a year ago She identified she had no other concerns about her care. (12/16/2016 10:07:17 AM)
			1. call placed to D Shannon - and it was identified that I would not be able to meet with her this week due to her and our schedule - that we will be in touch after the christmas break (12/19/2016 10:03:09 AM)
			1. arrived this am at approx 0900 - - leaving home at approx 1515 (12/14/2016 3:06:53 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. telephone call made to MD Dr McDonald this am at his office and message left with reception regarding purpose of my call and my request to set up a short meeting for Dec 20, 2016 to discuss an inspection currently being conducted at Telfer Place He called me back prior to lunch and was pleasant and asked the purpose of my call and need to visit - It was explained that I was conducting an inspection at the home and that during the course of this inspection it had come to my attention that once of the MD's who visits the home may have reported some concerns to the DOC at the home regarding a nurse that was "recently in the media". He identified right away that he was aware of the situation He identiifed that the home has had a number of challenges recently - some of which are visible to others which can make him nervous when at the home When he is called by the home he will ask the staff who they are, name, role etc.....he reported that some of the staff "felt harassed" by this He did contact the home regarding this concern (the DOC at the time - could not recall them by name but could by face, a description of both of the 2 former DOC's were given and he identified the DOC to be Sherri based on her dark brown and curly hair and shorter stature) HE also voiced concerns to her at this time that some of the staff were not prepared to give him answers to all of his questions regarding the residents.....the "process of inconsistencies" and "the value of those conversations" He verified that he never voiced any concerns about 1 specific staff member He identified issues and challenges with agency staff compared to those of staff at the home - knowing the job etc. I thanked for his time and he identified he was willing to help in any way that he could (12/15/2016 1:51:20 PM)
			1. call placed to former ED Dian Shannon at 1133 today at [redacted] - and message left explaining the purpose of my call and requesting a call back - awaiting a return call (12/15/2016 2:01:00 PM)
			1. this is a late entry from yesterday - interview conducted with FT RN Jasmine E during the course of this interview - notes recorded by inspector LE - the RN identified that the home had a p and p for the management of hypogylcemia posted in the room or in one of the binders in the med room the inspector accompanied the RN to the med room and looked for the document(s) she was referring to she eventually found the document posted on a board in the room and then verified it was not a p and p or direction - just signs and symptoms of hypo/hyper glycemia she was asked how would she know what to do in the case of hi or low sugars and she verified that the home did not have a procedure - but good nursing judgement and common sence was her guide (12/15/2016 2:16:21 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. second call to D Shannon today at 1549 - spoke with her briefly - she was at an appointment and agreed to call me back in about 20 minutes - she identified that she was no longer at REVERA and it was identified that the inspector was aware of this however would like to speak with her anyways - agreed to retum my call in 20 minutes (12/15/2016 3:48:05 PM)
			1. discussion with ED on phone today - still no word if the home has a hypo/hyper glycemia p and p in place - however it does not appear so - but will check with the former DOC ST - what was the decision following the MAC meeting --- he has yet to speak with the Medical Director regarding his allegations of abuse - has not yet been able to make contact (12/15/2016 4:17:30 PM)
			1. 2nd call placed to former DOC Michelle C - at her place of employment ([redacted] today at approx 1145 - reception identified that she (the DOC) was at the home yesterday but not at the home at the present time - may be back at at 1330 - will call back at 1400 (12/14/2016 12:57:59 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

Inspection No: 2016_188168_0020

Inspection Type: Complaint

		s. 8. (3)	1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. Telfer Place is a long term care home with a licensed capacity of 45 beds. The ED verified the staffing pattern for the home included at least one Registered Nurse (RN) (not including the Director of Care) on duty and present at all times, in addition to a mix of RPN's and PSW's to meet the nursing and personal care needs of residents. Interview with the ED identified that currently the home has a sufficient number of RNs on staff to fill all RN positions according to the staffing plan; however, there are occasions when due to vacation coverage or illness the home has vacant shifts which need to be filled. It was identified that the home consistently offers additional shifts to their RNs to fill these vacant shifts and offers overtime; however, when the RNs employed by the home are unwilling or unable to work one or more of the vacant shifts the home may fill the required shifts with RPN's employed by the home and have a RN on call, or with RNs employed with an employment agency, in an effort to provide RN coverage 24 hours a day seven days a week. The Registered Nurses Staffing Schedules were provided from June 25, 2016 until December 9, 2016, on request. It was identified that the home was able to supplement their staffing compliment with the use of the new graduate initiative program. A review of the schedules, by the scheduler, confirmed over the identified time period there were over 25 occasions there was only an agency RN in the building and on seven occasions there was only an RPN, employed by the home, in the building with a RN, on call. It was verified by the ED that the agency RN's were not members of the regular nursing staff. The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was member of the regular nursing staff on duty and present at all times. (12/14/2016 1:13:36 PM)
			1. Laura (the scheduler) confirmed that over the 6 month time frame - there were 27 occasions with only an agency RN in the building and a total of 7 occasions with an RPN in the home with an RN on call ---------- discussion was held regarding the sue of HFO (new grad initiative staff) and the role and the expectation that they are in addition to the staffing compliment ---------- (12/14/2016 1:14:18 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

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Inspection Type: Complaint

		s. 75. (2)	1. The licensee failed to ensure that screening measures were conducted in accordance with the regulations before they hired staff. Ontario Regulation 79/10 section 215(1)(2) identifies that the section applies where a criminal reference check is required before a licensee hires a staff member, as set out in subsection 75 (2) of the Act, and that the criminal reference check must be, conducted by a police force; and conducted within six months before the staff member is hired by the licensee. RN's #610, #609 and #605 worked at the long term care home, as agency registered nurses, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request. RN #610 worked occasionally at the home from February 2015 until the spring of 2016. RN #609 worked occasionally at the home from 2014 until the fall of 2016. RN # 605 worked only one shift, independently at the home in October 2016. Interview with the ADOC identified that the RNs provided direct care to residents as part of their duties during the shifts they worked at the home. The former DOC, who was in place at the home for a portion of 2016, identified that it was the expectation of the home that the employment agency completed all of the required screening, for any staff they arranged to work at the home. The ADOC verified that they had not obtained criminal reference checks from the employment agency that employed the RNs nor had they requested that the staff provide verification of a completed criminal reference check before they performed their responsibilities. Screening measures were not conducted as required. (12/14/2016 1:21:00 PM)
			1. The licensee failed to ensure that the persons described in clauses (1) (a) to (c) were provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before they provided their services. RNs #610 and #607 were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the, licensee and an employment agency or other third party. LTCHA, 2007, section 76(2) identified that training must be provided to staff, as defined in the Act, before providing their services in the areas of: 1. Residents' Bill of Rights, 3. Policy to promote zero tolerance of abuse and neglect of residents, 4. Duty to make mandatory reports under section 24, 5. Whistle-blower protections under section 26, 7. Fire prevention and safety 8. Emergency and evacuation procedures 9. Infection prevention and control. The ED identified that to their knowledge the home utilized the services of the employment agency to fill vacant shifts to cover vacation time, of regular employees of the home, and/or to cover sick calls. A. RN #610 worked at the home, beginning in February 2015, as an

agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request.

A review of orientation and training records, provided by the home, for RN #610 identified that they did not receive training in the areas of 1. Residents' Bill of Rights, 3. Policy to promote zero tolerance of abuse and neglect of residents, 4. Duty to make mandatory reports under section 24, 5. Whistle-blower protections under section 26, and 9. Infection prevention and control.

Interview with RN #607, who completed the orientation with RN #610, was shown a copy of the trainees "Orientation Checklist" and identified that they could not specifically recall the orientation. It was verified that during the orientation process they would have followed the checklist and that the items identified by the Inspector were not recorded as being completed according to the document provided. To the recall of RN #607, they were not aware of any additional handouts or a package given to agency staff as part of the orientation process, in 2015.

On request the ADOC reviewed the employee records for RN #610 and verified that the only orientation and training records available did not include that all of the mandatory training was completed.

Orientation and training was not provided as required for RN #610 in the area of Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services.

B. According to orientation records RN #609 worked at the home, beginning in May 2014, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request. The ADOC identified that the home continued to utilize the services of the RN intermittently, as required until approximately the fall of 2016.

A review of the initial orientation, from 2014, provided by the home, for RN #609 identified that they did not receive training in the areas of 1. Residents' Bill of Rights, 4. Duty to make mandatory reports under section 24, 5. Whistle-blower protections under section 26, and 9. Infection prevention and control.
The RN who completed the initial training, with RN #609, was not available to be interviewed regarding the orientation process.

On request the ADOC reviewed the employee records for RN #609 and verified that the only initial orientation records available did not include that all of the mandatory training was completed.

Interview with the ADOC identified that in the summer of 2016, the role of staff development was added to their position. At this time they implemented a agency staff training booklet. In addition efforts were made to provide retraining to all regular agency staff in the areas of mandatory training.

Training records, identified that RN #609 was retrained and provided with a hard copy of the required training on August 22, 2016. This training

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			was completed with the support of the former DOC, who was in place at the home in August 2016. A review of the sign off records and training materials presented and interview with the ADOC identified that the RN was provided with all required training, when they were retrained in August 2016. Orientation was not initially provided as required for RN #609 in the area of Residents' Bill of Rights, 4. Duty to make mandatory reports under section 24, 5. Whistle-blower protections under section 26, and 9. Infection prevention and control, prior to providing their services. Interview with former DOC, who was at the home in 2014 and 2015 and was responsible for staff development, identified that in 2015, agency staff would have received a minimum of a four hour orientation, with a RN from the home, to complete an orientation checklist. The former DOC also indicated that at some time, as the DOC, the home implemented a "booklet" for agency staff, to review which included mandatory training to be completed along with a sign back form for the agency staff to complete and return to the home, to be retained as a record that the training was complete; however, the exact time of this implementation was unknown. (12/14/2016 1:28:55 PM) 2. (3/21/2017 3:12:11 PM)
			1. reported to ED Jim at 1440 the statements made by MD Dr Williams today regarding allegations of abuse which he identified he reported to the former DOC MC in 2015 -- The ED was informed that an interview with former DOC today MC identified that she had not received any such report from the MD regarding abuse as she would have recalled this and knows that this would need to report this to the MOHLTC The ED thanked me for the information and indicated that he will FU with the MD to get more details and investigate as appropiate (12/14/2016 2:49:17 PM)
			1. leaving home at 1600 hours today (12/12/2016 4:05:00 PM)
			1. this is a late entry - arrived at LTCH at approx 0920 hours (12/13/2016 11:09:52 AM)

AdHoc Notes

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Inspector Name: LISA VINK

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Inspection Type: Complaint

			1. ED Jim Eagelton - was provided 3 dates/shifts and asked who was the RN on call at these times as it did not appear that there was an RN on call on the schedule he was given the following dates Wed Aug 6, 2016 10-6 Fri Aug 19, 2016 Fri Aug 5, 10-6 Jim returned and identified to the inspectors that in August 2016 - when agency staff was in the home - it was the former DOC (Michelle) who was on call - not an RN from the home --- telephone discussion held with manager KF regarding this inspection and interviews to be completed - she identified that if the purpose of the interview (in the 2 examples given - former acting admin who now lives in windsor and former DOC who currently works in hamilton but was already interviewed) decision made for best use of time to call and completed telephone interviews and in both situation the questions are not specifically about the nurse but rather processes and systems in place --- a. former DOC MIchelle C - called at approx 1158 today at current place of employment (Baywoods place) and message left asking 2 questions 1. when at the home, as the DOC, and there was an agency nurse in place was there someone on call, from the home and if so who 2. during her time at the home, the home used a # of agency RN's to fill shifts - does she know why the agency staff were used - ie, vacation coverage, sick calls, not enough staff to fill vacent lines, or an emergency (unforseen event) she was given my name and contact # and asked for a return call b. call placed to former DOC Ruthanne F at approx 1201 - by LE inspector message left to identify that we would be completing a phone interview that we would have having some documents from the home r/t the management of complaints sent to her electronically by the home for her review and requested that once she has had the opportunity to do this to please give us a call - name and contact info given papers given to ED Jim - to scan and sent to Ruthanne F (12/13/2016 12:02:55 PM)
			1. leaving LTCH at 1630 today - interviews conducted - and will be inputted in am on Dec 14, 2016 (12/13/2016 4:15:13 PM)
			1. impromptu discussion conducted with Medical Director Dr Williams this am in the harvest room Inspector LV initiated this discussion as he was entering the home and he agreed to speak briefly - this discussion was initiated without inspector LE present - however LE joined during the course of the discussion and this may have been the reason that the MD repeated much of his previous initial comments to the inspector

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notes of this discussion

He was informed of the purpose of our visit and the agency staff member we would be speaking about

He identified that he had already spoken to the police about this

He identified that he did not recall the RN at all - and that he thought she worked only occasionally and during the night - that for this reason he really would not have had reason to interact with her at all

When the police asked him about her (the nurse) he really could not tell them anything - it was not until this time that he was aware that the nurse who allegedly gave resident ST insulin and the nurse that he spoke with the DOC MC about was identified to be the same person

He confirmed that he did report a nurse to the DOC MC - back in 2015 - he came in to do evening rounds one night and noted a nurse to be swearing and verbally abusive to some residents - he did not know who she was - her behaviour was not acceptable - there was no physical abuse - swearing and threatening (he did not give any specific examples regarding to who, or what was said)

He reported his concerns first thing the next day - he went to the DOC and informed her (MC) of the situation - he was unaware of who the nurse was

To his understanding - the DOC contacted the agency and she no longer visited the home after this (the police identified that they had an email which indicated that there was another concern about this individual (EW) as well)

He is aware of his role as the Medical Director in the home, that of more than an attending physician, and his responsibilities/obligations as part of the team to report concerns which are relevant to his role.

He identified that some issues are "gray zone" ie a nurses personality he would not report this - but in this case he reported the concern

He identified that he is also the attending physician for resident ST. That although she is a diabetic she was not on insulin at the time and that the hypoglycemia episodes were managed appropriately and effectively and did not cause any deterioration to the resident - it was not until she developed pneumonia in the winter of last year did she have a decline in her condition. He has discussed this with the family and they are in support of his statements regarding this.

He was shown the 2 management of diabetes algorithms (provided by the home) and to his recall these were discussed at the MAC meeting approx 18 months ago however were not approved or implemented (for a number of reasons which were identified verbally). He, along with a RN monitor all diabetic residents and completes diabetic checks q 4-5 months and report this back to MAC as part of the QI program. The home has a new program for the management of diabetes which will be implemented in Jan 2017.

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			He identified that resident ST - would not have had an order for glucagon based on her medical status and for this reason glucagon would not have been administered. He identified that he was pleased with home and home and organization has managed this issue - supporting the staff and giving direction ie in terms of confidentiality and cooperating with parties such as the police and MOHLTC (12/14/2016 10:28:18 AM)
			1. (12/14/2016 1:20:57 PM) 2. RN's #610, #609 and #605 worked at the long term care home, as agency registered nurses, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request. RN #610 worked occasionally at the home from February 2015 until the spring of 2016. RN #609 worked occasionally at the home from 2014 until the fall of 2016. RN # 605 worked only one shift, independently at the home in October 2016. Interview with the ADOC identified that the RNs provided direct care to residents as part of their duties during the shifts worked at the home. The former DOC, who was in place at the home in 2016, identified that it was the expectation of the home that the employment agency complete all of the required screening, for any staff that arranged to work at the home. The ADOC verified that they had not obtained criminal reference checks from the employment agency that employed the RNs nor had they requested that the staff provide verification of a completed criminal reference check before they performed their responsibilities. Screening measures were not conducted as required. (12/14/2016 12:30:22 PM) 3. The licensee failed to ensure that screening measures were conducted in accordance with the regulations before hiring staff and accepting volunteers. Ontario Regulation 79/10 section 215(1)(2) identifies that the section applies where a criminal reference check required before a licensee hires a staff member, as set out in subsection 75 (2) of the Act, and that the criminal reference check must be, conducted by a police force; and conducted within six months before the staff member is hired by the licensee. (12/14/2016 12:22:35 PM)

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Inspector Name: LISA VINK

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Inspection Type: Complaint

			1. NO ANC _ able to locate assessment (2/17/2017 3:23:07 PM) 2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. Resident [redacted] had episodes of hypoglycemia and the physician ordered increased reassessment in the form of monitoring of the resident's blood sugar levels. A physician's order was received on September 7, 2015, at 1100 hours, for "blood sugar checks every two hours and may change to four times a day once blood sugar levels remain above 5.0 consistently". The home recorded the value of the blood sugar readings in the progress notes and/or under the "Weights and Vitals" tab in Point Click Care (PCC). On September 7, 2015, at 2223 hours, a progress note, by RN # 610, for resident [redacted] indicated "blood sugar tested every two hours as ordered, all values were above five". There were no entries under the Weights and Vitals tab or specific blood sugar values recorded in the progress notes for the identified shift. The licensee failed to ensure that any actions taken with respect to a resident under a program, including reassessments were documented during the evening shift on September 7, 2015. (2/16/2017 2:59:30 PM)
			1. NO ANC _ able to locate assessment (2/17/2017 3:22:48 PM) 2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. Resident [redacted] had episodes of hypoglycemia and the physician ordered increased reassessment in the form of monitoring of the resident's blood sugar levels. A physician's order was received on September 11, 2015, at 1130 hours, for "blood sugar checks every four hours for 24 hours then four times a day". The home recorded the value of the blood sugar readings in the progress notes and/or under the "Weights and Vitals" tab in Point Click Care (PCC). A. A review of the clinical record included a blood sugar reading for September 11, 2015, at 1923 hours, at 12.6 mmol/L and then not again until September 12, 2015, at 0529 hours, at 10.6 mmol/L. The resident's blood sugar was monitored every four hours as ordered. B. A review of the clinical record included a blood sugar readings on three occasions only on September 16, 2015 and not the four times a day as required in the order. C. A review of the clinical record included a blood sugar readings on two occasions only on September 17, 18, 19, 21, 23, 22, XXXXXXX, 2015 and not the four times a day as required in the order. Care was not provided to the resident as specified in the plan of care when the resident's blood sugar was not monitored as required. (2/16/2017 3:32:10 PM)

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			1. questioned Lindsay A (ADOC) in the presence of L Edwards inspector and C Muise (corporate staff) in FU to interview held with former DOC Michelle C - Lindsay was asked if she recalled a complaint from a physician regarding agency RN EW- - she identified that she was aware of it but not which MD it was nor the issue as it went directly to the former DOC Michelle Lindsay also was informed that we would need the information we previously requested regarding the 3 med errors - she verified that she completed our requested and would locate the information and get it to us ---------- C Muise was asked and identified that Ruthann Foltz (regarding the complaints process) not longer regularly comes to the home and on requested provided us with her phone # to contact [redacted] call placed to Ruthann today at 1101 by inspector L Edwards and spoke with Ruthann she identified that she is working in Windsor and is not coming this way "near Paris" any time soon - she offered to complete interview by phone - it was suggested that at this time we would look at our schedule and the best use of our time and get back to her will get direction from KF HSAO manager ---------- (12/12/2016 10:55:09 AM)
			1. entered the LTCH today at approx 0930 - (12/12/2016 11:23:52 AM)
			1. PHB notes Nov 04, 2016 - 12:38 - On November 3, 2016 the Acting DOC confirmed that Lindsay Astley RPN (Associate DOC) was the designated lead for training and orientation in the home. A review of the home's Orientation Package identified as "Agency Staff Orientation-RN"(copy of the package is included in this inspection package) was completed (notes recorded on page 4, 5 & 6 of notebook (copied and included in this inspection package Potential issues identified: Date of "National Orientation and Onboarding Program" identified as July 31, 2016/August 31, 2016 (will request previous package and policy) -managers are responsible for monitoring the orientation process for new employees in their departments -orientation checklists will serve as Revera's permanent documentation of orientation. -individual parts of the orientation program will be reviewed by the manager and new employees -orientation checklists were reviewed for 3 agency staff #610, # 605 and #609 -all three checklists are noted to be incomplete -all three checklists have no documentation that indicated the DOC reviewed the orientation program with the staff - on of the three staff (#605) a newly onboarded agency RN (two shifts in the home) was given the orientation package and signed an aknowledgment form indicated they had read and understood the

material.
-no documentation was provided to verify that staff # 609 (May 8, 2016) or staff # 610 (Feb. 15, 2015) were provided with training in relation to: Resident's Bill of Rights, Home's policy to promote zero tolerance of abuse, Duty to make mandatory reports, Protection provided under section 26, Fire prevention & safety, emergency evacuation procedures or Infection control and prevention.
Nov 01, 2016 - 13:25 - On October 31, 2016 Registered staff # 605 (agency RN) was observed during 1700hr. medication pass.
-this staff person indicated that they had received their certificate in August 2016 and that this was the second shift they had worked in the home.
-the staff person went on to explain that they had received a total of 6 hours of orientation prior to being assigned to work in the home. The orientation consisted 2-2 hour AM sessions and 1-2 hour PM session with staff from the home.
-they confirmed they were NOT orientated to the Resident's Bill of Rights or the Duty to make mandatory reports.
-confirmed they were orientated orientated to the Home's Policy to Promote Zero Tolerance of Abuse (by Jasmine-home staff), Protection Provided under section 26 (by Jasmine), Fire prevention and safety (by Susan-home staff), Emergency Evac. Procedures (by Susan) and Infection Control (by Susan)
Oct 31, 2016 - 11:03 - The home was asked to provide a copy of the staffing agency contract with the home and the employment record for Ms. Wettlaufer and provided the following documents: Service Contract and Agreement for Payment between Lifeguard Homecare (the agency) and the home, Agency Staff Orientation Checklist-Reg. Staff for Betty Wettlaufer RN and an email sent to a manager at the agency about complaints made about Ms. Wettlaufers practice and relationships with staff in the home.

1. The home provided a copy of the Service Contract and Agreement for Payment between Lifeguard Homecare (the agency) and the home, signed on July 24, 2015. (copy included in this inspection package)
-this document did not identify what training the agency was responsible for providing to staff who were assigned to work in the home

2. The home provided a copy of the Agency Staff Orientation Checklist-Reg. Staff for Betty Wettlaufer RN that was signed on February 15, 2015 by both Ms. Wettlaufer and home staff Susan Farley RN. Copy included in this inspection package)
-this document directed "DOC to review checklist with agency staff each time new agency staff comes into home" -there is no indication of the form that the DOC has reviewed the document.
-the document indicated the following areas where not part of Ms. Wettlaufer's orientation: How to complete a report to the ED, MARs and Quarterly Med Review, ordering and receiving medications from pharmacy, Incident Report (resident or staff), transfer sheet, appointments, SALT/Mechanical Lifts Program overview, emergency preparedness, Resident non-Abuse Policy, security checks, telephone & intercom systems, care of aggressive residents, wanderer's checklist, least restraint policy, smoking policy, hazardous waste disposal and overview of privacy policy.

3. Email sent from Michelle Cornelissen (DOC) to Hedi Smith (manager at

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Lifeguard Homecare-agency) on April 20, 2016 confirming a telephone conversation these two people had early on the same day. (copy included in this inspection package)
-practice concerns raised by a PSW that the nurse did not monitor a resident who was demonstrating responsive behaviours when the PSW identified she was concerned for the safety of the resident and co-residents.
-on April 20, 2016 the physician had expressed concern related to this staff person and did not fell confident in their ability to assess residents and carry out basic nursing duties and felt they lacked accountability as a nurse and to the residents of the home.
-also mentioned to the agency manager was the vulgar and inappropriate comments made by BW when speaking with staff in the home
-the email concludes that as a result the home would no longer feel comfortable about utilizing this agency staff RN again.

Sufficient Staffing
Nov 01, 2016 - 14:00 - The 1700hrs. medication pass was being observed on October 31, 2016 when PSW staff #606 approached this inspector and disclosed that "they were working short staffed again tonight" "they have 3 PSWs working and they should have 5 working"

A review of the staffing plan provided by the home (copy included in this inspection package) that the home was to have 4 PSW staff working 2-10 shift and 1 PSW working a 4-8 shift.

A review of the PSW schedule for October 29 to Nov. 11, 2016 (copy included in this inspection package confirmed that 2 staff were scheduled and worked 2-10 and 1 staff was scheduled and worked 4-8

Medication
Nov 01, 2016 - 11:33 - Medication Administration pass was observed during the 1700hrs pass on October 31, 2016
Two staff were observed during this period of time: Registered Nurse (agency) # 605 and Registered Practical Nurse # 604

Both staff were noted to move medication carts to the central area in front of the nursing station and the lounge. The staff were observed to pour meds., lock medication carts, walk to residents who were scheduled to get medications at this time and administer the medications.

Registered staff #604 was assigned to administer insulin to resident [redacted]
-the registered staff approached the resident in the lounge to complete a CBG level - the resident indicated he did not feel it was necessary to leave the lounge area to have this procedure completed. The procedure was completed (as per the order to monitor CBG BID on Monday and Thursday) and the resident's CBG was noted to be 11.
-the staff person reviewed the order for insulin on the computer monitor attached to the med. cart, opened the resident's medication drawer and removed the insulin pen. The staff person checked the insulin pen for the resident's name and again with the directions in the MAR and confirmed

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that the resident's name was on the pen and the pen was labeled as Novolin GE Toronto and that the directions for dosage matched the MAR as "give 6 units tid at meals". The staff person checked the date on the pen to ensure the pen was not out of date and dialed 6 units on the pen.
-the staff took alcohol swabs and the insulin pen into the lounge area and indicated to the resident it was time for their insulin. The resident indicated "OK" (the staff person is familiar with this resident) and asked the resident if they could go somewhere private, the resident indicated he did not need privacy and the staff person gently persuaded the resident to come to the family room (a room not occupied with a bed in it).
-The resident began to lift their shirt and the staff person asked if he wanted the injection in their abd. - the resident indicated "yes".
-The staff person talked the resident through the actions she was taking (swabing and injecting) and then assisted the resident to adjust their clothing and then assisted the resident to exit the small room. The resident was then able to self propel back to the lounge area.
-the staff person returned to the medication cart - unlocked and opened the computer and documented that the resident had received their insulin.
No-non compliance was identified during this observation

Registered Staff #605 (agency RN) was assigned to administer medications to residents on the Maple Road wing.
-while waiting for registered staff to administer medications to resident [redacted] t he actions of this staff were being monitored in relation to medication practices
-the staff person was noted to open the electronic MAR, check for a resident that was to receive medications at this time, review which medications were to be administered, open the appropriate resident drawer in the medication cart and remove the medication pouch for the designated medications, review the medications listed on the pouch with the medication orders on the MAR, open the pouch, poor the medications into the medication cup and walk down the hall to administer the medications - the staff then returned to the med. cart and documented the administration of the medications in the MAR
-this staff person was specifically observed to administer medications to resident [redacted] The staff person opened the MAR to check if there were medications to be administered to this resident at 1700hrs, they opened the resident's drawer in the med. cart and removed a pouch of medications that were to be administered at 1700hrs, they checked the medications identified on the pouch with the directions in the MAR, confirmed that they were correct, opened the pouch and poured the medications into the pouch, locked the computer, locked the medication cart, took a glass of water and walked down the hall to the resident's room.
-the resident was in their room sitting in a lounge lounge chair - the staff person greeted the resident, indicated she had their supper medications and confirmed that the medication contained a medication for pain. The resident took the med. cup, took the medications out of the cup, put all three medications in their mouth and drank half a glass of water.
-the staff person returned to the medication cart, unlocked the computer, and documented the medications had been given
-the medication pouch and orders confirmed that the resident that the resident was provided with Acetaminophen 500mg, Furosemide 40mg and Levothyroxine 0.05mgs as per the physician orders.
-No non-compliance identified during this observation. (12/12/2016 11:30:58 AM)

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			1. on request the ED provided the home -the 2016 staffing plan -the procedure for diabetes management --- interview held with Laura - rest co-ord (with inspector LE present)- who provided MOHLTC with June 25 - 2016 - until Dec 9, 2016 - RN's schedule to demonstrate agency staff use (this was requested earlier in the day of the ED by the inspectors) she was asked about when an agency RN was in the home - she identified that the DOC and or another home RN would be on call if this was the case these schedules are being reviewed by inspector LE will interview ED regarding why agency used during this time period there appears to be a total of 41 occasions where their was an agency RN in the building and a few occasions where there appears to be a only an RPN in the building ---------- questioned Linsday A, ADOC (in her office with inspector L Edwards) she verified that when an agency RN is used there is always a home RN on call - that this process was changed from the DOC bing on call when they have a turn over in DOC's as she herself (lindsay) is not an RN and for that reason this was initiated for consistency she also indicated that they never use an agency RPN - of it they do they work as a PSw and not an RPN she was questioned regarding the staffing plan and identified that the entire plan had been completed and filed already and that they just printed off this copy of us as we asked for a copy ---------- (12/12/2016 12:11:50 PM)
			1. The licensee failed to ensure that the persons described in clauses (1) (a) to (c) were provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before they provided their services. RNs #610 and #607 were identified as "staff" according to the interpretation of "staff" in the LTCHA, 2007, as a person who worked at the home, pursuant to a contract or agreement between the, licensee and an employment agency or other third party. LTCHA, 2007, section 76(2) identified that training must be provided to staff, as defined in the Act, before providing their services in the areas of: 1. Residents' Bill of Rights, 3. Policy to promote zero tolerance of abuse and neglect of residents, 4. Duty to make mandatory reports under section 24, 5. Whistle-blower protections under section 26, 7. Fire

		s. 76. (1)	prevention and safety 8. Emergency and evacuation procedures 9. Infection prevention and control. Executive Director #618 identified that to their knowledge the home utilized the services of an employment agency to fill vacant shifts to cover vacation time, of regular employees of the home, and/or to cover sick calls. A. RN #610 worked at the home, beginning in February 2015, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request. A review of orientation and training records, provided by the home, for RN #610 identified that they did not receive training in the areas of: Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control. Interview with RN #607, who completed the orientation with RN #610, was shown a copy of the agency RN's "Orientation Checklist" and identified that they could not specifically recall the orientation. It was verified that during the orientation process RN #607 would have followed the checklist and that the items identified by the Inspector were not recorded as being completed according to the document provided. To the recall of RN #607, they were not aware of any additional handouts o packages given to agency staff as part of the orientation process, in 2015. On request the ADOC reviewed the employee records for RN #610 and verified that the only orientation and training records available did not include that all of the mandatory training was completed. Orientation and training was not provided as required for RN #610 in the area of Residents' Bill of Rights, policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services. B. According to orientation records RN #609 worked at the home, beginning in May 2014, as an agency nurse, as arranged by their employer, an employment agency who held a contract with the home, to provide professional nursing services on request. The ADOC identified that the home continued to utilize the services of the RN intermittently, as required until approximately the fall of 2016. A review of the initial orientation, from 2014, provided by the home, for RN #609 identified that they did not receive training in the areas of: Residents' Bill of Rights, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control. The RN who completed the initial training, with RN #609, was not available to be interviewed regarding the orientation process. On request the ADOC reviewed the employee records for RN #609 and verified that the only initial orientation records available did not include that all of the mandatory training was completed.

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			Interview with the ADOC identified that in the summer of 2016, the role of staff development was added to their position. At this time they implemented a agency staff training booklet, in addition efforts were made to provide retraining to all regular agency staff in the areas of mandatory training. Training records, identified that RN #609 was retrained and provided with a hard copy of the required training on August 22, 2016. This training was completed with the support of DOC #620, who was at the home in August 2016. A review of the sign off records and training materials presented and interview with the ADOC identified that the RN was provided with all required training, when they were retrained in August 2016. Orientation was not initially provided as required for RN #609 in the area of Residents' Bill of Rights, duty to make mandatory reports under section 24, whistle-blower protections under section 26, and infection prevention and control, prior to providing their services. Interview with DOC #619, who was at the home in 2014 and 2015 and was responsible for staff development, identified that in 2015, agency staff would have received a minimum of a four hour orientation, with a RN from the home, to complete an orientation checklist. DOC #619 also indicated that the home did implemented a "booklet" for agency staff, to review which included all mandatory training to be completed, along with a sign back form for the agency staff to return to the home, for retention as a record that the training was complete; however, the exact time of this implementation was unknown. The training was not completed as required. (3/21/2017 3:12:15 PM)
			1. FU call placed for former ED - Dian Shannon today she answered the phone and identified that since she had not heard from us for a while though that she was no longer needed she was reminded of the purpose of our meeting and agreed to meet with myself and L Edwards at 1015 on Mon Feb 13 she was informed that the meeting should take 30-60 minutes she is located at Chartwell Westmount Retirement Community (across from Westmount LTC) [redacted] she was informed that we would be leaving from Telfer Place and identified that the drive would be approx 30-35 min depending on traffic (2/9/2017 9:41:53 AM) 2. call placed to former ED Dian Shannon today at 0956 and message was left at [redacted] reminding her of the purpose of my call and to hopefully set up a meeting for MON FEB 13, 2017 - awaiting call back call placed to former DOC SHERRI T. - she was informed that we had a few more questions to ask of her - she agreed to meet on FEB 13 at 1400 hours at her LTCH (2/7/2017 10:10:23 AM)
		s. 76. (2)	1. kk (3/21/2017 3:13:23 PM)
			1. called and spoke with Jermery today and he was informed that we too would be interested in dates (of video) for the same time period that the

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			OPP were interested in Sept 2015 as he identified on his last voice mail - I then asked if he had tapes for that time range - he identified that they DID NOT have ant tapes for that time frame or around that time frame -he was informed that we like the police would most likely not be taking this matter further - however if needed, once I discussed with my manager I would be in touch to get information regarding his legal department he appreciated the call (2/16/2017 11:51:28 AM) 2. voice mail message received from Jermery Deboer today indicating that the dates that the OPP was interested in having the video tapes for were September 3-10 2015 however he did not confirmed if these were the dates which he had tapes for will FU with Jermery Deboer - in a call on Feb 16, 2017 to clarify which dates he had tapes for (2/15/2017 9:59:55 PM) 3. based on interview conducted with former ED D Shannon - completed on Feb 13, 2016 call placed to former vender used to test new continence indicator Jermery Deboer [redacted] call placed this am at approx 1000 he was informed of who I was and the purpose of my call he was asked if he recalled the home - and identified yes he was asked if he did a trial at the LTCH which involved video cameras in specific resident rooms he then stopped my questions and identified that he had already been contact by the OPP regarding this matter that since the time that he was in the home his company has now been bought out by a much larger company and that it is based in Sweden that due to potential issues with PHI and residents and that this is a much larger company now - to be cautious that he suggests that we go thru their legal department for any additional information he was asked if the OPP ever got these tapes and he identified NO - that based on the dates of the tapes that they (the OPP) were not interested in them I was asked if he would be willing to share the dates with me as well - and that based on this info as well - we too may not be interested - he identified that he did not think that this would be a problem but that he would have to check on this he agreed to take my name and # and get back to me within the next 72 hours info given and awaiting FU (2/14/2017 10:07:18 AM)
			1. call placed to LTCH and ADOC provided the following info for resident

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ST - POA is son C.T. -[redacted]
the ADOC also identified that the family no longer answer their phone as they have been receiving harassing phone calls r/t the recent media
email contact is (d-i-l) F.W. at [redacted] (3/6/2017 12:56:26 PM)
2. family of Sandy Towler returned call today and opted to speak with the inspectors over the phone

telephone interview conducted with son (C.T. daughter in law [F.W. inspectors Lisa Vink and Lesley Edwards

interview conducted today at 1100

Writer introduced inspectors and explained the purpose of of call - conducting an inspection at Telfer Place, which has gained media attention, regarding their mother and our role in inspections and where we work

The family identified that they were aware of the incident which I was speaking of

They were informed that I was sorry for the negative attention that their family had received due to the media attention and anything that may have happened to their mom as identified in the media

The family were informed that the inspectors have been inspecting on an off at Telfer Place for a few months now, have interviewed a number of present and former staff, spoke with the MD, have observed to provision of care, reviewed their mom's records and have attempted to interview the resident but she was not able to answer our questions only smile and wave. They were informed that they too were an important part of this inspection as they were the decision maker for Sandy.

They were asked if they had any concerns regarding the care and services provided at the home

The family identified that they were "realistic" and had not concerns

The family identified that so far they did not know all of the details regarding the nurse - details such as how she got to the hospital and the nurse involved

It was explained that although it must be frustrating for them that I too was not able to share any of these details

It was shared that I would have to speak with another manager, higher than Karin Fairchild to get information regarding what and when we could share with them and get back to them at a later date
.....they seemed understanding to this fact and stated that they were aware that there would be a trial etc.

It was again asked if they had any concerns regarding the care at the home
It was expressed by the family that in their opinion the home does a pretty decent job with Sandy and it has always been good there.....both family members confirmed that this was an accurate statement - that mom is

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always clean and her room is clean ....no concerns

They identified that during the hospital transfer they were confused as to what had happened - they know her Dx of diabetes and thought maybe an infection or a mistake in medications - but in their opinion it was handled well. The son identified that everyone explained it was hard to pin point what happened as she too (mom) could not communicate well already at that time.

The family went on to say that historically they had no care concerns, are realistic, as **F.W.** use to take care of Sandy, and that they are quite pleased - with the exception of this once incident/staff member who has come to light
again it was identified that the home was never dirty, her briefs are changed, room is clean, no odours in the home, the care and the empathy of the staff is excellent (which was supported by both family members)

C.T. did identify that he now knows that the nurse still worked at the home "after this" and he did note that at times his mom (Sandy) was agitated when he would come to visit and wonders
He did identified that mom's condition has changed drastically over the years and that she no longer demonstrated agitation

He was asked if he every reported the agitation or if anyone brought it to his attention, or when it happened and he identified that he did not - but now in hindsight. He then identified that maybe he did report it once to Joanne (who was identified to be Joanne who works in retirement) but he wonders if there was something - he assumed that they would have taken it seriously - but is not sure what they could have figured out

It was identified that the family has a meeting with the Crown Attorney tomorrow and it is hopeful that they can get some answers at that time

The process of inspections (RQI, CCF) was explained briefly as well as the inspection process where there is a complainant - it was communicated by the inspector again that direction would be obtained about how and when we may share info with them

The family expressed that they understood the need for things to be tight and that eventually all would come out - they are pleased with the care at Telfer place and are in no rush for answers at this time

They were thanked for their time and informed that they now had our contact info should they have any other info

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Call placed to LTCH and spoke with Joanne Forrester at 1115 - based on info given to us by the family of ST

she was informed of who we were and the purpose of our call

she was asked if she ever recalled an occasion where the family (son) of ST was leaving the LTCH and ran into to her and voiced some concerns about the resident being agitated - she was informed that I did not have a date, time, season etc.

Joanne identified that she was attempting to recall such an event and

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could not but that there practice is always to tell the family who to talk to the DOC, ED etc. and then herself to FU with the DOC, ED etc.
She verified that she does not complete a CSR form as she would not take the info - but refer them
To her recall of event if something like this did happen it would have to be more than 3 years ago based on her contact with the family
If something like this came to her attention she would have brought it to the attention of D Shannon or the DOC - but she had no recall (3/21/2017 12:22:01 PM)
3. I called the family of ST today - 1/2 way during my phone message the d -i-l **F.W.** picked up the phone.
She was informed of who I was and the purpose of my call
She identified that they may be willing to speak with us but will need to "check us out first".
Email below sent on request

Good morning **F.W.**

Thank you so much for taking the time to speak with me today.

As I shared with you on the phone, I would like the opportunity to speak with you and your husband, regarding an inspection the Ministry is currently conducting at a long-term care home.

Included below is the information which you have requested to verify my position with the Ministry.

I am a long term care homes inspector with the Ministry of Health and Long Term Care and I work out of the Hamilton Service Area Office.

Our office address is:
Ministry of Health and Long Term Care
Ellen Fairclough Building
119 King Street West, 11th floor
Hamilton, ON L8P 4Y7
1 800 461 7137

My direct phone number is [redacted]

My cell number is [redacted]

My email is lisa.vink@ontario.ca

My direct manager is Ms Karin Fairchild who may be reached at 905 546-8215 or karin.fairchild@ontario.ca

Thank you again for taking the time to speak with me today and please let me know if you require any additional information.

Lisa Vink (3/20/2017 11:52:27 AM)

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		r. 234. (1) 1. 2. 3. 4.	1. The licensee failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member: where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession. It was identified by the Administrator that the home had a staffing plan and a minimum staffing level that they would maintain to provide care and services to the residents. When the home was unable to achieve this level, with staff employed by the home, they utilized the services of employment agencies, who held a contract with the home, to provide professional nursing services on request. There was a contract between the home and Lifecare Homecare Agency which identified that all staff provided would be in good standing with the College of Nurses (CNO) and that the company would endeavor to provide proof of insurance, WSIB (Workplace Safety and Insurance Board) and proof of registration/license upon request. A. Agency RN #610 worked at the home and was responsible to provide direct care to residents intermittently from February 2015 until a request was made that they no longer provide care at the home in April 2016. The home had not requested proof of registration/license, from the agency or the staff member nor had they verified the nurses standing with the CNO by other means such as the services of "Find a Nurse" as identified by the ADOC. The home did not maintain a record of the RN's verification of current registration with the CNO. B. Agency RN #609 worked at the home and was responsible to provide direct care to residents intermittently from 2014, according to orientation records until the fall of 2016. The home had not requested proof of registration/license, from the agency or staff member nor had they verified the nurses standing with the CNO by other means such as the services of "Find a Nurse" as identified by the ADOC. The home verified the nurses status with the CNO, on August 22, 2016 and maintained documentation to support that the nurse was "entitled to practise with no restrictions". Interview with the ADOC verified the practice, prior to the summer of 2016, when they utilized the services of an agency to provide registered nursing staff, was that they had not requested proof of registration/license with the CNO nor checked the status for the specific registered nursing staff who worked in the home as placed by the employment agency. Until August 22, 2016, the home did not maintain a record of the RN's verification of current registration with the CNO. Interview with the ADOC verified the past practice, when they utilized the services of the agencies to provide registered nursing staff, that they had not requested proof of registration/license with the CNO nor checked the status for the specific registered nursing staff who worked in the home as placed by the employment agency, as it was assumed that the agency screened staff as outlined in their contact. (2/15/2017 10:35:50 PM)
			1. will be leaving LTCH today at approx 1625 (11/9/2016 3:58:54 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

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			1. leaving at approx 1425 today admin indicated that he has located 2015 complaints - will give to inspectors on next visit for review (11/10/2016 4:11:19 PM)
			1. arrived onsite at 0855 - informed ED that we were onsite - - and would be meeting with ADOC he provided us with a hard copy of the 2015 complaints for review meeting held with ADOC LINDSAY - see notes taken by inspector LE she (the ADOC) identified that she had a meeting at the police station today and is nervous about that as well she provided us a copy of the orientation checklist provided to and signed off by the identified nurse EW she identified that the orientation checklist and process is currently under review by corporate she identified that the orientation checklist currently in place is the same as the checklist in place in 2015 (based on her review of the checklist in place for an agency staff member used in early 2015) she was given our cards and informed that we may need to speak with her again (11/14/2016 9:46:05 AM)
			1. cont..... Nov 14, 2016 - 13:26 - Interview: Former DOC Michelle Cornelissen Interview Date and Time: November 14, 2016 at 1157 at Baywoods Place Interviewer: Lisa Vink Recorder: Lesley Edwards 1. Who is your current employer, what is your role in this position and when did you start at this home. MC - Revera is my employer since April 4, 2016, Currently the DOC at Baywoods place started Oct 11, 2016, prior to was the DOC at Telfer Place until Oct 7, 2016 2. Prior to your current position where did you work and will you please share with me the dates of your employment there and what was your position. -----see response to question #1 3. As the DOC will you please share in general your roles and responsibilities at Telfer Place. Responsibilities/roles included: -staff onboarding and off boarding -interview RN, RPN, PSW's -letters of job offers -family /resident complaints -reviewed progress notes/assessments and audits nsg care, CIS submissions -internal for Revera, risk management, IC and incidents -in charge of schedule, LOA's , vacation etc. staff performance Then asked if she was responsible for staff training or orientation and she identified MC - No to staff orientation or training - when she got there there was no staff educator at the home but Lindsay (the ADOC) took on this role. Her role for staff ed. was to call the educator to organize and to organize

orientation shifts

4. Are you aware if the home ever had the opportunity/need to use agency registered staff during your time at the home
MC - yes

5. As the DOC what was your role related to the orientation process for agency registered nurses?
MC - Not involved in orientation of agency nurses - she set up their passwords for PCC and for revera - - they do not have online policies and procedures - but she thought that there was a seperate orientation checklist for agency staff

6. What was the homes process for onboarding agency RN's who had never worked in the home? (orientation and training)
MC - it was the expectation that they complete the orientation checklist from revera and the agency contract would set out orientation on the floor.
In her opinion Lindsay was being educated on her role of being educator when she was there

7. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found?
MC - she confirmed that there were new agency staff that came into the home during her time of employment at the home and identified that they did not get a CERT. of COMPENTENCE but used "find a nurse" in the home. No to criminal reference checks, but thought that this was part of the agency requirement, no to training provided by the agency and again this was an agency expectation

8. How did you monitor agency staffs orientation to Telfer Place?
MC - For exsisting agency staff that were inherited - she would monitor for gaps in documentation, issues which other staff brought forward - and then would notify the agency of the gaps. With new agency staff she would ensure the checklist was done

9. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?
MC - in her opinion all of these areas were included in the checklist

10. Do you recall if agency staff nurse BW ever worked at the LTCH and did you have any concerns related to her practise.

MC- Yes. Yes, concerns were identified just when she started April 4, 2016 during her (the DOC's) general orientation. The next week she was at the home probally around APRil 19, 2016 had a conversation with agency Heidi who employed the nurse.
SHE WAS THEN GIVEN HER EMAIL TO REVIEW
She heard from staff rumours. Lynn Jackson PSW (she thinks but there may have been others) and union rep regarding on nights (EW worked

mostly nights at the home) and the union rep worked evenings....most off the cuff statements and comments. She (the RN) made statements about requesting sperm from male staff and from Lynn putting tic tacks in her vagina when med went down on her so that she was fresh when they went down on her. There were signs posted in the staff bathroom - if you have diarrhea to clean up after yourself. She questioned this and it was identified by Lindsay (ADOC) that staff would go into the staff bathroom and find feces all over and on the stall walls. Staff were thinking it was from RN EW - although the ADOC identified there was no proof just staff saying this.
Then Lauren Gallent PSW on nights also identified a concern
-she contacted the DOC regarding a situation for resident D.A. - a PN (by the DOC) effective date 4/18/2016 at 0100 - - she got a call from Lauren with D.A. - the PSW identified that she did not feel that the RN EW supported her during her workplace incident, Charge nurse if to complete a workplace incident. Lauren felt this was not completed (this is one of the things included in her email to Heide). Lauren asked EW to keep an eye on the (as he was aggressive and kicked the staff) but EW did not do this and did not report his action to the oncoming shift.
Michelle had to completed the incident report and document a late entry in the resident's record
She was new to the home and hearing all of these vulgar comments made to staff and potential responsive behaviour not addressed - - so she called Heide and FU with an email
She recalls that either Lindsay or Laura spoke with Heide first and felt resistance from Heide. She made a comment that every nurse she sends to the home they have concerns with - Heide was defensive according to the staff
She could not recall who was the MD who made the concerns regarding the staff - it was Williams or MacDonald (although she suggested that Lindsay may know)
She (the DOC) told Heide on the phone that the nurse could not come back. Heide wanted to set up a meeting - wanted to negotiate - - No meeting was held just verbally on the phone she was not going to negotiate and she did not want her back based on the comments and suspicions and lack of FU for the responsive behaviour. She never called her back to the home
She (DOC) did speak with the ED D Shannon who supported her reasons not to bring the nurse back
She (the DOC) never called the nurse herself nor discussed the concerns with her - they had no contact info for her it was always to go through the agency - - again she was not sure who some of the statements came from regarding the inappropriate statements towards staff - may be from Lindsay as well
She verified there was no minutes of any of these conversations

11. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail.

If "no"
a. Lindsay the current ADOC identified that she reported to you reports of verbal complaints made by a number of staff at the home related to the employees communication to them and statements made. Do you recall this - if so - action taken and outcome.
b. See email review reports from a PSW, Physician and person indicating

vulgar and inappropriate comments to staff in the home, identified in an email sent to Heidi Smith on April 20, 2016. Please explain, specifically what these concerns were and who was the MD?

(The email sent from Michelle to Heidi)

SEE QUESTION #10

12. Did you have a subsequent meeting with Heidi based on her email to you on May 4, 2016. If "yes" what was discussed at this meeting? Were there minutes of this meeting or notes taken ? If yes, do you have a copy and may we have this please
SEE QUESTION #10

13. How did you manage complaints/concerns as the DOC?
MC - If a resident/family concern - verbal complaint a CRS form - FU with family and resolution. If a written complaint write it up as a CIS to be submitted
When asked if there was any written action taken r/t concerns related to the identified nurse she noted that there would not be a CSR form completed only if resident/family initiated .....if dentures missing reported by a PSW on behalf of a resident would fill out a CSR - would then involve the family - - not really a black and white question

14. How did you manage medication incidents/errors as the DOC?
MC - - An incident report, notify MD, notify SDM, internal incident Revera, fax pharmacy CIS

15. Did the home consistently report medication errors to the resident's SDM, the MD and pharmacy - how and where would documentation of this be. Show medication incident reports.
MC - in her experience yes they did this as above, all steps. Michelle was showed several incident reports from the home and reviewed them. She identified that they were before her time of employment and although they had she signature they were leftovers, from prior to her arrival, and she just entered them into the internal risk management system and entered them into PCC, on the medication incident, PN or risk note.

16. Was it ever brought to your attention by pharmacy or anyone else that not all medication errors were not reported to the pharmacy? If yes action taken
MC - Yes, she thinks that she heard this - that she was told this in passing that this home did not report. Her action was to make sure if incidents happened they were faxed to FU on

We may need to contact you again at a later date if we have further questions. (11/14/2016 6:28:38 PM)
2. Interview: Former DOC Michelle Cornelissen
Interview Date and Time: November 14, 2016 at 1157
Interviewer: Lisa Vink
Recorder: Lesley Edwards

1. Who is your current employer, what is your role in this position and when did you start at this home.
MC - Revera is my employer since April 4, 2016, Currently the DOC at Baywoods place started Oct 11, 2016, prior to was the DOC at Telfer Place until Oct 7, 2016

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2. Prior to your current position where did you work and will you please share with me the dates of your employment there and what was your position.
-----see response to question #1

3. As the DOC will you please share in general your roles and responsibilities at Telfer Place.
Responsibilities/roles included:
-staff onboardinging and off boarding
-interview RN, RPN, PSW's
-letters of job offers
-family /resident complaints
-reviewed progress notes/assessments and audits nsg care, CIS submissions
-internal for Revera, risk management, IC and incidents
-in charge of schedule, LOA's , vacation etc.
staff performance

Then asked if she was responsible for staff training or orientation and she identified
MC - No to staff orientation or training - when she got there there was no staff educator at the home but Lindsay (the ADOC) took on this role. Her role for staff ed. was to call the educator to organize and to organize orientation shifts

4. Are you aware if the home ever had the opportunity/need to use agency registered staff during your time at the home
MC - yes

5. As the DOC what was your role related to the orientation process for agency registered nurses?
MC - Not involved in orientation of agency nurses - she set up their passwords for PCC and for revera - - they do not have online policies and procedures - but she thought that there was a seperate orientation checklist for agency staff

6. What was the homes process for onboarding agency RN's who had never worked in the home? (orientation and training)
MC - it was the expectation that they complete the orientation checklist from revera and the agency contract would set out orientation on the floor.
In her opinion Lindsay was being educated on her role of being educator when she was there

7. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found?
MC - she confirmed that there were new agency staff that came into the home during her time of employment at the home and identified that they did not get a CERT. of COMPENTENCE but used "find a nurse" in the home. No to criminal reference checks, but thought that this was part of the agency requirement, no to training provided by the agency and again this was an agency expectation

8. How did you monitor agency staffs orientation to Telfer Place?

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MC - For exsisting agency staff that were inherited - she would monitor for gaps in documentation, issues which other staff brought forward - and then would notify the agency of the gaps. With new agency staff she would ensure the checklist was done

9. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?
MC - in her opinion all of these areas were included in the checklist

10. Do you recall if agency staff nurse BW ever worked at the LTCH and did you have any concerns related to her practise.
MC- Yes. Yes, concerns were identified just when she started April 4, 2016 during her (the DOC's) general orientation. The next week she was at the home probally around APRil 19, 2016 had a conversation with agency Heidi who employed the nurse.
SHE WAS THEN GIVEN HER EMAIL TO REVIEW
BEGIN HERE

11. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail.

If "no"
a. Lindsay the current ADOC identified that she reported to you reports of verbal complaints made by a number of staff at the home related to the employees communication to them and statements made. Do you recall this - if so - action taken and outcome.
b. See email review reports from a PSW, Physician and person indicating vulgar and inappropriate comments to staff in the home, identified in an email sent to Heidi Smith on April 20, 2016. Please explain, specifically what these concerns were and who was the MD?

(The email sent from Michelle to Heidi)

12. Did you have a subsequent meeting with Heidi based on her email to you on May 4, 2016. If "yes" what was discussed at this meeting? Were there minutes of this meeting or notes taken ? If yes, do you have a copy and may we have this please

13. How did you manage complaints/concerns as the DOC?

14. How did you manage medication incidents/errors as the DOC?

15. Did the home consistently report medication errors to the resident's SDM, the MD and pharmacy - how and where would documentation of this be. Show medication incident reports.

16. Was it ever brought to your attention by pharmacy or anyone else that not all medication errors were not reported to the pharmacy? If yes action taken

We may need to contact you again at a later date if we have further

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questions.
Nov 14, 2016 - 10:39 - Interview: F (11/14/2016 1:26:45 PM)
3. Interview: Former DOC Michelle Cornelissen
Interview Date and Time:
Interviewer:
Recorder:

1. Who is your current employer, what is your role in this position and when did you start at this home.

2. Prior to your current position where did you work and will you please share with me the dates of your employment there and what was your position.

3. As the DOC will you please share in general your roles and responsibilities at Telfer Place.

4. Are you aware if the home ever had the opportunity/need to use agency registered staff during your time at the home

5. As the DOC what was your role related to the orientation process for agency registered nurses?

6. What was the homes process for onboarding agency RN's who had never worked in the home? (orientation and training)

7. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found?

8. How did you monitor agency staffs orientation to Telfer Place?

9. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?

10. Do you recall if agency staff nurse BW ever worked at the LTCH ANd did you have any concerns related to her practise.

11. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail.

If "no"
a. Lindsay the current ADOC identified that she reported to you reports of verbal complaints made by a number of staff at the home related to the employees communication to them and statements made. Do you recall this - if so - action taken and outcome.
b. See email review reports from a PSW, Physician and person indicating vulgar and inappropriate comments to staff in the home, identified in an email sent to Heidi Smith on April 20, 2016. Please explain, specifically

what these concerns were and who was the MD?

(The email sent from Michelle to Heidi)

12. Did you have a subsequent meeting with Heidi based on her email to you on May 4, 2016. If "yes" what was discussed at this meeting? Were there minutes of this meeting or notes taken ? If yes, do you have a copy and may we have this please

13. How did you manage complaints/concerns as the DOC?

14. How did you manage medication incidents/errors as the DOC?

15. Did the home consistently report medication errors to the resident's SDM, the MD and pharmacy - how and where would documentation of this be. Show medication incident reports.

16. Was it ever brought to your attention by pharmacy or anyone else that not all medication errors were not reported to the pharmacy? If yes action taken

We may need to contact you again at a later date if we have further questions. (11/14/2016 11:07:18 AM)
4. Interview: Former DOC Michelle Cornelissen
Interview Date and Time:
Interviewer:
Recorder:

1. Who is your current employer, what is your role in this position and when did you start at this home.

2. Prior to your current position where did you work and will you please share with me the dates of your employment there and what was your position.

3. As the DOC will you please share in general your roles and responsibilities at Telfer Place.

4. Are you aware if the home ever had the opportunity/need to use agency registered staff during your time at the home

5. As the DOC what was your role related to the orientation process for agency registered nurses?

6. What was the homes process for onboarding agency RN's who had never worked in the home? (orientation and training)

7. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found?

8. How did you monitor agency staffs orientation to Telfer Place?

9. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of

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abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?

10. Do you recall if agency staff nurse BW ever worked at the LTCH

11. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail.

If "no"
a. Lindsay the current ADOC identified that she reported to you reports of verbal complaints made by a number of staff at the home related to the employees communication to them and statements made. Do you recall this - if so - action taken and outcome.
b. See email review reports from a PSW, Physician and person indicating vulgar and inappropriate comments to staff in the home, identified in an email sent to Heidi Smith on April 20, 2016. Please explain, specifically what these concerns were and who was the MD?

(The email sent from Michelle to Heidi)

12. Did you have a subsequent meeting with Heidi based on her email to you on May 4, 2016. If "yes" what was discussed at this meeting? Were there minutes of this meeting or notes taken ? If yes, do you have a copy and may we have this please

13. How did you manage complaints/concerns as the DOC?

14. How did you manage medication incidents/errors as the DOC?

15. Did the home consistently report medication errors to the resident's SDM, the MD and pharmacy - how and where would documentation of this be. SHow medication incident reports.

16. Was it ever brought to your attention by pharmacy or anyone else that not all medication errors were not reported to the pharmacy? If yes action taken

We may need to contact you again at a later date if we have further questions. (11/14/2016 10:39:32 AM)
5. Interview: Former DOC Michelle Cornelissen
Interview Date and Time:
Interviewer:
Recorder:

1. What were your dates of employment at Telfer Place?

2. Were you employed as the DOC during this time?

3. As the DOC, what was your role related to the orientation process for agency registered nurses?

4. Did you ever receive any complaints or concerns (verbal or written) in

			relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail. 5. If "no", review reports from a PSW, Physician and person indicating vulgar and inappropriate comments to staff in the home, identified in an email sent to Heidi Smith on April 20, 2016. Please explain, specifically what these concerns where. (The email sent from Michelle to Heidi) 6. Did you have a subsequent meeting with Heidi based on her email to you on May 4, 2016. If "yes" what was discussed at this meeting? 7. What was the homes process for onboarding agency RN's who had never worked in the home? (orientation and training) 8. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found? 9. How did you monitor agency staffs orientation to Telfer Place? 10. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found? 11. How did you manage complaints/concerns as the DOC? 12. Where would the records of complaints/concerns be found? 13. How did you manage medication incidents/errors as the DOC? 14. Where would the records of medication incidents/errors be found? We may need to contact you again at a later date if we have further questions. (11/14/2016 10:25:14 AM)
			1. Interview: Former DOC Sheri Toleff Interview Date and Time: NOv 14, 2016 at approx 1415 hours at Riverbend Place in Cambridge Interviewer: Lisa Vink Recorder: Lesley Edwards Prior to the beginning of the interview ST asked if she was allowed to speak with us as this was an open investigation - she verified that she had already spoke with the police - she was informed that we were given approval to speak with her as part of this investigation 1. Please tell me your current employer, dates of employment and position

ST - Current employer is Riverbend Place by Revera she began at the home in the position of DOC (4 d a week) the first week of Feb 2016

2. Who was employer prior to this home and what were your dates of employment there and your role.
ST - Telfer Place - from Dec 2008 until Feb 2016 0 as DOC and staff educator (this was added to her position in 2011 or 2012

3. Please briefly describe your roles and responsibilities as the DOC at Telfer Place - - did this include staff training and orientation including for agency staff
ST - Roles and responsibilities included:
-MOHLTC guidelines ensure staff are following
-staffing
-HR
-education "mandatory"
following legs and reg and general DOC duties
She had a role in orientation for all new hires in the building - responsible for regular MOH orientation plus Revera 2 day orientation
For agency staff they got at least 4 hours with a regular RN and completed the checklist completed with agency staff - may have increased beyond 4 hours if it was requested
-she also implemented the "contract staff" revera document - - can not recall exactly when this booklet was started but confirmed that the it was initiated at some time and given to agency staff along with the completion of the checklist
.....she was shown a copy of a completed agency checklist and she verified that this was the checklist in place when she was a DOC/staff ed at the home
.....she was shown the document given to us by Lindsay (at Telfer) which Lindsay identified she implemented as part of the agency staff orientation - - ST identified that this was not the document but parts of it were included in the booklet she provided - - she identified that her current staff educator (Meridith) had a copy and she called her to get us one - but she was unsure of when it was last revised
she identified that the booklet contained the following education - - non abuse, fire, person centered care, codes, emergency procedures, health and safety
she identified that she would get the completed checklist back immediately after the agency staff orientation shift and the staff would keep booklet and give back the sign off sheet

4. Are you aware if Telfer Place ever had the need/opportunity to use agency registered staff
ST - yes they did

5. Please generally describe the process in place, when you were at the home, for the training and orientation of agency registered staff (was there more than a checklist)
See question #3

6. Are you aware of agency registered staff EW and did she work at Telfer place.
ST - yes she did

7. The document (Agency Staff Orientation Checklist-Reg. Staff), provided by the home was signed by "the nurse" and Susan Farley RN

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and indicated that the nurse completed orientation on February 15, 2015. Susan Farley initialed in the space identified as "DOC initial"-did you review this orientation checklist?
ST - Was shown a copy of the checklist for the identified employee
ST - identified that she probably did review this orientation checklist - but that it was the practise for the RN to sign it as she was the nurse that completed all of the tasks when training the nurse on the floor

If "yes"-what action did you take to ensure orientation was provided in the areas that had not been initialed by "the nurse" or Susan Farley?
ST - verified that not all areas of the check list were checked off, unsure if they were completed and verified that she did not FU on this and did not ensure that these areas were completed

8. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police check or verification of training provided by the agency for this nurse? Where would verification of this be found?
ST - she did not get a Cert. of Competence but would have looked the staff on up FIND A NURSE, Lifeguard would have completed a criminal reference check (she did not ask for one) nor did she ask for agency provided training

9. How did you monitor agency staffs orientation to Telfer Place?
ST - typically through the nurse and other PSW's who would give feedback, report issues

10. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found.
ST - to her recall all of these thing with the exception of mandatory reports and Infection Control she could not recall specifically if these were included in the booklet

11. Did you ever have any concerns regarding the identified employee - if yes please specify
ST - Overall no major concerns
She remembered that she (the RN) was telling people that she was a recovering alcoholic - PSW's came forward. The DOC spoke with Heide at Lifeguard to discuss the issue and in the DOC's opinion it did not affect her performance. Heide FU and told Sherri that it was FU on - - she denied any concerns or complaints which impacted the residents.
She did recall an incident where she spoke with the nurse regarding her documentation post fall (not enough detail) - and called Heide to let her know she had done this

12. Did you receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail.
ST - NO

13. How did you manage complaints/concerns as the DOC?
ST - Resident / family issues addressed and FU on - she did identify a

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CRS form also filed out - she was asked for clarification to deal with issues with staff or process and identified that case by case

14. How did you manage medication incidents/errors as the DOC?
ST - med incident form - staff would fill this out
Sherri was shown a copy of a medication incident report - and verified that this was the correct report
She verified the expectation that the error was shared with family the MD, pharmacy and FU on and actions taken. She identified that VPN was a required Revera form to be completed as well but that she did not do this
15. CAn you verify if med errors were consistently reported to the SDM, MD and pharmacy - if so where would this be recorded

16. Were you ever notified that not all med errors/incidents were reported to pharmacy as required - if so action taken
ST - identified incidents were all faxed to pharmacy and MD and SDM's notified - in her opinion they did not get many incidents - but felt that all of the necessary steps were done - including the pharmacy notification
She would assume that this did happen at PAC they would comment that they did not get many but were never identified that the process was not followed

.....the contact staff booklet was then provided and reviewed by the DOC - she identified that this is the booklet that she recalled - the only difference was the addition of the information on abd. thrusts which was confirmed by Meridith

We may need to contact you again at a later date if we have further questions. (11/14/2016 8:52:21 PM)
2. Interview: Former DOC Sheri Toleff
Interview Date and Time:
Interviewer:
Recorder:

1. Please tell me your current employer, dates of employment and position

2. Who was employer prior to this home and what were your dates of employment there and your role.

3. Please briefly describe your roles and responsibilities as the DOC at Telfer Place - - did this include staff training and orientation including for agency staff

4. Are you aware if Telfer Place ever had the need/opportunity to use agency registered staff

5. Please generally describe the process in place, when you were at the home, for the training and orientation of agency registered staff (was there more than a checklist)

6. Are you aware of agency registered staff EW and did she work at Telfer place.

7. The document (Agency Staff Orientation Checklist-Reg. Staff), provided by the home was signed by "the nurse" and Susan Farley RN

and indicated that the nurse completed orientation on February 15, 2015. Susan Farley initialed in the space identified as "DOC initial"-did you review this orientation checklist?

If "yes"-what action did you take to ensure orientation was provided in the areas that had not been initialed by "the nurse" or Susan Farley?

8. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police check or verification of training provided by the agency for this nurse? Where would verification of this be found?

9. How did you monitor agency staffs orientation to Telfer Place?

10. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found.

11. DId you ever have any concerns regarding the identified employee - if yes please specify

12. Did you receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail.

13. How did you manage complaints/concerns as the DOC?

14. How did you manage medication incidents/errors as the DOC?

15. CAn you verify if med errors were consistently reported to the SDM, MD and pharmacy - if so where would this be recorded

16. Were you ever notified that not all med errors/incidents were reported to pharmacy as required - if so action taken

We may need to contact you again at a later date if we have further questions.

We may need to contact you at a later date if we have fu (11/14/2016 11:16:51 AM)
3. Interview: Former DOC Sheri Toleff
Interview Date and Time:
Interviewer:
Recorder:

1. What were your dates of employment at Telfer Place?

2. Were you employed as the DOC during this time?

3. Did you receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes",

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			explain specifics in detail. 4. As the DOC, what was your role related to the orientation process for agency registered nurses? 5. At the time 'the nurse" was orientated to the home can you explain the orientation process/procedures that were in place for agency registered staff. 6. The document (Agency Staff Orientation Checklist-Reg. Staff), provided by the home was signed by "the nurse" and Susan Farley RN and indicated that the nurse completed orientation on February 15, 2015. Susan Farley initialed in the space identified as "DOC initial"-did you review this orientation checklist? 7. If "yes"-what action did you take to ensure orientation was provided in the areas that had not been initialed by "the nurse" or Susan Farley? 8. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police check or verification of training provided by the agency for this nurse? Where would verification of this be found? 9. How did you monitor agency staffs orientation to Telfer Place? 10. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. 11. How did you manage complaints/concerns as the DOC? 12. Where would the records of complaints/concerns be found? 13. How did you manage medication incidents/errors as the DOC? 14. Where would the records of medication incidents/errors be found? We may need to contact you again at a later date if we have further questions. We may need to contact you at a later date if we have fu (11/14/2016 10:25:47 AM)
			1. Interview: Associate DOC Lindsay Astley Interview Date and Time: November 14, 2016 at 0915 am Interviewer: Lisa Vink Recorder: Lesley Edwards

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: LISA VINK

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1. What is your position at the LTCH and how long have you been in this role?

Associate Director of Care and has been here for 7 ½ years.

2. What are responsibilities in your position - have these responsibilities changed since February 15, 2015? If yes please describe how.

Rai MDS all coding and staff education.
Lisa asked have your roles changed since 2015 February was doing a lot of scheduling don't do that anymore.

3. Does this position require you to orientate, train or organize staff education - specifically for nurses, if yes please explain.

Now since June 2016 for yearly orientation and staff orientation.
Lisa so when you lost scheduling you took on orientation- Lindsay yes.

4. Are you aware of the home has ever had the opportunity/need to utilize agency registered staff in the LTCH
Yes

5. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found?
Since Lindsay took over yes does find a nurse does not get the criminal reference check- no
Verification from the agency for training - no

6. Is there any training or orientation provided to agency registered staff prior to them preforming duties in the LTCH.

Orientation checklist with the nurse and education package with a knowledge of understanding. They have 4 hours of orientation then ready to go.
7. Are you aware of there is a different process or procedure for the orientation/training of regular registered staff employees of the home or of agency registered staff. If yes please describe.
Regular orientation is 2 day in class general orientation before starting the floor regular staff 5 shifts on the floor 2 days, evenings and night shift.

8. As the ADOC, what was/is your role related to the orientation process for agency registered staff?

IT is done by the staff nurses on the floor not agency

8. Will you please describe the current process in place for the orientation and training of agency registered staff, including providing us a copy of any documents/checklists used in this process.
They leave the signed package for me at my office and I keep this file in my office.

9. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of

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Inspector Name: LISA VINK

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abuse, duty to make mandatory rereports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?

Bill of rights- in the package
Duty to make mandatory reports- not sure
Section 26 – not sure
Abuse in neglect- yes
Fire safety and emergency process in the package
Infection Control- in the package – all packages are found in my office now.

10. Previously, during this inspection, you indicated to inspector PHB that there was a change in the orientation process in the Summer of 2016 for agency registered staff - will you please confirm this and detail what was the process prior to the Summer of 2016.
There use to only be a checklist not the package as Lindsay created it. They still had 4 hours of orientation Sherry did this as the DOC

11. Do you recall if you provided or organized orientation or training for the identified agency registered staff. Please describe the training/orientation she received.
No Lindsay did not provide orientation to the nurse, she believes that she just had the checklist

13. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail and actions taken as result.

Verbal complaints from nurses in April 2016 of inappropriate comments the new DOC started and told her not to come back. Cannot recall any written complaints but is trying to get deleted emails back on her computer.
Was this directed to residents- no just staff to staff Lindsay confirmed none to her but thinks probably to Michelle.

14. Are you aware or did you receive any verbal complaints, which could not be resolved within 24 hours, or any written complaints in 2015? Is yes please describe and actions taken. Would there be a record related to these complaints or concerns? If yes where.

As above #14

15. Are you aware of the process in the home for medication incidents? If so please explain.

Yes these are all completed by the DOC. IF DOC not here would you assist I can instruct but would need corporate help.

16. Please see these medication incidents would these incidents be faxed to the pharmacy and would the family be called regarding all these incidents? If yes where would we find this information?

Gave Lindsay the list of medication incidents and she will confirm if physician was notified, SDM's and if they were sent to pharmacy.

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			17. Could you please confirm if these incidents were sent to pharmacy and if families were notified regarding these medication incidents. Lindsay will follow-up We may need to contact you again at a later date if we have further questions. Comments made during interview were reviewed by the interviewee: Interviewee made following comments: (additional comments/corrections) Interviewee verified, the information provided as accurate: information provided: Lindsay signed Lisa Vinks book that all answers were transcribed from that this was accurate. Added to Ad Hoc notes in IQS: (11/14/2016 10:27:11 AM)

This is Exhibit "J"
to the Affidavit of LISA VINK,
Sworn before me this 24th
Day of July, 2018

Farzin Yousefian LSO# 66541H

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

Inspection No: 2016_188168_0020

Inspection Type: Complaint

Resident #	Risk Name	Criteria Name	Notes
			1. Called Heidi Smith from Lifeguard agency to set a time up for an interview at 11:10 on November 3, 2016 and left a message with Shirley for her to call me. (11/3/2016 11:10:33 AM)
			1. Arrived at the home on November 4, 2016 at 0830. (11/4/2016 1:15:10 PM)
			1. Called the consultant pharmacist to set up an interview to discuss medication IP in the home Tae Laplante and a meeting has been scheduled for Wednesday at 10:00 at Telfer Place November 9, 2016 (11/4/2016 1:15:37 PM)
			1. Arrived at the home at 0900 am today and spoke with Jim and met with inspector Lisa Vink. (11/9/2016 12:20:15 PM)
			1. Inspector arrived at the home at 0850 on November 14, 2016 and immediately proceeded to complete an interview with Lindsay Astles the Associate Director of Care. (11/14/2016 9:45:52 AM)
			1. Will be going to meet former DOC Michelle Cornelissen at Baywoods place this morning and will be going to Cambridge to meet Sherri Toleff former DOC at her home in Cambridge. (11/14/2016 9:52:43 AM)
			1. Arrived at the home at 1200 with inspector #129 and spoke with Cheryl Muise the Regional Manager and stated we are back at the home to start this inspection regarding the nurse that worked at the agency. We then met with the Administrator Jim Eagleton who is in training and has had three days of orientation. Told the home we would be here for several days and that we will be doing the inspection in phases and will be working closely with our Director. Met with Ruth Ann who is the acting Administrator and has requested we speak with Cheryl for information regarding this case. (10/28/2016 12:19:55 PM)
			1. The home provided an updated list of shifts to clarify which shifts the agency nurse worked or did not work as it was unclear on the schedule for some of these dates. These dates are provided in the package. (10/28/2016 1:56:19 PM)
			1. Arrived at the home at 0915 on October 31, 2016. (10/31/2016 10:45:49 AM)

AdHoc Notes

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Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Left the home at 1615 on October 31, 2016 and arrived at the home on November 1, 2016 at 0845. (11/1/2016 9:21:31 AM)
			1. Arrived at Telfer Place at 1030 and reported to Admin Jim Eagleton. Told him I needed to speak to Tracey Raney and a PSW by the name of Cassandra and that I would be completing the med IP as I needed to look at some items as well. (1/3/2017 11:54:42 AM)
		r. 101. (2) (a) (b) (c) (d) (e) (f)	1. C. An email complaint was sent to the ADOC on February 7, 2016, from RN #612 regarding the care and services to residents provided by an agency RN at the home. The ADOC sent a response to RN #612 saying thank you, I have passed your concerns onto DOC #103 who is now a former DOC of the home. A review of the home's complaints logs did not include a CSR form regarding these concerns identified. An interview with the former DOC #103 confirmed that they did not recall any concerns regarding care and services provided to the residents by agency staff at the home. An interview with the ADOC on February 18, 2017, confirmed that they did not complete a CSR form and confirmed that the home did not follow the complaints process. (2/21/2017 11:27:31 AM)
			1. Arrived at the home at 1430 and met with the Acting Executive Director Ruth Anne Foltz whose title is Regional Manager of Education and Resident Services. I explained why I was at the home and stated that I will only be gathering some information and will return tomorrow with Lisa Vink another inspector who will be the lead. The Acting ED confirmed that they were just working on the CIS. I asked if I could have the police contact which I have and a list of all the shifts the agency worked which I have and a list of all the residents that passed away while the staff member was working. I have requested to have all medication incidents that occurred while this nurse worked at the home. Met with Cheryl Muise who will be acting as the DOC as of next week and there title is Regional Manager of Clinical Services. She was able to give me copies of the schedules and the list of dates of deaths and will now work on all medication incidents. Have asked to have Point Click care access for tomorrow am and the medication incident policy and all incidents as Cheryl has not pulled that up through states she is just starting her investigation as well. Did inform me that the police would not be happy that we are involved. The schedules are from Feb 2015 to March 2016. Worked February 15,16 and 19, 2015 from 2-10 April 24, 2015 2-10

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

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Inspection Type: Complaint

May 1, 2015 2-10
May 6 and 7, 2015 10-6
May 9, 10, 2015 2-10
and May 15, 16 and 17, 2015
May 27, 2015 6-2
June 16, 17 2-10 and June 24, 2015 6-2
June 29, 2015 10-6
July 4 and 5, 2015 6-10pm
July 9, 2015 6-2
July 11, 2015 2-10 p
July 12, 2015 6-10p
July 17 and 18, 2015 10-6
July 20 and July 24, 2015- 6-2
July 25 and 26, 2015 2-10
July 28, 29 6-2 July 30, 31, 2015 2-10
August 1, 2, 6, 2015 6-2 and August 7, 2015 10-6
August 9, 10, 11, 12 and 13, 2015 10-6 and August 21, 2015 6-2
August 25, 26, 28, 2015 2-10
August 29, 2015 3-6
August 30, 2015 6-2
September 2 and 3, 2015 10-6
September 5, 2015-10-10
September 6 and 7, 2015 2-10
September 12, 2015 6-2
September 21, 2015 6-2
October 1, 2015 2-10
October 13 and 15, 2015 2-10
October 17 and 18, 2015 6-2
October 19, 2015 2-10
Dec 5, 6 and 100 6-2
Dec 21 and 22, 2015 2-10
Dec 24 and 25, 2015 10-6
Dec 28, 2015 2-10

January 1, 2016 and January 2, 2016 10-6
January 7, 8, 2016 6-2
January 15, 16, 2016 10-6
January 21, 22 2016 6-2
Janaury 24, 25 and 26, 2016 10-6
January 29, 2016 2-10
January 30 and 31, 2016-10-6
Feb 25, 2016 2-10
March 3, 2016 6-2
March 5, 7, 10 and 11, 2016 2-10
March 13, 2016-10-6
March 14, 2016 - 2-10
March 16, 2016 10-6
March 17, 2016 2-10
March 19 and 20, 2016 2-10
March 22, 2016 6-2
March 26 and 27, 2016 6-2 and 6-2 and 10-6
March 31, 2016 6-2
April 4, 8, 2016- 6-2
April 10,11,12, 13 and 14, 2016 -10-6
April 17 and 18, 2016 10-6 and then they asked her not to come back.
(10/5/2016 3:04:16 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. Was asked by my Manager Karin Fairchild today if I could deliver the package that I received from the home regarding the agency nurse and drop that off at the Woodstock police station at 45 Metcalfe. I delivered the package with the required information that was asked that I obtain to Detective Sergeant Kevin Talsma. I met with Mr. Talsma at 1500 today and delivered the package to him. (10/7/2016 4:15:50 PM)
			1. Spoke with Tracy Raney and she has the emails but did not bring them with her I said that is fine she will be working again on Thursday or Friday and I will come and get them. (1/3/2017 1:42:53 PM)
			1. Interview with Cassandra PSW at 1500 in the nurses room on January 3, 2017 everything Cassandra said was written down and signed for by Cassandra as being true. Interviewer Lesley Edwards Recalls the nurse Elizabeth Wettlaufer Worked with her quite a bit actually Approximately 17 shifts out of 45 moset evenings and change of shifts Confirmed working when ST change of condition the second time Noted a real change in condition after mat leave Not acting herself around dinner But it was not the nurse in question Tracey was doing paperwork The nurse who is not the nurse in question but an ICU nurse said she is not a diabetic and tracy stood up and said yes she is Lynn and Cassandra put Sandy in bed nurse still did not come was shaky with tremors and got nures to do CBG and it was HI Between her and Trancy must have called paramedics kept going back to working in ICU at hospital and what she would have done there but this was not Elizabeth I believe the staff are getting the nurses confused. DID you have concerns with Elizabeth Appearance residents feel she was sloppy and actions inappropriate young residen S.L. Beth doing meds and kept calling S.L. and then when S.L. would look she would turn around and Twerk crazy stories about personal stuff about her life Anything that would be abusive yes inappropriate but abusive towards residents no just needed to keep away as made me feel unconfortable frustrating to be near her.

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			Went to management Sherri former DOC pretty much answer we got was we are desperate. Beth was considering a DOC here when Sherri was to leave. Kept coming back and wondering why as there were so many concerns. Updated our concerns to Darlene health and Wellness director at the lodge. She did not come back for awhile then she came back only for a few night shifts and told the nights shift to wathc our backs as was going to make working at Telfer difficult for her as they reported her. Then just stopped coming did not need as much. (1/3/2017 3:16:22 PM)
			1. Interview with Jasmine E RN December 14, 2016 at 1:51 pm at Telfer Place Lisa Vink asked the questions and Lesley transcribed #1 Asked her regarding training H.D. Show them what the RN would do like days sequence of tasks in the morning routine things Cannot go through all this while working Doing medication pass while watching hard to orientate at the same time A fire what do you do and her role in fire Showed red binder its here- dont read it showed her who to call on call manager etc. Fire Panel showing them where it is and how to read it Alarm system under ADT have to call they get alerted Emergency codes Did not tell her missing code code blue and code red did not discuss code yellow black or white Any handouts yellow or blue folder with policy and procedures yes was given this Have you been on call Yes have been on call when RPN working evening shift and that I would be on call SEpt 29 and 30, 2016 was on call Abuse training Just had training today went over all required items-yes Medication errors

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			Resident okay, vital signs call physician med incident form may call DOC and POA give to ADOC or DOC yes we notify pharmacy and we fax and the DOC will do this. Complaints process CSR form identify issue give it to DOC or executive director and they manage.it Hypoglycemia policy HAve seen algorythm No But have received training for hypoglycemia Have process in narcotic book that how they will look if hypoglycemia. Lisa and Jasmine went to look for this but this was not there. (12/15/2016 3:07:17 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. Interview with Jim Eagleton ED December 14, 2016 at 10:06 am at Telfer Place Lisa Vink asked the questions and Lesley transcribed #1 Why agency staff used in LTC Used because of retention problems as was my understanding 1 reg staff for 45 residents. Took advantage of the new grad initiative goal for RN and RPN on days and evenings. Is in place on days only right now which is helping with retention currently have sufficient staff to fill all RN lines still run into problems with call ins, vacation etc. Agency staff RPN's were not used for registered scheduling purposes now were hired to give medications did provide care previously- currently 1 RN x 24 hours, 1 RPN x 8 hours #2 RPN schedule to ensure reg staff in building how many times RPN done Would say that probably did happen (RN agency x 41 in 6 months agency RN the only RN in the building and how many times RPN in the building with RN on call. Jim will check this. #4 Confirm 0 police checks x 3 and 0 CNO prior to hire and 2 late. Can confirm process has changed have to for agency staff have in class orientation bill of rights and abuse training Rec all mandatory training such as Bill of rights, abuse, fire, emergency and infection control. Criminal reference checks and College of Nurses Agency has to provide proof of this we can do that my practice is to do that and print this off. Police check that is the expectation now to have in the home before staff start. Policy and procedures for hypoglycemia Diabetic policies is that what you gave me in draft that will be rolled out in January 2017? Correct and you will provide education Jim- Yes (12/15/2016 3:17:38 PM)
			1. Arrived at the home at 1000 pm waited in parking lot for another inspector to come and went into complete an interview with Dianne Beauregard RN at Telfer Place. LEft the home at 11:05 pm. (12/15/2016 3:29:03 PM)

AdHoc Notes

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Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Interview on December 22, 2016 at 1430 with Tracey Raney RN in the medication room Lisa Vink asked the questions and Lesley Edwards transcribed. Tracy read over interview and signed and dated the notes which are included in the hard copy of the package. Does not remember the incident when it happened I was working on RAI not on the floor. The PSW's came to that nurse not sure if it was Beth. Trust the girsl and one of them said SAndy is off I told the nurse she is diabetic the agency nurse said no. You need to check her sugars. More verbal then is now. More lethargic. Unsure what time she checked sugars Said it was high she needs to go to the hospital the nurse said I am an ICU nurse Unsure what action were taken or further assessments PSW was CAssandra. (12/22/2016 2:46:00 PM)

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Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Lisa Vink went to ask Tracy what Cassandra's last name was.... Tracy said she had some concerns so we went to meet with Tracy again. Concerned if she was going to get into trouble Lisa said not get in trouble by us and as a registrant have a responsibility. Address concerns with supervisor told it would be her supervisor not us. Sherri was the DOC brougth concerns regarding Beth. Verbally then felt my concerns were not taken seriously started putting this in an email. Felt like a mom leaving their kids with an incompetent babysitter. Left the med cart open and med room door open. Inappropriate discussion with PSW's Interactions with nurse and residents and care i.e med cart. Usually only 1 reg staff on most heard from PSW's not reporting issues Sherri wasnted to know everything and Michelle did not want to know anything. PSW's would come to Tracy would ask PSW's to go to management Concerns after this send email got a response once thanks will look into this. Please can we have these emails. Nursing concern assessment Insulin pens - lantus every night the stopper was never where it was supposed to be Prime 30 mls to get insulin. Abusive to residents? Nothing at the top of my head PSW's would come and say you have to go to management. Asked a resident why could I not marry you. and asked a PSW if he wanted 2000 dollars I need a sperm donor. (12/22/2016 3:12:54 PM)

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Inspector Name: Lesley Edwards

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. Interview with Jim stated he will get POC records. Yes that that is the only diabetic protocol that I know of. Asked about CBG's I will look. Asked about the physician's alleged abuse..... The physician said he could not recall the resident or the nurse but assumes it was the agency nurse. that he reported it to Michelle. (12/22/2016 3:21:07 PM)
			1. Interviews with Susan Farley RN on December 13, 2016 at December 13, 2016 1543 hours Lisa Vink asked the questions and Lesley Edwards transcribed the answers. Please note this was signed hard copy by Susan Farley. Question #1 With orientating new staff what is your role? Susans role in training and orientating of agency staff they shadow me around they have a form. Lisa showed her a form with her initals which she confirmed was. 2 What does the following mean a emergency response b location of fire and emergency manual c Fire procedures 1. Panel ii. Alarm system d Emergency codes review i. missing person ii. priority code What does emergency response means not sure what this means it is vaque to me. Lisa told what Lindsay though it meant maybe I would have gone over fire procedure. Safety procedures what do we do show the panel, the nurse is fire chief read where the light is that is where the fire is code red via phone. 2d. 2 codes you do go over we do have other codes maybe went over those ones- if that if we have time. 3 Any other booklets/handouts given if yes what is the process 4 If not signed on the checklist was it done probably not if not signed would you have gone over it no Bill of rights no

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Inspector Name: Lesley Edwards

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			Abuse no Fire and emergency was done 5. Do you recall BW? Did she get training on BOR Abuse p&p Mandatory reports protection undid fire prevention and safety Emergency evac IC no HAve you been on call Yes no RN in building if RPN working the unit if they need to call on call for agency RN HAve you had abuse training give handouts probably done in the last year #8 Med errors what would you do med form incident report ie 3 nitropatches on resident told physician notify doctor management POA should tell them tell pharmacy only by form Diabetes P&P agorythms Showed them to Susan Has not seen this form What would Susan do assess resident and give them a drink with sugar in it if consious would follow the directions If unconsious hope they have glucagon if dont call the doctor and call 911. Vaguely remembers Sandra Towler and calling physician I would have to have glucagon order before giving Any concerns with Beth Caring nurse- odd personality only worked with her on orientation no concerns. done (12/14/2016 12:13:11 PM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Signed form in package from Lindsay with answers from interview this is signed by Lindsay and in the package as well. I st Elizabeth worked alone (not orientation) FEb 16, 2015 Police check-no CNO- no Dorothy Sibanda start date Police check - no CNO check -no Harpinder Deol OCt 16, 2016 start date First day on own - October 31, 2016 October 20 Police check no (12/14/2016 12:42:01 PM)
			1. Spoke with the FSM regarding a complaint for J.E. nd she said she remembers discussion at management meeting about this concern but does not remember having the form. (12/14/2016 2:39:58 PM)

AdHoc Notes

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Inspector Name: Lesley Edwards

Inspection No: 2016_188168_0020

Inspection Type: Complaint

			1. Interview with staff member Lauren Gallant on December 15, 2016 via telephone interview at 1:45 pm I explained why I needed to speak to Laura and why I was calling. This PSW lives in Binbrook and is on sick leave and pregnant so we were given the okay by manager Karin Fairchild to interview over the phone. Laura immediately knew who I was talking about and I asked what the incident that took place was with the identified nurse. Laura stated when they were doing round checks and change their briefs she heard a bed alarm and went to attend to him and grabbed me by my wrist I started to call for help and Beth came in slowly and said nurse Beth to the rescue and the resident let go of my wrist. I asked her to give him ativan and Beth said he is not worked up enough for me to give him ativan yet. I felt he was putting myself, other residents and himself at risk. Told Beth to check on him frequently and she did not she fell asleep in the office. I asked if she reported it and she said I did the following night after there was no documentation and I reported it to Dian Shannon and Michelle Corneillisan at the time. Did you work with Beth often She worked with agency and picking up night shifts. Any concerns with her before this No not to residents. Inappropriate comments to staff and witnessed one. Asked male staff jokingly if he could be her sperm donor? Did you report this? No I think the staff member reported it. So no concerns regarding performance or not following resident's plans of care? No (12/15/2016 2:24:09 PM)
			1. Interview with Dianne Beauregard RN on night shift and found resident ST unresponsive Interview was completed in the lounge at 1030 pm on December 14, 2016 Lisa Vink asked the questions and Lesley Edwards wrote the responses To note Dianne did sign and date the hard copy in the package. Recall about that shift

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Changes in condition of ST ie hypoglycemia

We do rounds touch the resident to change them. Her skin was cool and clammy and know she is diabetic took BS which was 2.2 took vitals called paramedics. Paramedics gave dextrose 20 minutes later was awake took cookies and drink did not send to hospital monitored her blood sugar lower called on call dr Dr. Vlar no he said do not send her to hospital if she is eating and drinking monitor BS every 1 hour and hold Diamacron.

What is the diabetes protocol?
Cant say we have one Lisa showed her the two algorythms and she had not seen this

How did you know what to do

Need to give sugar read how BS going low decided to sent to hospital came back on her shift.

Monitored blood sugar and it flucuated

Any concerns with the nurse BW did she ever say anything to you

Apparently worked shift prio do not remember getting report and worked the following.

Dianne does not remember anything regarding the nurse - does not remember getting report.

How do you know if a resident is on glucacon?

Glucagon only if we have an order only have one resident.

Any concerns with the nurse

Interaction with residents was always kind altercation with two residents and stayed to help measure and clean the wounds.

Abuse Training

Yes call manager on call for direction

Last three years face to face

Package yes

HAve you ever been on call at the home

No

MEdication incidents

assess residetnts, call Dr, notify POA, incident report, notify pharmacy via fax

When would you notify management

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			One incident the next day if significant call manager on call. Complaints process in the home Document in progress notes, email to DOC, used CSR for missing dentures not for complaints. (12/15/2016 2:35:31 PM)
			1. Interview with Michelle Corneillisan former DOC telephone interview December 14, 2016 at 2:14 Lisa asked questions and Lesley wrote responses Michelle were you ever on call as a DOC ever on call when agency staff worked Yes all the time Michelle was reminded regarding the email that she sent to the agency by Lisa The medical Director confirmed concerns of a nurse concerns related to swearing and verbally abusive Said what - if he did bring them to you what would you do It is reportable I actually thought it was Dr. Mac Donald Only worked at nights when I was there. (12/15/2016 3:03:08 PM)
			1. Arrived at the home on December 12, 2016 at 0900. (12/12/2016 10:58:47 AM)
			1. Spoke with Jim the Administrator in the DOC's office in the presence of Lisa Vink. Reviewed the unconsious policy to verify if she would need the unconsious hypoglycemia policy and or consious hypoglycemia policy. Lisa reviewed the first couple lines of the resident's progress notes which indicated that the resident was unresponsive to verbal and painful stimulus and Jim said he felt it was the unconsious policy Lisa would need and he went to obtain this policy. Brought the policy back. (12/12/2016 2:56:11 PM)

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			1. Lindsay Astley was able to verify the residents that the POA's were not called regarding the medication incidents that I had asked her to verify us for Feb 9, 2016 and the pharmacy was also not faxed the medication incidents either. She was able to say that all residents had a progress note to say the resident's physician's were notified via communication book and this is where the doctor would write or make any recommendations as needed. There will be non compliance issued regarding medications. (12/12/2016 3:16:48 PM)
			1. Left the home at 1619. (12/13/2016 4:19:56 PM)
			1. Arrived at the home at December 14, 2016 at 0915. (12/14/2016 9:42:08 AM)
			1. Interview with Lindsay Astley on December 13, 2015 at 3:17 pm Lisa Vink asking the questions and Lesley Edwards writing the responses This was regarding training and orientation. To note that the written answers have been signed and dated by Lindsay in the hard copy package. 1. Orientation Checklist 1a What does emergency response mean? that would be there role and responsibilities i.e fire. 1b. Location of Fire and Emergency plan Manual? We would have a fire plan and where the manual is. 1c. Fire procedures- panel and alarm system Fire panes is next to the nurses station showing them where it is and how to read it. 2 step alarm 1d Emergency code reviews i. missing person and ii priority code missing person and one intruder. 2. If o other checklist was anything else done. There is acknowledgement checklist If Lindsay does not get acknowledgement form or a check list I scan them and have them sign off If not I would write a note about this and that I have called the agency. Lisa asked Lindsay to get the actual date the nurse worked for us.

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CNO and criminal reference check for the nurse- Lindsay will check.

Lindsay did retraining Lindsay gave Dorothy the package May 8, 2014 and Michelle signed the form.

2016

Tried to give all nurses who worked prior to Lindsay started got all nurses to complete the package and provide retraining and Michelle did

Lisa Did Dorothy do you have a police check

No typically dont get police checks

Need to look for CNO for Dorothy Lindsay to get.

Herpinder

Her first date on her own

CNO October 20, 2016 can you confirm if have any police checks or CNO completed.

Question # 4
Confirm the checkist for three staff did not meet all legislative requirements

Bill of rights
Its on the package
Homes abuse policy- yes
Make mandatory reports- yes
Whistleblowing protection - yes
Fire prevention and safety -yes
infection prevention and control -yes

Did all of the training Harpinder

Dorothy has the same form checked off

Elizabeth Wetttlaufer

Was not in place.

#5
Glucogon protocol when, how do we know when last trained

Lisa reviewed Sandra T's care plan with Lindsay.

Lindsay said when speaking Cheryl Muise about the glucagon policy was mixed opinion from physicians so not all homes were using this protocol.

Not sure if this protocol was in place

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Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			FU with complaints Does not recall J.E. complaints Angela Dik does not recall. (12/14/2016 11:13:52 AM)
			1. First draft of interview questions - additional specific questions r/t medication errors and written complaints will be added by inspector LE Interview: Associate DOC Lindsay Astley Interview Date and Time: November 14, 2016 at 0915 am Interviewer: Lisa Vink Recorder: Lesley Edwards 1. What is your position at the LTCH and how long have you been in this role? Associate Director of Care and has been here for 7 ½ years. 2. What are responsibilities in your position - have these responsibilities changed since February 15, 2015? If yes please describe how. Rai MDS all coding and staff education. Lisa asked have your roles changed since 2015 February was doing a lot of scheduling don't do that anymore. 3. Does this position require you to orientate, train or organize staff education - specifically for nurses, if yes please explain. Now since June 2016 for yearly orientation and staff orientation. Lisa so when you lost scheduling you took on orientation- Lindsay yes. 4. Are you aware of the home has ever had the opportunity/need to utilize agency registered staff in the LTCH Yes 5. Did you request verification (from the agency) of Certificate of Competency (or did you verify this yourself), verification of police criminal reference check or verification of training provided by the agency? If "yes" where would verification of this be found? Since Lindsay took over yes does find a nurse does not get the criminal reference check- no Verification from the agency for training - no 6. Is there any training or orientation provided to agency registered staff prior to them preforming duties in the LTCH. Orientation checklist with the nurse and education package with a knowledge of understanding. They have 4 hours of orientation then ready to go. 7. Are you aware of there is a different process or procedure for the orientation/training of regular registered staff employees of the home or of agency registered staff. If yes please describe.

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Regular orientation is 2 day in class general orientation before starting the floor regular staff 5 shifts on the floor 2 days, evenings and night shift.

8. As the ADOC, what was/is your role related to the orientation process for agency registered staff?

IT is done by the staff nurses on the floor not agency

8. Will you please describe the current process in place for the orientation and training of agency registered staff, including providing us a copy of any documents/checklists used in this process.
They leave the signed package for me at my office and I keep this file in my office.

9. How did you ensure that agency staff received the required training? (Resident's Bill of Rights, homes policy to promote zero tolerance of abuse, duty to make mandatory reports, protection provided under section 26, fire prevention and safety, emergency evacuation procedures, infection control and prevention). Where would verification of this training be found. Where would verification of this training be found?

Bill of rights- in the package
Duty to make mandatory reports- not sure
Section 26 – not sure
Abuse in neglect- yes
Fire safety and emergency process in the package
Infection Control- in the package – all packages are found in my office now.

10. Previously, during this inspection, you indicated to inspector PHB that there was a change in the orientation process in the Summer of 2016 for agency registered staff - will you please confirm this and detail what was the process prior to the Summer of 2016.
There use to only be a checklist not the package as Lindsay created it. They still had 4 hours of orientation Sherry did this as the DOC

11. Do you recall if you provided or organized orientation or training for the identified agency registered staff. Please describe the training/orientation she received.
No Lindsay did not provide orientation to the nurse, she believes that she just had the checklist

13. Did you ever receive any complaints or concerns (verbal or written) in relation to "the nurse's" practice or their work in the home? If "yes", explain specifics in detail and actions taken as result.

Verbal complaints from nurses in April 2016 of inappropriate comments the new DOC started and told her not to come back. Cannot recall any written complaints but is trying to get deleted emails back on her computer.
Was this directed to residents- no just staff to staff Lindsay confirmed none to her but thinks probably to Michelle.

14. Are you aware or did you receive any verbal complaints, which could not be resolved within 24 hours, or any written complaints in 2015? Is

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			yes please describe and actions taken. Would there be a record related to these complaints or concerns? If yes where. As above #14 15. Are you aware of the process in the home for medication incidents? If so please explain. Yes these are all completed by the DOC. IF DOC not here would you assist I can instruct but would need corporate help. 16. Please see these medication incidents would these incidents be faxed to the pharmacy and would the family be called regarding all these incidents? If yes where would we find this information? Gave Lindsay the list of medication incidents and she will confirm if physician was notified, SDM's and if they were sent to pharmacy. 17. Could you please confirm if these incidents were sent to pharmacy and if families were notified regarding these medication incidents. Lindsay will follow-up We may need to contact you again at a later date if we have further questions. Comments made during interview were reviewed by the interviewee: Interviewee made following comments: (additional comments/corrections) Interviewee verified, the information provided as accurate: information provided: Lindsay signed Lisa Vinks book that all answers were transcribed from that this was accurate. Added to Ad Hoc notes in IQS: (11/14/2016 10:22:48 AM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Interview with Darleen Barber on Feb 13, 2017 at 0915. Lesley Edwards transcribed the meeting and Lisa Vink asked the questions. Darleen Barber has signed the notes in the book. Darleen Barber's role is an RPN and is the Director of Health and Wellness in the assisted living - DOC for retirement. Time frame in question between DOC in LTC assisting Lindsay with schedules and Laura was off on maternity leave. Michelle Corneillisen was here less than a week. The Day in Question Had schedule and was going to nurses station looking for someone to do a night shift. Asked Cassandra if could do a double shift was not happy. Asked who was working nights the registered staff and said Beth. She said no I dont want to work with Beht other staff members around cant remember who. Why dont you want to work with Beth? Because she has said inappropriate things to staff not residents. Discussed about tic tacs and sperm donor. Why did you not tell anyone- why did you not tell anyone told Sherri and did not do anything. I will be reporting this and walked into Michelle and told her. Other staff supported but does not remember who was there. Michelle was appalled- Beth did not come back after this I believe. Lisa- no other concerns regarding Beth and residents No- I told Beth she should applied here very personable- good with residents No concerns with residents actions or assessments just staff. HAve you spoken to anyone else i.e police No. (2/14/2017 10:10:42 AM)
			1. Interview with Dian Shannon on Feb 13, 2017 at 1030. Lesley Edwards transcribed the meeting and Lisa Vink asked the questions. Dian Shannon has signed the notes in the book.

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This meeting was conducted at [redacted] where Dian Shannon now works.

Role at Telfer Place was the Executive Director time period Feb 2011- ended July 2016

Roles and Responsibilties

Adm role
Work with the team FSM, ESM, DOC, Office MAnager, Program MAnager, restorative care would report to her

-compliance for regulations fire, public health and ministry was the leader

Role in Staffing- Director of CAre was responsible to work with the DOC regarding investigations, disciplines. DOC generally do staff hires and training etc.

Monitoring of Nursing- DOC issues staff might bring them to her. IF DOC not available had a presence in ltc.

Complaints Process at Telfer Place

Lisa any complaints regarding identified staff Tracy Raney- said Beth was not doing all the paperwork assigned.

Paper work- referrals, updating care plan review care plan quarter Beth not doing this- complaint regarding Dr.s orders i.e referral forms

Tracy identified areas- Tracy complained to everyone very unhappy with nurse

DOC, ADOC and Dian Shannon

Beth worked a better part of a year.

Tracy works evening this stuff is supposed to be done and not

Tracy voice any concerns about resident care i.e not completing RAI's referrals not concerns regarding care.

Lauren who works on nights came to Dian Lauren is a PSW BAck is getting sore, I have to rounds by myself Beth does not help Bath goes to staff room and sleeps

(Lauren Gallant was previously interviewed on December 15, 2016.

CCTV in office and could see not sure if it was myself Sherri or Michelle Beth went into staff room and 2 hours came back out.

Any follow-up actions taken regarding concerns

Dian spoke to Beth herself regarding paperwork not being completed. Beth said she is okay Dian reminded her paperwork needs to be completed.

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Michelle and Sherri not sure who I checked with checked with nurse checked if paperwork being done someone said Bth got everything done.

Remember conversations with Michelle (I think Michelle)
Touch base with agency they need to know what is going on for disciplining and our job to ensure paperwork

Dont remember about if issue re allegation of sleeping in room was dealt with.

Dont remember if Michelle follow-up with agenc re paperwork.

Very pleasant and seemed to know what she was doing. Benign did not feel hostility with residents and staff.

Concerns re paperwork a number of complaints re lazy one of the staff said she was sharp with a resident. Believe Lauren said this told Michelle we are done with Her (Beth).

Enact Pandemic plan Dian had to work feces stem to stern.

Went to Sandy Towlers room affected by enteric outbreak.

Beth and Dian went to Sandy Towler.

Beth rolled her towards herself and Dian washed her and then SAndy Towler Beth said okay we are done.

Dian said no- Beth said I can't see her from here maybe she could not she was short.

Sandy was alarmed showed her who I was because of the masks gowns.

Might have been in JAnuary

Innovation project for brief teaching staff how to use.

Sandys is family wanted her to give back to the community to trial a new a sensor for brief Sandy took it off happened in January.

Diane was annoyed will be done when clean and fresh.

Used cameras - roomated and families had to consent to this

Period time had cameras when team was on sited sensassure team

Lisa do you have a contact for this.

JEremy Deboer [redacted] Sweden until end of the month.

JAn 2016
March 2015.

Sensassure was the name of the company.

Wouldn't have anything for us
Cameras no wont need to contact them.

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			Any concerns, complaints from staff injections medications One complaint bottle of vodka went to get a drink and was not much left months before he had a drink 3 or 4 different agency nurse impossible to track put a sharpie line on it and replaced a bottle Do you remember completing a complaints and concern form yes Any physicians reporting any concerns regarding abuse, neglect medications No dont recall had 2 or 3 Physicians had abuse training dont remember this Spoken to anyone else regarding this case The police Anything else you feel you need to add that you told the police No they recorded a statement Annoyed regarding videotape from the home not identified during their investigation. CCTV cameras only in corridors 16 of them and major exits points, laundry room above the nurses station in the hall. Small dining room part , part of two halls, entrance to Maple, activity room 3/4 room down evergreen records for 30 days and deletes. (2/14/2017 10:29:49 AM)

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Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Interview at 11:14 via phone with Dan Relic who lives in Halifax and works with the VON. Lisa asked questions and Lesley transcribed. Dan informed us he worked at Telfer Place in Paris- yes so brief it was maybe 3-4 weeks Feb- Jan 2016 Early part of 2016 3-4 weeks very briefly as the DOC. Time at Telfer Place as a DOC. Complaints process that was in place YEs was aware Lisa Do you recall any complaints? No Heard thins indirectlt after I left the home Do you remember a resident named A. Son name E.D. dont recall remember speaking to someone Dont remember sorry Ongoing saga with people wish I could be of help Lisa asked if he would elaborate Plead the 5 th staff that worked their not families. Explained what was going on in Ontario regarding agency Dan said he was not happy with agency staff the home was using regarding point clikc care nursing is nursing Agency not providing good staff not proficient in pcc not resident neglect I would have dealy with and if brougth to me for a small home it was very busy was not there long (2/14/2017 11:31:57 AM)

AdHoc Notes

Home Name: TELFER PLACE

Inspector Name: Lesley Edwards

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Inspection Type: Complaint

			1. Interview with Sherri Toleff Former DOC at her new place of employment on Feb 13, 2017 at 1:30 pm. Lisa Vink asked questions and Lesley Edwards transcribed. We thanked Sherri for agreeing to meet with us again and shared during the course of the inspection we have talked to more people and some things have come up with her name on them, specifically emails and we provided her with copies of this to read. Sherri reviewed emails that were sent to her from Tracy Raney REmember that email the JAn 6, 2016 email don't remember specifically what I did if I spoke to Beth or Heidi. Does not remember follow-up with Tracy Raney after email. I think I called Heide but dont recall. Jan 10, 2016 email Sherri does not remember this one at all. Lisa- asked is Sherri was still at the home Yes No recollection of this one at all. Sherri Did I respond? Lisa this is all we have. Insulin pens purging - priming with 20 units or 2-3 units are you aware of this No Anything else you would like to add? No (2/14/2017 11:37:38 AM)

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			1. From the email provided to us in January 2017 from RN Tracy Raney it was apparent that the RN had some concerns regarding agency staff and their care and services towards residents. In an interview with Dan Relic he could not confirm that he was given any complaints and or concerns as he was here for such a short time and could not recall concerns regarding agency staff regarding care and services just about point click care etc. Interview with Lindsay shows that she rec the email and fowarded it on to Dan but confirms that a CSR form was not completed Also a review of CSR forms showed that there were none completed for this time frame with the identified concerns. The email is in the package. (2/21/2017 11:27:44 AM)