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 MELANIE SMITH

I, Melanie Smith, of the Village of Iona, in the County of Elgin, 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 "Long-Term Care Homes Inquiry"). I have firsthand knowledge of the matters discussed in this affidavit, except where it is stated to be on information and belief, in which case I have identified the source and believe it to be true.

2. I graduated as a Registered Practical Nurse ("RPN") from Fanshawe College in 1992. I worked as an RPN between 1992 and 2012. I worked at Terrace Lodge, a long-term care home in Aylmer, from July 1992 to May 2012. During this period, I also worked at East Elgin Family Health Team/Dr. Graham from June 2001 to May 2012.

3. I was hired at Meadow Park in May 2012 in the position of Staff Educator/RAI Co-ordinator. In 2013, I took on the role of Co-Director of Care.

4. In 2014, I took an Administrator's course through AdvantAge Ontario (at the time OANHSS). I obtained a certificate in the OANHSS Administrator Leadership Program in or around June 2014.

5. In December 2014, I became the Administrator at Meadow Park. I resigned in November 2015 to take on an Administrator role in another long-term care home.

DESCRIPTION OF THE HOME

6. Meadow Park is licenced for 126 beds. In 2014, the Home was divided into 4 home areas – Kent, Lambton, Oxford and Elgin. Wildwood was on the lower level and previously operated as a retirement home. When I worked at Meadow Park, Wildwood was no longer operating as a retirement home. I believe that in the Spring of 2015 (when I was the Administrator), long-term care beds were moved to Wildwood and that is when the home areas were assigned colours e.g. Yellow, Blue, Pink and Green. Attached hereto and marked as Exhibit "A" is a copy of the main floor plan at Meadow Park in 2014.

7. I have reviewed the nursing staff levels chart prepared on behalf of Meadow Park. To the best of my recollection, the chart is accurate with respect to the total staff in the Home. I cannot recall the precise breakdown of PSWs assigned to each home area. Attached hereto and marked as Exhibit "B" is a copy of the nursing staff levels chart.

MY DUTIES AS CO-DIRECTOR OF CARE

8. As Staff Educator/RAI Co-ordinator, my role centered around the resident assessment tool that is used for the classification of residents. There was another staff educator that looked after the rest of the education. Marilyn Hauser was initially the Staff Educator and then it went to Valerie Boult. There may have been a short time that Lia

Dionysakopoulos performed the role of Staff Educator as well. Around the time that I left Meadow Park, Helena Miners was promoted to the position of Staff Educator.

9. In 2013, when I took on the role of Co-Director of Care, the Director of Care was Lia Dionysakopoulos. I believe that Ms. Dionysakopoulos left that role in the Spring of 2014. Heather Nicholas was then hired as the Director of Care. I was the Co-Director of Care and then the Administrator while Ms. Nicholas was at Meadow Park.

10. The role of Co-Director of Care was very busy with a population of 126 residents from 4 home areas. My duties as Co-Director of Care included assisting with the operation of the front-line PSW staff and the RPNs. I would facilitate monthly PSW meetings, the positive discipline process and performance appraisals. I would also follow-up on what was happening in the home, read the daily reports, ensure that follow-up was made for any concerns or complaints from family or residents, ensure that the staff were meeting the needs of the resident care plans and assessments, complete required audits (e.g. handwashing, Point Click Care documentation), complete documentation to ensure and demonstrate compliance with the MHLTC and College of Nurses requirements, and facilitate the Infection Control Management and Behaviour Management Committees.

11. Residents came first. Staffing was a challenge as I often received complaints from PSWs relating to stressful work load, especially with resident behaviours in the mix.

12. The Co-Director of Care role is a managerial role so I wouldn't work a specific shift as an RPN but I was staffing backup. My regular hours were 8:30 a.m. to 5 p.m. from Monday to Friday, but I often worked 8:00 a.m. to 6 p.m. or later. There sometimes was a management presence at the Home during the weekday evenings. On the evenings

and weekends, I could be a manager on call (on a rotating basis) to respond to an emergency situation and management presence in the Home was required. While I was the Co-Director of Care, I did work shifts as a PSW or as an RPN when there was a staffing shortage due to someone calling in sick at the last minute.

13. I was at Meadow Park as the Administrator when the Home transitioned the lower level retirement home (empty at the time) to long-term care beds.

THE HIRING AND EDUCATION OF REGISTERED STAFF

14. I received education from Classic Care on the medication management program. I received that education annually and whenever necessary, as did other staff. Staff signed for education once it was completed. Records were kept.

15. I do not remember being part of the interview process for the hiring of Elizabeth Wettlaufer. The process is usually that the Director of Care reviews the applications. The Director of Care (or her designate) calls the RN for an interview – that is usually step one. Quite often, the interview process involved group interviews of RNs, RPNs and PSWs. Then there would be an individual interview of the candidate with the Director of Care. The group interviews could also involve me or a Staff Educator.

16. As part of the hiring process, vulnerable sector checks, proof of education, registration with the College of Nurses and reference checks are completed. The Director of Care usually completes the reference checks or she could assign it to another nurse manager. I may have assisted with reference checks if asked by the Director of Care. I do not recall assisting with any screening or reference checks for Elizabeth Wettlaufer.

17. Jarlette did have a written process for hiring called "Hiring the Jarlette Way". Quite often, if assisting with the hiring process, I would automatically go to the policy to ensure that the steps were followed. Jarlette as a corporation encouraged that.

18. In terms of orientation of registered staff, based on my recollection during the time that I was Co-Director of Care, the staff had a two-day orientation which was provided by the Staff Educator. I believe that the Staff Educator at the time was Marilyn Hauser (she retired in April 2014) followed by Lia Dionysakopoulos (who took on the role part-time while she was completing her studies as a nurse practitioner).

19. In addition, the pharmacy would usually come in and do orientation on Point Click Care, EMAR and medication management. They did it for each new registered staff. The pharmacy and the Home were required to track that orientation was done.

20. The training may not have been as extensive for someone who was coming from another long-term care facility and was familiar with Point Click Care.

21. There were also in-services that would be given by the Pharmacy apart from orientation, which included mandatory medication management training for the RNs and RPNs.

22. Orientation on the floor consisted of a shadow orientation. The Home would always try to have the new staff member shadow a full-time person. That orientation consisted of two day shifts, two afternoon shifts and one night shift. I believe that there needed to be a sign off that the person was oriented on the shift.

23. The staff was also able to have open communication with the Director of Care to give feedback as to how the new person was performing.

24. It is difficult to retain registered staff. A lot of times registered staff, especially part-time people, end up going to work at the hospitals. The workload is different, the demands are different. The residents in long-term care are becoming more complex. People are living longer, the behaviours are different than they used to be. They seem to be more pronounced. I do not think that the hospitals can afford to keep people who have a chronic disease so it is kind of a domino effect back down to long-term care.

25. There is a lot more complex care going on in long-term care. It is not as predictable as it used to be. There are feeding tubes, CPAPs, chronic wounds. Such issues now may require more of a skillset and that may attract nurses. But the new graduates still look at the hospital as being the place to go because there are skills that are utilized in the hospitals that wouldn't necessarily be utilized in long-term care.

MEDICATION MANAGEMENT

26. The pharmacy participated in the development of policies regarding medication management and conducted quarterly medication reviews and annual reviews.

27. When a medication incident was found, the nurse was required to fill in a Risk Occurrence Report Form as per the Home's policy on medication errors. That report would be submitted to the Director of Care and immediate action taken. The pharmacy would be notified as well. Pharmacy also participated in risk management. Pharmacy would have received a copy of the Risk Occurrence Report Form. If the incident involved incorrect dispensing, the pharmacy would respond by looking into errors on its end. Also, if the medication was dropped or wasted and additional would need to be sent, it

would be done. If a medication was missing, pharmacy would also respond by assisting with investigating and locating the missing drug.

28. Omission of any mediation is considered a medication incident. There should be a Risk Occurrence Report Form filled out and submitted to the Director of Care. The information completed on the report would identify the medication error, reason it happened, action taken and outcome. Pharmacy would also get a copy of the report if it was a medication error.

29. A dropped medication that was supposed to be administered to a resident that was not would still be considered a medication incident.

30. The physician would be notified of a medication error as well. If there was an adverse reaction to the medication error, the nurse's responsibility was to, upon notifying the physician, take direction from the physician and the resident would be monitored according to the direction given by the physician. It was absolutely the expectation of the Home that medication errors must be self-reported.

31. If the resident was not capable, the resident's substitute decision maker (e.g. Power of Attorney) was notified of the medication error.

32. If a resident experienced a change of condition and was sent to hospital because of a medication error, it became a critical incident that was reported to the MHLTC. A missing medication that was not found in a timely manner was also to be reported to the MHLTC.

33. Pharmacy had its own policies regarding medication management. The Home also had its own policies developed by Head Office in consultation with the pharmacy. The Home's written medication policies and procedures were reviewed by the Director of Care and the pharmacy. To the best of my knowledge, the Home's policies on medication management were consistent with pharmacy policies.

34. Professional Advisory Committee meetings were held in the Home. Dr. Payne (the Medical Director at the time), the Director of Care, the Co-Director of Care, the pharmacist and the Administrator attended the meetings. Sometimes, the physiotherapist and respiratory therapist attended as well. I believe that written records of the minutes from the PAC meetings were kept in the Administrator's office.

35. Pharmacy completed medication audits. The Director of Care would receive the pharmacy audits in paper form and later through the computer portal. The Pharmacy Liaison would meet with the Director of Care to review the audits.

36. In terms of the management of controlled substances and narcotics, a registered staff would have to receive them from the pharmacy driver. This was usually in the evening. The controlled substances and narcotics were in a separate bag from the non-controlled drugs and were labelled by unit in the Home. The nurse who received the bag(s) would sign for receipt together with the pharmacy driver. The nurse then had to deliver each bag to the nurse on the specified unit. The unit nurse would be responsible for completing the individual narcotic count sheet for the card, which was checked and co-signed by another nurse. In addition, the unit nurse was to add the drug count into the inventory count record.

37. When a medication cart was transferred from one nurse to another nurse, they were required to count the narcotics and both signed the inventory count record. The resident's individual narcotic count sheet was also to be compared against the medication card by the nurses. It would be the incoming and the outgoing nurses who would be responsible for doing the narcotic count.

38. When a narcotic or controlled substance was administered, the nurse was required to sign the resident's individual narcotic count sheet. If a nurse was giving a resident a controlled substance or narcotic, it would also be signed on the EMAR.

39. In terms of the discontinuation of controlled substances and narcotics, the nurse would have to remove the card from the double locked drawer at the bottom of the medication cart. The drawer inside the medication cart which holds the medication cards is locked and then the cart itself is locked. The nurse would have to photocopy the signed individual narcotic count sheet. The original would be filed in the resident's paper chart and the photocopy would be attached to the card and they would be put in the one-way narcotic destruction bin. I cannot recall where the photocopied individual narcotic count sheet would go after the Director of Care and pharmacy disposed of the discontinued medication in the narcotic destruction bin.

40. Registered staff would have to make sure that their signature was on the individual narcotic count sheet. The date the narcotic was put into the bin would also be recorded on the individual narcotic count sheet and then it should be double signed by another nurse who was confirming the quantity left to be destroyed. The reason why the drug

was discontinued should also be noted. The completed individual narcotic count sheet would be photocopied before the nurse could stick it into the narcotic destruction bin.

41. Nurses and the Director of Care have access to the locked medication rooms. Only the Director of Care had access to the double locked narcotic destruction bin. The narcotic destruction bin was in the Oxford medication room and was permanently affixed to either the floor or the wall.

42. The actual destruction of the controlled substance and narcotic would be done by the pharmacist and the Director of Care. The controlled substances and narcotics were removed from the narcotic destruction bin and counted by the pharmacist and Director of Care before they were denatured in a bucket.

43. For non-controlled drugs, if a medication was discontinued, it would have been documented in the doctor's orders that the medication was discontinued. The medication would be removed from the medication cart and stored in the locked medication room in a box for destruction. The box stored in the medication room was only accessible by registered staff. The box was not a one-way container. When those medications were destroyed by a registered staff designated by the Director of Care, they were put into a bucket (same as narcotics) to denature them.

44. I cannot answer whether there were any records kept of the destruction of non-controlled substances. I was not involved with medication destruction but know from my own practice as a nurse that it was a requirement for the non-controlled medication to be inventoried with the amount discarded and the reason for it being discontinued. A

physician's order is required after a resident is deceased to destroy all medication and release the body.

THE HANDLING OF INSULIN

45. In terms of the handling of insulin at Meadow Park, the Home was on the pen and cartridge system for some time. I have not actually given insulin in a long time, however, based on my experience, and my role as Co-Director of Care, I verily believe that the process is as follows:

    a. Five insulin cartridges come in a box. The box is labelled with the resident's name, type of insulin, the amount to be given, how often it is to be given, the doctor's name, date filled and prescription number. There is an expiry date on the box and on the cartridges.

    b. There was a peel away label on the cartridge box. You would take that label and place it in the Drug Record Book, sign off on it and then fax it to the pharmacy to re-order the insulin.

    c. Medications were usually received from the pharmacy by the Home around 6 p.m. They were delivered by a delivery service contracted by the pharmacy.

    d. When the insulin was received in the Home, the nurse would have to match what was received to what was faxed to the pharmacy.

    e. The insulin is refrigerated. Meadow Park had three refrigerators, one in each medication room.

f. The boxes of insulin sit on the shelf in the fridge. In 2014, there were a few residents on insulin although I do not recall how many. Residents may have more than one box of insulin when the reorder was delivered from the pharmacy. There were some residents that were on two types of insulin.

g. The individual cartridges did not have the resident's name on them. The cartridges had the manufacturer's label with the drug name and its concentration.

h. Meadow Park labelled the pens and the pen cases with the resident's name by using a labeler.

i. The resident may have brought their pen from home when they came to Meadow Park. If not, one would be ordered on admission. The pen is not replaced until needed.

j. Each type of insulin usually had its own colour band around the cartridge. The insulin itself could be a clear or a milky colour.

k. I do not recall a requirement for a registered staff member to sign that he or she has opened a new cartridge. However, I believe they recorded the date the cartridge was opened using a sticker placed on the cartridge itself.

l. Each resident on insulin is prescribed insulin for a certain number of units, or a sliding scale of units depending on their blood sugar measurement at the time of administration.

m. The insulin pens, in their case, were stored in a drawer on the medication cart because they did not fit in the individual resident's box in the med cart. The pen cases were labelled with the resident's name.

n. In order to use the pen, you would insert a needle and prime it. A new needle would be used for each injection. Usually a couple of units of insulin would be wasted when priming. Then you would dial up the dose that was needed by the resident.

o. Once the insulin is injected into the resident, the dial goes back to 0.

p. Insulin is a medication that can negatively impact a resident if not given correctly.

q. New nurses would have been coached on the administration process if they were not used to giving insulin. They would have another nurse check the insulin dosage before injection if they thought the nurse was new at administering insulin. We encouraged new nurses to ask for a double-check until they became familiar with administration.

r. To the best of my recollection, the EMAR had a guide for the site of injection.

s. In terms of double-checking insulin, when I first went into nursing they were drawing from vials and there were double checks. When they switched to pen and cartridge, there was double-checking initially but I believe that the practice didn't continue because there was less risk of not giving the proper mix. I do

not recall there being a double check at Meadow Park, except in the case of overseeing new nurses.

t. Even if you checked with someone that you had dialed up 10 units for a resident, you could dial up another 10 units as you were walking away. When the dose is given, the dial goes back to 0.

u. The cartridges are not marked per unit measurement and it would be a very small measurement to check. The markings on the cartridges are in increments of 20 units. It would be difficult to visualize if someone gave a resident 10 or 15 units.

v. Best practice is that when you pick-up the pen, you look at the cartridge to ensure that what is in the pen is actually what you want to dispense. You have to check the EMAR, the pen and the cartridge to ensure that the right insulin is given to the right resident in the right dose.

w. If there is not enough insulin in the pen to complete the resident's dose, the best practice would be to get a new cartridge rather than give the resident two injections. There is no ability to "draw up" from two different cartridges for a single injection.

x. When you put a new cartridge into the pen, you have to dial up probably 4 to 6 units just to get the medication to the end of the needle. Sometimes, you could be wasting up to 10 units. I would waste it into a med cup on my medication cart and then the waste from priming the pen would be immediately thrown out into

the sharps container. Someone could save up the insulin that is being wasted but that would take a long time.

y. If there was just a couple of units (miniscule amount) left in a cartridge, I would put the cartridge in the one-way sharps container. There would have to be a fair amount of insulin left for someone to put it in the medication destruction box rather than the sharps container.

z. If a resident died and had a number of cartridges in the fridge and one in the pen, nothing prevents the nurse from taking the cartridge in the pen and only throwing the cartridges in the fridge into the medication drug destruction box. There is no counting or audit with insulin.

46. The pharmacy does provide drug utilization statistics. We reviewed them quarterly at the PAC meetings. Those statistics were more focussed on tranquilizers, pain medication and psychotropics. I do not recall any drug utilization statistics specific to insulin other than perhaps the percentage of residents within Meadow Park on insulin.

MEADOW PARK'S COMPLAINT PROCESS

47. In terms of the Home's complaint process in 2014, any complaints that came to the Home were documented and investigated according to what the complaint was about. They were documented in the residents' charts. As well, the complaint was then submitted to the Director of Care and possibly the Administrator if the complaint could not be resolved. Written complaints are also submitted to the MHLTC.

48. The Home kept the complaint records in the Administrator's office. However, complaints were recorded in the resident's chart as a conversation with the family or resident about a concern. Details of the investigation would not be in Point Click Care.

49. In terms of training on how to do investigations, my training was basically hands-on and I followed the Home's policy. When I was at Meadow Park, I would get direction from the Director of Care or Administrator, one of whom would be involved in conducting the investigation.

50. In terms of investigating medication errors, my involvement would depend on what I was directed to do by the Director of Care. Medication errors always went to the Director of Care. She may assign it to me and ask if I can look and see what happened.

51. Recently, I received further and extensive training on completing an investigation – a retired police officer gave that education. This education would have been useful at Meadow Park because you are taught how to record the specific details, the importance of asking the question more than once, perhaps rewording the question. The biggest thing that I learned is that you need someone to be asking the questions and someone to be transcribing the answers. It is very difficult to be asking the questions and documenting as well.

52. In terms of investigating abuse of a resident who is non-verbal, the investigation may identify a bruise on the resident that had been noticed by the PSW. We use our best clinical skills to determine what has transpired with the resident. You need to ask a lot of questions of many staff, examine times frames and look at documentation.

THE INSTITUTIONAL PATIENT DEATH RECORD

53. In terms of the Institutional Patient Death Record, there was a record kept within the Home that identified the number of resident deaths. There was a threshold of every 10 deaths to report to the coroner at one time. The number of transfers to hospitals was one of the monthly quality indicators recorded on Point Click Care by the nursing leadership team. Front line staff would not necessarily know the number of transfers to hospital for the whole home unless they knew to access that information on Point Click Care.

ELIZABETH WETTLAUFER

54. I was familiar with Elizabeth Wettlaufer. She went by Bethe. She was a registered nurse, evening shift.

55. I am not aware of any medication incidents by Elizabeth Wettlaufer.

56. I did receive one concern from a resident regarding the care that Elizabeth Wettlaufer had provided. It was regarding the time of the resident's medication. He wanted his medication at a specific time which was before it was actually scheduled to be given. Basically, it was addressed and explained to him that Elizabeth Wettlaufer wasn't denying him the medication, that she was giving it according to the direction. I do not recall whether there was a written record of that concern.

57. I do not recall any concerns from family in regards to Elizabeth Wettlaufer's performance. I don't recall any staff concerns regarding her performance. After reviewing Doc IDs LTCI00017584 and LTCI00017585, which are attached hereto and

marked collectively as Exhibit "C" to this my Affidavit, I vaguely recall a concern from Felina Cabrera, the night RN, in regards to Elizabeth Wettlaufer's job performance. I believe that Felina had a conversation about the issue with Heather Nicholas.

58. I do not personally recall ever having any concerns regarding the performance of Elizabeth Wettlaufer.

59. In terms of my interactions with Elizabeth Wettlaufer, when she came on shift there may be a general conversation of "how are things going today" etc., and what might be happening on the unit. She was a staff member who, if you communicated with her, always seemed to want to try to have an open dialogue.

60. Elizabeth Wettlaufer never presented as having an addiction or mental health issues. She presented as someone who lacked self-confidence and wanted to fit in. She seemed like a person who was very jovial and needed to fill her life with something. With no encouragement, the only thing she shared with me was that she was looking at a weight loss program and she was doing really well on it and she was trying to get healthy. I believe that at the time of that discussion, Elizabeth Wettlaufer was living with her parents. She had a habit of bringing food in for fellow staff members.

MR. HORVATH

61. I am aware of an incident with Arpad Horvath and a personal support worker who had been providing care to him. The PSW was African American and Mr. Horvath called her a derogatory name and spit on her. The staff responded by spiting on Mr. Horvath during care. I was involved in the investigation, to the extent of being made aware of

the incident by the Nursing Manager on call, along with the Administrator. As the senior nursing manager at the time, I reported the incident to the MHLTC after hours reporting line. I do not recall being involved in the actual investigation. I know that the staff member was terminated.

62. I do not recall an incident where Mr. Horvath was found by Elizabeth Wettlaufer with his jogging pants string tied to the bed rail when she went in to assess him. If a staff member did witness a situation like that, if it was an evening shift they would call the manager on-call and then the manager would follow-up. The Director of Care would be made aware. The Ministry should be made aware under the LTCHA's Regulations if abuse was suspected. Based on the progress notes Doc ID LTCI00020697, it is not clear to me whether someone wrapped and tied Mr. Horvath's draw strings or he did it himself.

THE MISSING NARCOTICS

63. I am aware of a medication incident regarding a narcotic card that went missing from the Home. There was a particular incident where the nursing team was made aware that a narcotic card had not been delivered from pharmacy. Specifically, on October 2, 2014, one of the RPNs in the Kent unit reported to me that pharmacy had said they delivered a narcotic card but it could not be located at the Home.

64. It wasn't until the staff went to retrieve a new card, because the one that they were using was finished, that they could not find a new card. Instead, the staff utilized the same medication, the same dose that the resident had as a PRN. It wasn't until October 2, 2014 that they actually said something to management and said "you know we have been utilizing this PRN Card" and then they contacted the pharmacy and the pharmacy

said they sent it. It should have been reported right away that the new card was not there.

65. The resident had not missed any medications because she had the same medication as a PRN which the nurses had been giving to her.

66. Upon receiving this report, I had a nurse in each unit check the medication rooms and medication carts to ensure that the medication card had not been misplaced. I called the pharmacy and spoke to the Pharmacy Liaison. She confirmed that the medication had been delivered on September 26, 2014. It was a routine narcotic, so routine narcotics were always sent a couple of days before the resident actually needed it according to the way it was reordered.

67. Meadow Park could not locate the card so immediately the investigation began. I looked back at the Drug Record Book and confirmed that the medication had been ordered with no confirmation that it had been received. I believe that the missing narcotic was the only narcotic delivered to the Kent unit that day because the bag containing the narcotic card and the drug record sheet sent by pharmacy with the card had disappeared.

68. I do remember that through the investigation, it was demonstrated that the card should have been received on Friday, September 26, 2014 in the evening and it was on October 2, 2014 that I and the Director of Care were made aware by staff that the narcotic card was missing.

69. The routine for receiving medication is that the Classic Care delivery person would bring the medications in bags to the front desk and the RN in charge would have to accept

the bags and sign for them. Narcotics were in a separate bag from regular medications. The bags were labelled with the unit of the Home to which they were to be delivered. The nurse would take the medication for her unit and lock it in the medication room immediately before distributing the remaining bags to the other unit nurses. The unit nurse was to ensure that the narcotics had been locked in the medication room for the unit.

70. The bags should be taken still sealed to the medication room. The bags should not be opened or unsealed until the narcotics can be double counted.

71. When the missing narcotics were delivered on September 26, 2014, there may have been three white bags of narcotics and one brown bag of regular medication for four bags in total. But that doesn't mean that the bag actually went to the Kent unit. It could have been that Elizabeth Wettlaufer simply took the whole bag or unsealed the bag, took out the narcotic card and the drug record sheet and destroyed the bag. The missing narcotic card never got double-counted into the medication cart. It was like it never existed.

72. The outcome was that we could not locate the narcotic card. It, in fact, had been sent by pharmacy.

73. I reported the missing narcotics to police. I believe that Ms. Nicholas reported the critical incident to the Ministry.

74. I believe the missing narcotics incident was a joint investigation between Ms. Nicholas and myself. Attached hereto and marked as Exhibit "D" is a copy of the documentation related to the investigation of the missing narcotics.

75. I believe that it was near this time that Ms. Nicholas received a call from Elizabeth Wettlaufer who said she was in the hospital because she had overdosed. It was my understanding that Elizabeth Wettlaufer told Ms. Nicholas that she was the one who had taken the narcotic card.

76. I also think that Tanya Adams from the pharmacy did an audit track from the processing of the medication to the delivery.

77. I can't recall whether I saw Elizabeth Wettlaufer's resignation letter Doc ID LTCI00017578, which is attached hereto and marked as Exhibit "E" to this my Affidavit. I do know that she resigned and I know that it was around the same time that Ms. Nicholas had this phone conversation with Elizabeth Wettlaufer about the overdose.

78. During the course of this Inquiry, I have been given a police statement to review. It does not reflect all of the parties involved in questioning at the time by police about the missing narcotics. I know I wasn't alone, I know that Heather Nicholas was there and perhaps others may have been there and I know that some of the comments in the police statement are not mine. For instance, I do not recall Elizabeth Wettlaufer ever meeting with me to discuss her resignation and I do not recall ever receiving or seeing the doctor's note, Doc ID# 17579. It is Ms. Nicholas' handwriting on the doctor's note. Attached hereto and marked as Exhibit "F" is the police statement Doc ID

LTCI00053318. Attached hereto and marked as Exhibit "G" is a copy of the doctor's note provided by Elizabeth Wettlaufer [Doc ID LTCI00017579].

79. I don't know if there is a duty to report to the College of Nurses if someone resigns and identifies an addiction that does not affect their performance. I believe that Rob VanderHeyden and Ms. Nicholas had a conversation about reporting Elizabeth Wettlaufer to the College with respect to substance abuse. I am unaware of whether they had a conversation about reporting Elizabeth Wettlaufer to the College of Nurses with respect to the missing narcotics.

ELIZABETH WETTLAUFER'S CRIMES

80. I was no longer at Meadow Park and was not employed there at the time when the crimes became public. These events have been very disturbing to me as I did not suspect anything in terms of Elizabeth Wettlaufer committing these crimes. I have had many sleepless nights spent trying to remember my days at Meadow Park, asking myself if I missed anything. I feel that these crimes could have happened in any long-term care home given that nurses are trusted to properly handle drugs and care for residents. In the long-term care home where I am currently working as an Administrator, it has been very concerning for residents, family and staff that it is possible for a nurse to perform these crimes without being detected. Elizabeth Wettlaufer was a wolf in sheep's clothing.

81. I swear this affidavit for no improper purpose.

SWORN BEFORE ME at the City of London, in the Province of Ontario on June 12, 2018
LR

Commissioner for Taking Affidavits
(or as may be)

Melanie Smith
Melanie Smith

10561.0015/11347986_.1

Leanna Gail Reiss, a Commissioner, etc., Province of Ontario, while a Student-at-Law. Expires June 20, 2020.

This is Exhibit "A" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.
Province of Ontario, while a Student-at-Law.
Expires June 29, 2020.

Meadow Park London - 2014

MAIN FLOOR PLAN

This is Exhibit "B" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.,
Province of Ontario, while a Student-at-Law.
Expires June 20, 2020.

MEADOW PARK LONDON - NURSING STAFF LEVELS FROM APRIL TO AUGUST 2014

UNIT	DAYS 0630 to 1430	EVENINGS 1430 to 2230	NIGHTS 2230 to 0630
KENT 33 beds	2 RN (shared 0630-1430) 1 RPN (shared 0630-1430) Kent - 3 PSW (1x630-1030, 1x630-1400, 1x630-1430) Lambton - 4 PSW (2x 630-1400; 2x 630-1430)	1 RN (shared 1430-2230) 1 RPN (shared 1430-2230) Kent - 3 PSW (2x 1430-2100, 1x 1430-2230) Lambton - 3 PSW (1x 1430-2030, 1x 1430-2100, 1x 1430-2230)	1 RN 1 RPN 4 PSW (one of each unit)
LAMBTON 33 beds			
ELGIN 28 beds	2 RPN (shared 0630-1430) (reduces to 1 every other weekend) Elgin - 5 PSW (1x630-1030, 1x630-1400, 3x630-1430) Oxford - 4 PSW (1x 630-1030, 2x 630-1400, 1x 630-1430) *two of the 630-1430 PSWs at Elgin are shared with Oxford	1 RN (shared 1430-2230) 1 RPN (shared 1430-2230) Elgin - 3 PSW (1x 1430- 2030, 1x 1430-2100, 1x 1430-2230) Oxford - 3 PSW (2x 1430-2100, 1x 1430-2230)	
OXFORD 32 beds			
TOTAL FOR HOME 126 beds	2 RN 3 RPN 16 PSW (approx.)	2 RN 2 RPN 12 PSW (approx.)	1 RN 1 RPN 4 PSW

CURRENT NURSING STAFF LEVELS

UNIT	DAYS 0630 to 1430	EVENINGS 1430 to 2230	NIGHTS 2230 to 0630
YELLOW (Kent & Elgin) 30 beds	1RN/RPN 4 PSW (2 x 630-1430, 2x 630-1400)	1 RN/RPN 3 PSW (1x1430 to 2230, 2x1430-2100)	2 RN/RPN 4 PSW (one of each unit)
BLUE (Lambton) 33 beds	1RN/RPN 4 PSW (2 x 630-1430, 2x 630-1400)	1 RN/RPN 3PSW (1 x 1430-2230, 2x 1430-2100)	
PINK (Oxford & Elgin) 33 beds	1RN/RPN 4 PSW (2 x 630-1430, 2x 630-1400)	1 RN/RPN 3 PSW (1 x 1430-2230, 2x 1430-2100)	
GREEN (Lower Level-Wildwood) 30 beds	1 RN/RPN 4 PSW (2 x 630-1430, 2x 630-1400)	1 RN/RPN 3 PSW (1 x 1430-2230, 2x 1430-2100)	
TOTAL FOR HOME 126 beds	4 RN/RPN (1 must be an RN). Also, 1 RN float. 16 PSW	4 RN/RPN (1 must be an RN). Also, 1 RPN float position posted. 12 PSW	2 RN/RPN (1 must be an RN) 4 PSW

This is Exhibit "C" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.,
Province of Ontario, while a Student-at-Law.
Expires June 20, 2020.

September 16, 2014

To: Elizabeth Wettlauffer , RN
Re: Pertinent Matters

I can sympathize with you in dealing with busy shift due to all the commotions , giving pills to more or less than 30 residents, dealing with behaviors, family members; however, we all have to take our own loads, it is a part of our responsibilities .
I understand that after a long busy day, you just want to go home right away and I also understand the concept of 24 hour nursing but you also have to understand I have to clean up after you which does not only take 5 minutes of my time and do all the work left for me to do before I can even start my own shift. I don't think it is fair for me to be left with the mess and just assume because of my sense of responsibility that I can and have to do the work without it causing a burden on me. If it happens only once or twice, I don't mind doing these and would not have said anything but this has been happening frequently and I have to bring it up to your attention already. These are the things that I have observed:
1) Please do not make it a habit of not counting meds before you leave. It is not safe and proper putting your signature, trusting me and let me do the counting alone. I was just waiting for you to finish charting so I did Lambton first and waited for you to call me and count meds with you but you were already gone by the time I came back to Kent. This is not the first or second time this has happened.
2) Please tidy up your mess at the nurse's station and med room before you leave. It is not fair for me to clean up after you. I have to always throw overflowing garbage after your shift, sometimes even contaminated dressings are left in the garbage bin on the side of the treatment cart.
3) Tonight, I was left with eight charts, not only needing second checks but some have to be completely processed.
Please bear in mind that I just don't sit down the whole night doing nothing, aside from my patient care (I also give meds and do treatments), the whole building and every individual, whether it be a resident or staff, is my responsibility. Just to give you an idea of what I do at night, here are the following duties that I do and 90% of these are done by me alone.
1) Check the building for safety, do shift audit that we are required to do and get supplies for the next shift.
2) Help or assist, answer questions of RPN especially if she or he is new. RPN tonight states she was not given proper preceptorship and she has a lot of questions on what and how to do things.
3) Answer call bells when PSWs are on break.
4) Check charts for any possible unprocessed orders that may have been missed and inadvertently placed in the rack especially on Tuesdays and Thursdays.
5) Do quarterly med reviews, MDS once a week.
6) Write and fax labs for Tuesdays and Fridays lab works.
7) Destroy meds at least once every two weeks.
8) Check med strips with previous ones on Wednesdays when I am scheduled, that is every other week.
9) File labs and cut backs.
10)Write new narcotic sheets so that it does not take anybody's time anymore.
11) Take charts of discharge patients apart and compile them before being taken for storage.
12) Put admission charts together and do care plan for new admits.
I'm sure there are still things that I do that slip my mind at this moment. I have not enumerated any of these to anyone but today because I just want staff, who think that I don't do anything at night, to understand that I probably have more responsibilities than any staff RN in this facility but you never hear me complain . I am not trying to single you out and I hope you don't take this personally.
Thank you for your kind understanding and consideration.

Felina Cabrera, RN

copy for Heather Nicholson, RN-DOC

CHARTS I HAD TO CHECK/DO AFTER QUARTERLY MED REVIEWS:

D.D -- unprocessed; I had to do the whole processing

E.M. ---first signature by me- faxed by Vanna Sok, RN

M.V.M. --- second sig by me - first sig by Vanna

R.P. --second sig by me - first sig by Vanna

M.B. --First sig by me - faxed by Cassidy Pizzaro, RPN

J.R. ---First sig by me -faxed by Vanna

H.D. ----First sig by me- faxed by Vanna

R.D. ---First sig by me- faxed by Cassidy

* lab req`s made out by Cassidy and Vanna

Felina Cabrera, RN

This is Exhibit "D" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.,
Province of Ontario, while a Student-at-Law.
Expires June 20, 2020.

Ontario CRITICAL INCIDENT REPORT

2643-000013-14

MEADOW PARK NURSING HOME (LONDON)
1210 SOUTHDALE ROAD EAST
LONDON

CI Date and Time	Date and Time CI first Submitted to MOH	Current Status
2-Oct-2014 11:00	2-Oct-2014 19:00	CHANGED ON 17-Oct-2014 10:27 AMENDED
		Previous Status SUBMITTED

I Mandatory/Critical Incident Description

Area/Location of Unusual Occurrence:

Other (please specify)

Please specify (Area/Location)

missing Narcotic medication investigation

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

Mandatory Report (LTCHA, 2007)

Which Mandatory Report category best applies?

Other Mandatory Report

Description of the incident, including events leading up to the incident

On October 2, 2014 it was brought to CoDOCs attention that Hydromorphone 1 mg card was ordered for Kent resident D.G. on September 26, 2014. Medication was not received. Investigation conducted by CoDOC, in consultation with Pharmacist T.A. and Pharmacy Liason T.S.. Shipping reports, Delivery Driver report and Drug record book all confirmed that medication ordered September 26, 2014 and delivered September 26, 2014. Driver's log book confirmed that RPN S.B. received 3 white bags of narcotics and 1 brown bag of regular medication - 4 bags in total. Further investigation noted that all medications were delivered, received, signed and accounted for except for the Hydromorphone HCL 1 mg in question. CoDOC informed Administrator R.V., Director of Care H.N. and Police (Constable D.W.)(incidnet #14 110166) Police came and met with Administrator, DOC, CoDOC and Pharmacist. Took statements, and copies of all documents related to investigation. Also documented Registered staff's names, dates of birth and phone numbers that work September 26, 2014 both evening and night shift.

Other Mandatory Report (please specify)

Controlled Narcotic Missing

II Identifying Information

Resident(s) Involved

Name of resident(s) INVOLVED in Unusual Occurrence: D.G.

Name of resident(s) INVOLVED in Unusual Occurrence:

Resident(s) Involved

Date of admission of resident(s) (MM/DD/YYYY): 04/10/2014

Date of admission of resident(s) (MM/DD/YYYY):

Resident(s) Involved

Date of birth of resident(s) (MM/DD/YYYY): 09/26/2014

Date of birth of resident(s) (MM/DD/YYYY):

Name of Staff who were PRESENT and/or DISCOVERED the Unusual Occurrence
Staff who were PRESENT: Julie Nooren RPN

Name of Staff who were PRESENT and/or DISCOVERED the Unusual Occurrence
Staff who DISCOVERED: Melanie Smith CoDOC

Name of other person(s) PRESENT and/or DISCOVERED the Unusual Occurrence
Other person(s) who were PRESENT: Tanya Adams - Pharmacist

Name of other person(s) PRESENT and/or DISCOVERED the Unusual Occurrence
Other person(s) who DISCOVERED: Terri Skelding Snell -Pharmacy Liason

Name of home staff RESPONDING to Unusual Occurrence
Heather Nicholas DOC, Melanie Smith CoDOC

III Actions taken

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

No affect to resident. Resident received proper doses of medication. Investigation was conducted as to the location of the dispensed card in question. Police were phoned and met with senior team. Police Investigation initiated - Occurrence # 14-110166 Called police to see what has been done thus far October 10 and October 17 2014 police are still investigating and have not reported back to home as of yet. Medication in question hasn't been found.

By whom?
Administrator R.V., Director of Care H.N, Co Director of Care M.S. Pharmacist T.A. (assisting)

Was physician called?
Yes

Date and Time physician called (MM/DD/YYYY HH:MM)
10/02/2014 13:00

Name of physician
Dr. Payne

Physician's action
No action required from Physician at this time

What other authorities were contacted about this Unusual Occurrence?
Police

What other additional authorities were contacted ? (e.g. First Nations Band Council, Veterans Affairs Canada, Ministry of Labour, etc.)
Authority name: Pharmacy- Classic Care, Corporate Office.

For resident-related occurrences

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

No

If No, why not?

No Resident did not miss any doses of medication. Received appropriate doses, utilizing a PRN card of exact dose.

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

Investigation occurring presently

IV Analysis and follow-up

What immediate actions have been taken to prevent recurrence?

Daily surveillance of medication receiving records. Pharmacist completing an immediate audit of Narcotic medications

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

In-services have been set up with Pharmacy to train staff on Policies, Procedures and Protocols with the use of Narcotic medications. Pharmacy will be conducting additional audit at this time

Name of person initiating report

Melanie Smith, Heather Nicholas

Category of person initiating report

Director of Care (DOC)

Date of report (MM/DD/YYYY)

10/02/2014

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

Yes

General Notes

Most Recent Note : Please amend CI indicating the outcome of both police and internal investigations. Please state if the missing medication has since been located. Thank you.

10/16/2014 10:00 | Melinda Turner | CI form reviewed

Shipping Report

Classic Care Pharmacy, 112 Newbold Court, London ON N6E 1Z7
Phone: (866) 773-1354 Fax: (866) 773-1355

Report Parameters
Excluding Rxswith batch flag on or in a batch.
Fill Date 26/09/2014 00:00 to 26/09/2014 23:59
Sort By: Home/Ward/Patient
Med Sort By: Generic Name

Shipping Report — Printed on: 26/09/2014 16:28:37

Narcotics

Home: MPLN - Meadow Park London Long Term Care, Ward: Lambton

Patient Name / Rx #	DIN	Qty	Drug	Cards	Check
J.B.					
2163867	00885444	30	TAB HYDROmorphone HCl 1mg	2+5	
D.D.					
2163871	00653276	30	TAB Acetaminophen/Caffeine/Codeine Phos 30/15/300mg		
K.R.					
2163868	00885444	15	TAB HYDROmorphone HCl 1mg		

Total 3 Rxs

Total Cards 4 / 30

Received By _____

Shipping Report

Classic Care Pharmacy, 112 Newbold Court, London ON N6E 1Z7
Phone: (866) 773-1354 Fax: (866) 773-1355

Report Parameters
Excluding Rxswith batch flag on or in a batch.
Fill Date - 26/09/2014 00:00 to 26/09/2014 23:59
Sort By: Home/Ward/Patient
Med Sort By: Generic Name

Shipping Report

Printed on: 26/09/2014 16:28:37

Targeted

Home: MPLN - Meadow Park London Long Term Care, Ward: Oxford

Patient Name / Rx #	DIN	Qty	Drug	Cards	Check
J.C.					
39211620	00711101	30	TAB Lorazepam 0.5mg		
39211622	00711101	30	TAB Lorazepam 0.5mg		

Total 2 Rxs

Total Cards

Received By

Shipping Report

Classic Care Pharmacy, 112 Newbold Court, London ON N6E 1Z7
Phone: (866) 773-1354 Fax: (866) 773-1355

Report Parameters
Excluding Rxswith batch flag on or in a batch.
Fill Date - 26/09/2014 00:00 to 26/09/2014 23:59
Sort By: Home/Ward/Patient
Med Sort By: Generic Name

Shipping Report

Printed on: 26/09/2014 16:28:37

Narcotics

Home: MPLN - Meadow Park London Long Term Care, Ward: Oxford

Patient Name / Rx #	DIN	Qty	Drug	Cards	Check
M.K.					
2163827	00653241	30	TAB Acetaminophen/caffeine/codeine Phos 15/15/300mg		
N.P.					
2163826	00885436	30	TAB HYDROmorphone Hcl 2mg		

Total 2 Rxs

Total Cards

Received By

* Please use black or blue ink

90

DRUG RECORD BOOK CLASSIC CARE PHARMACY

LONDON
FAX: 1-866-773-1366

Entry	Drug / Resident	Ordered By	Date Ordered	Received By	Qty	Date Received	Rx Number
P.N.	Blood Glucose Test Strip 50 STR DAT; MPLN - Meadow Park London Long Term C... L11 - D; Classic Care Pharmacy 08-Sep-2014		27.9.14			27.9.14	
J.B.	HYDROmorphone HCl 1mg; MPLN - Meadow Park London Long Term C... L11 - B; Classic Care Pharmacy 08-Sep-2014		Sept 28/14		30	28.9.14	
K/L Units	Pls send 50 copies of Medication Reconciliation and Admission Order Form	B	Sept 25/14				
D.D.	Ind #3 ½ Tab; Oral QID PRN		Sept 26/14			26.9.14	
R.M.	Nitroglycerin 0.4mg/hr 30 PAT MYL; MPLN - Meadow Park London Long Term C... K21 - D; Classic Care Pharmacy 24-Jul-2014		25.9.14	BW	1	9/25/14	39201014
D.G.	HYDROmorphone HCl 1mg 15 TAB PMS; MPLN - Meadow Park London Long Term C... K6 - A; Classic Care Pharmacy 19-Sep-2014	NB RN	26.9.14				
L.B.	...cellulose 667mg/ml 500 ML RPL; MPLN - Meadow Park London Long Term C... K1 - C; Classic Care Pharmacy 10-Feb-2014		25.9.14	BW	1	9/25/14	39201185
H.M.	Advair; discus	IB RN	26.9.14	BW	1	9/26/14	39212309
A.V.M.	Loperamide HCl 2mg; MPLN - Meadow Park London Long Term C... L13 - A; Classic Care Pharmacy 25-Aug-2014		25.9.14		30	28.9.14	
M.B.	Acetaminophen/Caffeine/Codeine Phos 30... 30 TAB; MPLN - Meadow Park London Long Term C... K21 - A; Classic Care Pharmacy 22-Sep-2014		28.9.14		1	Sept 25 2014	
K.R.	HYDROmorphone HCl 1mg 15 TAB PMS; MPLN - Meadow Park London Long Term C... L10 - A; Classic Care Pharmacy 22-Sep-2014	B	Sept 26/14		30	28.9.14	
M.C.	Morphine Sulfate 5mg 10 TAB PAT; MPLN - Meadow Park London Long Term C... K23 - A; Classic Care Pharmacy 18-Sep-2014		28.9.14		1	Sept 29 2014	
M.A.	TraZODone Hcl 50mg 15 TAB APX; MPLN - Meadow Park London Long Term C... L4 - A; Classic Care Pharmacy 20-Aug-2014	B	Sept 26/14		30	28.9.14	
H.D.	OxyCODONE Hcl/Acetaminophen 5... 30 TAB APX; MPLN - Meadow Park London Long Term C... K15 - A; Classic Care Pharmacy 19-Sep-2014		28.9.14		1	Sept 29 2014	

"PLEASE INDICATE RESIDENT NAME WHEN USING EMERGENCY MEDICATION BOX"

Shipping Report

Classic Care Pharmacy, 112 Newbold Court, London ON N6E 1Z7
Phone: (866) 773-1354 Fax: (866) 773-1355

Report Parameters
Excluding Rxswith batch flag on or in a batch.
Fill Date - 26/09/2014 00:00 to 26/09/2014 23:59
Sort By: Home/Ward/Patient
Med Sort By: Generic Name

Shipping Report

Printed on: 26/09/2014 16:58:37

Narcotics

Home: MPLN - Meadow Park London Long Term Care, Ward: Kent

Patient Name / Rx #	DIN	Qty	Drug	Cards Check
[redacted]	00885944	15	TAB HYDROmorphone HCl 1mg	

Total 1 Rxs

Total Cards _____

Received By _____

Rx:N2163877 Fri 26-Sep-2014 14:23
R: K6 WC:cm

[redacted]

Sex: Female
London, ON DOB: [redacted]
Last TMR Date: 01-Jul-2014 MPLN
[redacted]

15 YAB HYDROmorphone HCl 1mg O/W: Faxed
Script To: Dilaudid 1.Narcotic PMS
DIN: 00885444 9.59/100 Generic Sub Days: 7
Loc: Safe B

Dr. Payne, William L [26217] Doc# 01:26217
330 Pond Mills Rd REFILL
London, ON PART FILL
Phone: (519) 681-5663 No Script Image

1/2 TABLET (0.5MG) BY MOUTH FOUR TIMES A DAY (ALSO HAS PRN ORDER) (RX)

Orig-Rx:2156047 Auth:300 Rem:160 (12)
Prev:19 Sep-14(2162694) Age:7 First: 09-Aug-14(2146047)
Cost:1.44 Mkup:0.12 Fee:8.83 Total: 10.39
Pst:0.00 Disc:2.01 Old Price: 8.38
T.P:8.38 =ODB(8.38), ONNMS(0.00)

Pms-HYDROmorphone DIN: 00885444

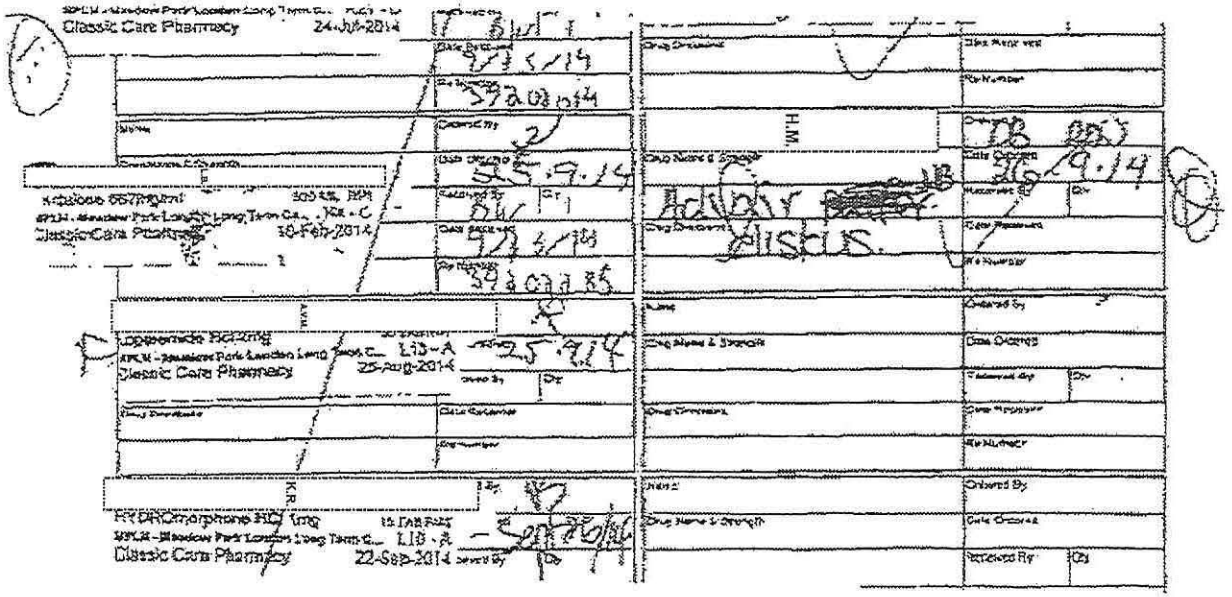
May make you drowsy or dizzy. Drive with caution
Avoid alcohol/other drugs that make you sleepy
Taking a larger dose may cause breathing problems.
Call Dr before increasing dose or frequency.
MD may need to reduce the dose before you stop it.
May be habit forming
Caution: Be careful not to stand up too quickly
Discuss risks/benefits if woman of childbearing age

Allergies
ibuprofen; 'milk; Oranges, Fragrances / Perfumes, Flowers
Conditions
Abdominal Aneurysm, Small Cell Lung Cancer,; Atrial fibrillation; *Cataracts; Chronic Obstructive Pulmonary Disease; Gastroesophageal Reflux; Hypertension; Migraine; Osteoporosis

Name

- ☐ Dose Change
- ☐ Counselling needed
- ☐ Brand changed
- ☐ Medication in fridge
- ☐ Balance owing We owe _____
- ☐ Special Order, please call in advance
- ☐ Additional info. needed _____

Rx Start: 09-Aug-2014 17:42
Cycle: Kent, Med Type: 1.Narcotic, Card. 1



P.R.N.

CLASSIC CARE PHARMACY Corp.

D.G. 20-Aug-2014

MPLN - Kent RKG B-A Refills: 12

Dr. Payne, William (26217) DIN:00045444 PHS

15 TAB HYDROmorphone HCl 1mg

Equiv. To: Dilaudid

1/2 TABLET (0.5MG) BY MOUTH EVERY 4 HOURS AS NEEDED (NEED RX) (ALSO HAS REGULAR ORDER)

Rx: N2157752

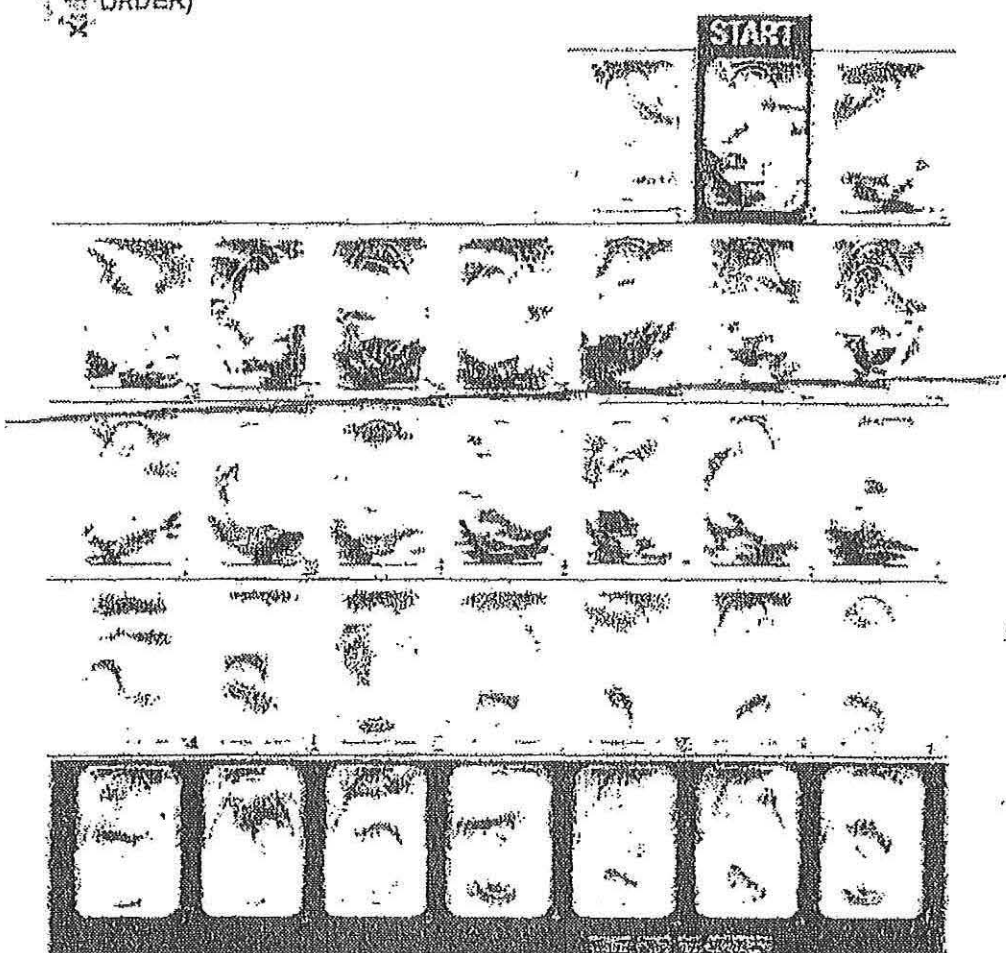
D.G.

HYDROmorphone HCl 1mg

[illegible]

Classic Care Pharmacy 20-Aug-2014

REORDER



CLASSIC CARE PHARMACY

"Setting the Standard for Care"

Burlington - Ottawa - London - Orillia

CLASSIC CARE PHARMACY

Resident's Individual Narcotic and Controlled Drug Count Sheet

CLASSIC CARE PHARMACY Corp.

D.G. — 16-Sep-2014 — Refills: 13
MPLN - Kent — RK6 B:A
Dr. Payne, William E (26217)
Rx: N2162694
15 TAB HYDROmorphone HCl 1mg
Equiv To: Dilaudid
1/2 TABLET (0.5MG) BY MOUTH FOUR TIMES A DAY (ALSO HAS PRN. ORDER) (RX)

Each Narcotic Rx Number Must Have It's Own Count Record

Date	Time	Quantity Given	Quantity Wasted	Quantity Left	Signature of Person Administering or Receiving Medication
Amount Received from Pharmacy →					
22.9.14	1130	½		29	
22.9.14	1630	1		28	Bw
22.9.14	0130	1		[illegible]	Bw error Bw
22.9.14	2015	1		27	Bw
23.9.14	[illegible]	½		26 ~~27~~	
23.9.14	[illegible]	½		25 ~~26~~	
23.9.14	1700	1		24	
23.9.14	2100	1		23 ~~24~~	
24.9.14	0800	½		22 ~~23~~	
24.9.14	1130	½		21 ~~22~~	
24.9.14	1700	½		20	AT
24.9.14	2000	½		19	AT
25.9.14		1		18	EJ
25.9.14		1		17	EJ
25.9.14	1600	1		16	
25.9.14	2045	1		15	Bw
26.9.14	0735	1		14	
26.9.14	1130	1		13	
26.9.14	1600	1		12	Bw
26.9.14	2100	1		11	Bw
27.9.14	0800	½		10	
27.9.14	1130	½		9	
27.9.14	1700	1		8	
27.9.14	2100	1		7	
28.9.14	0730	½		6	
28.9.14	1100	½		5	
28.9.14	1700	1		4	
28.9.14	2100	1		3	
29.9.14	0730	½		2	
29.9.14	1130	½		1	

* For Disposal Only - Circle remaining quantity above and draw a diagonal line through remaining spaces *
* When completed, place sheet and medication for disposal together in double-locked location designated for narcotic and controlled drugs awaiting disposal *
* In LTCH's, all narcotic and controlled drugs will be denatured by Rx/Rp creation in a waste container with water and/or discontinued liquid medication when they are destroyed *

Circle reason for destruction: Discontinued — Deceased — Discharged — Other: ______

Quantity Remaining: ______ — Quantity Destroyed: ______

Signature of Reg Personnel: ______ Removal Date: ______ — Signature of Reg Personnel: ______ Destruction Date: ______

Signature of Reg Personnel: ______ Removal Date: ______ — Signature of Reg Pharmacist: ______ Destruction Date: ______

In LTCHs, circle means of destruction: Tabs/caps removed from blister — Liquid poured — Patch folded onto itself — Ampoule cracked/vial emptied — Other: ______

[illegible] 24.2014 1630 1 C C

CLASSIC CARE PHARMACY

PRN

Resident's Individual Narcotic and Controlled Drug Count Sheet

CLASSIC CARE PHARMACY Corp.

D.G. | 20-Aug-2014
Refills: 18
Dr. Payne, William
15 TAB HYDROmorphone HCl 1mg
Equiv To: Dilaudid
1/2 TABLET (0.5MG) BY MOUTH EVERY 4 HOURS AS NEEDED (NEED RX) (ALSO HAS REGULAR ORDER)

N2157752

Each Narcotic Rx Number Must Have It's Own Count Record

Date	Time	Quantity Given	Quantity Wasted	Quantity Left	Signature of Person Administering or Receiving Medication
Amount Received from Pharmacy				30	
9/18/14	0415	I		29	[illegible]
9/18/14	0430	I		28	MJ
9/22/14	0600	II		27	[illegible]
9/26/14	2345	i		26	MJ
Sept 29 2014	2045	i	regular dose	25	[illegible]
Sep 30/14	0400	i	Regular dose	24	[illegible]
Sept 30/14	1200	i	Regular dose	23	[illegible]
Sept 30/14	1700	I	Regular dose	22	[illegible]
Sept 30/14	2000	I	Regular dose	21	[illegible]
Oct 1/14	0445	I	[illegible]	20	MJ
Oct 1/14	0800	1		19	[illegible]
Oct 1 2014	1200	i		18	Julie
Oct 1 2014	1700	i	regular dose	17	[illegible]
Oct 1 2014	2042	i	regular dose	16	[illegible]
2.10.14	0800	1		15	[illegible]
2.10.14	1200	1		14	[illegible]

* For Disposal Only - Circle remaining quantity above and draw a diagonal line through remaining spaces *
* When completed, place sheet and medication for disposal together in double-locked location designated for narcotic and controlled drugs awaiting disposal *
* In LTCH's, all narcotic and controlled drugs will be destroyed by ... in a ... container with other and/or discontinued liquid medications when they are destroyed *

Circle reason for destruction: Discontinued | Deceased | Discharged | Other: ____

Quantity Remaining: ____ | Quantity Destroyed: ____

Signature of Reg Personnel | Removal Date: | Signature of Reg Personnel | Destruction Date:
Signature of Reg Personnel | Removal Date: | Signature of Reg Pharmacist | Destruction Date:

In LTCH's, circle manner of destruction: Tabs/caps removed from blister | Liquid poured | Patch folded onto itself | Ampoule cracked/vial emptied | Other ____

I am driver for Classic Care Pharmacy. License Plate#_____
If you have any concerns please contact the On-Call Pharmacist @ 855-518-4406

DRIVER: BLUE BAGS HORACE FRIDAY RUN DATE Sept. 26 2014

HOME	# OF BAGS/ BOXES	WHITE BAGS	OTHER	CPL MAIL	RECIPIENT SIGNATURE	ARRIVAL TIME	RETURNS
RGTN THE VILLAGE NURSING RIDGETOWN 519-674-5427	BAGS 1		1 ENV		RGTN	1850	
RGTE RGTR	BAGS BOXES 1 BAGS 1	1			RGTE, RGTR	1855	
BLNM BLENHEIM VILLA BLENHEIM 519-676-8119	BOXES 1 BAGS 2	2			BLNM	1915	
BCVR BLENHEIM RETIRE BLENHEIM 519-676-8119	BOXES 1 BAGS 1		1 ENV		BCVR	1916	
MPCH 1160 SANDY STREET CHATHAM 519-351-1330	BAGS 2	2			MPCH	1840	
BANW BANWELL GARDEN TECUMSEH 519-735-3200	BOXES 2 BAGS 3	1	1 ENV		BANW	2105	
RSID RIVERSIDE WINDSOR 519-974-0148	BAGS 2	1	6 ENV		RSID	2115	
BERKS 4 BERKSHIRE PLACE WINDSOR 519-256-7868	BAGS 6		LOCK BOX (1) 1 ENV		BERKS 4	2145	
LIFE LIFETIMES RIVERSIDE WINDSOR 519-948-5293	BAGS 1	1			LIFE	2130	
ILEN 111 ILER AVE ESSEX 519-776-9482	BOXES 4 BAGS 2				ILEN	2012	
ILER 111 ILER AVE ESSEX 519-776-5243	BAGS				ILER		
HERO 11350 McNorton St. Windsor 519-979-8717	BOXES 5 BAGS 3		LOCK BOX (1)		HERO	2102	
MPLN 1210 SOUTHDALE ROAD LONDON 519-686-0484	BAGS 4	3			MPLN		
BROMA 11900 Brouillette Court Tecumseh 519-735-9810	BAGS 1		LOCK BOX 2 ENV		BROMA	2052	

Meadow Park (LONDON) Inc.

TIME SCHEDULE: RN'S

(D) 0630-1430 (E) 1430 - 2230 N- 2230-0630

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
Aug 10/14-Sept 7/14 Subject to change	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6
Heather Nicholas DOC		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Melanie Smith Co-Doc		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Christina Gluette Staffing Coordinator		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Valerie Boult Staff Educator		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Stephanie Cardoso Staff Educator		D	D	D	D	D			D	O	D	D	D			D	D	D	D	D			D	D	D	D	D	

ELGIN/OXFORD

Vanna Sok FIL	D	D			D	D			D	D	D	D		D	D	D		D	D	D			D	D	D	D		D
Lucy Spasic	D		D	D		D EO	E	E		D EO							D			D EO	D	D		D EO			D	
Arlene Esler	E	E	E	E	E		E	E	E		STAT	STAT	V			V	V	V	V		V	STAT	E		E	E	E	

KENT/LAMBTON

(owned by Andrea Vaincourt) Linda Smith c/o		D	D	D	D		D	D	D		D	D	D			D	D	D	D		D	D	D		D	D	D	
Dottie Duncan			E			S	S	S		S			E KL				V			V	E	E		E			E KL	
Elizabeth Wettlaufer	E	N		E	N	E			E	E	E	E		E	E	E		E	E	E	D	D	E	E	E	E		E

NIGHTS (Kent/Lambton)

Felina Cabrera		N	N	N	N	N		N	N	N	N	N	N	N		N	N	N	N			N	N	N		N	N	N
MaryAnn Flynn	N			N		N	N			N	N				N					N	N				N			

NP-NICU BAND

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Meadow Park (LONDON) Inc.

TIME SCHEDULE: Casual RN'S

(D) 0630-1430 (5) 1430 - 2230 N- 2230-0630

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
Aug 10,2014-Sept 7,2014 Subject to change	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6
Lia Dionysakopoulos		E E/O								E E/O	E/O	E/O	E	E E/O	E/O		E	E	E/O	E/O								Ekl
Lucy Spasic as of 8/19/14																					V	V	V	V	V	V	V	Dkl
Gabrielle Gogas								KL D		E/O E/K			E/O E		E	E E/O	E										D E/O	
Ameena Rahaman	D E/O						D						E	E/O D	E/O D		E/K						D					
Maria Mackiewicz																												
Fedaa Izreig N/A																												

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LTCI0007201

... SCHEDULE: KPN'S

(D) 0630-1430 (5) 1430 - 2230 N- 2230-0630

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
Aug 10,2014-Sept 7,2014	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6

ELGIN/OXFORD

Chandra Chunilall	D	D		D	D	D	D		V	V	V	V		V	V	V		V	V	V			STAT	D	D	D	D	
Alexandra Atsriku			D				D			D		D	D				D				D		D			D		D
Cassidy Pizarro			D	D	D					D		D	D	D	D			D	D					D			D	D
Jen Stewart-Paff		D	eso							V			V	V	V	D	eso	D									eso	5
Susan Proctor		5	5	5	5		5	5	5		5	5	5			5	5	5	5		5	5	5		5	5	5	

KENT/LAMBTON

Julie Nooren		V	V	V	V						V	V	V	V		V	D	D	D					D	D	D	
Nicole Bailie		D	D					D	D		D					D	D			D		D	D		D			
Linda Pridham	5	5			5	5					5	5		5	5	5			5	5					5	5		5
Khushbu Patel							5	5											E		5	5						

NIGHTS (Elgin/Oxford)

Peter Glebe owned by Joan Lennox	N	N	N	N		N	N	N							N	N	N	N		N	N	N		N	N	N		
Christina Cain owned by Peter Glebe					B				N				N	N			NO		N				N				N	N

5* =Floats where needed

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LTCI0007201

Meadow Park (LONDON) Inc.

TIME SCHEDULE: CASUAL RPN'S

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
Aug 10,2014-Sept 7,2014 Subject to change	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4	5	6
Maria Ivanovski																												
John Anderson																												
Beena Joseph																												
Bancy Varghese																												
Lucia Miron																												
Ansu Thomas																												
Smitha Benny																												
Reeja Siby																												
Jomy Jose																												
Gail Copeland																												

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Meadow Park (LONDON) Inc.

TIME SCHEDULE: RN'S

(D) 0630-1430 (S) 1430 - 2230 N- 2230-0630

Sept 7/14 - Oct. 4/14	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4
Heather Nicholas Director of Care		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Melanie Smith Co-Director of Care		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Christina Goetter Staffing Coordinator		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Valerie Boult Staff Educator		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
Stephanie Cardoso Staff Educator		D	D	D	D	D			D	D	D	D	D			D	D	D	D	D			D	D	D	D	D	
ELGIN/OXFORD																												
K/L Vanna Sok	D	D		D	D	D			D	D	Stat	S		D	D	D		D	D	D			D	D	D	D		D
E/O			D				D	D		D							D				D	D		D				
Arlene Esler		E	E	E	E		E	E	E		E	E	E			E	E	E	E		E	E	E		E	E	E	
KENT/LAMBTON																												
Linda Smith owned by: Andrea Valincourt		D	D	D	D		D	D	D		D	D	D			D	D	D	D		D	D	D		D	D	D	
Dottie Duncan			E KL			E E/O	E	E		E KL			E KL				E KL			E	E	E		E			S	
Elizabeth Wettlaufer	E	S		Stat	N/A	N/A			E	E	E	E		E	E	E		Absent	E	E			Absent	Absent	Absent	Absent		Absent
NIGHTS (Kent/Lambton)																												
Felina Cabrera		N	N	N	N			N	N	N		N	N	N		N	N	N	N			N	Stat	N/A		N	N	N
MaryAnn Flynn	N					N	N				N				NF					N	N		Np	N	N			

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Meadow Park (LONDON) Inc.

TIME SCHEDULE: Casual RN'S

(D) 0630-1430 (5) 1430 - 2230 N- 2230-0630

Sept 7/14 - Oct. 4/14	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4
Lia Dionysakopoulos	E													E	E													
Lucy Spasic	D													D	D													D
Gabrielle Gogas						S									Np							S					
Ameena Rahaman				Ep						Dp										Dp				Dp				E
Georgina Soares		D ORIEN	D ORIEN	D ORIEN							S	E ORIEN																

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Meadow Park (LONDON) Inc.

TIME SCHEDULE: RPN'S

(D) 0630-1430 (5) 1430 - 2230 N- 2230-0630 (T)Trade (Green Box) Staff Trading the Shift/Not working

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F
Sept 7/14 - Oct. 4/14	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3
ELGIN/OXFORD																											
Chandra Chunilall	N/A	N/A		N/A	N/A	N/A			N/A	N/A	N/A	N/A		D	D	D		D	D	S			D	D	D	D	
Alexandra Atsriku	5T		D			D	DT			D		D	D		5T		D			S	DT			S		D	D
Cassidy Pizarro	D	5P		D	S	S				D			D	D	D			V	V				Ekc	D	Ekc		D→E
Jen Stewart-Paff	5T		BSO	DT		5T	DT			BSO			5T	6T	5T		6T	DT		D	DT			BSO			4 hrs +S
Susan Proctor		5	5	5	5		5	5	5		5	5	S			5	5	S	5		STAT	STAT	5		5	5	5	
KENT/LAMBTON																											
Julie Nooren		D	D	D	D		V	V	D		D	D	D			D	D	D	D		D	D	D		D	D→E	
Nicole Bailie		D	D			D	Dp	D	D		D	Dc	DP			D	D		DP	D		D	D		D		S(am)
Linda Pridham	S	S		5	5	5			5	5	5	5		5	5	5		5	5	5			Stat	5	5	5		
Khushbu Patel	5P				5P		5	5													N/A	5		Ekc			
NIGHTS (Elgin/Oxford)																											
Lucia Miron covered by Joan Lennox	D	D		DT	D	D		Np		Nc			5T		N	N	N	N		N	2.5hr +N	N		N	N	N	
Peter Giebe	N	N	N	N		N	S	STAT	N	N/A	N/A	N/A							N				N				N

5* =Floats where needed

Please do not remove this original

Meadow Park (LONDON) Inc.

TIME SCHEDULE: CASUAL RPN'S

D) 0630-1430 (5) 1430 - 2230 N- 2230-0630 (₸)Trade (Green Box) Staff Trading the Shift/Not working

Sept 7/14 - Oct. 4/14	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S
	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4
Maria Ivanovski							D	D			Dp																	
John Anderson																					S left @ 1900	5						
Christina Cain					N	5₸			N				N	N			5₸											
Beena Joseph		Ec			Dc				Dc	5p	S																	
Ansu Thomas			5			Dc		Dc	S	D		D		5₸			D	D₸	Dp		5p		5p	5		Dc		Dc
Smitha Benny						5c				Absent	N	N								5	S							
Jomy Jose																								5 ORIEN				Ekp
Gail Copeland		D ORIEN	Dp							D ORIEN						resign			resign			resign			resign			resign

Please do not remove this original

LTCI0007201 1

Just wanted to do a recap on the series of events that happened this evening and the conversations that occurred around the concerns. If you happen to get a call from James regarding this in my absence then you have a reference.

1. Dottie came and spoke to me asking how Beth was. She stated that the Classic Care Driver had asked when delivering meds last evening how the nurse was that had over dosed (staff had assumed it was Beth as her absence???) I expressed to Dottie (RN) that Beth was fine but stated that I was not confirming anything about any over dose, and asked that there be no further conversation about any questions. And I left the building. (needed to think how I was going to handle)
2. When I arrived home, I called Tanya as I was concerned about why the driver would have known about this nor had the right to discuss with our staff. I had to attend an appointment around the time having discussion with Tanya, as did she so we decided to reconvene our discussion later this evening.
3. I received a call from the facility at approximately 1920, Dottie stating that Rudy from Classic Care had called and requested to speak with me. She gave me his phone number. I then also spoke with Arlene and asked that she share with me the comments that had been made by the drive from classic care the night before. She stated that when he came in there conversation lead to him asking about how the nurse was that overdosed. When Arlene responded that she didn't know what he was talking about, he replied by saying something like "I have been in this industry a long time and it is not unheard that an RN take narcotics". I asked Arlene to write down the discussion on paper, place in a sealed envelope and place under my door. I also requested that the conversation not be shared with anyone else.
4. I then called Rudy back around 2015 and had discussion. Rudy felt that the conversation that Horse (CC driver) had was out of concern for the nurse and meant no harm. I expressed my concerns that staff were not aware of the issue with the overdose as it was personal and confidential to the staff member despite its relevance to the case of missing narcotics. He stated that Peter, Griese and Jennifer Brown had also been contacted thru the evening. Rudy stated he had spoke to Horse as well and they would be discussing this concern internally tomorrow as well.
5. I then called Jenn Brown to explain the reason for the initial call so she was aware of the chain of events transpiring. She was reassured that James Abraham was aware of the occurrence and investigation. She was also reassured that the CIS had been completed by Heather and Melanie on Thursday evening (day of findings) and police involvement. She was also informed that the investigating officer had phone my cell late day today requesting that I return his call tomorrow to touch base as to the progression and status of the investigation.
6. I then called Heather and informed of the series of events this evening. Heather had stated on the phone that Dottie had spoke to earlier about the missing card but did not at that time mention that she was aware of the nurse overdosing comments from the delivery employee.

Hope this information is helpful. We can then copy and paste this to a report if it is required by head office or classic care.

Mel

PHYSICIAN'S NOTES
MEADOW PARK (LONDON)

RESIDENTS NAME:
PHYSICIANS NAME:
ROOM #:

DATE	TIME	PHYSICIAN'S NOTES
Oct 7/14		Horace (driver from Classic Care Pharmacy) delivered medication today @ evening. After signing for meds he asked "How is she?" I said "what, I don't know what you're talking about." He said "she overdosed, that's what I heard". I had no idea what he meant. He said "you know, last week... I've been in this business a long time and it's nothing new for an RN Nurse is an addict to steal narcotics from a nursing home. It happens all the time." I said that I didn't know anything about that. He acted like I should know what he meant saying "oh, come on."
		Kahler RN

LTCI00072011

This is Exhibit "E" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.,
Province of Ontario, while a Student-at-Law.
Expires June 20, 2020.

Thursday September 25, 2014

Attention Heather Nicholas

MeadowPark Nursing Home

London Ontario

Dear Heather: Thank -- you for the opportunity to work as a registered nurse here at MeadowPark Nursing Home. I have enjoyed and appreciated the opportunity to use my skills and knowledge. I have also enjoyed the opportunity to continue to learn people management skills.

Unfortunately, I must tender my resignation. I have an illness which will require long term treatment.

I will be unable to work during this treatment and also unable to work as an RN following treatment.

It is therefore with huge regret that I tender this resignation effective Wednesday October 15, 2014.

Thank you

Bethe Wettlaufer RN

Received Sept 25/14

This is Exhibit "F" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.,
Province of Ontario, while a Student-at-Law.
Expires June 20, 2020.

Narrative: **CIVILIAN WITNESS STATEMENT - 1**
SMITH, MELANIE
Author: **401041 WHEELER DEREK**
Related date: **Thursday, 2014-Oct-02 at: 15:45**
Related event: **2014110166**

DESCRIPTION OF INTERVIEW LOCATION:
[Interview Room]
OTHER PERSONS PRESENT DURING INTERVIEW:
[
]

I would like you to tell me what happened. Everything you tell us is important, and I will be typing everything you say. I can not type as fast as you can speak, so please talk very slowly. I want to be able to type everything you say, so I will be repeating it back to you. If you feel I am typing something you did not say, please stop me, and we will correct it immediately. Please tell me what happened in this incident, starting at any point you feel is appropriate.

[I guess registered staff could not locate a medication card carrying hydromorphone 1 mili gram, 30 doses. And we order the medication on October 1, 2014. Originally ordered September 26, 2014. there was no documentation of receiving the medication on September 26, 2014 for that one individual card.

October the 2, 2014 registered tag received a phone call from the pharmacy for the request of october 1, for the med re-order as the card had been ordered on September 26, 2014. The pharmacy is classic care, located in Nebold Court in London.

So immediately the staff from that response searched the medication room and cart, and still the cart could not be located. Pharmacy was then informed and sent out a liaison to search the medication room again at our location. They searched the medication room again and secondary med rooms and carts in our facility. This was this morning. They were unable to locate the one card.

So then documentation was assessed as to what was actually received over the last week and the sheet of paper that should of been received along with the one card was no where to be found either.

So then I notified staff and spoke with one person Susan Procter who is a RN. Just to ask what the routine was when medication is delivered and if she was working on the the night of September 26. She was not working She described when medication are delivered they are signed by a registered

nurse and are delivered to the appropriate unit by the registered nurse.

Pharmacy again did a thorough investigation as to when the medications had been ordered and if they had been accounted for when delivered. So then the administrator and the DOC were notified. And you folks were called.

Why do you believe Elizabeth is responsible?

Yesterday after noon beth came into my office. She had resigned to say she was leaving us for medical reasons. And her last day is to be October 15, 2014. And so she worked September 26, 2014 it's on the roster. She came into my officer yesterday. I asked Valerie to be in the office. She had missed days at work. She brought a doctors note in and it said she has an alcohol and drug problem. And she said she almost died last weekend.

She said she was reconsidering to come back after getting treatment but she would be off until January for sure. But she wished to come back here to work. I said I was sorry she was having this problem. And I told her I would think about it. But I had already accepted her resignation.

And then we also have to report this to the ministry.

How much medication was stolen?
There was a total of 15 mg of Dilaudid because it was 30 dosses of Dilaudid 0.5 mg. So that's half tabs. The medications come on a card. So there's 30 have tablets basically. It's hydro morphone so it's 4 times as potent as morphine.

How much does this cost?
Total cost of the card is $8. But if you were to sell it on the street it would be a lot.

When was the medication purchased?
It was September 26, 2014 it was filled by the Pharmacy at 2:23pm. It was delivered here at 6:30 pm roughly.

Who is in charge of ordering?
Nurses are responsible. The doctor prescribes it.

Who was the order for?
D.G. [redacted] She is in Kent unit.

Does one nurse specifically deal with D's medication?
Anyone who is working in the Kent unit. It's on the main floor on the South/West side.

Do you have documentation of the medication being ordered?
Yes.

Who is responsible for receiving the medication?
The registered nurse who's working. The driver gets the nurse to sign to say they got it. We are just waiting on the fax for that info. They are in white bags so usually the Oxford Elgin nurse receives it and they bring it to the Kent nurses. It is personally hand delivered to the nurse they don't lay anywhere.

Where do the medications go from there?
To the locked room and into a locked cart. The room is adjacent to the nursing station.

Who all have access to these rooms?
Only the registered nurses who are on duty. They have the keys on them. They are not aloud to have the keys on them if they are not working.

Do you have any surveillance footage where the medication are dropped off/stored?
No.

When did you release the medication were missing?
Today.

Do you have any idea what day the medication was actually taken?
We believe it was taken September 26, 2014 because it was never checked in. When it was delivered the box was not signed for that one missing card. 2 registers nurse have to count all medications. A count would of done at 11pm. The account didn't account for the new delivery. If it would of been here at that time on September 26 it would of been counted and accounted for.

Beth had signed for other medications for H.M. who is also on her wing on Sept/26/2014 they are accounted for but there is no signature for D.G.'s medication which was stolen. This can be seen on the drug reference sheet we gave you.

We have the Narcotic count as well. Indicating that the new medication received wasn't counted.

Was there any signatures on the rest of the document that was received?
We have the document and we can cross reference the signatures.

Who were the RN's working that night?
It was Dottie Dunan [redacted] she was probably the one who received it. The RN who would of done the account would be Mary Ann Flynn [redacted]. Linda Pridham [redacted]. Linda Pridham [redacted] .Smitha Beeny [redacted]

Beth is the only one who has the key on Kent for the med cart and room.

Who signed to receive the medications on Sept 26, 2014?
It looks like Smitha Beeny. She didn't put the time she was suppose to. We will have to talk to the driver. On the sheet it said 3 white bags, which means 2 narcotic bags. We have 2 of them but we are missing the third.

Did you speak to any other of the employee's in relation to this occurrence?

No. We haven't called them yet. We wanted to confirm because we wanted all the faxes and documention.

Is there anything else you wish to add?
No I think that's it.]

STATEMENT, END TIME: [h]
TIME READ, START: [ ]
TIME READ, FINISHED: [ ]

*** END OF HARDCOPY ***

This is Exhibit "G" referred to in the Affidavit of Melanie Smith, sworn June 18, 2018

Commissioner for Taking Affidavits (or as may be)

Leanna Gail Reiss, a Commissioner, etc.,
Province of Ontario, while a Student-at-Law.
Expires June 20, 2020.

Dr. Jonny Tam
Jonny Tam Medicine Professional Corporation
959 Dundas Street East
Suite 203
Woodstock, ON
N4S 1H2, Canada
Phone: 519 537-6229
Fax: 519 537-2402

Oct 1, 2014

Re: WETTLAUFER, Elizabeth T
DOB: June 10, 1967
857 James Street
Apartment 2504
Woodstock, ON
N4S 8H6, Canada

WORK ABSENCE CERTIFICATE

To Whom It May Concern:

This letter is to certify that above patient was assessed in this office and is recommended to be off until further notice.

Sincerely

Dr. Jonny Tam M.D. _____

Received Oct 01/14