**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 SHERRI TOLEFF

I, Sherri Toleff, of the City of Cambridge, in the Regional Municipality of Waterloo 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 to which I hereinafter depose. Where 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"). I received my Diploma in 2004 from Conestoga College. Following my graduation, I worked for a short time as an RN at Cambridge Country Manner. From 2004 to 2008, I worked in Cambridge at St. Andrew's Terrace as an RN. I became the Director of Care at Telfer Place in 2008, and I left in January 2016.

3. Attached hereto and marked as Exhibit "A" to this my Affidavit is a copy of my Position Summary as Director of Care [Doc ID LTCI00072705]. The Position Summary is an

accurate reflection of my duties as Director of Care with the exception of reviewing all of the resident applications for Telfer Place. Instead, I would review the applications that the Lifestyle Consultant identified as needing my review (for example, if a resident had responsive behaviours). Additionally, there were many other tasks which arose throughout each day and these are captured by the "duties as assigned" portion of the Position Summary.

4. My duties as Director of Care were to oversee clinical care at the home and to manage human resources issues, including recruiting, training, and scheduling. In 2011, I also became the staff educator for the home. I provided orientation at Telfer Place for new employees. I also oversaw the mandatory education provided to staff as required under the *Long-Term Care Homes Act, 2007 ("LTCHA")*.

5. Telfer Place maintained 24-Hour Report Sheets at the nursing desk. Throughout the day Lindsay Astley, who was the Associate Director of Care and a Registered Practical Nurse ("RPN"), and I would review the 24-Hour Report Sheets and she or I would follow-up on any matter as appropriate.

6. We had a lot of meetings at Telfer Place. For example, we had a Morning Manager Meeting every day. Managers from the retirement facility and the long-term care facility attended these meetings with Dian Shannon, who was the Executive Director. We would also have WIG (Wildly Important Goals) meetings every week. The same group of managers would attend these WIG meetings with Dian Shannon.

7. Some of my other duties included implementing policies and speaking with families. Some families visited their relatives daily and some we never saw. It was very busy.

8. Whenever we required an Agency nurse, this resulted in an increase in my workload. First, I had to take the necessary steps to contact the Agency and secure the Agency staff member. If it was a new Agency staff member, I also had to ensure that the Agency staff member received orientation, which I discuss further below. Since new Agency staff members were not familiar with our residents or procedures, it sometimes took them extra time to complete tasks. It was part of my responsibility to ensure that the Agency staff were providing appropriate care and completing required documentation.

9. My office was near the nursing desk. The main entrance was also near my office, so I was able to see anyone walking by. Attached hereto and marked as Exhibit "B" to this my Affidavit is a copy of the Floor Plan of the long-term care floor of Telfer Place [Doc ID LTCI00072533].

10. If we were short staffed, and I could not find replacement staff, I would occasionally work on the floor as the charge nurse.

11. During the time that I worked at Telfer Place, the Executive Director was Dian Shannon. Dian Shannon was not an RN. Dian was in charge of the three types of accommodation within the building (i.e. the seniors' apartments, the retirement living and the long-term care).

12. Under the LTCHA, we have to have a Registered Nurse in the building at all times. Attached hereto and marked as Exhibit "C" to this my Affidavit is a copy of the Staffing Levels within Telfer Place from 2015 onwards [Doc ID LTCI00072535].

13. Recruiting RNs was difficult. The ratio at Telfer Place is 45 residents to one RN. The Nursing and Personal Care Envelope ("NPCE") is used to pay the PSWs, RPNs and RNs. Dian, Lindsay Astley and I would often meet to discuss staffing and the budget. Ultimately, Dian was responsible for the budget.

14. In terms of the use of Agency nurses, I think that Lifeguard was the first Agency we used. The extent of the use fluctuated. We had our own RNs but if they went off on vacation or sick leave, and we couldn't back fill with our regular staff, we would use Agency nurses.

15. I do not remember being involved in arranging the contract between Lifeguard and Telfer Place. I do not recall how we came to use Lifeguard in the first place, or when we started using them.

16. I do not recall being aware of the Revera policy for External Service Provider Agencies during the time I was at Telfer Place. Attached hereto and marked as Exhibit "D" to this my Affidavit is a copy of that policy [Doc ID LTCI00025535].

17. When we needed an Agency nurse at Telfer Place, I would call Lifeguard. I would tell Lifeguard that we needed certain dates covered. We requested that the Agency nurse be familiar with long-term care. We would also ask that the Agency nurses be notified that Telfer Place's long-term care home has a 45 to 1 ratio.

18. If the Lifeguard nurse was new to Telfer Place, he or she would receive orientation. Additionally, before a new Agency nurse's first shift, I would do a College of Nurses of Ontario ("CNO") registration review to make sure that the RN or RPN was in good

standing. The Agency nurses received either four or eight hours of orientation. Orientation was very important because we needed the Agency staff member to be familiar with Telfer Place's policies and procedures.

19. The RN who conducts the orientation for the Agency nurse receives an orientation checklist. The RN and the Agency nurse would have to go through the checklist and we expected the nurses to go through everything on the checklist.

20. Lifeguard was responsible for ensuring that its nurses submitted criminal record checks, including vulnerable sector screening. Telfer Place did not request copies of the criminal record checks. We would not see the vulnerable persons checks. We relied on Lifeguard to make sure one had been obtained.

21. We did not ask for an Agency nurse's references and we did not ask questions about the history of the nurse, other than requesting that the nurse had long-term care experience.

22., Telfer Place also had an "Annual Education for Contracted Services" policy, which I attach hereto as Exhibit "E" to my affidavit [Doc ID LTCI00025545]. Contracted staff were provided with a copy of this document and were asked to sign the last page, which was returned to us for our records. I recall providing this document to contracted staff, such as physiotherapists and hair dressers, and I believe that it was provided to some agency staff. I have no specific recollection of providing a copy of this document to Elizabeth Wettlaufer, and I understand that no signed copy was found in her file. We did not ask Lifeguard what other training or education its staff may have received.

23. If anyone came to me with concerns about a staff member, I would listen to that person's concerns and I would ask him or her any necessary follow-up questions to ensure that I understood the issue. Once I felt like I understood the concern, I would go to the person about whom the concern was about and I would discuss the issue with him or her. If the complaint was something like a staff member was taking too long of a break, for example, I would talk to that person and I would try to resolve it between the staff. I would not usually document these types of complaints or discussions or bring them to the attention of Dian Shannon.

24. If there was a medication error, the Registered staff member, including Agency staff, would have to fill out a Medication Incident Report. The Medication Incident Report would come to me and I would follow up, as necessary. I would notify a resident's Power of Attorney if the medication error affected a resident. For example, if the medication error was a pharmacy error and it was caught before it affected a resident, we would not notify the resident's Power of Attorney. Further, not every Medication Incident Report resulted in notice to the Ministry through a Critical Incident Report - in fact, very few did. Typically, at that time (2015-2016), we would only complete a Critical Incident Report if there was a negative consequence to the resident. At that time, we were not focused on reporting risk of harm but rather actual harm. Today, there is generally more of a focus on reporting risk of harm.

25. At some point we changed to computerized Medication Incident Reports. I do not remember when that was.

26. We are supposed to send all Medication Incident Reports to the pharmacy. There is a section on the Medication Incident Report form which addresses the follow-up steps taken with respect to that incident. If I followed-up with a nurse, I would set out my notes from that conversation on the Medication Incident Report form. If I talked to others I would typically write down what they said. I may not keep those notes.

27. I have had training on how to conduct an independent investigation. I'm not sure if the training was conducted by someone at Revera's head office or by Dian Shannon. Dian came from a Human Resources background, so she taught me how to conduct investigations.

28. I would typically investigate Medication Errors and other issues and I was the person who typically completed Critical Incident Reports for the Ministry of Health and Long-Term Care ("MHLTC") if one was necessary.

29. Given my position, it was not uncommon for staff or family members to bring their concerns to my attention. We encouraged all staff members to report anything that was concerning to them. It was not uncommon for me to receive multiple complaints in any given week. These concerns and complaints were of a varied nature. Some, due to their seriousness or risk for potential harm, we treated more formally than others. On occasion, staff were placed on administrative leave while investigations were conducted. These types of investigations were typically documented. Other concerns or complaints, although taken seriously, did not require the same degree of investigation and consequently, may not have been documented.

30. I was aware that Sandra Towler went to hospital in the Fall of 2015. I don't remember conducting an investigation because no one suspected any wrongdoing. It was not a situation, based on my knowledge at the time, for which I would have completed a Critical Incident Report.

**ELIZABETH WETTLAUFER**

31. Elizabeth Wettlaufer was first assigned by Lifeguard to Telfer Place in February, 2015. Attached hereto and marked as Exhibit "F" to this my Affidavit is a copy of the shift schedule for that time period [Doc ID LTCI00026297].

32. If someone was scheduled to receive orientation at Telfer Place, I would write an "O" beside their name and there would be two RNs working on that shift.

33. Elizabeth Wettlaufer received 8 hours of orientation on February 15, 2015. Attached hereto and marked as Exhibit "G" to this my Affidavit is a copy of the Agency Staff Orientation Checklist for Elizabeth Wettlaufer [Doc ID LTCI00024849].

34. Susan Farley, a Registered Nurse, orientated Elizabeth Wettlaufer. Susan Farley was an RN who had been with Telfer Place for many years. Elizabeth Wettlaufer would have shadowed Susan Farley during that shift.

35. I believe Elizabeth Wettlaufer's Orientation Checklist would have come back to me. I note now that there were some items that were not initialed by Susan Farley or Elizabeth Wettlaufer. I do not recall if I noted this at the time or if I went to Susan Farley about those items that were not checked off. Typically, I would follow up on any

items that were missed during an Agency nurse's orientation but I have no specific recollection of doing so with respect to Elizabeth Wettlaufer..

36. Telfer Place had no formal policy for evaluating Agency nurses. If concerns were brought to my attention, I would typically discuss the matter with the Agency nurse and follow-up with Lifeguard as appropriate.

37. Elizabeth Wettlaufer would be the charge nurse during her shifts at Telfer Place. She would be the only nurse with a key to the medication room and the only one to have a key to the medication cart. It would not be possible to do an independent double check of insulin with another Registered staff on the night shift, because she would be the only Registered staff on shift Best practice, however, is that the Registered Nurse prepares the insulin, puts it down, then comes back to the insulin and checks the dosage again. I do not believe, however, that the Registered staff follow this practice on a regular basis.

38. On the night shift, Elizabeth Wettlaufer was responsible for all of the staff. If someone called in sick for the day shift, Elizabeth Wettlaufer would have to find someone to fill the shift. Telfer Place does not have a staff scheduler. Lindsay Astley, Laura Eaton (our Restorative Care Manager) and I were primarily responsible for Telfer Place's scheduling.

39. Around when Elizabeth Wettlaufer worked her first few shifts at Telfer Place, I remember having to address an issue with respect to her documentation of falls. Elizabeth Wettlaufer was not completing all of the fall assessment documentation. When I learned of this issue, I discussed it with her and I also called Lifeguard.

Elizabeth Wettlaufer resolved the issue and correctly completed the fall assessment documentation thereafter. I probably didn't document those conversations. Typically, I would advise Heidi Wilmot-Smith of any concerns I had with her agency nurses. If I was able to contact Heidi Wilmot-Smith by phone, I probably would not have followed up with an email.

40. I understand that, on October 24, 2015 (which was a Saturday), Elizabeth Wettlaufer was scheduled to work the evening shift (2:00 PM to 10:00 PM). She did not show up for her shift. All though I have no present recollection of this event, since it was a Saturday, I expect that the day nurse contacted me to inform me that Elizabeth Wettlaufer had not shown up for her shift. I probably would have been the person to contact Lifeguard to advise them of Elizabeth Wettlaufer's missed shift. I cannot recall what efforts were made to fill the shift but I note from the shift schedule that the day nurse ended up working a double shift. Later, I received an email from Heidi Wilmot-Smith on October 26, 2015 that attached a letter of apology from Elizabeth Wettlaufer. I attach a copy of Heidi Wilmot-Smith's October 26, 2015 to my affidavit as Exhibit "H" [Doc ID LTCI00017399, Doc ID LTCI00017400]. I understand from the evidence provided to this Inquiry by Heidi Wilmot-Smith that, in addition to being out of town, Elizabeth Wettlaufer reported to Lifeguard that she could not work the shift because she had been drinking. This fact was never reported to me.

41. In the Fall of 2015, I had concerns about Telfer Place's staffing compliment. While I do not recall the conversation specifically, I believe that I spoke with Cheryl Muise (the Regional Manager of Clinical Services) about these concerns. Cheryl and I looked at changing the nursing model so that it would no longer be a 45 to 1 ratio, but it was not

in the budget to do that. We also looked at trying to free up some of our RNs' time by having an RPN be assigned to the coding and RAI/MDS assessments. The general idea was that we wanted to reduce or eliminate our use of Agency nurses because it is always better to have your own staff and because Agency nurses cost more. Attached hereto is Exhibit "I" [Doc ID LTCI00072530] is a copy of a staffing action plan, dated December 2015, with subsequent updates. I do not recall seeing a copy of this document and believe that it was implemented after I left Telfer Place in January 2016.

42. From my review of the shift schedules, I can see that Elizabeth Wettlaufer was scheduled to work the evening shift on December 28, 2015. I believe I was on vacation this week. I remember getting a call from Dian Shannon to let me know that the Agency nurse had called in sick. I recall that I was sitting in a Subway parking lot with my children at the time that I received the call. I believe she told me that arrangements were being made to cover the shift. I cannot recall the particulars.

43. I understand that Heidi Wilmot-Smith has testified at this Inquiry that she and I had a phone call on or about January 15, 2016 while she was on vacation in Florida. I understand that Ms. Wilmot-Smith's testimony was that she had received a call from her office requesting her to call me. Although I have no recollection of this phone call, I do recall that in or about this time, Dian Shannon had concerns about the amount of money we were spending on Agency staff and had entered into a contract with a new agency (Dawn of Angels). It was my understanding that Dawn of Angels was less expensive than Lifeguard. I believe I was interested in discussing with Ms. Wilmot-Smith whether or not Lifeguard would be able to lower its prices.

44. I also understand that Ms. Wilmot-Smith testified at the Inquiry that I advised her of the following during this phone call:

    a. that Elizabeth Wettlaufer had said something to one of the PSWs to the extent that "he could leave his shoes under her bed anytime". I have no recollection of this comment or of relaying that information to Ms. Wilmot-Smith. It is, however, possible that I did so and I just do not recall.

    b. I understand that Ms. Wilmot-Smith testified that I told her that Elizabeth Wettlaufer had disclosed to others that she was a recovering alcoholic. Again, I have no recollection of relaying this information to Ms. Wilmot-Smith or of knowing at this time that Elizabeth Wettlaufer was a recovering alcoholic. I believe that it was brought to my attention at some point before I left Telfer Place that Elizabeth Wettlaufer was a recovering alcoholic but I cannot be certain or recall when.

    That information alone would not have necessarily caused me any concern. I have worked with recovering alcoholics in the past and, provided they are not actively drinking, it has not been a problem. Further, I did not know at the time that Elizabeth Wettlaufer had told Lifeguard that she was drinking again. If that information had been conveyed to me, I would have asked that she not return to Telfer Place, because I would have seen that as a risk to resident care.

45. From my recollection, Elizabeth Wettlaufer always presented appropriately. There was never a time that I thought she was under the influence of drugs or alcohol. Similarly, no

one ever raised with me any concerns or suspicions about Elizabeth Wettlaufer being under the influence of drugs or alcohol.

46. I have read the police statement of Lynn Jackson which is attached hereto as Exhibit "J" to this my Affidavit [Doc ID LTCI00054713]. In that statement Ms. Jackson states that she reported to me that Elizabeth Wettlaufer had spoken of another home in which a resident had put tic tacs in her vagina. I do not remember this incident. While I do not remember this incident, I vaguely recall hearing that Elizabeth Wettlaufer made an inappropriate comment while on shift at Telfer Place. I do not remember what the comment was.

47. I also remember hearing that Elizabeth Wettlaufer had asked one of our PSWs to be a sperm donor. I'm not sure when this occurred. I am sure that I would have called Heidi Wilmot-Smith about the sperm donor comment. I don't remember if I spoke to the PSW directly about the incident. I don't remember if I talked to Elizabeth Wettlaufer about the incident.

48. If I had any concerns about Elizabeth Wettlaufer, I would go through Heidi Wilmot-Smith because Heidi Wilmot-Smith was Elizabeth Wettlaufer's employer.

49. I have no independent recollection of these incidents but I believe that I would have brought them to Dian Shannon's attention. I always let Dian Shannon know what was going on in the home. I don't believe I documented my discussions with the staff or Dian Shannon. We were very busy. I didn't always write things down.

50. Tracy Raney used to raise any concerns she had to me. She would bring her concerns to me in person or she would sometimes send me emails. Tracy worked the 2:00 PM to 10:00 PM shift and I usually left around five. There was not a lot of overlap between us.

51. I did not hear Elizabeth Wettlaufer talk about her sexual orientation. I don't recall anyone raising it with me. I don't recall Tracy Raney reporting that Elizabeth Wettlaufer kept telling a resident how much she loved her and that, because of the times now, they could get married.

52. In terms of Tracy Raney's email of January 6, 2016 regarding Elizabeth Wettlaufer leaving the medication door open, it would have been my practice to speak to Elizabeth Wettlaufer about that issue. We had a sign on the medication room door to remind RNs that the door needed to be kept locked. This had been posted before Elizabeth Wettlaufer started working with us, as a reminder to all staff to keep the door closed. I didn't document any conversations I may have had with Elizabeth Wettlaufer about the medication room door incident. Although I have no specific recollection of doing so, I believe that I may have mentioned this incident to Heidi Wilmot-Smith, but I am not certain. Attached hereto and marked as Exhibit "K" to this my Affidavit is a copy of the email [Doc ID LTCI00072536].

53. I do not recall Tracy Raney's email of January 10, 2016. I have no reason to believe, however, that I did not receive the email. If there is a bleed after a resident's toenail care, typically the foot care nurse would tell the RN who was on shift. The RN would be expected to make a note in the progress reports, treatment record and the 24-Hour

Shift Report and to discuss it with the incoming nurse at the shift report. We would monitor it and contact the family. Although I have no recollection of Tracy Raney's email, I believe that I would have conveyed the complaint to Dian Shannon and I would have spoken to Elizabeth Wettlaufer. Further, although I have no specific recollection of doing so, it would have been my practice to relay a complaint of that nature to Heidi Wilmot-Smith. Attached hereto and marked as Exhibit "L" to this my Affidavit is a copy of the email [Doc ID LTCI00024212].

54. I do not recall the second issue raised in Tracey's email, being the issue of the resident with sleep apnea. Best practice in such a circumstance would depend on what is going on with the resident. It could be just a progression of her disease and there may not have been a need to call the doctor. Once it gets to a certain point, however, you would call the doctor and put the appropriate drug regimen in place. Although I have no recollection of doing so, I think I would have gone to Tracy Raney for further clarification and I would have looked at the resident's chart. I would also have gone to Elizabeth Wettlaufer to ask what had happened.

55. I resigned from Telfer Place in January 2016. After my resignation, for a short period of time, I split my hours between Telfer Place and Riverbend during the month of January 2016. By the end of January 2016, I was at Riverbend full-time.

56. I understand that Heidi Wilmot-Smith testified at the Inquiry that she reached out to me in May 2016 to schedule a meeting. I do recall her reaching out to me, but she did not indicate why she wanted to meet with me. I do not recall having actually scheduled a meeting but I do know that we never met. At no point in time did Ms. Wilmot-Smith

indicate to me that she wanted to discuss Elizabeth Wettlaufer. I have no further recollection about this incident.

**THE IMPACT OF ELIZABETH WETTLAUFER'S CRIMES**

57. In my experience, those who work in Long-Term Care are by and large caring individuals, who have the sincere best interests of the residents at heart. It is personally troubling to me that an Agency staff person at Telfer Place would have intentionally harmed a resident. I certainly saw no sign at the time that would have indicated to me that Elizabeth Wettlaufer was capable of the crimes to which she has now confessed. I am hopeful that the attention this Inquiry is bringing to the Long-Term Care industry will result in positive changes. I do not know, however, if those changes could have prevented Elizabeth Wettlaufer from committing her crimes.

58. I swear this affidavit for no improper purpose.

**SWORN BEFORE ME** at the City of St. Thomas, in the County of Elgin on June 26, 2018

Commissioner for Taking Affidavits
*(or as may be)*

This is Exhibit "A" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

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# Position Summary

## Director of Care (LTC)

Reporting to the Executive Director of the home, the Director of Care is responsible for planning, directing, coordinating and supervising the overall nursing program for residents within the home.

### KEY RESPONSIBILITIES

- To facilitate and promote the interdisciplinary approach within the home through the Nursing, Dietary, Activation, Environmental Service and Administrative Departments
- To review all resident applications for admission to determine appropriate level of care; assist with processing of admission and discharge papers
- To implement and monitor control and safekeeping of drugs and narcotics supervise the drug administration program including the administration of medication by all registered staff
- To direct and monitor the maintenance of health care records to ensure compliance with regulations and quality care for the resident
- To participate in Care Conferences as appropriate, meet with residents/family to resolve problems/ concerns/complaints
- To assist the Executive Director by collaborating with the Medical Advisor to ensure that medical attention and records are in compliance with regulations
- To hire, orient, schedule To assist the Executive Director in ensuring staff are knowledgeable about Resident Bill of Rights and Health and Safety Standards
- To monitor and review resident care staff compliance with all facility policies and procedures, including safety rules and safe working practices
- To comply with all relevant Provincial and Federal Acts and Regulations
- To assist the Executive Director with budget preparation and implementation for the Nursing Department
- To participate in the review process by regulatory bodies
- To investigate complaints
- To co-ordinate and monitor the Infection Control Program for the Nursing Department
- To assume administrative duties as required in the ED's absence

- To uphold and promote the organization's values and philosophy relating particularly to ethics, morality, and integrity as set out in Revera's Code of Conduct
- To complete all other duties as assigned
- Supervise and evaluate the performance of nursing personnel; including use of disciplinary process in conjunction with Executive Director

## QUALIFICATIONS

- Minimum of one (1) year of experience working as a Registered Nurse in the long-term care sector
- Minimum of three (3) years of experience working as a Registered Nurse in a managerial or supervisory capacity in a health care setting
- Current registration as a Registered Nurse with the applicable Provincial license body is required as well as the successful completion of Nursing Unit Administrator Program, BScn, MN, or equivalent and a program in Gerontology or equivalent
- A minimum of three years relevant experience in organizational management and/or long-term care
- Current C.P.R. designation required
- Demonstrated leadership and communication skills
- Possession of strong motivational, team building and time management skills
- Professional competencies related to life-long learning, public relations and health environment awareness
- Must be computer literate in Microsoft Office Suite
- Proficiency in a second language is considered an asset.

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This is Exhibit "B" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

LTCI0007253

LONG TERM CARE
ROUTES OF EVACUATION

Emergency Exit

Emergency Exit Courtyard

Emergency Exit Main Door

Emergency Exit

L.T.C.

Med Room

Rm 101 B
4 Bed ward Rm.
from Feb 12 2016
- Sept 27 2016
one room in Rm
105.

UNIT 111
UNIT 109
UNIT 107
UNIT 105
UNIT 103
UNIT 101
ACTIVITY ROOM
TUB
UNIT 108
UNIT 104
UNIT 102
UNIT 100
LOUNGE
UNIT 201
UNIT 203
UNIT 205
UNIT 207
TUB
UNIT 216
UNIT 217
UNIT 219
CORRIDOR
UNIT 200
UNIT 202
UNIT 204
UNIT 206
UNIT 208
UNIT 210
UNIT 212
UNIT 214
UNIT 216
DINING ROOM
KITCHEN
STOR
LIFT

This is Exhibit "C" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

## REVIEW OF LTC STAFFING LEVELS - TELFER PLACE

| Month/Year | Shift | Discipline | Hours Scheduled |
|---|---|---|---|
| September 2015 | Day | RN | 7.5 hours |
| | | RPN | 7.5 hrs Mon, Tues, Thurs, Fri |
| | | PSW | 4 X 7.5 hrs & 1 X 6 hrs |
| | Evenings | RN | 7.5 hours |
| | | RPN | 0 |
| | | PSW | 4 X 7.5 hrs & 1 X 4 hrs |
| | Nights | RN | 1 X 7.5 hrs |
| | | RPN | |
| | | PSW | 1 X 7.5 hrs |
| December 2015 | Day | RN | 7.5 hours |
| | | RPN | 7.5 hrs Mon, Tues, Thurs, Fri |
| | | PSW | 4 X 7.5 hrs & 1 X 6 hrs |
| | Evenings | RN | 7.5 hours |
| | | RPN | 0 |
| | | PSW | 4 X 7.5 hrs & 1 X 4 hrs |
| | Nights | RN | 1 X 7.5 hrs |
| | | RPN | |
| | | PSW | 1 X 7.5 hrs |
| December 2016 | Day | RN | 7.5 hours |
| | | RPN | 7.5 hrs Monday- Friday |
| | | PSW | 4 X 7.5 hrs & 1 X 6 hrs |
| | Evenings | RN | 7.5 hours |
| | | RPN | 0 |
| | | PSW | 4 X 7.5 hrs & 1 X 4 hrs |
| | Nights | RN | 1 X 7.5 |
| | | RPN | |
| | | PSW | 1 X 7.5 hrs |
| April 2017 | Day | RN | 7.5 hours |
| | | RPN | 7.5 hrs Monday- Friday |
| | | PSW | 4 X 7.5 hrs & 1 X 6 hrs |
| | Evenings | RN | 7.5 hours |
| | | RPN | 0 |
| | | PSW | 4 X 7.5 hrs & 1 X 4 hrs |
| | Nights | RN | 1 X 7.5 hrs |
| | | RPN | |
| | | PSW | 1 X 7.5 |
| December 2017 | Day | RN | 7.5 hours |
| | | RPN | 7 hrs every day |
| | | PSW | 4 X 7.5 hrs & 1 X 5.5 hrs & 1 X 4 hrs |
| | Evenings | RN | 7.5 hours |
| | | RPN | 5 hrs |
| | | PSW | 4 X 7.5 hrs & 1 X 7 hrs |
| | Nights | RN | 1 X 7.5 |
| | | RPN | |
| | | PSW | 1 X 5 hrs |

| Month/Year | Shift | Discipline | Hours Scheduled |
|---|---|---|---|
| April 2018 | Day | RN | 7.5 hours |
| | | RPN | 7.5 hrs every day |
| | | PSW | 4 X 7.5 hrs & 1 X 5.5 hrs & 1 X 4 hrs |
| | Evenings | RN | 7.5 hours |
| | | RPN | 5.5 hrs |
| | | PSW | 4 X 7.5 hrs |
| | Nights | RN | 1 X 7.5 |
| | | RPN | |
| | | PSW | 1 X 8 hrs & 1 x 6 hrs |

This is Exhibit "D" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

| | | |
|---|---|---|
| **SECTION:** | **Risk Management** | **INDEX:** LP-C-60 |
| **SUBJECT:** | External Service Provider Agencies | **PAGE:** 1 of 4 |
| **APPROVED BY:** | VP, Clinical Services and Quality | **Effective Date:** April 2011<br>**Revised Date:** Aug. 2012<br>*New SOP links Feb. 2014* |

## STANDARD

Accountability and quality risk management standards will be clarified and communicated to external service provider agencies.

External service provider agency staff may be utilized for two reasons:

- Staff replacement; and
- Private duty care/services requested by the Resident/Client/designate for a variety of reasons.

**Revera Home Health (RHH)** is the preferred external service provider agency for the provision of staffing for Revera Retirement (RET) and/or Revera Long Term Care (LTC), within legislative requirements and whenever possible, for private duty care/services for individual residents. RHH meets all required quality and risk standards, and employees from RHH have completed Revera general/frontline employee orientation components, meeting all requirements of the Orientation Checklist.

We have an obligation to allow Residents/Clients/designates to contract private duty care providers and will encourage all agencies to follow the guidelines outlined in Table A below; however, Revera must balance the private contract in place with our obligations to ensure Resident safety and wellbeing in our homes. Furthermore, we must meet jurisdictional procedures and visitor responsibilities. The responsibilities are reflected in Revera policy and procedures, including visitor responsibilities. Revera will not recommend any external service provider agencies that do not comply with its requirements.

## STAFF REPLACEMENT

The risk management and accountability for the use of external service providers for staff replacement is the responsibility of the long term care home. The Executive Director (ED) is responsible to ensure that an agreement is established with the External Service Provider Agency to ensure that the requirements, outlined in Table A, are met. The use of external service providers for staff replacement will comply with all applicable union agreements in place at the Home.

| | | |
|---|---|---|
| **SECTION:** | **Risk Management** | **INDEX:** LP-C-60 |
| **SUBJECT:** | External Service Provider Agencies | **PAGE:** 2 of 4 |
| **APPROVED BY:** | VP, Clinical Services and Quality | **Effective Date:** April 2011<br>**Revised Date:** Aug. 2012<br>*New SOP links Feb. 2014* |

## PRIVATE DUTY

Private duty services, obtained from an external service provider agency, are the responsibility of the individual initiating the services, not the LTC home.

Revera/RHH staff and volunteers cannot be hired as individuals directly by Resident/ Client/designate for private duty services. Revera/RHH employees can be hired through RHH to provide private duty services. RHH is a preferred provider as they meet all Revera Risk Management standards. The ED can provide a brochure to the family for this service.

### *Definitions*

**Designate:** any person with the legal authority to make decisions on behalf of the Resident.

## PURPOSE

To assure the continuous provision of care to Residents and support Residents/Substitute Decision Makers/designates/families in the safe hiring of private duty companions.

## NATIONAL OPERATING PROCEDURE

1. The Home will maintain a list of alternate external service provider agencies within their respective communities that meet Revera's standards. The agency must provide evidence of the following requirements:

**TABLE A – Revera Standards**

| Standard | Requirements |
|---|---|
| Insurance | Comprehensive liability insurance is in place that provides a minimum coverage of $5 million per occurrence. |
| Criminal Record Check | A process is in place to ensure that all employees assigned to the Revera Home have a clear criminal record check and vulnerable persons screening. |

| Standard | Requirements |
|---|---|
| WSIB/WCB | There is evidence that the agency is in good standing with the provincial Workers' Compensation Board. |
| Employee Fitness | A process is in place to ensure that all employees assigned to the Revera Home have clear 2 step TB status upon hire, and have been advised to follow guidelines as set out by the Public Health Agency of Canada related to immunization of health care workers. |
| Other | All employees assigned to the Revera Home are able to communicate with staff in the predominant language of the home (i.e. English, or French if applicable). |

2. External service provider staff will be oriented to the LTC site according to Table B:

**TABLE B - Orientation**

| Staff Replacement | Private Duty |
|---|---|
| • RHS staff hired for staff replacement will complete a general orientation which is documented on the Orientation Checklist [*LTC-L-20-05*]. A Registered Staff orientation checklist will be completed for those in charge positions [*LTC-L-20-10*]<br>• The on site orientation completed at the home prior to the first shift is paid for by the LTC site. This can be shared when it benefits both parties. | • These individuals are hired by the Resident/Client/designate. LTC homes can provide brochures from external service provider agencies that meet the requirements outlined in Table A.<br>• Site-specific orientation is facilitated by a member of the management team. |

| | |
|---|---|
| • Site-specific orientation is facilitated by a member of the management team. | |

**Note:** All Registered Nurses must also complete the Revera RN/RPN/LPN/Charge Nurse orientation which is provide regionally and or by the site based on the established registered staff orientation program.

3. Management at the Home will ensure external service provider employees sign in and out of the home using the site-specific External Service Provider Employee Sign-In Sheet [*LTC-L-20-15*] on arrival at and departure from the site.
4. Management will have a process in place to discuss Resident/Client/designate concerns/suggestions regarding care by the external service provider employee, including but not limited to agency, regulatory bodies, policies, services, as required.

**STANDARD OPERATING PROCEDURE** (province-specific)

LP-C-60-05-ON ~ General Orientation Checklist - Ontario

LP-C-60-10-ON ~ Reg. Nurse Orientation Checklist - Ontario

**QUALITY MANAGEMENT**

All programs have a Quality Management component that includes outcome indicator tracking as well as CQI audit tools to monitor outcomes and identify opportunities for Quality Improvement.

**EDUCATION/RESOURCES**

A comprehensive education program will be available.

**OUTCOME**

Revera quality risk management and client safety standards will be met.

This is Exhibit "E" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

Elizabeth Heyett

*Commissioner for Taking Affidavits (or as may be)*

revera

# Annual Education for Contracted Services

This package is intended for the education/knowledge development of Contracted Service personnel within Revera homes. It is in addition to education & training provided by Marquise to all their personnel.

## Table of Contents

## Revera Mission and Values

At Revera, we believe it is a great privilege and a great responsibility to serve seniors and our other clients. In the spirit of honouring the people we serve, Revera's name is derived from the root word 'revere'. We are guided in all of our interactions by our mission *of enhancing lives with choices in community living, warm hospitality and compassionate care.*

Our Mission and Values make up our corporate identity: who we are, what we do and what our stakeholders can expect. They help us make decisions and set the standard for how we will conduct ourselves and how we differentiate ourselves from our competitors.

Revera Mission:

To enhance lives with choices in community living, warm hospitality and compassionate care.

### *Revera's vision is to "Celebrate the ageless spirit of people through service and innovation."*

The words of our vision have an important meaning in relation to the work that we do:

*Celebrate:* We will recognize, praise, and revere each other and everyone we serve. We will celebrate people in every interaction.

*Ageless spirit:* Everyone is a person first, regardless of age or capabilities. We will value each individual, and nurture his or her mind, body, and ageless spirit.

*People:* We are in a human business. We will have a positive, heartfelt impact on the lives of the people we touch.

*Service*: We will go above and beyond to make each person feel important and appreciated. We will anticipate needs and exceed expectations. We will serve, as we want to be served.

*Innovation*: We will be bold. We will continuously improve and expand to be innovative leaders in ways big and small.

Our core values are the foundation of our company and set the standard for everything we do.

Revera Values:

Respect – Everyone is important

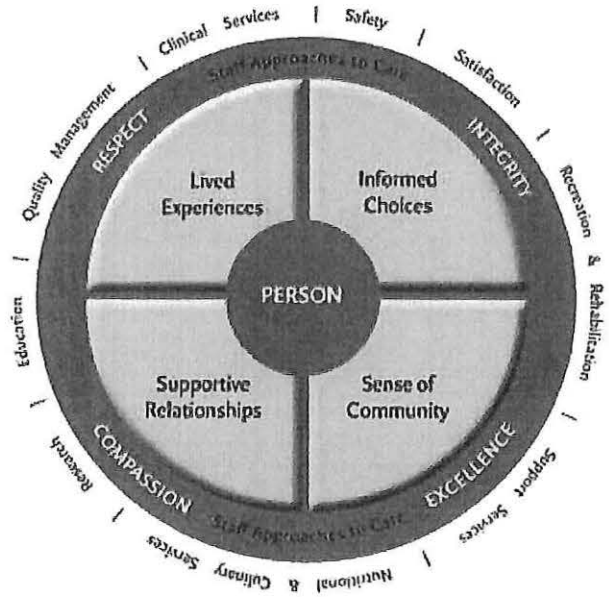
Integrity – Doing the right thing

Compassion – Caring with passion

Excellence – Being the best

**Professional Practice Model**


**Person-Centred Model**




Revera has developed a model of person centred care to depict how all our interactions with our Residents are centered on the needs of the Resident. If we can always focus our care approaches from the perspective of the Resident then the outcomes can lead to improved quality of life, including the prevention of abuse.

There are four areas that support this model of care.

- Consideration for each resident and staff's individual experience
- Collaborative decision-making
- Care for ourselves, our teams, our residents
- Purposeful contributions to our community

Each of these focuses on the holistic approach to care, ensuring that the resident is the heart of our work.

## Code of Conduct & Ethics

We are committed to treating all of our Clients with dignity and respect at all times. It is important to recognize that our places of work are also the homes of our Clients. As such, we must work to promote an atmosphere of comfort and understanding, which supports the provision of excellent care.

Every day, our clients and their families, our owner, lenders, service and product suppliers, our co-workers and the communities we serve put their complete trust in us. This trust is earned by acting honestly and ethically every day, and in everything we do.

All service provider personnel are required to adhere to the Revera Code of Conduct and Business Ethics ("Code"). This Code contains general guidelines outlining how business at Revera Inc. and its subsidiaries are to be conducted to ensure we meet the highest ethical business standards. The guidelines set out in this Code are to be followed by all of us within our organization, including our directors, officers, employees and agents. Please see your Manager for more information.

No matter what your role or position, your job is about caring for people. This includes caring for not only our clients and their families, but also all of the people we serve and interact with. We must all continue to work together to ensure we keep doing the right things in the right ways

The Code of Ethics addresses a number of areas, including:

- Client Care
- Equal Employment & Fair Treatment
- Harassment-Free Workplace
- Health, Safety & the Environment
- Charitable & Political Activities
- Conflicts of Interest
- Gifts, Travel & Entertainment
- Interactions with the Government
- Fraud & Theft
- Use of Company Property
- Unfair Competition
- Proprietary & Confidential Information
- Media Relations, Email, the Internet & Use of I.T. Property
- Record-keeping & Information Management
- Information Requests & Privacy, Signing Contracts & Dealing with Lawsuits
- Reporting Inappropriate Activities

It is important for all personnel to review and adhere to the company's guidelines at all times.

## Ethics

A true ethical dilemma involves a situation where there is no clear and obvious right course of action. Ethics is about making the right decision for the right people for all the rights reasons.

Ethical issues are situations where values come into conflict.

Ethics involves critical reflection on moral/ethical problems faced in health care settings toward:

- deciding *what* we should do
- explaining why we should do it
- describing *how* we should do it (Dr. Barbara Secker)

There is an Ethics lead and committee in each home to provide guidance and resources to all staff and service providers. Revera provides an Ethics Framework to assist with dilemmas.

## Privacy & Confidentiality

Personal information is any information "about" an identifiable individual, in oral or written form. This definition is very broad and covers things like an individual's age, income and opinion. An individual is "identifiable" by information where there is a serious possibility that the individual could be identified from information through the use of that information alone, or in combination with other available information. Personal health information refers to personal information that relates to the health of an individual or the provision of health services. Many provinces have their own laws that address the treatment of personal health information and Revera has legal obligations regarding the protection of this personal health information, and regarding the protection of personal information generally. There are various rules that govern how we must collect, retain, use, disclose and dispose of personal information and personal health information.

Some general rules about privacy are to not disclose, or share with anyone, any health, or other personal information about a client **except** with:

- Only those others within the company or outside authorities/health care practitioners that need to know the information to be able to help care for the resident.

- If the resident is incompetent, only those that are Power of Attorneys or Substitute Decision Makers or if there are none, with next of kin.
- Only those authorities that have a legal right to ask for such information by law, and only to the extent of the requested information.

Failure to comply with privacy legislation could result in any of the following:

- Written warning from the Federal Privacy Commissioner
- Financial penalty imposed from the Office of the Privacy Commissioner or
- Privacy Audit

Examples of safeguards to protect client's personal information:

- Don't leave any resident or employee information, including scheduled visits, in the open;
- Don't leave your computer screen accessible when you are with a resident or stepping away from the computer.
- Don't save resident info on your personal computer or other device
- Always make sure you are in a private place for discussions
- Don't leave a message containing personal information on a home phone
- Always ask to whom you are speaking to on the phone

## Complaint Management

**If You Have a Concern**

Refer to the "If You Have a Concern" poster posted on Information Bulletin Board or speak with your manager or supervisor.

**How to Respond to a Concern**

All Revera staff will immediately respond to concerns or complaints brought forward by residents, families and other stakeholders using the HEART approach. Staff will be responsive in an effort to resolve the issue. When necessary, concerns or complaints are elevated to ensure all appropriate resources are utilized to address the issue in a manner that is satisfactory to the person.

The H.E.A.R.T. Approach

HEAR the person fully
EMPATHIZE with the person's feelings
ACKNOWLEDGE their concerns & apologize
RESPOND by asking questions
THANK them for bringing their concerns to your attention

If concerns cannot be resolved immediately at point of service, the individual who is first aware of a concern will initiate the CSR form. A copy of the form as it is initially completed will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern.

## Living the Value of Integrity

**Mandatory Reporting of Abuse**

Each staff person has a duty to report. If abuse is suspected or witnessed, you must verbally, report the incident immediately to your supervisor. Any staff who is aware of or suspects any of the following must report it as soon as possible in accordance with the reporting procedures of your province.

***DO THE RIGHT THING – REPORT IMMEDIATELY.*** *Failure to report suggests that you condone the activity, which can result in the same disciplinary action as the abuser.*

**Whistle-blowing Protections - No Retaliation or Discouragement of Reports**

The home will protect staff members from harassment, coercion, penalty or discipline in the context of the following:

- Reports in good faith under this policy; and
- Disclosure

Staff members must not do anything to discourage any of the following:

- Reports under this policy;
- Mandatory/immediate reports as per provincial legislation; and
- Disclosure

**Reporting In Good Faith**

In making a report under this policy, a person must not act maliciously or in bad faith. A person who makes a report maliciously or in bad faith may be subject to disciplinary action, which may include termination or removal.

**Screening Measures**

The criminal reference check is to be conducted by a police force within six months before the staff member is hired or the volunteer is accepted by the home. It must include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

Declaration forms must be provided promptly, (a) after the person has been made aware that they have been charged or an order has been made; and (b) after the person has been convicted or a charge is otherwise disposed of. Failure to do so will result in discipline up to and including termination

An **Adverse Event**. It is an event, which results in unintended harm to the Resident. The event is related to the care and/or services provided to the Resident rather than to the Resident's underlying medical condition. This could include but is not limited to Resident falls, improper administration of medication or any type of injury or harm to a Resident while in the home's care.

A Near Miss. This is a potential adverse event that did not reach the Resident because of timely intervention or good fortune.

**These events are reportable to the Quality Committee of the Board and are quality performance indicator for the organization. Monthly tracking, trending and reporting to ensure transparency and due diligence is a priority.**

## Residents' Rights

Residents' Rights must be supported at all times. Not following or respecting the resident's rights is breaking the law.

**Residents' Bill of Rights**

We will ensure that the following rights of Residents are fully respected and promoted in our home:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to:
    a. participate fully in the development, implementation, review and revision of his or her plan of care;
    b. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequence of giving or refusing treatment;
    c. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to and from a long term care home or secure unit and to obtain an independent opinion with regard to any of those matters; and
    d. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under the Long-Term Care Homes Act, 2007 and subject to the requirements provided for under that Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice, and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours a day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself/herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else:
    a. the Residents' Council;
    b. the Family Council;
    c. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII of the Long-Term Care Homes Act, 2007, a member of the committee of management of the home under section 132 or of the board of management for the home under section 125 or 129 of that Act;
    d. staff members;
    e. government officials;
    f. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships, and to participate in the life of the home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting the services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas to enjoy outdoor activity, unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident, attend any meeting with the licensee or the staff of the home.

## Resident Non-Abuse

Abuse is defined as intentional mistreatment or neglect that does, or is likely to, cause physical or psychological harm, death, or loss of property.

Abuse has also been defined as the unwarranted and/or inappropriate use of physical force, psychological stress, non-consensual physical contact of sexual nature or any unwarranted and inappropriate act of omission, by Revera staff or other persons interacting with residents, during daily interactions.

This includes actions, which may:

- leave physical scars,
- cause mental anguish,
- diminished self-esteem,
- self-worth or loss of dignity,
- withdrawal,
- negative changes in behavior or avoidance of contact with caregiver.

Revera has a zero tolerance for abuse in any form. Preventing a resident from making decisions which may affect his/her own life, is also considered to be abuse.

## Neglect

Neglect is the failure to provide a client with the treatment, care, services or assistance required for health, safety or well-being. This includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of a resident(s).

**Violating Residents' Rights/Power Imbalances**

What does that look like? When we do not commit to living our values – it looks like violating residents' rights

Power imbalances & trust positions – living the values in positions of power?

Promotes the appropriate use of power to ensure Resident's needs are foremost and their vulnerability is protected.

Within the nurse-client relationship, a power imbalance exists.

Care givers are considered to be in a position of power and trust; the resident having less power and dependent for care of their basic needs. As caregivers, it is our responsibility to be aware of these potential imbalances, the vulnerability of residents and ensure we maintain a therapeutic relationship.

| Type of Abuse | Definition | Examples |
|---|---|---|
| **Physical** | Any deliberate act of violence or rough treatment of a Resident/client causing injury, bodily harm, pain or discomfort | - attacking, slapping, striking, hitting, pinching, pulling, rough handling, pushing, grabbing (in an attempt to control or destroy a part of one's anatomy), misuse of restraints, forced confinement to room, beating, cutting, burning, striking with any object or weapon |
| **Sexual** | Any act involving unwanted or forcible touching, or unsolicited sexual contact of any kind which includes inappropriate verbal exchange of a sexual nature | - sexual speech<br>- unwanted touching or molestation that is sexual in nature<br>- engaging Residents/clients in conversation about sexual acts without clinical justification<br>- sexual assault<br>- sexual harassment<br>- rape |
| **Psychological / Mental / Emotional** | Any mistreatment of a Resident/client that may hurt that person's sense of identity, dignity or self-worth or is likely to cause fear for their safety or wellbeing | - humiliation, intimidation<br>- infantilization<br>- imposed or sudden isolation<br>- sarcasm, mocking, ridiculing<br>- name calling<br>- scolding<br>- any forms or acts of punishment<br>- threats \ instilling fear |
| **Verbal** | Inappropriate verbal or non-verbal communication directed towards the Resident/client | - inappropriate tone of voice<br>- abusive language, yelling, swearing<br>- rude, offensive or sexual comments or gestures |
| **Financial** | The deliberate misuse or misappropriation of a Resident/client's money or assets, or unlawful conduct that results in harm or risk of financial harm to a Resident/client | - theft<br>- extortion<br>- unauthorized consumption of Resident/client's food<br>- misusing Resident/client's telephone to place local and long distance calls<br>- withholding or borrowing money or valuables<br>- money, valuables or property being taken away from a Resident/client<br>- forging of a Resident/client's signature |

| Type of Abuse | Definition | Examples |
|---|---|---|
| | | - cashing a cheque or possessing/using a Resident/client's credit/debit card without authority<br>- acting as a power of attorney |
| **Neglect** | Active neglect is the intentional or deliberate withholding of care or the necessities of life; passive neglect is unintentional neglect manifested by a refusal, inability or failure on the part of the caregiver to fulfill a job-related duty/function | - unreasonably ignoring a call for assistance<br>- refusing to provide assistance to the bathroom when the Resident/client requests or requires such assistance<br>- neglecting the Resident's physical needs with respect to cleanliness, such as neglecting to provide grooming, bathing, hair care, or teeth and nail care<br>- sensory deprivation (glasses, hearing aids, dentures, prolonged inactivity)<br>- withholding meals and/or nutritional fluids<br>- lack of necessary safety precautions to prevent injury to the Resident/client |

## S.T.O.P. Abuse Intervention

Revera's S.T.O.P. [Abuse] Intervention is a strategy to prevent abuse in the client and caregiver relationship. It guides staff on how to handle challenging situations; supports a respectful, client-centered relationship between clients and caregivers and finally promotes the appropriate use of power to ensure resident's needs are foremost and their vulnerability is protected.

**The word STOP is an acronym for:**

**S = STOP**

**T = THINK**

**O = OBSERVE**

**P = PLAN**


Identify other "actions" or responses that each letter in the acronym could signify.

**STOP**

You must always Stop:

- What you are doing if there is any resistance or lack of consent from the resident you are caring for;
- Think about your response and how your actions are impacting the resident.
- Do you have the resident's permission to proceed?

**THINK**

It is essential that you think about the residents:

- Are they comfortable, do they have any fears?
- Are there any factors or triggers that are contributing or influencing the situation?
- Think, is there anyone who could help in the current situation?

**OBSERVE**

Observe the resident's reactions and response to your approach and care. Some residents have difficulties or impairment, cannot ask for help and must rely entirely on other people and caregivers to identify and meet their needs.

- Is the resident aware of and receptive to your intentions?
- Has the resident had sufficient time to process the conversation or instructions?
- Another consideration is if the resident's communication is compromised.
- It is important that you are aware of what your own emotions are telling you.
- Is the environment or surroundings impacting the situation?

**PLAN**

Planning may include learning more about what individual resident's wishes are; getting more help; organizing the care differently or talking to others and finding out what is working for them. Consideration is necessary to plan a different approach.

- What could be done differently?
- Is the intervention required?
- If the resident does not understand is a different explanation needed?
- If the resident has a dementia diagnosis – is diversion or distraction needed?

Examples of specific situations when the S.T.O.P. intervention might be triggered:

a) Situations when multi-demands are being placed on you and you are being pulled in many directions in a fast-paced environment.
b) S.T.O.P. should be applied in situations when challenging behaviors are displayed by a resident.
c) Staff fatigue or caregiver stress are other situations when it is essential that S.T.O.P. is applied.

**Understanding Intervention**

- **Intervene** : To involve yourself in a situation with the intention of influencing the outcome
- **Intervention** : The act of intervening
- **Interdisciplinary Team**
- **Interprofessional approach**

**Think about the needs and desires of the resident.**

Some abuse or apparent abuse may not be intentional it could be situational

To help de-escalate use the code word/phrase, this will alert the individual that the situation appears to be abuse; it can also offer support to the individual by offering assistance

## Emergency Preparedness

| | | |
|---|---|---|
| **Code Black** | Bomb Threat | |
| **Code Brown** | Hazardous Material/Chemical Spill | |
| **Code Blue** | Medical Emergency | |
| **Code Red** | Fire | |
| **Code Yellow** | Missing Resident | |
| **Code White** | Violent Resident | |
| **Code Orange** | External Disaster | |
| **Code Green** | Horizontal Evacuation | |
| **Code Green Stat** | Vertical Evacuation | |
| **Total Evacuation** | Total Evacuation | |
| **Priority Code** | Intruder Alert | |

Emergencies, disasters, accidents and injuries can occur any time and without warning. Being prepared physically as well as psychologically to handle emergencies is an individual as well as organizational responsibility.

Revera has established Emergency Response Procedures for you to follow so the effects of those emergencies can be minimized.

**Your safety and the safety of our residents is our prime importance**

The more you are prepared, the better you can act and minimize panic or confusion when an emergency occurs. No matter what the crisis: Think before you act, and then act swiftly to minimize your exposure to danger.

## Medical Emergency – Code Blue

**Standard**

Code Blue will be used to alert individuals in the home of a medical emergency and provide a systematic approach for responding to it.

NOTE: A medical emergency is defined as a medical condition requiring immediate treatment, for example a cardiac and/or respiratory arrest, convulsive seizure, acute chest pain, respiratory distress, syncope and/or any other situation where clinical assistance is needed.

**Procedure**

1. Upon discovering the emergency:
    a. Pull the nearest call bell and alert nearby staff by shouting Code Blue;
    b. Stay with the individual;
    c. If no response to the call bell or the call for help, page "CODE BLUE", floor number, room number, then return to the resident and begin assessment and/or resuscitation.
2. Upon receiving the page for "Code Blue":

a. The RN/RPN of the floor above and/or below or his/her designate will bring the emergency equipment, which contains suction, oxygen, and ambubag to the area called.
b. The Nurse Manager/ADOC, the DOC and/or the Executive Director will go immediately to the area of Code Blue and direct it until ambulance personnel arrive. At all other times, the Charge Nurse will attend the code and assume responsibility.

3. The Nurse Manager/ADOC on duty will direct the code and ensure appropriate resuscitation endeavors:
   a. The Nurse Manager/ADOC will direct 911 to be called where appropriate and the person will give name, address, floor and room location.
   b. A HCA will be assigned to put elevator on 'service' and wait for ambulance on main floor (after reception hours)

## Fire – Code Red

**Standard**

Emergency Code Red will be used:

- To alert all occupants when a fi re is discovered;
- When conducting FIRE DRILLS and;
- When there is a suspicious event that may lead to a fi re (e.g. smoke, smelling something burning).

**Procedure**

**A. If you discover a Fire/Smoke**

Call out "CODE RED", and fi re location; R.E.A.C.T:

R: Remove Residents from immediate area

E: Ensure windows and doors are closed

A: Activate Alarm

C: Call the Fire Department

T: Try to extinguish fi re (if possible)

REMEMBER: Pulling the alarm is the quickest way to get help. The First responsibility is the safety of the residents

**B. If you hear the alarm**

- Check pull station locations to see if activation is on your Resident home area.
- Clear corridors.
- Staff not in their area must return to their assigned home areas after the code location is announced. DO NOT USE ELEVATORS. DO NOT ENTER FIRE ZONE DIRECTLY FROM STAIRWELL.
- Initiate room-to-room search. Assign a staff member to each hall.
- All rooms to be checked as follows:
  - Close windows
  - Check closets
  - Check bathrooms
  - Close doors
  - Note location of Residents
- Proceed with pre-planned fi re procedures for your area.

## Evacuation Procedures – Code Green

**Standard**

Code Green will be used to evacuate Residents from immediate danger in the event of an impending emergency disaster. All employees are responsible for understanding the use of Code Green in the event of a disaster/emergency situation.

**Procedure**

1. **Code Green** means "Horizontal Evacuation".
2. Code Green – to be used to completely evacuate Residents from disaster area to a designated safe area on the same floor.
3. All Residents to be horizontally evacuated to a safe area beyond the fire barrier doors.
4. Code Green Stat means "Vertical Evacuation"
5. Code Green Stat is used to completely evacuate Residents from the disaster area in a vertically downward direction.
6. The decision to initiate Code Green/Code Green Stat is the responsibility of the person in charge at the disaster scene or the Fire Department if present.
7. Horizontal/Vertical evacuation will be announced on the communication system as "Code Green" or "Code Green Stat" followed by location(s) to be evacuated. For example "Code Green, 2 North".

## Missing Person – Code Yellow

**Standard**

Code Yellow will be used each time a Resident is discovered missing. An immediate and thorough search of the home and the immediate environment will be conducted upon the suspicion/notification that a Resident is missing.

**Procedure**

<u>Initial Search</u>

1. In the event a Resident is suspected to be missing from a home, the staff member will notify the person in charge immediately.
2. The person in charge/designate will check the sign out book and health record to see if the Resident is signed out of the home. If applicable, the Resident wanderer's observation checklist will be checked to determine the time and location the Resident was last recorded as being seen. Registered staff will check with Recreation staff to account for all Residents engaged in social/programming activities and report findings to the Charge Nurse.
3. After a thorough check of the Resident Home Area, Registered Staff will notify the Charge Nurse immediately of a suspected missing Resident.
4. The person in charge/designate will page three times "CODE YELLOW, NAME OF MISSING RESIDENT, ROOM NUMBER", e.g. "Code Yellow, Mrs. Smith, Room 213" followed by a brief description of what the missing Resident is wearing.
5. Registered staff will initiate Missing Resident Search Checklist [EPM-F-10-05] to record the time, sequence, and details of the search. The Code Yellow Identity Chart [EPM-F-10-10] is completed and kept in the Resident's chart when the Resident is assessed as a high-risk wanderer.

Note: if not using Code Yellow Identify Chart, complete specify identify chart supplied by local police department or Alzheimer Society.

6. Registered staff will instruct staff to conduct a thorough search of all areas identified on the Missing Resident Search Checklist [EPM-F-10-05]. Home-specific areas not listed should be added to this checklist.

**Second Search – when the Resident is not found:**

Immediately on completion of the first search and before an exterior search is carried out, the Charge Nurse/designate will notify the Police. Staff will begin a second search, following the procedures outlined in Steps 1 through 7 above, and continue utilizing the Missing Resident Search Checklist [EPM-F-10-05]. Refer to the Emergency Plan Manual [EPM-F-10] for additional procedures for Code Yellow.

## Bomb Threat – Code Black

Any information received by Revera concerning a bomb placement is to be considered a real threat.

**If you receive a threat by telephone:**

Keep the caller on the phone as long as possible and attempt to learn:

- Location
- Type of bomb
- Time it is set to go off
- Description of the device
- Why he/she is doing it

**DO NOT HANG UP** under any circumstances, even if the caller hangs up, the call may still be traced.

Utilize the bomb threat found in this Emergency Response Guide.

**CALL 911 AS SOON AS POSSIBLE FROM A SAFE LOCATION.**

**If you receive a threat by note or letter:**

- DO NOT handle note.
- CALL 911 IMMEDIATELY
- Contact your Supervisor immediately.
- If you notice a package or foreign object in a strange place DO NOT TOUCH IT.
- Prepare to evacuate – do so if you perceive danger.
- Await further instructions

**If you should receive a bomb threat:**

- Listen
- Be calm and courteous
- Do not interrupt the caller
- Obtain as much information as you can

**Questions to ask:**

- What time will the bomb explode?
- Where is it?
- Why did you place the bomb?
- What does it look like?
- Where are you calling from?
- What is your name?

**Record:**

- Date
- Time
- Duration of call
- Exact wording of threat

**Identifying Characteristics:**

- Sex (Male/Female)

- Accent (English, French, etc...)
- Voice (loud, soft, etc...)
- Speech (fast, slow, etc...)
- Diction (good, nasal, lisp, etc...)
- Manner (calm, emotional, vulgar)
- Background Noises
- Voice was familiar (specify)
- Caller was familiar with area

## Acts of Violence – Code White

**Standard**

Code White will be used to obtain immediate assistance in a situation related to violent/aggressive behaviours.

**Procedure**

1. Call out "Code White". Unit staff to respond immediately to area of concern.
2. Remove residents/visitors from immediate area.
3. Page "Code White", floor number and location (e.g. "7th Floor, Room 220")
4. Return to Resident and ensure environment is safe. Using principles noted in the aggressive behavior policy, attempt to diffuse the situation.
5. Charge Nurses must always respond to Code White.
6. Once situation is assessed then:
    a. If able to diffuse violent behaviours, stay with Resident, provide reassurance and assess contributing factors. Document on MDPN's interventions and outcomes.
    b. If unable to diffuse violent behaviours, call 911 for emergency response. Notify physician, family, DOC/Executive Director. Complete Unusual Occurrence report and document strategies on MDPN's.

## Hazardous Chemical Spill – Code Brown

The spill or leak of any hazardous material can result in immediate danger to life or health, disruption of resident care and threaten both the property and the environment.

These procedures must be carried out immediately for:

- The unplanned and/or uncontrolled release of any hazardous or potentially hazardous chemical in any quantity.
- The spill or leak of any UNIDENTIFIED SUBSTANCE.

In the event of a spill or leak of any substance as defined above, the person(s) involved or discovering the spill/leak shall:

**S:** Safely evacuate everyone from the immediate area.

**P:** Prevent the spread of fumes by closing doors, if possible.

**I:** Initiate notification of Dietary Manager or Health & Safety Rep. Over the P/A system and state the unit and exact location of the spill as well as the chemical if known.

**L:** Leave all electrical equipment, appliances and switches alone. **Do not turn them on or off.**

**L:** Locate any information regarding the chemical spills from the M.S.D.S.

## Emergency Disaster Response Plan in Effect – Code Orange

**Standard**

Code Orange is paged to alert employees that the home will be receiving an influx of Residents as a result of an external disaster.

**Procedure**

1. The Executive Director/designate will approve the receipt of Residents from another facility or the community following an external disaster.
2. On request, the receptionist/designate will communicate "Code Orange Alert" to advise employees of a potential influx of Residents. "Code Orange" or "Code Orange Confirmed" will be communicated to declare a confirmed influx of Residents.
3. The reception plan [EPM-H-20] will be implemented to handle the influx of Residents.

**Outcome**

Code Orange is paged and the reception plan is implemented upon notification of an influx of residents subsequent to an external disaster.

**Departmental Responsibility**

Departments are expected to develop a detailed plan, which will expand on the duties and responsibilities of the department in the event of a disaster while being congruent with the overall Emergency- Disaster Response Plan for Revera.

## Infection Prevention & Control

**What is Infection Control and why is it important?**

Infection Control is the practice by which the home prevents and manages infections. Infection Control principles are included in all aspects of providing care for Resident

- Prevention of illnesses acquired within health care facilities (30-50% of all infections are preventable)
- Infection spreads easily through long term care homes seriously impacting on the wellbeing and lifestyle of residents
- Infections can cause inconvenience, pain, or even death for resident.
- Infections can spread among staff and also their families

**The danger of infection is always present.**

**Why do Infections Occur in Long Term Care Homes?**

- Long-term care residents are at high risk for acquiring infections
- In Health Care facilities, there are:
    - Many microorganisms
    - Frequent contacts between people
    - Large amounts of contaminated wastes
    - Many people are treated in close quarters.
    - Aging effect and medication effect on the immune system
    - Some procedures and treatments may increase risk

**How do Infections Spread?**

**CHAIN OF INFECTION**

3 LINKS WHICH ALL MUST BE PRESENT FOR INFECTION TO OCCUR

- A **PATHOGEN** (A MICROORGANISM) must be present
- It needs a mode of **TRANSMISSION** (how it is spread)

- The host must be **SUSCEPTIBLE** (likely to become infected)

Infection Control Procedures are aimed at breaking the infection chain by removing one of these links.

**What is the best method of preventing infections?**

Hand washing is the single best and most effective prevention against the spread of infection. In order to protect the spread of infections our staff to wash their hands often and we encourage Residents and visitors to do the same. We advise hands to be washed when you arrive, and before you leave the building. Using a paper towel to turn off the taps keeps the hands clean.

## Safe Ambulation & Lifting Techniques (SALT)

Revera has a comprehensive Safe Ambulation & Lifting Techniques program (SALT) which includes overview of the program & principles, logo system and discipline specific Skills Checklists. Please see your Manager or Staff Educator for more information on Safe Ambulation & Lifting Techniques (SALT) as it applies to you.

## Abdominal Thrust

**Choking is a life-threatening situation and requires some quick thinking and acting by the bystander.**

**Preparation is the key and learning about effective techniques to deal with a choking situation.**

The **abdominal thrust** should only be performed when the situation meets the following guidelines:

- The person cannot talk, cough, or breathe. (If the person is coughing, they are not choking, do not perform it.)
- The person nods to the question, "Are you choking?"

**Partial Obstruction**

The airway is still open, some air exchange and can cough. If you are there to assist, you MUST encourage the person to cough. DO NOT INTERFERE!

**Complete Obstruction**

- The person is unable to breathe/speak/cough.
- They may be turning gray or blue (because of lack of oxygen).
- They may have a high-pitched or weak cough.

You will also need to consider the age of the victim. Performing the abdominal thrust on small children or infants can do more harm than good, so follow the guidelines for the different age groups. The force applied to a person's abdomen must be enough to dislodge an object, but it is appropriate to adjust the strength of the thrust depending on the body type.

**If choking is occurring, the Red Cross recommends a "five and five" approach to delivering first aid:**

1)

**Ask the person,** "Are you choking?"

- A resident may be choking when they cannot speak, cough or breathe or is making high pitched noises.
- If the resident can speak, cough or breathe, encourage the person to cough to help clear the obstruction.
- Call and for someone who is CPR certified to be on standby.

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2)

- **If the resident is choking,** stand behind or beside the resident and wrap one arm across the chest.
- With the heel of your other hand, give 5 firm back blows between the shoulder blades.

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3)

- If the object does not come out, place a fist just above the belly button. Place your other hand over your fist and pull sharply in and up, doing 5 abdominal thrusts.
- Continue the cycle of 5 back blows and 5 abdominal thrusts until the object comes out of the person or they begin to breath or cough.

---

4)

- If the resident is obese, in a chair or a wheelchair, you should perform chest thrusts by **positioning your hands higher** in the middle of their breast bone.
- Proceed with chest thrusts, pressing hard into the chest, with a quick thrust.
- Continue **alternating** between 5 firm back blows and 5 chest thrusts until the object comes out or resident begins to breathe or cough.

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Please see your Manager or Staff Educator for more information on how to complete the Food Safety Education online modules as it applies to you.

## Service Provider Acknowledgement Form

This Education/Information Package has been prepared to help you understand the policies, philosophies and practices of Revera Inc. Please read it carefully. Upon completion of your review of this package, please sign the statement below and return to your Manager/Supervisor.

I, _____, have received and read the contents of the Annual Education for Contracted Services and have had the opportunity to ask questions regarding the contents with my supervisor. By my signature below, I acknowledge, understand, accept and agree to comply with the information contained in the package provided to me by Revera Inc.

_____

Contracted Services Name (Please print)

_____

Contracted Services Signature

_____

Date

This is Exhibit "F" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

RN/RPN Schedule

| EMPLOYEE | Saturday 07-Feb | Sunday 08-Feb | Monday 09-Feb | Tuesday 10-Feb | Wednesday 11-Feb | Thursday 12-Feb | Friday 13-Feb | Saturday 14-Feb | Sunday 15-Feb | Monday 16-Feb | Tuesday 17-Feb | Wednesday 18-Feb | Thursday 19-Feb | Friday 20-Feb | Lieu Bank | Lieu Paid |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Church, Karen PT Days | | | | 6-2 | 6-2 | | | 6-2 | 6-2 | | | | 6-2 | 6-2 | | |
| Raney, Tracy FTEvenings | 2-10 | 2-10 | 2-10 S | | | 2-10 S | 2-10 S | | | 2-10 S | 2-10 S | | 2-10 S | | | |
| Estoesta, Jasmin FT Days | 6-2 | 6-2 | 6-2 | | | 6-2 | 6-2 bp | | | 6-2 | 6-2 | 6-2 | | | | |
| Farley, Susan PT, Evenings | | | | 2-10 S | 2-10 S | | | 2-10 | 2-10 | | | 2-10 | | 2-10 | | |
| Beauregard, Dianne FT, Nights | 10-6 | 10-6 | 10-6 OT | 10-6 OT | 10-6 | 10-6 | | | | 10-6 | 10-6 | | | 10-6 | | |
| Davidson, Sharon FT, Nights | | | 10-6 S | 10-6 S | | | 10-6 bp | 10-6 | 10-6 | | | 10-6 | 10-6 | | | |
| Smith, Jessica FT RPN | | | 6-2 & 10 | 2-10 OT | 2-10 | 8-4 2-10 | 8-4 | | | 6-2 | 8-4 2-10 | | 8-4 | 8-4 | | |
| Gray, Tricia Casual | | | | | | | | | | | | | | | | |
| Bestline Agency Bedhallers RN | | | | | | | | | 2-10 | 2-10 | | | 2-10 | | | |
| Dorothy RN Agency | | | | | | | | 6-2 | | | | | | | | |
| | | | | | | | | | | | | | | | | |

This is Exhibit "G" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

# AGENCY STAFF ORIENTATION CHECKLIST – REG. STAFF

DOC to review checklist with agency staff each time new agency staff comes into the home.

| | | Agency initial | DOC initial |
|---|---|---|---|
| **INTRODUCTIONS** | Tour of the building | | |
| **REPORTING:** | Introduce agency to:<br>▪ all staff who report to agency nurse | BW | AF |
| | Identification of residents | BW | AF |
| | 24 Hour Report – Shift Report | BW | AF |
| | How to complete Report to ED ( if applicable) | | |
| | Giving and receiving report from HCAs | BW | AF |
| | Doctor On-Call | BW | AF |
| | Date Lab comes in - Check for blood work orders & FBS | BW | AF |
| | Unit Calendar/ reference materials | BW | AF |
| | ▪ | | |
| | Care Assessments/Change in Condition process… | BW | AF |
| | Emergency Response | BW | AF |
| | | | |
| **TEAM RESPONSIBLITIES:** | Job routines as per manual<br>▪ Nightly checks<br>▪ All residents must be accounted for | BW | AF |
| | PCA/PSW/HCA Assignments / time schedules | BW | AF |
| | Food Services<br>▪ Highlight special services (as applicable) | BW | AF |
| | Staff Replacement –<br>▪ location of time sheets<br>▪ call-in list/ procedure<br>▪ absence reports | BW | AF |
| | | BW | AF |
| **LOCATION OF:** | Long Term Care Services Manual | BW | AF |
| | Fire & Emergency Plan Manual | BW | AF |
| | Pharmacy Manual | BW | AF |
| | Nursing Supplies | BW | AF |
| | Telephone Numbers/ phone system<br>▪ Numbers for on call manager<br>▪ Environmental Manager | BW | AF |
| | Other: | | |
| | | | |
| **MEDICATION:** | Med Room & Treatment Supplies | BW | AF |
| | Sign master signature list | BW | AF |
| | First Aid | BW | AF |
| | Equipment for Vital Signs | BW | AF |
| | Review medication system:<br>▪ time of med passes | BW | AF |

| | | Agency initial | DOC initial |
|---|---|---|---|
| | ▪ list of diabetics<br>▪ emergency drug supply | BW<br>BW | DF<br>DF |
| | MARS and Quarterly Med Review | | |
| | Narcotic Count | BW | DF |
| | Individual Narcotic Record | BW | DF |
| | PRN Medication and documentation | BW | DF |
| | Ordering and receiving medication from Pharmacy | | |
| | Drug re-order book | BW | DF |
| | | | |
| **KEYS** | Review keys on ring:<br>▪ include food service dept. keys | BW | DF |
| | | | |
| **RESIDENT CHART & DOCUMENTATION:** | Resident Charts / Care Plans | BW | DF |
| | Advanced care directives<br>▪ Emergency contact<br>▪ Phone numbers | BW | DF |
| | PSW/HCA/ Documentation Records | BW | DF |
| | Admission /Discharge Procedure | BW | DF |
| | Procedure when a resident dies | BW | DF |
| | Incident Report (resident or staff) | BW | DF |
| | Transfer Sheet | | |
| | Appointments | | |
| | SALT/Mechanical Lifts Program overview (if applicable) | | |
| | | | |
| **SAFETY:** | Fire Procedures:<br>▪ Fire Panel<br>▪ Alarm Systems | BW | DF |
| | Emergency Preparedness | | |
| | Resident Non-Abuse Policy | | |
| | Security Checks | | |
| | Door Alarm Systems and all exits to the building | BW | DF |
| | Telephone & Intercom systems | | |
| | Maintenance Requisition Book | BW | DF |
| | Care of aggressive residents | | |
| | Emergency codes – review<br>▪ Missing person – code yellow<br>▪ Priority Code | BW | DF |
| | Wanderer's Checklist | | |
| | Least Restraint Policy | | |
| | Smoking policy | | |
| | Hazardous waste disposal | | |

| | | Agency initial | DOC initial |
|---|---|---|---|
| | | | |
| | | | |
| **OTHER:** | Overview of Privacy policy | | |
| | | | |
| | | | |
| | | | |

Print Agency Staff's Name: Bethe Wettlaufer

Name of the Agency: Life Guard Homecare

Home's Charge Nurse Signature/ Person Orientating: [signature]
Date: Feb 15/15

Agency Staff's Signature: [signature]
Date: Feb 15/15

This is Exhibit "H" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

## Louise Allard

**From:** Heidi Wilmot Smith
**Sent:** Monday, October 26, 2015 7:14 PM
**To:** Sherri Toleff (Director of Care)
**Cc:** Taryn Smith; Louise Allard
**Subject:** Follow up to my meeting with Bethe

Sherri:

Hello there. I did meet with Bethe today. Please find attached her note of apology.

Hopefully we will not have a repeat of this situation, and I have reviewed with Bethe the importance of checking her email daily.

Best Regards,
Heidi Wilmot Smith
President
[redacted]
www.lifeguardhomecare.com

*'The greatest compliment you can give us, is your referral.'*

**Heidi Wilmot Smith**

**From:** Bethe W.
**Sent:** Monday, October 26, 2015 6:07 PM
**To:** Heidi Smith
**Subject:** missed shift

Dear Heidi : On October 24th, I missed my scheduled shift at Telfer Place in Paris. This was due to my not recording the shift when it was assigned and to my not checking my schedule in StaffPoint. When I was alerted on Saturday by the on call supervisor that I had missed the assigned shift, I was out of town and unable to come back to work the shift.
I am sorry for the huge inconvenience and staffing problems this caused for Telfer Place. I am also sorry for the way this incident poorly reflected on Life Guard.
In the future I will be diligent in daily checking my StaffPoint schedule and in checking my emails for StaffPoint alerts.
Again, I am sorry for missing my shift and for the problems this caused.

Sincerely
Bethe Wettlaufer RN

This is Exhibit "I" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

April 25th –

# Telfer Place – Staffing Action Plan

# Quality Improvement Action Plan: Telfer December 2015

| Improvement Opportunity RAI and clinical | Action | Timelines | Action Update | Action Update |
|---|---|---|---|---|
| Recruitment and Retention of new hires<br>High agency use, Registered staff have to stay over an hour past shift to complete all work<br>Registered staff are working 19 days in a row and DOC and ADOC do meds and fill in as well. Agency do not want to return due to complaints that workload is too heavy | GOAL two registered staff days and evenings Monday to Friday as budget allows. | | | |
| Medications: 1 nurse to give meds for 45 residents- new hires leave because of workload, agency staff do not want to return:<br>a) Medication times require streamlined as administration times are every half hour on eMAR<br>b) Excess supplements- double the expected per diem rate<br>c) Medication compression is needed<br>d) Will require two med carts for new model | 1. To have TAE from classic care come in and do review of medication times and compress<br>2. Contact Classic care to bring in another med cart<br>3. Ensure that medications arrived divided by home area and not alphabetically<br>4. Review supplement list and administration times with FSM and RD<br>5. Shift routine to be completed<br>6. Cheryl did a list of all medications being administered at odd times and sent to pharmacist for review<br>1/15/16<br>1. Cheryl has sent Dian recommendations for moving RAI C hours to evenings with additional med administration times for consideration- to reduce evening workload. RAI C currently working full day shift Monday to Friday | Completed by March1 | Cheryl spoke with FSM and they will be moving to 'food first' process to reduce supplement costs and medication administration times<br><br>Cheryl notified Donna regarding change in units for Feb. 1 day shift<br><br>Kilean's shift routine used as reference<br><br>Tae has reviewed medications and made recommendations- follow-up needed with MD | 1/12/16<br>Med cart will arrive on the 27th<br><br>Home goes live Feb 1 with two med carts1/12/16<br>RPN has agreed to work shorter shifts Monday to Friday to accommodate new model<br><br>Shift routine for day RPN completed by Lindsay |

# Quality Improvement Action Plan: Telfer December 2015

| | | | | |
|---|---|---|---|---|
| | **Update 2017**<br>Two med carts working well with two registered staff on duty. Med compression has been done x 2. Med compression to be done again now that we have new medical director and new pharmacy. Nurses instructed not to answer phones during med pass- memo to families on the best time to call. Instructions to office staff to take a message or ask families to call back if they call during med admin times. Instructions to PSW staff regarding when and how to interrupt a nurse during med passes. New phone line installed for doctor's and pharmacy to be able to reach the nurse during med pass times.<br>DO NOT disturb sign posted on med carts. | | | |
| Processes:<br>a) Phone lists out of date<br>b) Grab and go binders for quick and easy access- high risk binder review<br>c) Organize forms<br>d) Current binders requires review for accuracy and that they are current (e.g. deaths- coroner number is wrong)<br>e) Audit to ensure current tools are used (24 hour report, huddles, weights) and are effective<br>f) Create skin tear grab and go kits<br>g) Camera is missing- have recreation staff keep resident pictures current | 1. Adrienne came in and organized forms by clinical program<br>2. Michelle C. created checklists for clinical programs and posted in charting room<br>3. Cheryl updated 'death' binder<br>4. Cheryl taught WCC to take pics with mobile device and upload into POC<br>5. Jim created an improved huddle process<br>6. Weight action plans audited and remains in good standing | | | March 2017completed |

# Quality Improvement Action Plan: Telfer December 2015

| | | | | |
|---|---|---|---|---|
| Staffing model: new nursing model needed for sustainability- currently 17,000 over spent in nursing mostly due to agency bills. Home has high CMI for next year- mostly due to increased frailty of residents- more than half require extensive to total assistance to eat- therefore PSW hours cannot be re-allocated to registered staff hours.<br><br>30 hours per week of RPN hours- re-allocated to floor<br><br>12 hour RN shifts to be considered. Collective agreement does not support 12 hours shifts unless the RNs agree. RNs may agree if there is support on the floor (3 large med passes are required for day shift)<br>Consider changing from 6-6 to 7-7 due to supper pass and last minute charting?<br>Sample schedule:<br>Days<br>RN 6 to 6<br>RPN 7 to 1300<br>Evenings:<br>RN 6 to 6<br>RPN 4-8 (looking at the restorative care lead line for funding for now)<br><br>Exploring how the schedule will work with 12 hours shifts- concern is when a 12 shift needs to be filled – it will harder to fill<br><br>For 12 hour shifts we need 14 shifts covered in 2 weeks- sample schedule shows that 4 RNs can | ADOC/DOC and RMCS created 2 samples of a 12 hour shift schedule today to present to registered staff for the next schedule.<br>Jan 5/16 Dian and Sherri met with union<br>12 hour shifts not acceptable to registered staff<br><br>2 RN applications received-<br>1/15/16- offer letter is going out for one RN<br><br>Home is set for go live two registrants on days Monday to Friday Feb. 1 2016<br><br>Update:<br>Home hired two registered nurses via New grad initiative one has remained as casual and one has remained as part -time nurse (back up WCC and Continence lead)<br><br>Starting April 1 2017 two registered staff are now scheduled for days and evenings. Recruitment remains an ongoing process. | | | New nursing model now fully implemented. April 2017 |

| | | | | |
|---|---|---|---|---|
| cover – sick calls will continue to be an issue until new staff can be recruited<br>Self-scheduling model was suggested | | | | |
| Documentation:<br><br>Registered staff will need to be retrained on coding<br>New ADOC and RAI C onboarding | Cheryl created new coding assignment by clinical leads. Education provided to Continence lead, pain lead and BSO lead. Further education provided to registered staff by attending coding and beyond. | | August 2017- requires constant review by RAI C | |
| August 3 2017<br><br>Home received compliance order for RN 24 hour coverage<br>Home requires 6 RNs to cover current 8 hour shifts.<br><br>Home has 8 RNs one just resigned today (for full time job) leaving 3 FT and 4 part time RNs are now on staff.<br><br>NOTE: 12 hours nursing schedule will require 4 full time nurses plus casual for call-ins<br>8 hours nursing schedule requires 3 full time plus 3 part time plus casual for call-ins | Action Plan:<br>Continue with med compression strategies<br>Revisit 12 hour shifts for RN coverage for high need times such as vacation and holidays as we have a different staffing complement then when we approached them previously<br>Michele/Jim to be the 'RN on the floor' when home staffing plan calls for 2 RPNs" this is when no RNs available to work<br>Continue to recruit RNs<br>Work on absenteeism with the two evening nurses that frequently call in<br>Conduct 'scheduling' meetings with registered staff prior to high need times to ensure that vacations/time offs can be granted and still staff the floor. | | | |
| | | | | |

This is Exhibit "J" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

# Witness Statement

| | |
|---|---|
| **Witness name:** | **LYNN JACKSON** |
| **Statement number:** | S129 |
| **Date of Statement:** | 15/11/2016 08:58 |
| **Home Address:** | [redacted]<br>ONT<br>[redacted]<br>Canada |
| **Statement Taken By:** | Constable SHANE POLLET 9933<br>Ontario Provincial Police<br>Western Region |
| **Telephone:** | (519) 3233130 Ext. 6346 |

## Evidence

Tuesday 15 November 2016
Interview begins at 08:58 hours
A PSW at Telfer Place past 21 years, and heard what she is charged with, it blows my mind, I worked with her quite a bit, and heard from co-workers that the investigation involves Sandra TOWLER.
I am Sandy's primary carer, and recall that Casey RANEY another RN was working that night with Bethe.
That night I glanced into her room and thought something is not right, I asked if she was alright, she doesn't talk, she didn't look right so I spoke to Bethe. She went in with blood pressure cuff, came out and said that her vitals are fine. I looked at her again, Sandy was still not looking fine. I went to Bethe again and told her to check Sandy's blood sugar as Sandy is a diabetic. Next day the doctor said that Sandy had had a stroke, cannot remember the date it was a 2-10p.m. shift.
Because of everything that came out and co workers told me an investigation about Sandy, I started remembering. Bethe was with us July / August, Sandy with us maybe 5/6/7 years.
The day is blurry, Bethe would come in 3/4 days in a row then be off for a while. One of the co-workers reported her for inappropriate comments in the men's ward, with a PSW. She spoke about another resident in another home who put tic tacs in her vagina, so we called her tic tac from then on.
Often she came in mad, her look of anger and walk gave her away, she was mad at being reported, cannot recall if the shift with Sandy was the same shift she was mad.
I'm Sandy's primary care giver, have 10 residents in total, not sure if I was putting someone else to bed or not when I noticed Sandy was not well. Sandy usually goes to bed around 7/7:30 I would care for all 4 residents in her room, she would be the first on the list to be put to bed. When I put her to bed she was fine. She was a sit and stand at that time, then became a mechanical lift and smiling, stood ok.
The resident beside Sandy was Diane she was loud and yelling, maybe that is why I went back in, glanced at Sandy who was in the first bed and noticed, asked her what's wrong with you.
Bethe was doing meds on that wing for residents, she was right at the first room, not in the room with me probably doing other meds. She would have given meds after I put Sandy to bed, Bethe would still be in there doing meds. Dianne CRONKWRIGHT was the other resident she is a needle diabetic, Sandy is not a needle diabetic, Irene and Gerty, the other roommates, were not needle diabetic either.
There was another ward room next to Sandy, and 3 privates across the hall, 4 - 4 - 1 - 1 - 1 total of 11 residents, there was just the 4 residents in the room when I returned. Bethe was in the hallway with the med cart, in the next ward room. I went back in probably because Diane yelling or Diane had a bed alarm, no one else had one then.
Found Bethe at the front desk when spoke about Sandy, that was odd, and unknown why she was there, she must have been done her meds, believe her med cart was at the front desk.
Sandy's room is one of the first for the med pass, she'd do both sides of meds 20 residents in total, some are not medicated at bedtime. Tracey RANEY was also at the nurses desk, she was behind doing paperwork. I told Bethe to check Sandy as something was not right, she went to the room alone with the blood pressure cuff, came out said her vitals were fine, I continued with my rounds. 5 minutes later I see Sandy again and she was still not right, I asked Bethe if she checked Sandy's blood sugar, she said no, Tracy said you better check that. Bethe went with the tester, came out, unknown if she tested the blood sugar.
The next shift I think that Diane worked or it could have been an agency nurse I can't recall, don't recall any other

staff.
If anything happened it would be on the report of the RN shift, Bethe was the charge nurse that night so she would have done the report, unknown to me if anything passed on, I am not included in the reporting.
I think I was there the next day or the day after as Dr. Williams was in and said that Sandy had a stroke. Sandy's transfers changed after her stroke to a full lift from a sit and stand, she couldn't hang onto anything anymore. I don't think they sent Sandy to the hospital that night, the girls on the floor said that Dr. Williams diagnosed Sandy with a stroke, never in a million years thinking anything.
Supper breaks Bethe would be with me, she was on her phone a lot, she spoke of her over weight dog and of her parents and that she was a recovering alcoholic. Bethe did not work there for long, they were trying to get rid of her she was weird, inappropriate, we complained to management, can't recall when she started there or when she left.
I approached management the DOC Sherri TOLEFF and told her about the tic tac thing.
Bethe said something to a guy about a sperm donation or having kids. Michelle was the DOC after Sherri told her too, no didn't talk to Michelle, can't remember if Bethe was still there or not.
Worked with Bethe on shift, maybe 10 times she wasn't there that long but worked a lot, and worked all shifts.
PSW have to enter care for everyone onto the computer and report verbally to the RN any concerns, they then enter that onto the computer and the report..
I don't recall a report from me on the night that we spoke of, the PSW report is called a POC (don't know what the stands for), there is nothing specific for Sandy's POC, likely just toileting. I feed Sandy every night, there are no issues with her food, and her intake is recorded. If she could talk she would, she responds to touch and sound with facial expressions, her mealtime is 5p.m.
Laura EATON she is one of the restorative manager and checks reports if there is something missed she highlights it in red i.e. a missed bath.
I don't have any hand written notes, we did have paper sheets for each resident, recording food and drink intake it was a duplicate of the computer data so we stopped doing those, started and stopped this year.
I didn't socialize with Bethe outside of work, she took a selfie of herself once in the bathroom and showed it to me. Her comments sometimes were stupid in an effort to make us laugh.
Bethe never made any comment of her intent to harm residents and I did not observe her to do so. I have seen her angry but not towards the residents, I recall her being angry one time when she was reported. she was good with residents that is why this is so mind-blowing, you never know what somebody is really liked. She was a good nurse just weird, I think I would feel confident with her caring for my mother, never seen her be rough or mean or angry to residents.
09:48 - 09:53 break
I did not know the blood sugar levels when Bethe checked them. When I did my last rounds Sandy was awake and still appeared weird, the look on her face. I can't remember if Bethe was mad that night abut being reported, she told me that someone had reported her. The incident with Sandy was last year possibly July or Aug, it was summertime.
10:02 ended
Interview by D.C Pollet, and monitored by D.C Milton

This is Exhibit "K" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

**RE: Agency staff**

Sherri Toleff

**Sent:** Wednesday, January 06, 2016 1:55 PM

**To:** Tracy Raney

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I will follow up, thank you!

Thanks,

**Sherri Toleff RN**
**Director of Care, LTC**

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**From:** Tracy Raney
**Sent:** Wednesday, January 06, 2016 1:31 AM
**To:** Sherri Toleff
**Subject:** Agency staff

Hi Sherri--Despite the signs on the door, Beth continues to leave the med room door and chart room door wide open and walks away, far away down the hall. Noted on the last night shift that she followed me. Thought you should know. Thanks--Tracy

# RE: Agency staff

Lindsay Astley

**Sent:** Monday, February 08, 2016 6:17 AM

**To:** Tracy Raney

Hi Tracy,

Thank you, I have passed your concerns on to Dan.

Thanks,

*Lindsay Astley*

Associate Director of Care/Restorative Care Coordinator- LTC

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**From:** Tracy Raney
**Sent:** February 7, 2016 11:56 PM
**To:** Lindsay Astley
**Subject:** Agency staff

Hi Lindsay--I have some concerns in regards to the new Agency RN that worked this weekend. She did not give out all the narcotics, she put feed into the water bag of David's jevity, she did not complete dressings ie. Mary V. which did not have a dressing on at all for Saturday until I came on and put it on, other meds were missed. I am past frustrated with these Agency girls, they seem to only want to do the bare minimum and nothing else. Last night Bethe from Lifegard was on a mission trying to find out the name of the other Agency that we are using because Heidi thinks they are underbidding her. I don't want to be dragged into that. Many thanks--Tracy

This is Exhibit "L" referred to in the Affidavit of Sherri Toleff, sworn June 26, 2018

*Commissioner for Taking Affidavits (or as may be)*

# Agency

Tracy Raney

**Sent:** Sunday, January 10, 2016 11:06 PM

**To:** Sherri Toleff

**Cc:** Lindsay Astley; Tracy Raney

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Hi ladies--I have some concerns in regards to Beth from the Agency. I am not sure of the role they are supposed to take in LTC. Beth does not always relay important information to Dr.s and to other Registered staff. I had a nurse from Jenuine Care call tonight to ask how [redacted]'s toe was after nail care because there had been a bleed post care on January 7th. No information had been passed onto me the next shift, she did not chart on it nor write it in the report book. Therefore for 3 days it ihas not been assessed until the foot care nurse called to inquire how it was doing. The other issue I have is that on January 7th she addressed that [redacted] had apnea and that she called the family but did not call the Dr. When I called the Dr. he came in, changed her status to palliative and initiated all the necessary drug changes in regards to palliation status. Yet she apparently did not feel a need to inform the Dr. herself. Unsure what to think about these issues. Thanks--Tracy