In the Matter Of:

The Long-Term Care Homes Public Inquiry

DAY 6 / VOL 6

June 12, 2018

---

neesons

77 King Street West, Suite 2020
Toronto, ON M5K 1A2
1.888.525.6666 | 416.413.7755

THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 6/Volume 6 of the Public Hearings in the above Inquiry proceedings taken at the Elgin County Courthouse, Court Room 201, 4 Wellington Street, St. Thomas, Ontario, on the 12th day of June, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

REPORTED BY: Deana Santedicola, CSR, CRR, RPR & Carissa Stabbler, RPR, CSR

A P P E A R A N C E S:

Mark Zigler, Esq., & Elizabeth Hewitt, Esq., & Rebecca Jones, Esq., & Lara Kinkartz, Esq.,	Commission Counsel
Jane Meadus, Esq., & Suzan E. Fraser, Esq.,	Ontario Association of Residents' Councils
David M. Golden, Esq.,	Caressant Care Nursing and Retirement Homes Limited, Caressant Care - Woodstock
Denise Cooney, Esq., & Megan Schwartzentruber, Esq.	College of Nurses
Paul H. Scott, Esq.,	Jon Matheson, Pat Houde, Beverly Bertram
Dianne Martin, Esq.,	Registered Practical Nurses Association
Rita Bambers, Esq., & Judith Parker, Esq.,	Her Majesty the Queen in Right of Ontario

A P P E A R A N C E S (CONT'D):

Alex Van Kralingen, Esq., & Mark Repath, Esq.,	Arpad Jr. Horvath, Laura Jackson, Don Martin, Andrea Silcox, Adam Silcox-Vanwyk Shannon Lee Emmerton, Jeffrey Millard, Judy Millard, Sandra Lee Millard, Stanley Henry Millard, Susie Horvath
Kate Hughes, Esq., & Nicole Butt, Esq.,	Ontario Nurses Association
Lauren Binhammer, Esq.,	Registered Nurses' Association of Ontario

INDEX OF PROCEEDINGS

PAGE

WITNESS:
HELEN CROMBEZ; Under Prior Oath
Continued Cross-Examination by Ms. Hughes. 1141
Cross-Examination by Ms. Meadus..... 1172
Cross-Examination by Ms. Binhammer..... 1205
Cross-Examination by Ms. Martin..... 1210
Re-Examination by Mr. Golden..... 1215

WITNESS:
Karen Routledge; Sworn
Examination-in-Chief by Ms. Hewitt..... 1240

INDEX OF EXHIBITS

NO.	DESCRIPTION	PAGE
26	Registered Staff Contingency Plan For Working Short-Staffed.....	1136
27	Caressant Care Woodstock overtime document dated April 19, 2013.....	1136
28	Professional Responsibility Workload Reports filed by RN Lois Durbidge on December 20, 2010.....	1139
29	Professional Responsibility Workload Report filed by RN Jennifer Emmerson on March 23, 2011.....	1140
30	Professional Responsibility Workload Reports filed by RN Jacquelyn Morris on June 16, 2013.....	1140
31	Document entitled "RN and RPN Practice: The Client, the Nurse and the Environment.".....	1172
32	Inspection Report dated March 20, 2012.....	1188
33	Affidavit of Karen Routledge.....	1241

08:53:27 -- Upon commencing at 9:29 a.m.
09:29:18 MS. HEWITT: Commissioner,
09:29:22 Ms. Hughes is continuing her
cross-examination.
THE COMMISSIONER: Thank you so
much. Good morning, Ms. Hughes.
MS. HUGHES: Good morning. Just
a couple of housekeeping matters
with regard to marking exhibits
if we could start off with,
Madam Commissioner.
09:29:28 Yesterday I referred to two
09:29:29 documents, and I don't think
09:29:31 that they were marked as an
09:29:32 exhibit. The first is the
09:29:36 Caressant Care Woodstock memo
09:29:38 called Registered Staff
09:29:38 Contingency Plan For Working
09:29:43 Short-Staffed dated April 19,
09:29:43 2013. And I understand the next
09:29:45 exhibit is Exhibit 26.
09:29:47 THE COMMISSIONER: All right.
09:29:48 Just a minute there. I think I
09:29:56 remember that exhibit yesterday,
09:29:59 but I'm looking at the April
09:30:01 19th overtime. That's not the
09:30:02 same one; right?
09:30:04 MS. HUGHES: That's not the
09:30:04 same -- that's the one I would
09:30:05 like to mark as Exhibit 27.
09:30:06 THE COMMISSIONER: Sorry, I've
09:30:08 got it here. Registered Staff

09:30:08 Contingency Plan For Working
09:30:14 Short-Staffed?
09:30:14 MS. HUGHES: Yes.
09:30:14 THE COMMISSIONER: And
09:30:15 exhibit --
09:30:15 MS. HUGHES: 26 I'm advised.
09:30:17 THE COMMISSIONER: Thank you
09:30:18 very much. Madam Clerk, exhibit
09:30:20 26.
09:30:20 EXHIBIT NO. 26: Registered
09:30:20 Staff Contingency Plan For
09:30:22 Working Short-Staffed.
09:30:22 MS. HUGHES: And then if the
09:30:22 next document that you have, the
09:30:24 same Caressant Care Woodstock
09:30:26 overtime document dated
09:30:28 April 19, 2013, if we could mark
09:30:30 that Exhibit 27.
09:30:31 THE COMMISSIONER: Exhibit 27.
09:30:32 Thank you.
09:30:24 EXHIBIT NO. 27: Caressant Care
09:30:25 Woodstock overtime document
09:30:27 dated April 19, 2013.
09:30:33 MS. HUGHES: And then I handed
09:30:35 up -- and I was just in the
09:30:36 middle of reviewing three what's
09:30:38 called Professional
09:30:41 Responsibility Workload Reports.
09:30:41 And I'd like to mark those while
09:30:43 we're marking exhibits.
09:30:46 THE COMMISSIONER: Yeah, just
09:30:47 the moment, please.

09:30:48 MS. HUGHES: And if we could do
09:30:50 that in chronological order.
09:30:50 The first one is dated
09:30:53 December 20th, 2010, and it's
09:30:54 filed by RN Lois Durbidge.
09:31:02 THE COMMISSIONER: Just a
09:31:03 moment, please. So it's the ONA
09:31:18 Professional Responsibility
09:31:20 Workload Report form you said?
09:31:21 MS. HUGHES: That's correct.
09:31:23 THE COMMISSIONER: The first one
09:31:23 is not Jennifer Emmerson, which
09:31:23 I have, so --
09:31:25 MS. HUGHES: There's three of
09:31:26 them, and I'm just going to mark
09:31:28 them in chronological order if
09:31:31 that's possible.
09:31:32 THE COMMISSIONER: Yes,
09:31:33 absolutely. Just, again, I'm
not sure what tab --
MS. HEWITT: I just note,
Commissioner, that only one of
them so far has been put to the
witness.
THE COMMISSIONER: At least
let's get them organized, but
for some reason, I am only
09:31:53 finding they one from Jennifer
09:31:55 Emmerson, but I believe the
09:31:55 other one you already referred
09:31:56 to yesterday; right?
09:31:58 MS. HUGHES: I referred to one,

09:31:59 and I was just going to go
09:32:01 quickly through all three, but
09:32:03 if I can mark all three just to
09:32:05 mark it more efficient.
09:32:08 THE COMMISSIONER: All right. I
09:32:16 do apologize. Madam Clerk, can
09:32:19 you just give me a hand? I
09:32:20 don't seem to -- I have the
09:32:22 Jennifer Emmerson one.
09:33:04 Do you have yours, Madam Clerk?
09:33:06 THE COURT CLERK: I don't
09:33:06 believe I -- I'm not seeing
09:33:10 anything. I have 25 here.
09:33:11 THE COMMISSIONER: Do you have
09:33:12 spare copies?
09:33:13 MS. HUGHES: I don't know if we
09:33:14 could -- if anyone else -- I
09:33:15 handed them all --
09:33:16 THE COMMISSIONER: I'm sure that
09:33:17 you did. I think that what
09:33:18 happened when we broke --
09:33:21 interrupted the
09:33:23 cross-examination to let the
09:33:25 College in, perhaps the
09:33:26 documents got out of order
09:33:28 somewhat.
09:33:29 MS. HUGHES: Perhaps could we
09:33:30 just take a short break then?
09:33:32 THE COMMISSIONER: I think that
09:33:32 that would be helpful. And I do
09:33:35 apologize if that's my fault.
09:33:37 So what I'll do, Ms. Hughes,

09:33:39 is I will put what I have as the
09:33:42 big package of documents that I
09:33:43 thought came from you yesterday,
09:33:46 and I will obviously say that
09:33:49 anybody who wants to go through
09:33:50 these and see if they're
09:33:51 somewhere there, I would be
09:33:53 grateful.
09:33:54 MS. HUGHES: Thank you.
09:33:55 THE COMMISSIONER: All right.
09:33:58 Five minutes just or less.
09:34:08 THE COURT CLERK: Court is in
09:34:11 recess for five minutes.
09:34:11 -- RECESSED AT 9:34 A.M. --
09:46:30 -- RESUMED AT 9:46 A.M. --
09:46:30 THE COMMISSIONER: Okay, so we
09:46:50 entered Exhibits 26 and 27, and
09:46:54 now you would like to enter --
09:46:57 MS. HUGHES: I would like to
09:46:58 enter the three Professional
09:47:02 Responsibility Workload Reports.
09:47:02 And I think it makes sense in
09:47:03 chronological order, Madam
09:47:03 Commissioner.
09:47:06 So if I could start with the
09:47:10 one that was filed by RN Lois
09:47:10 Durbidge on December 20th, 2010,
09:47:12 which is, for the record, ID
09:47:14 Document 72587.
09:47:17 THE COMMISSIONER: Exhibit 28
09:47:18 then, Document 72587.
09:46:58 EXHIBIT NO. 28: Professional

09:47:10 Responsibility Workload Report
09:47:10 filed by RN Lois Durbidge on
09:47:11 December 20, 2010.
09:47:24 MS. HUGHES: The next one is
09:47:24 Professional Responsibility
09:47:11 Workload form dated March 23,
09:47:11 2011, filed by RN Jennifer
09:47:31 Emmerson, ID number 72584.
09:47:33 THE COMMISSIONER: Okay,
09:47:33 Madam Clerk, I do need that one
09:47:37 out of that stack. Thank you.
09:47:37 EXHIBIT NO. 29: Professional
09:47:10 Responsibility Workload Report
09:47:10 filed by RN Jennifer Emmerson on
09:47:11 March 23, 2011.
09:47:42 MS. HUGHES: And the next one is
09:47:45 a Professional Responsibility
09:47:45 form dated June 16, 2013, filed
09:47:47 by RN Jacquelyn Morris. If we
09:47:52 could mark that Exhibit 30.
09:47:53 That's ID Document 72585.
09:47:57 THE COMMISSIONER: Exhibit 30
09:47:58 then, Document 72585.
09:48:02 Thank you.
09:48:02 EXHIBIT NO. 30: Professional
09:47:10 Responsibility Workload Reports
09:47:10 filed by RN Jacquelyn Morris on
09:47:45 June 16, 2013.
09:48:09 THE COMMISSIONER: So if some of
09:48:10 those have not been referred to
09:48:12 and there's any problem,
09:48:12 Ms. Hughes, I think we will deal

09:48:15 with it at the time unless you
09:48:15 think there's not going to be a
09:48:16 problem with these documents.
09:48:18 All right. And anything
09:48:18 else?
09:48:18 MS. HUGHES: There will be one
09:48:21 more document I'll be referring
09:48:23 to. If you would like me to
09:48:24 mark it now, I can do so, or we
09:48:26 can wait until it comes up.
09:48:26 THE COMMISSIONER: Let's wait,
09:48:28 then, until it comes up.
09:48:28 MS. HUGHES: Okay.
09:48:31 THE COMMISSIONER: All right.
09:48:31 Thank you so much. Go ahead
09:48:33 then.
09:48:33 CROSS-EXAMINATION BY MS. HUGHES:
09:48:33 Q. Helen, if I could ask you
09:48:35 some questions about the Professional
09:48:37 Responsibility Workload Report form. I asked
09:48:38 you a couple yesterday, and I just want to ask
09:48:40 you, if we could look at each one of them, each
09:48:44 one seems to be professional responsibility
09:48:47 concerns about working short. Would you agree?
09:48:49 A. Yes.
09:48:51 MR. GOLDEN: Could we --
09:48:53 Commissioner, we only dealt with
09:48:54 one yesterday. Before we start
09:48:57 treating them as a group and
09:48:58 asking Helen questions about it,
09:49:00 I'd like to establish that she's
09:49:02 seen them, that she's aware of

09:49:04 them, what her connection to
09:49:06 them is before we get into
09:49:08 making inferences about what
09:49:10 they say or don't say.
09:49:11 BY MS. HUGHES:
09:49:11 Q. All right. As a director of
09:49:15 nursing, you would receive all Professional
09:49:19 Responsibility Workload Report forms; is that
09:49:19 correct?
09:49:19 A. Yes.
09:49:19 Q. And so you've seen all of
09:49:21 these documents; is that correct?
09:49:22 A. Well, I don't recall them,
09:49:24 but I see them now, yes.
09:49:26 Q. But as your position, you
09:49:32 were responsible for looking at those when
09:49:34 they're filed; is that correct?
09:49:35 A. Yes.
09:49:35 Q. Okay. And so with respect to
09:49:37 all three, all three deal with concerns about
09:49:41 nurses or concern about the safety because
09:49:44 they're working short; is that correct?
09:49:45 A. The safety? They talk to the
09:49:58 change in patient acuity and unable to complete
09:50:04 some of the assigned duties.
09:50:08 Q. So with respect to the first
09:50:10 one, for example, the RN was left with, as we
09:50:13 can see in Section 2, a total of 163 residents
09:50:16 to care for, is that correct, alone?
09:50:18 A. She would oversee the care of
09:50:22 163, yes.
09:50:25 Q. And if you could look

09:50:26 underneath that where at the very bottom
09:50:29 corner, if we move that up in that section, it
09:50:30 says:
09:50:30 "An ongoing problem."
09:50:31 And it's checked yes; is that correct?
09:50:33 A. That's correct.
09:50:33 Q. If we could look at the
09:50:35 second page under "Recommendations," and we can
09:50:41 see that:
09:50:43 "Adjust RN staffing."
09:50:43 And that's marked; is that correct?
09:50:44 A. Yes.
09:50:46 Q. Okay. And there's also
09:50:49 another one in the middle. It says:
09:50:51 "Float/casual pool."
09:50:53 Did you have a pool of float nurses or casual
09:50:57 nurses that you could call upon?
09:50:59 A. We didn't really have a float
09:51:01 pool. We had part-time RNs that would take
09:51:06 calls.
09:51:06 Q. And if we could look at the
09:51:09 next document, 72584, this is a different RN
09:51:12 who has reported, and this is now 2011. And,
09:51:16 again, she indicates that she's short-staffed
09:51:23 and that there is -- she says:
09:51:27 "Short-staffed, therefore the
09:51:29 writer responsible for 164
09:51:31 residents. Approximately 3
09:51:33 residents for palliative and 1
09:51:34 passed away and 2 people on
09:51:37 HRI."
09:51:37 Which is head injury; is that correct?

09:51:39 A. That's correct.
09:51:39 Q. Okay. And then she goes on
09:51:42 to say:
09:51:43 "Nursing home in gastro outbreak
09:51:46 twenty plus residents on line
09:51:47 listing with symptoms."
09:51:48 So that was an extremely heavy workload to work
09:51:54 short-staffed. Would you agree?
09:51:56 A. Yes.
09:51:56 Q. And she's indicated below
09:51:58 that:
09:51:58 "Ongoing problem."
09:51:59 And she's marked X?
09:52:01 A. Yes.
09:52:01 Q. And if you look at page 2,
09:52:03 under "Remedy," and then we see under B:
09:52:11 "Short-staffing on N ongoing
09:52:16 issues."
09:52:16 Do you see that?
09:52:16 A. Yes.
09:52:17 Q. And under "was it resolved,"
09:52:20 and it's marked "no"?
09:52:22 A. Yes.
09:52:22 Q. And if you could look at
09:52:23 page 3, under "Recommendations," there's a
09:52:29 check mark for "adjust RN staffing." Do you
09:52:32 see that?
09:52:32 A. Yes.
09:52:32 Q. And for -- at the top:
09:52:35 "Review nurse/patient ratio."
09:52:37 Do you see that?
09:52:38 A. Yes.

09:52:39 Q. All right. If we could go to
09:52:42 the next document, Document 7285, which is a
09:52:45 third RN, Jacquelyn Morris, filing this report
09:52:49 in June of 2013. And under Section 2, we see:
09:52:59 "Short-staffed again."
09:53:00 Do you see that?
09:53:00 A. Yes.
09:53:00 Q. And then in the second line:
09:53:02 "Overtime was not allowed for
09:53:04 day RPN to do the medication
09:53:08 pass."
09:53:09 Do you see that?
09:53:09 A. Yes.
09:53:09 Q. Okay. And then underneath
09:53:15 that, it says -- marked off for an ongoing
09:53:17 problem.
09:53:19 And then at the bottom of the
09:53:20 page under Section 4, this RN has written:
09:53:24 "Lack of help. Too many
09:53:26 residents/nurse ratio."
09:53:27 Do you see that?
09:53:28 A. Sorry, what page is this?
09:53:34 Q. The bottom of the first page,
09:53:36 Section 4:
09:53:37 "Lack of help. Too many
09:53:39 residents/nurse ratio."
09:53:40 So she's raising the resident/nurse ratio
09:53:45 issue. Do you see that at the bottom?
09:53:45 A. Oh, yes.
09:53:48 Q. And if you could go to page
09:53:50 2, under B, under "Resolution":
09:53:59 "Manager on call was notified of

09:54:02 1 the crisis, and no actions were
09:54:03 2 taken of the manage" --
09:54:09 3 I can't read the next word. Something of the
09:54:12 4 manager. And indicates under that, to discuss
09:54:17 5 the issue with the manager, it says:
09:54:18 6 "Issue was discussed in person,
09:54:20 7 by phone. No action taken."
09:54:21 8 Do you see that?
09:54:21 9 A. Yes.
09:54:22 10 Q. Okay. And was that brought
09:54:24 11 to your attention by the Assistant Director of
09:54:26 12 Nursing?
09:54:26 13 A. I don't recall.
09:54:29 14 Q. Is it possible it was?
09:54:32 15 A. Yes.
09:54:33 16 Q. All right. And under
09:54:33 17 "Recommendations" again, we have
09:54:35 18 recommendations under -- "adjust RN staffing"
09:54:39 19 is marked off. Do you see that?
09:54:44 20 A. Yes.
09:54:44 21 Q. And handwritten:
09:54:46 22 "Should allow one of the day
09:54:48 23 RPNs to stay for first
09:54:50 24 medication pass to allow to stay
09:54:54 25 overtime from days."
09:54:56 26 Do you see that?
09:54:56 27 A. Yes.
09:54:56 28 Q. Okay. And so when you were
09:54:59 29 asked earlier about whether or not nurses were
09:55:03 30 advocating for more staff, it's clear that your
09:55:06 31 nurses have been consistently advocating for
09:55:09 32 more nursing staff; is that correct?

09:55:10 A. Yes.
09:55:11 Q. Okay.
09:55:12 A. And I was, you know, advertising for staff, and we were following up with those nurses that had attendance that -- issues that put a strain on the nursing department as well.
09:55:29 Q. Okay. And in addition to the nurses who may call in sick, because everyone gets sick from time to time, Brenda also said she thought that there needed to be more RNs on every shift when she gave evidence here at this proceeding. Do you agree with that?
09:55:46 A. Yes, I would.
09:55:48 Q. And she thought that the nurse/patient or nurse/resident ratio was not right, and she thought it would be more in the order of 10 to 1. Do you agree with that too?
09:56:00 A. I had a slightly different ratio in mind.
09:56:09 Q. Okay. And what ratio did you have in mind?
09:56:11 A. I thought 20 patients per RN, 20 residents.
09:56:19 Q. In any case, whether or not it's 20, that would involve more nurses on every single shift, wouldn't it?
09:56:25 A. Yes.
09:56:26 Q. And that would be in both areas, A and B?
09:56:28 A. Yes.
09:56:29 Q. And as the Director of

09:56:31 Nursing, in addition to looking at staffing
09:56:36 issues, you're also responsible for
09:56:39 administering and implementing the Collective
09:56:42 Agreement for the nurses; is that correct?
09:56:43 A. I follow the Collective
09:56:53 Agreement as far as vacation time and statutory
09:56:56 holidays.
09:56:56 Q. Okay. Well, we won't go
09:56:58 through every element of the Collective
09:57:02 Agreement, but you're familiar with the
09:57:03 Collective Agreement? That's part of your job
09:57:04 to be familiar?
09:57:05 A. I don't know it line by line.
09:57:08 I would refer to it, you know, when I needed
09:57:09 to.
09:57:09 Q. And as well as the Director
09:57:12 of Nursing, you're responsible for knowing
09:57:15 College standards, policies, and guidelines to
09:57:15 ensure that your regulated staff are working in
09:57:20 accordance with College regulations; is that
09:57:22 correct?
09:57:22 A. Yes.
09:57:22 Q. Okay. And in terms of the
09:57:24 residents, I think you've already told us that
09:57:26 the acuity of the residents in long-term care
09:57:29 homes has been increasing. Certainly you've
09:57:32 seen that over the 30 years you've been in
09:57:34 long-term care; is that correct?
09:57:35 A. Yes.
09:57:36 Q. And so therefore, what you're
09:57:38 seeing now is residents with more complex
09:57:41 medical conditions; is that correct?

09:57:42 A. More complex or they're just
09:57:49 frailer when they come. We also have residents
09:57:55 with more behaviours. That takes a lot of time
09:58:00 and effort.
09:58:01 Q. And as well, you have
09:58:03 residents with what's called comorbidity. So
09:58:08 they have multiple different medical problems;
09:58:10 is that correct?
09:58:10 A. That's correct.
09:58:11 Q. Okay. As a result, that
09:58:12 requires both more of a workload and more of an
09:58:16 assessment because people could be less
09:58:18 predictable with these comorbidities and
09:58:22 frailty; is that correct?
09:58:23 A. That's correct.
09:58:23 Q. And, of course, then there
09:58:25 would be with being frailer and having
09:58:30 comorbidities, you're going to have more risk
09:58:32 of negative outcomes, so it requires more
09:58:35 complex assessments. Would you agree with
09:58:38 that?
09:58:38 A. Yes.
09:58:38 Q. Okay. And I'm going to ask
09:58:39 you to look at the document in front of you.
09:58:42 It's 54989.
09:58:46 MS. HUGHES: Madam Commissioner,
09:58:47 we haven't marked it as an
09:58:49 exhibit yet. It's a College of
09:58:51 Nurses document called "RN and
09:58:52 RPN Practice."
09:58:52 BY MS. HUGHES:
09:59:00 Q. And, Helen, you would be

09:59:01 1 familiar with this College document; is that
09:59:03 2 correct?
09:59:03 3 A. What's the number, please?
09:59:16 4 Q. It is 54989. It's on the
09:59:22 5 screen. "RN and RPN Practice."
09:59:22 6 A. Yes.
09:59:22 7 Q. Okay. If we could turn to
09:59:24 8 page 5, the College has what those in the
09:59:28 9 nursing profession know as called the
09:59:31 10 three-factor framework at page 5, and that sets
09:59:34 11 out the client factors as:
09:59:37 12 "1. Complexity.
09:59:40 13 2. Predictability.
09:59:41 14 3. Risk of negative outcome."
09:59:42 15 Are you familiar with that?
09:59:43 16 A. I haven't thought about it in
09:59:48 17 quite some time, but yes.
09:59:49 18 Q. Okay. And it indicates that
09:59:51 19 there's a continuum. And if we could look at
09:59:56 20 the last paragraph on that page, it says:
09:59:58 21 "All nurses can autonomously
09:59:58 22 care for clients who have been
09:59:59 23 identified as less complex, more
10:00:02 24 predictable, and low risk of
10:00:03 25 negative outcomes, but the more
10:00:06 26 complex the care requirements,
10:00:07 27 the greater the need for
10:00:08 28 consultation and the greater the
10:00:10 29 need for an RN to provide the
10:00:12 30 full spectrum of care."
10:00:14 31 Do you see that?
10:00:14 32 A. Yes.

10:00:15 Q. And so what we have in terms
10:00:16 of these types of assessments, that would fall
10:00:19 on the continuum for the RN versus the RPN; is
10:00:22 that correct?
10:00:22 A. I don't believe that that's
10:00:26 how it was designed or set up at Caressant
10:00:33 Care.
10:00:33 Q. And that's the College's
10:00:35 guideline; is that correct?
10:00:36 A. That's correct.
10:00:36 Q. Thanks. Now, so in terms of
10:00:42 the Inquiry, because the Inquiry is looking at
10:00:45 issues like how to -- the main issue, how to
10:00:48 prevent similar situations in the future.
10:00:52 And would you agree with me that
10:00:53 what you need in long-term care is both enough
10:00:56 staff and the staff with the right skills to be
10:00:59 able to assess these vulnerable residents?
10:01:02 A. Yes, but you have to have the
10:01:09 staff to hire in the first place, and that's
10:01:12 one of the big issues, I think, across the
10:01:19 spectrum.
10:01:21 You know, driving in today, we
10:01:22 saw several signs asking -- or two signs
10:01:26 actually specifically, one -- or two signs
10:01:28 asking for PSWs and one asking for registered
10:01:33 nurses.
10:01:34 Q. Okay. And so you've said
10:01:36 that there's a shortage of nurses, and you've
10:01:39 told us about that.
10:01:40 Did you actually have approval
10:01:41 from head office to hire more nurses more than

10:01:46 was set out as being one night nurse
10:01:49 for example, more than one RN? Did you have
10:01:52 approval?
10:01:53 A. No.
10:01:53 Q. Now, we've heard some
10:01:55 evidence and we have in various Overview
10:02:00 Reports that -- for instance, if you could look
10:02:02 at your Affidavit, paragraph 248 as an example.
10:02:09 And that's at page 48 of your Affidavit.
10:02:16 And this is where you talk in
10:02:21 your Affidavit with respect to what you found
10:02:23 out afterwards. You, of course, didn't know
10:02:26 about Ms. Wettlaufer's crimes at the time. And
10:02:28 at paragraph 248, you said:
10:02:30 "We reviewed the documentation
10:02:32 together" --
10:02:33 That's with the police.
10:02:33 "-- and it was clear that what
10:02:35 she said was probably true.
10:02:37 There were three residents who
10:02:38 had symptoms of sweating, which
10:02:41 is a symptom of low blood
10:02:44 sugar."
10:02:44 And so we have heard about that, and in order
10:02:48 to -- for the residents to be assessed for
10:02:53 whether or not they should or should not be
10:02:56 sweating, whether or not there was a change in
10:02:59 condition knowing their medical conditions and
10:03:02 then to act quickly on it to reverse insulin
10:03:05 overdose, you're going to need the right staff
10:03:07 to do that; is that correct?
10:03:08 A. That's correct.

10:03:09 Q. Now, I want to now turn to
10:03:14 the Collective Agreement, which you have in
10:03:15 front of you, Exhibit 12. And if you could
10:03:17 turn -- and that is Document 70956. We've
10:03:21 marked it as Exhibit 12. If we could turn to
10:03:25 page 16.
10:03:34 And, Helen, you'll see there's a
10:03:38 section called "Probationary Period." You
10:03:41 hired Ms. Wettlaufer in June 27, 2007, so she,
10:03:45 of course, would be on a probationary period;
10:03:48 is that correct?
10:03:48 MR. GOLDEN: Madam Commissioner,
10:03:48 I just rise because this
10:03:50 Collective Agreement was not in
10:03:51 place when Ms. Wettlaufer was
10:03:53 hired, and I think if there's
10:03:54 going to be questioning about
10:03:56 the Collective Agreement that
10:04:01 applied when Ms. Wettlaufer was
10:04:02 hired, that's the document that
10:04:04 should be put to the witness,
10:04:05 not this one.
10:04:08 MS. HUGHES: All right. I'll
10:04:10 ask the witness general
10:04:12 questions then.
10:04:13 BY MS. HUGHES:
10:04:14 Q. This Collective Agreement --
10:04:15 and I understand all the previous Collective
10:04:17 Agreements had what's called a probation
10:04:18 period. Are you familiar with that?
10:04:19 A. Yes.
10:04:20 Q. Okay. And so when you hired

10:04:22 your nurses, they were put on a probationary
10:04:24 period; is that right?
10:04:25 A. Yes.
10:04:26 Q. Okay. And so for a part-time
10:04:29 nurse, I understand that the probationary
10:04:31 period was 450 hours worked or 6 months,
10:04:36 whichever comes first?
10:04:37 MR. GOLDEN: I rise again.
10:04:39 That's exactly quoting from the
10:04:41 2014 Collective Agreement. I
10:04:42 don't want there to be guessing.
10:04:44 If there's evidence here about
10:04:45 what it was in 2007 as opposed
10:04:48 to 2014, let's put that to the
10:04:50 witness; otherwise let's not
10:04:52 suggest to her it was 450 days
10:04:55 when that's reading right from
10:04:57 the 2014 agreement.
10:04:58 BY MS. HUGHES:
10:04:59 Q. Do you recall that there was
10:05:00 a probation period for Elizabeth Wettlaufer?
10:05:03 A. There was a probationary
10:05:06 period, but I don't recall the length of time.
10:05:08 Q. And I understand that the
10:05:09 length of time -- this section was in place at
10:05:12 the time. Do you know one way or the other?
10:05:14 A. Would you repeat that,
10:05:18 please?
10:05:18 Q. I understand that this --
10:05:19 this is not a new section in the probationary
10:05:21 period, that that was in place in 2007?
10:05:25 A. I can't recall.

10:05:25 Q. Okay. And in any case, with
10:05:28 respect to the probationary period then, we
10:05:31 know that an employer can let go someone during
10:05:36 the probationary period. They don't have to
10:05:39 have what you call a great case or just cause,
10:05:42 but it's a different standard. You're familiar
10:05:46 with that?
10:05:46 MS. HEWITT: Sorry, I mean, my
10:05:47 friend is quoting -- I hate to
10:05:50 interrupt you, but she's quoting
10:05:51 what appears to be a legal
10:05:52 argument without putting it to
10:05:54 the witness whether or not she
10:05:55 understands the argument itself.
10:05:58 MS. HUGHES: Madam Commissioner,
10:05:59 I keep being interrupted. I
10:06:01 have very short time. I've only
10:06:03 been given a very short period
10:06:05 of time for 27 witnesses for the
10:06:05 facilities, and I would like to
10:06:07 be able to ask -- cross-examine
10:06:09 this witness and ask her
10:06:10 questions.
10:06:10 I don't think I'm being
10:06:11 unfair to her. A probationary
10:06:13 period is a matter that is
10:06:15 standard across the industry.
10:06:16 As a Director of Nurses for 30
10:06:18 years, who hires nurses, she
10:06:20 would be familiar with it. And
10:06:21 I'm not being unfair to the
10:06:23 witness.

10:06:23 THE COMMISSIONER: I don't have
10:06:24 any problem with that, but I do
10:06:27 have a problem when you put
10:06:28 specifics that may have changed
10:06:30 over time such as duration or so
10:06:32 on.
10:06:32 MS. HUGHES: I don't believe it
10:06:34 has changed over time.
10:06:35 THE COMMISSIONER: Yes, you may
10:06:37 not, but I don't know that and
10:06:39 neither does the witness.
10:06:41 MS. HUGHES: All right.
10:06:43 THE COMMISSIONER: But the
10:06:43 nature of your questions in a
10:06:43 general way is acceptable, so if
10:06:43 you --
10:06:43 MS. HUGHES: Thank you.
10:06:43 THE COMMISSIONER: -- I don't
10:06:44 think there should be a problem.
10:06:44 BY MS. HUGHES:
10:06:46 Q. And so Elizabeth Wettlaufer
10:06:46 was put on probation; is that correct?
10:06:48 A. Yes.
10:06:48 Q. Okay. And so when you're on
10:06:50 probation, you can -- that is a period of time
10:06:53 for the employer to determine whether or not
10:06:56 the employee is suitable; is that correct?
10:06:58 A. Yes.
10:06:59 Q. Okay. And you don't have the
10:07:01 same standard with respect to having to have
10:07:03 just cause to terminate. You can simply say
10:07:06 before the probationary period is up, you're

10:07:09 unsuitable, let them go, and there will be no
10:07:11 grievance; is that correct?
10:07:11 A. Yes.
10:07:12 Q. Okay. And if you have
10:07:14 concerns about an employee, you can also ask
10:07:17 for a probationary period to be extended. You
10:07:21 could ask the union to extend it; is that
10:07:22 correct?
10:07:22 A. Yes.
10:07:22 Q. Okay. And so with respect to
10:07:25 the probationary period, you didn't ask for it
10:07:28 to be extended for Ms. Wettlaufer, did you?
10:07:32 A. I can't recall.
10:07:32 Q. And in the first six months
10:07:34 that she worked there, problems occurred for
10:07:37 her that you became aware of; is that correct?
10:07:39 A. Yes.
10:07:43 Q. Okay. And if I could look at
10:07:45 Document 16918. And this is meeting notes to
10:08:09 you, Helen, about matters in November 12th,
10:08:14 2017. You see from the dates. Do you recall
10:08:17 that?
10:08:17 A. I don't recall.
10:08:20 Q. Sorry, 2007. November 12,
10:08:22 2007. Do you recall that?
10:08:27 A. No, I don't recall that.
10:08:29 Q. All right. Then let's go to
10:08:31 Document 16917. This is an investigative
10:08:45 meeting November 12, 2007. And in attendance
10:08:47 is Bethe Wettlaufer, and you're in attendance
10:08:50 as well. Do you see that?
10:08:51 A. Yes.

10:08:52 Q. And a union rep called
10:08:57 Mirian Wright. So this was on November 12th.
10:09:00 We see that there was raising issues about a
10:09:05 medication error. Do you see that?
10:09:07 A. Yes.
10:09:07 Q. Okay. And if you could just
10:09:08 have the page pulled up a little bit. Two
10:09:08 issues were raised by you. First was the
10:09:19 medication error, and then the last line of the
10:09:20 second paragraph:
10:09:20 "Mrs. Crombez told Beth that her
10:09:23 attendance is below that which
10:09:24 is expected of a professional,
10:09:24 and that perhaps she make some
10:09:26 lifestyle changes or talk to her
10:09:29 Doctor."
10:09:30 So you thought that she had some health issues;
10:09:33 is that right?
10:09:33 A. Well, if she was missing work
10:09:36 because she was ill.
10:09:38 Q. And so my understanding is
10:09:40 that was during her probationary period, but
10:09:44 you didn't let her go at that time, did you?
10:09:46 A. No, I didn't.
10:09:49 THE COMMISSIONER: For my
10:09:50 clarification, was it during her
10:09:52 probationary period?
10:09:53 THE WITNESS: I assume so. I --
10:09:56 BY MS. HUGHES:
10:09:56 Q. And she was a part-time nurse
10:09:58 at that point; is that correct?
10:10:01 A. June --

10:10:02 Q. 27, 2007.
10:10:03 A. She was hired, so...
10:10:05 Q. So she was a part-time nurse.
10:10:06 She would assume that the probationary period
10:10:09 would continue to the end of December 2007?
10:10:10 A. Yes.
10:10:11 Q. So you indicated yes? It was
10:10:19 hard to hear.
10:10:19 A. Yes.
10:10:20 Q. Thank you. During that
10:10:21 period of time, we know that she overdosed,
10:10:27 both Ms. Adriano and Ms. DeMedeiros, and that
10:10:27 she murdered Mr. Silcox during that six-month
10:10:35 period.
10:10:35 MR. GOLDEN: What we know from
10:10:36 the confession and now is --
10:10:41 BY MS. HUGHES:
10:10:41 Q. Okay, we now know that,
10:10:43 right, during that period of time. All right.
10:10:44 Let's move on.
10:10:45 After the probationary period,
10:10:47 we have about 40 matters that you met with her,
10:10:52 counselled, verbal, written. I'm not going to
10:10:54 go through each one of those, but if you could
10:10:57 look at your Affidavit, paragraph 90. You've
10:11:12 got that?
10:11:13 So you indicated yesterday in
10:11:15 answer to someone's questions that the union,
10:11:19 quote, liked to grieve. There are -- with
10:11:23 respect to paragraph 90, there are a number of
10:11:27 issues, so we've got the June 19th, 2008,
10:11:32 counselling. That was not grieved, was it?

10:11:37 A. There's -- you have no right
10:11:38 to grieve a counselling, so that's a --
10:11:41 Q. It's disciplinary, and you
10:11:45 can grieve discipline; is that --
10:11:46 A. Counselling is not
10:11:47 disciplinary.
10:11:47 Q. All right. Then you have a
10:11:49 verbal warning on July 7th. That was not
10:11:52 grieved? 2010.
10:11:56 A. I don't really know. That
10:11:58 was, you know, usually the administrator and
10:12:00 head office that dealt with that.
10:12:01 Q. Okay. And so we've asked
10:12:03 Brenda about that, and that was not grieved.
10:12:05 I'm putting to you -- you said they liked to
10:12:07 grieve, but none of these matters that are set
10:12:12 out, including the verbal warnings, the written
10:12:12 warnings, and the one-day suspension on
10:12:14 August 26, 2011, that was not grieved?
10:12:16 A. And what about near the end
10:12:18 of her employment?
10:12:19 Q. Okay. And let's go to the
10:12:22 next grouping that you have in your Affidavit
10:12:26 with respect to this. And that would be found
10:12:32 at paragraph 93.
10:12:39 And those are matters with
10:12:40 respect to inappropriate comments and conduct.
10:12:44 She never grieved any of those, did she?
10:12:46 A. There was one that could be
10:12:50 grieved.
10:12:51 Q. And she did not -- ONA did
10:12:54 not grieve that?

10:12:56 A. I don't know.
10:12:57 Q. If we could now turn to the
10:12:59 next paragraph, and that's paragraph 104. And
10:13:04 there are ten matters there. And those --
10:13:11 there was no grieving with respect to work
10:13:16 performance; is that correct?
10:13:17 A. I can't recall.
10:13:18 Q. So you can't dispute Ms. --
10:13:24 Brenda when she indicated that there were no
10:13:26 grievances?
10:13:27 A. If that's what she said, then
10:13:31 that's true.
10:13:31 Q. Okay. In paragraph 185, and
10:13:34 this is where there's a listing of medication
10:13:36 errors. And with respect to the medication
10:13:44 errors, you see the item March 19, 2013, a
10:13:50 one-day suspension, that was not grieved; is
10:13:56 that correct? And then we have evidence on the
10:13:57 April 12th --
10:14:00 MS. HEWITT: Sorry, there's no
10:14:03 answer, and I think Helen --
10:14:05 Ms. Crombez has answered she's
10:14:05 not aware as to whether or not
10:14:07 they specifically were grieved.
10:14:10 BY MS. HUGHES:
10:14:10 Q. Okay. So with respect,
10:14:12 Helen, you said the union liked to grieve. For
10:14:14 these seven years and these many, many matters
10:14:17 that you had, there was a total of three
10:14:20 grievances; is that right?
10:14:22 A. For this particular employee,
10:14:25 yes.

10:14:25 Q. Okay. And so the five-day
10:14:28 suspension on April 12, 2013, it was grieved
10:14:30 and then very quickly withdrawn; is that
10:14:33 correct?
10:14:33 A. I don't have knowledge of
10:14:38 that. I've heard it here, and that's all I
10:14:42 know.
10:14:42 Q. All right. So then you
10:14:44 actually say you can't give any evidence other
10:14:46 than what you've heard here.
10:14:50 So then I will move to another
10:14:53 area then, which is the union rep, we know that
10:14:58 the union rep has changed, and one was
10:15:01 Karen Routledge.
10:15:02 When we look at the
10:15:03 documentation, she was the one that was there
10:15:08 more than the other union reps in terms of
10:15:10 meetings. But even her, out of what we've
10:15:14 counted as 43 matters that there were meetings,
10:15:17 she was only at 13 of them.
10:15:19 So would you agree with me that
10:15:21 she was only at a small number compared to the
10:15:24 matters that you --
10:15:26 A. She was --
10:15:27 MR. GOLDEN: Look, this is
10:15:28 very -- you've got to put to the
10:15:31 witness what grievances there
10:15:33 are, what meetings there were,
10:15:34 and where Karen attended. And
10:15:35 if Karen wasn't there, the
10:15:36 evidence has been so far there
10:15:39 were other union reps there.

10:15:41 1 So to suggest that
10:15:44 2 Karen Routledge was only there
10:15:46 3 for a, quote, small number,
10:15:47 4 let's put this into context.
10:15:50 5 I'm not sure what the question
10:15:51 6 is.
10:15:52 7 THE COMMISSIONER: Well, if I
10:15:53 8 can, I think perhaps you rose
10:15:55 9 just a bit early. The question
10:15:57 10 was partway through.
10:15:58 11 I believe that what the
10:15:59 12 question was is does this
10:16:01 13 witness agree that even though
10:16:03 14 Karen Routledge was at more
10:16:05 15 meetings than others, it was
10:16:08 16 still a small percentage. So in
10:16:11 17 that case, your complaint about
10:16:12 18 the question is?
10:16:13 19 MR. GOLDEN: Well, we would have
10:16:16 20 to go through and identify which
10:16:18 21 of the ones that Karen Routledge
10:16:20 22 is at, and I don't know whether
10:16:21 23 the witness is going to be asked
10:16:23 24 to do that.
10:16:24 25 THE COMMISSIONER: I guess the
10:16:25 26 difficulty I'm having is a bit
10:16:27 27 relaxed rules because it's an
10:16:29 28 inquiry, and much of this was
10:16:32 29 canvassed in the
10:16:35 30 examination-in-chief.
10:16:38 31 I'm sure that the witness has
10:16:40 32 been cautioned that if there's

10:16:42 any specks of the question that
10:16:45 she's not clear of or unsure of,
10:16:50 that she should say so.
10:16:52 She impresses me as someone
10:16:54 who is careful in the questions,
10:16:56 so why don't we let the
10:16:58 questioning go for a bit and see
10:17:00 how we do.
10:17:01 MR. GOLDEN: Sure.
10:17:03 BY MS. HUGHES:
10:17:04 Q. So, Helen, Ms. Routledge was
10:17:05 at less of meetings than you were at; is that
10:17:08 correct?
10:17:08 A. She -- Karen wasn't a union
10:17:09 rep for that whole period.
10:17:10 Q. Pardon me?
10:17:11 A. Karen wasn't a union rep for
10:17:13 that whole period.
10:17:15 Q. I agree.
10:17:17 A. And she wasn't always
10:17:18 available. So when she wasn't available, we
10:17:24 would ask a member to act as a witness.
10:17:28 Q. And at any time, did you
10:17:33 contact the Labour Relations Officer at ONA and
10:17:36 ask them to sit in for a meeting instead?
10:17:38 A. No.
10:17:40 Q. You always knew who the
10:17:42 Labour Relations Officer was; right? They
10:17:44 would send you a letter and advise you; is
10:17:47 that --
10:17:47 A. Yes, I believe so.
10:17:48 Q. All right. But in any case,

10:17:52 Karen Routledge was at, we understand,
10:17:54 approximately 13 of the matters -- 13 of the
10:18:00 meetings that you went through out of 43
10:18:02 matters that were canvassed by Ms. Hewitt with
10:18:05 you.
10:18:07 And in addition to that,
10:18:08 Ms. Routledge came to you independently and
10:18:11 raised concerns about Bethe Wettlaufer, didn't
10:18:14 she?
10:18:14 A. I don't recall.
10:18:17 Q. Let's see if you can recall
10:18:19 this: She came to you and said that Elizabeth
10:18:23 was scheduling breaks to coincide with the
10:18:28 students and socializing inappropriately with
10:18:30 the students, bringing in food for the students
10:18:33 and the PSWs, and she thought that that was
10:18:37 unprofessional. Do you recall that?
10:18:37 A. Yes. I believe we had a
10:18:39 meeting to that.
10:18:41 Q. And that was unprofessional
10:18:42 because the RN would be supervising, for
10:18:49 instance, PSWs and it may be that by giving
10:18:52 them food, et cetera, and becoming too chummy
10:18:56 with them, that they would not report things
10:18:58 about her?
10:18:58 A. That's true.
10:18:59 Q. Okay. And you dismissed her
10:19:03 concern, didn't you?
10:19:03 A. No. We had a meeting.
10:19:05 Q. And what was your position?
10:19:08 A. That was part of the
10:19:10 documentation.

10:19:12 Q. What was your response to
10:19:15 that concern when the ONA rep, Karen Routledge,
10:19:18 raised that with you?
10:19:19 A. That we would look after it,
10:19:24 or, you know, I would have asked her to put it
10:19:26 in writing if it was a verbal concern. And we
10:19:31 did talk to Bethe about that.
10:19:33 Q. Pardon me? I apologize for
10:19:36 interrupting you.
10:19:37 Are you sure that you told her
10:19:38 that? Because I believe it will be her
10:19:41 evidence today that you dismissed it out of
10:19:43 hand.
10:19:43 A. I believe there was evidence
10:19:48 that we talked to Bethe about rushing
10:19:51 downstairs at 5:30, and she said she rushed
10:19:57 downstairs because she was starving. That was
10:20:01 reviewed here at the inquiry.
10:20:06 Q. Now, I'm going to ask you to
10:20:08 look at your Affidavit again, the Affidavit at
10:20:13 page 17, paragraph 63.
10:20:21 And you indicated in your
10:20:23 Affidavit that you swore that you believed it
10:20:25 was only a year that you can rely on previous
10:20:29 discipline. And we've gone through this with
10:20:32 Brenda, and the period in the Collective
10:20:34 Agreement is actually 18 months.
10:20:37 Have you had a chance to review
10:20:38 that now and see that that was an error?
10:20:41 A. Yes.
10:20:41 Q. Okay. But that was your
10:20:44 understanding at the time?

10:20:45 A. Yes.
10:20:45 Q. Okay. And for the 18 months then, if there is no further discipline, then
10:20:47 some discipline comes off, but if there's no
10:20:51 18-month period that's discipline-free, it all
10:20:54 stays on; is that correct?
10:20:57 A. I hadn't really thought about it that far, but...
10:20:58 Q. And there's no 18-month period between disciplines for
10:21:02 Bethe Wettlaufer, was there?
10:21:03 A. No.
10:21:04 Q. And you indicated -- and you were candid about that -- that you didn't
10:21:10 track, you didn't have any of these disciplines
10:21:16 on a spreadsheet. And you've agreed,
10:21:18 I believe, that that was a mistake. That would
10:21:21 have been helpful for you; is that right?
10:21:23 A. Yes.
10:21:26 Q. Okay. And so as a result, you weren't able to see the big picture. You
10:21:27 were just looking back at the most recent
10:21:29 discipline; is that right?
10:21:33 A. Well, the most recent two or three.
10:21:35 Q. Okay. But you weren't seeing -- you were seeing a couple of pieces of
10:21:36 the puzzle, but you weren't seeing the whole
10:21:37 puzzle put together; would that be fair?
10:21:37 Sorry, was that yes?
10:21:40 A. Yes.
10:21:42 Q. Okay. Thank you. And with
10:21:45
10:21:51
10:21:52
10:21:52

10:21:55 1 respect to Ministry guidelines about what money
10:22:00 2 comes out of what envelope, had you ever
10:22:03 3 reviewed the Ministry guidelines to figure out
10:22:05 4 what monies settlement funds come out of?
10:22:08 5 A. No.
10:22:09 6 Q. Okay. And so at paragraph
10:22:13 7 65, when you say a settlement would come out of
10:22:16 8 nursing and personal care envelope, you didn't
10:22:19 9 actually know that for a fact; is that right?
10:22:21 10 A. Well, I knew it, but I -- you
10:22:26 11 know, I hadn't looked it up in the document.
10:22:28 12 Q. Okay. And who told you that?
10:22:28 13 A. Well, probably the
10:22:31 14 administrator.
10:22:32 15 Q. And that would have been
10:22:36 16 Brenda?
10:22:36 17 A. Or Bonnie. I have had seven
10:22:40 18 administrators.
10:22:41 19 Q. And so with respect to the
10:22:43 20 actual settlement funds, you weren't involved
10:22:47 21 at all in the settlement with Bethe Wettlaufer;
10:22:49 22 is that correct?
10:22:49 23 A. That's correct.
10:22:50 24 Q. Okay. Now, I want to turn
10:22:51 25 now to insulin because you were asked a lot of
10:22:54 26 questions by Ms. Hewitt about the insulin
10:22:57 27 procedures. And you were asked questions, you
10:22:59 28 may recall, about whether or not there were
10:23:02 29 windows in the three med rooms. Do you recall
10:23:04 30 that?
10:23:04 31 A. Yes.
10:23:04 32 Q. Okay. And would you agree

10:23:06 with me that even if you had huge windows in
10:23:09 all the med rooms, if there's no one there on a
10:23:13 shift to look in the windows, it wasn't going
10:23:15 to make a difference. Would you agree?
10:23:17 A. Yes.
10:23:18 Q. And with respect to the issue
10:23:23 of a practice that I understand that you put in
10:23:26 afterwards of insulin, that has to be signed by
10:23:29 two nurses; is that correct?
10:23:29 A. No, I don't recall that.
10:23:32 Q. You don't recall that that's
10:23:33 been put into place?
10:23:35 A. No.
10:23:35 Q. Okay. But would you agree
10:23:37 that that wouldn't prevent the problem that we
10:23:40 have here of Elizabeth Wettlaufer giving
10:23:43 insulin that was not required?
10:23:46 MR. GOLDEN: I just -- if this
10:23:48 is a practice that wasn't
10:23:49 introduced by Ms. Crombez,
10:23:51 I think we need to really
10:23:53 establish what that is, what
10:23:55 that practice really is and
10:23:56 describe it before we ask this
10:23:57 witness --
10:24:02 MS. HUGHES: All right. I'll
10:24:03 move on. It is in Agatha, who I
10:24:03 believe is the next witness, so
10:24:03 I'll move on.
10:24:04 BY MS. HUGHES:
10:24:04 Q. But in any case, when we talk
10:24:07 about insulin being locked up, kept in locked

10:24:09 rooms, do you agree that anybody can buy
10:24:12 insulin without a prescription at a drugstore?
10:24:15 For instance, I bought this
10:24:17 insulin at the drugstore two blocks away from
10:24:19 the courthouse without a prescription, and no
10:24:21 questions asked.
10:24:23 So are you -- do you know that?
10:24:25 Were you familiar with that?
10:24:27 A. No, I did not know that.
10:24:28 Q. And so you'd agree with me,
10:24:36 then, that Elizabeth Wettlaufer could -- and
10:24:38 this is the same insulin that you have at 100
10:24:42 units NovoRapid Penfill. We've got the
10:24:48 cartridges.
10:24:49 Those are the cartridges that
10:24:51 we've been talking about; is that correct? I
10:24:53 just want to make sure that that's what we're
10:24:55 talking about.
10:24:56 A. They're similar, yes.
10:24:57 MR. GOLDEN: We're really into
10:25:01 counsel here starting to give
10:25:02 evidence, and she's not in the
10:25:04 witness box and able to answer
10:25:06 what she said to the pharmacist,
10:25:08 what she asked for.
10:25:09 So it's -- we're going,
10:25:11 I think, too far in terms of an
10:25:16 experience that counsel had at a
10:25:18 local pharmacy and basing
10:25:21 questions on that.
10:25:21 MS. HUGHES: Madam Commissioner,
10:25:21 the expert report that we've

10:25:22 1 been provided by the Commission
10:25:24 2 Counsel indicates that you can
10:25:26 3 buy insulin over the counter in
10:25:29 4 Ontario. I have checked that
10:25:32 5 you can do that in Ontario,
10:25:32 6 southwestern Ontario included.
10:25:36 7 THE COMMISSIONER: The
10:25:36 8 difficulty I'm having is that
10:25:36 9 the witness answered your
10:25:37 10 question and said "I did not
10:25:39 11 know that." She did not know
10:25:41 12 that it could --
10:25:41 13 MS. HUGHES: All right. Fair
10:25:42 14 enough. You did not know that.
10:25:44 15 Thank you. Those are my
10:25:44 16 questions.
10:25:45 17 THE COMMISSIONER: Thank you
10:25:45 18 very much. The next person,
10:25:54 19 then, up to cross-examine.
10:25:57 20 MS. HEWITT: I believe it's
10:26:02 21 Ms. Meadus.
10:26:11 22 THE COMMISSIONER: Just before
10:26:12 23 you start, I'm sorry, I wonder
10:26:14 24 if we do need to enter the
10:26:16 25 practice guideline on the RN and
10:26:18 26 the RPN.
10:26:20 27 MS. HUGHES: Oh, yes. Thank you
10:26:20 28 for that.
10:26:23 29 THE COMMISSIONER: Thank you for
10:26:24 30 that. So the practice
10:26:25 31 guideline, then, is exhibit --
10:26:32 32 oh, gosh. Madam Clerk, would

10:26:35 1 that be Exhibit 31?
10:26:36 2 THE COURT CLERK: Yes,
10:26:38 3 Commissioner.
10:26:38 4 THE COMMISSIONER: Yes.
10:26:38 5 Thank you very much then. The
10:26:39 6 document that was referred to in
10:26:41 7 the cross-examination by
10:26:42 8 Ms. Hughes, "RN and RPN
10:26:43 9 Practice: The Client, the Nurse
10:26:44 10 and the Environment" will be
10:26:45 11 Exhibit 31. Thank you.
10:26:45 12 EXHIBIT NO. 31: Document
10:26:42 13 entitled "RN and RPN Practice:
10:26:43 14 The Client, the Nurse and the
10:26:44 15 Environment."
10:26:49 16 CROSS-EXAMINATION BY MS. MEADUS:
10:26:49 17 Q. Good morning.
10:26:50 18 A. Good morning.
10:26:51 19 Q. May I call you Helen?
10:26:53 20 A. Yes, please.
10:26:53 21 Q. Thank you. My name is
10:26:56 22 Jane Meadus, and I'm here representing the
10:26:58 23 Ontario Association of Residents' Councils, and
10:27:00 24 that's an umbrella association for all of the
10:27:03 25 Residents' Councils in Ontario.
10:27:05 26 It has approximately 400 member
10:27:08 27 Residents' Councils but provides assistance to
10:27:11 28 any Residents' Councils in Ontario. And I'm
10:27:14 29 assuming that you're familiar with Residents'
10:27:19 30 Councils in Ontario?
10:27:19 31 A. Yes. We had a Resident
10:27:21 32 Council at the nursing home.

10:27:23 Q. Okay. And have you always
10:27:24 had a Residents' Council even prior to the
10:27:27 Long-Term Care Homes Act?
10:27:28 A. I believe so.
10:27:30 Q. Okay. And you're aware that
10:27:32 prior to the Long-Term Care Homes Act, it was
10:27:35 not mandatory? Are you aware that after the
10:27:27 Long-Term Care Homes Act came in, that it was
10:27:40 mandatory to have a Residents' Council?
10:27:45 A. I didn't -- I really wasn't
10:27:48 aware of that.
10:27:49 Q. Okay. And the Residents'
10:27:51 Council is run by the residents themselves; is
10:27:52 that correct?
10:27:52 A. That's correct.
10:27:52 Q. And can you tell us what kind
10:27:54 of interactions you would have had with the
10:27:56 Residents' Council at the home?
10:28:00 A. They would have their monthly
10:28:02 meetings, and if there were any nursing
10:28:06 concerns, then that piece would be brought to
10:28:08 me.
10:28:08 Q. And what kind of nursing
10:28:10 concerns would they bring to you? For example,
10:28:19 would they bring issues around staffing and
10:28:21 amount of staffing in a home?
10:28:22 A. It wasn't so much that, I
10:28:28 don't think. Oh, gosh. Clothing was, you
10:28:41 know, a rather big issue. I know I dealt with
10:28:43 that a couple times.
10:28:46 Q. You're talking about clothing
10:28:47 going missing in the laundry, I would assume?

10:28:50 A. Yes, or being put in the
10:28:51 wrong closet. You know, residents would find
10:28:55 another resident's clothing in their closet.
10:29:01 We had, you know, a couple of different
10:29:03 situations where the residents would have the
10:29:05 same name, the same last name, so it was
10:29:08 important to have their full name.
10:29:10 We would just usually have the
10:29:13 first initial and their last name, but it was
10:29:16 important to have their whole name, you know,
10:29:18 on the clothing. So we, you know, changed some
10:29:22 things along that line.
10:29:23 Q. Would they ever bring issues
10:29:26 around specific staff members if there were
10:29:28 issues around specific staff members?
10:29:30 A. I don't recall that I ever
10:29:32 received any.
10:29:32 Q. But they would have been able
10:29:34 to do that through the Residents' Council; is
10:29:34 that correct?
10:29:37 A. They could have. It was
10:29:39 more like they would just come to my office,
10:29:42 you know.
10:29:42 Q. Individually they would come
10:29:43 to your office?
10:29:44 A. Individually, I think.
10:29:45 Q. All right. Thank you. And
10:29:46 so you talked a little bit yesterday about the
10:29:49 resident-first philosophy --
10:29:51 A. Yes.
10:29:51 Q. -- that came in. What was
10:29:53 the philosophy prior to that? Was there a

10:30:00 1 different philosophy at that time?
10:30:01 2 A. Well, the staffing was more
10:30:08 3 random, if you will. You know, there were some
10:30:12 4 shifts that were -- like, we had a 6:30, 2:30,
10:30:16 5 and that was in a specific area. So that kind
10:30:19 6 of met that resident first, but some of the
10:30:23 7 other shifts weren't directly assigned, so we
10:30:29 8 made that more -- or they were directly
10:30:34 9 assigned, but they weren't always in the same
10:30:37 10 area, so they would, you know, float around.
10:30:40 11 So we tried to make it more consistent for the
10:30:44 12 residents or with that schedule, or I did.
10:30:46 13 Q. So this was a change in
10:30:47 14 attitude of the home, would you say?
10:30:50 15 A. No, I don't think a change in
10:30:52 16 attitude. I think just learning that this is a
10:30:56 17 better way to do it. And, you know, I read the
10:31:00 18 document, and I thought this is a good idea,
10:31:04 19 and I implemented it.
10:31:06 20 Q. And we haven't really heard
10:31:09 21 about the residents' rights, and in long-term
10:31:12 22 care, there are residents' rights that are
10:31:16 23 posted in the home?
10:31:16 24 A. Yes.
10:31:17 25 Q. Is that correct? Under the
10:31:19 26 Nursing Home Act, there were 19 rights. I
10:31:20 27 don't know if you remember that.
10:31:21 28 A. Well, I thought there were
10:31:22 29 more, but I --
10:31:23 30 Q. And then it was changed under
10:31:29 31 the Long-Term Care Homes Act. There's 27 now.
10:31:29 32 A. Mm-hm.

10:31:29 Q. Okay. And can you tell us
10:31:29 how you implemented those rights within the
10:31:29 home? What was the perspective of the home in
10:31:35 implementing those rights? How did that affect
10:31:36 your day?
10:31:37 A. Well, we took those rights
10:31:40 very seriously, and we would do, you know,
10:31:45 different ways of educating staff on them. We
10:31:48 had our general staff meeting, and we would
10:31:54 review a right or two at every meeting.
10:31:59 Q. Okay.
10:32:00 A. The staff were also
10:32:03 in-serviced annually on residents' rights.
10:32:06 Q. What was that in-service on
10:32:08 the residents' rights?
10:32:10 A. What was it?
10:32:10 Q. What did you do for that?
10:32:12 Was it reading the rights? How did you do the
10:32:15 in-service?
10:32:16 A. Well, I, you know -- there
10:32:20 would have been a document to review, I think.
10:32:22 It was the Assistant Director of Nursing that
10:32:24 did the education.
10:32:27 Q. And did you, yourself, have
10:32:31 to undergo that training?
10:32:33 A. Yes.
10:32:33 Q. Okay. And you could be found
10:32:35 noncompliant if you were in breach of those
10:32:37 rights; is that correct?
10:32:38 A. That's correct.
10:32:39 Q. Okay. So I would like to
10:32:40 bring up exhibit -- sorry, Document 57094 from

10:32:46 Exhibit 6. And I believe we've seen this
10:32:58 already.
10:33:00 A. Yes.
10:33:00 Q. Okay. This was the
10:33:02 orientation that was given to the employees
10:33:04 when they came in. And I wasn't clear how that
10:33:12 information came in. So if you could scroll
10:33:12 down a little bit.
10:33:13 So we talked about the mission
10:33:14 statements and goals, abuse policy and violence
10:33:20 in the workplace. Again, was that reading
10:33:22 policies, or was there some kind of actual
10:33:25 training exercise that they underwent?
10:33:27 A. It changed over the years,
10:33:39 and I don't know when Bethe was there. It was
10:33:44 probably, you know, the policy and policy
10:33:49 review.
10:33:50 Q. Okay. All right. Thank you.
10:33:52 So I'm going to go to a new issue. So one of
10:33:55 the things that you talked about, and you spoke
10:33:57 about this on Friday, was how traumatic these
10:34:01 entire events were for everyone in the home,
10:34:04 especially the staff at the home. And I'm sure
10:34:06 you would agree that it also changed the lives
10:34:08 of the residents in the homes?
10:34:09 A. Yes.
10:34:10 Q. And, you know, when we see
10:34:13 something, a tragedy happens say, for example,
10:34:16 in a high school or a school, they bring in
10:34:20 grief counsellors to help the students.
10:34:21 Did anything like that happen
10:34:22 for the residents in the home? Were they given

10:34:26 grief counselling or any kind of special
10:34:29 outside support?
10:34:30 A. The chaplain was there a lot
10:34:33 during this time, and he was available by phone
10:34:37 for anyone that expressed any concerns. He
10:34:41 made that clear. And he was -- the residents
10:34:48 really liked him and, you know, would talk to
10:34:55 them if need be.
10:34:57 Q. Do you think that might be
10:34:58 something that might be a recommendation, that
10:35:00 something like that could be made on a more
10:35:03 proactive basis in homes if a tragedy happened?
10:35:07 A. I think that's probably a
10:35:09 good idea.
10:35:09 Q. Thank you. So at the time of
10:35:22 the termination of Ms. Wettlaufer, who would
10:35:27 have been told about her termination? Which
10:35:30 staff members would have been told?
10:35:32 A. Which staff members? I don't
10:35:36 think we told anyone. We just put a fine on
10:35:41 her --
10:35:43 Q. Sorry, put a --
10:35:43 A. Pardon?
10:35:45 Q. Can you repeat what you just
10:35:47 said. Put a --
10:35:50 A. Fine, F-I-N-E, meaning, you
10:35:59 know, finished -- on the schedule.
10:36:00 Q. And who was management at the
10:36:01 home at that time?
10:36:02 A. Who was management? Brenda
10:36:06 Van Quaethem was the administrator. I was the
10:36:10 Director of Nursing. Sandra Fluttert was the

Resident Care Coordinator.

Q. So would Sandra Fluttert -- is it Sandra or Susan?

A. Sandra.

Q. Sandra. Would she have been aware of the termination?

A. Yes. It would have been just management staff that were told directly.

Q. And so no one else would have been told specifically why Ms. Wettlaufer was leaving?

A. That's correct.

Q. Okay. So I'd like to turn your attention to the requirements regarding the abuse prevention under the legislation.

A. Okay.

Q. So you were aware that homes had to have an abuse prevention program?

A. Yes.

Q. Okay. And there were definitions in both the old system and the new system as to what abuse was in long-term care; is that correct?

A. Yes.

Q. Okay. It was -- in fact, in the Long-Term Care Homes Act, it very specifically said there's zero tolerance for neglect and abuse; is that correct?

A. Yes.

Q. Okay. And did your home have policies around that?

A. Yes, we did.

10:37:23 Q. Okay. All right. I'd like
10:37:25 to bring up exhibit 1648 -- sorry,
10:37:33 Document 16488, which is in Exhibit 6. So was
10:38:18 this one of the policies at the home with
10:38:21 respect to the issue around abuse and neglect?
10:38:26 A. Yes.
10:38:27 Q. Okay. And so if you want to
10:38:29 scroll down a little bit, please. So that
10:38:33 talks about the different kinds of abuse in the
10:38:36 home; is that correct?
10:38:36 A. Yes.
10:38:39 Q. It talks about
10:38:40 staff-to-resident abuse, resident-to-resident
10:38:42 abuse, resident-family-to-staff abuse, and
10:38:45 family-to-resident abuse; is that correct?
10:38:47 A. Yes.
10:38:47 Q. Okay. And so you would be
10:38:49 trained in all these types of abuse issues,
10:38:54 correct, about what they were and how to look
10:38:56 out for them?
10:38:57 A. Well, I thought I knew, yes.
10:39:00 Q. Okay. And just scroll down a
10:39:03 little bit more. So we've got different kinds
10:39:08 of abuse, so we have the physical,
10:39:10 psychological abuse, financial abuse. And
10:39:12 those are all set out in the legislation as
10:39:14 well as in your policy; correct?
10:39:17 A. Yes.
10:39:17 Q. Okay. And it talks about
10:39:18 neglect and sexual abuse as well as imbalance
10:39:21 of power; is that correct?
10:39:23 A. Yes.

10:39:23 Q. Now, imbalance of power is not in the legislation, but it's in the College of Nurses' documentation. Is that something you were concerned about in the home?
10:39:33 A. Concerned about?
10:39:34 Q. Mm-hm.
10:39:35 A. I thought most registered staff had a very good relationship with residents.
10:39:49 Q. So it wasn't something that was particularly -- that you were overly concerned about. It was just something that was in the policy?
10:39:58 A. That's correct.
10:39:58 Q. And is it something you would've ever looked at or discussed with staff? Is that something that came up in your training?
10:40:06 A. I can't recall.
10:40:07 Q. And can you just go down to page 5, please. This talks about -- just scroll down a little bit more. So this talks about the mandatory reporting. This would have been your understanding in 2014 as to how you reported; is that correct? You had to report it immediately to the Director of Nursing or the administrator?
10:40:51 A. Yes.
10:40:51 Q. Okay. And that would be you, the Director of Nursing?
10:40:53 A. Yes.
10:40:54 Q. Would most cases of that kind
10:40:55

10:40:56 1 of mandatory reporting -- would it be made
10:40:59 2 mostly to yourself, or would it have been made
10:41:02 3 to Brenda?
10:41:04 4 A. Sorry, could you repeat that?
10:41:05 5 Q. These mandatory reporting,
10:41:06 6 would it have been mostly to you or to Brenda?
10:41:09 7 Like, was there a preference within the
10:41:12 8 management, or it didn't matter?
10:41:12 9 A. Didn't really matter.
10:41:14 10 Sometimes it was whoever you ran into.
10:41:16 11 Q. Okay. And then it says that
10:41:18 12 the DON will immediately notify the
10:41:23 13 administrator. So even if it was you, you
10:41:23 14 would have to still notify them; is that
10:41:25 15 correct?
10:41:25 16 A. That's correct.
10:41:25 17 Q. Then you notified head
10:41:26 18 office?
10:41:26 19 A. Mm-hm.
10:41:27 20 Q. Provide support; is that
10:41:29 21 correct?
10:41:29 22 A. Mm-hm.
10:41:30 23 Q. Okay. And then the next
10:41:31 24 page. And then it talks about the person who
10:41:34 25 has reasonable grounds to suspect that any of
10:41:37 26 the following has occurred or may occur must
10:41:39 27 immediately report that suspicion and
10:41:42 28 information to the director appointed by the
10:41:44 29 Minister of Health and long-term care; is that
10:41:47 30 correct?
10:41:47 31 A. Yes.
10:41:49 32 Q. Okay. And then it sets out

10:41:52 1 five different things that you have to report,
10:41:55 2 which is improper, incompetent treatment, abuse
10:41:59 3 of a resident by anyone or neglect of a
10:42:02 4 resident by the home or staff, unlawful
10:42:04 5 conduct, misuse or misappropriation of a
10:42:07 6 resident's money, misuse or misappropriation of
10:42:09 7 funding. Those things have to be reported; is
10:42:12 8 that correct?
10:42:12 9 A. Yes.
10:42:12 10 Q. Okay. Was it the practice in
10:42:14 11 your home for the staff member who discovered
10:42:18 12 it to report it to the Ministry, or were they
10:42:22 13 to report it to you?
10:42:23 14 A. They were to report it to
10:42:24 15 management.
10:42:25 16 Q. Okay. And then once that was
10:42:26 17 reported, you would then report it to the
10:42:29 18 Ministry?
10:42:29 19 A. Well, we would investigate
10:42:31 20 and then report to the Ministry.
10:42:32 21 Q. Okay. And what was the
10:42:34 22 purpose of the investigation?
10:42:35 23 A. Just to make sure we had all
10:42:39 24 the facts that we needed.
10:42:41 25 Q. And then if you decided that
10:42:43 26 you didn't have all the facts, would you then
10:42:46 27 not report it?
10:42:46 28 A. Well, we had, you know, a
10:42:51 29 certain time frame, so we tried to, you know,
10:42:54 30 work with that time frame.
10:43:01 31 Q. But would you agree with me
10:43:03 32 that this section here in your own policy,

10:43:05 1 which is basically -- it's exactly what it says
10:43:08 2 in the Long-Term Care Homes Act, says that you
10:43:10 3 have to report it immediately?
10:43:13 4 A. "Who has reasonable grounds
10:43:17 5 to suspect that any of the following," but if
10:43:20 6 we investigated and we felt that there was no
10:43:25 7 abuse, then, you know, the suspicion was
10:43:30 8 alleviated and not -- you know, we had learned
10:43:35 9 or have learned that that's not the way that it
10:43:39 10 should be looked at.
10:43:41 11 Q. Right. So in preparing for
10:43:44 12 this, you've discovered that, in fact, perhaps
10:43:46 13 that wasn't the way that it should have been
10:43:49 14 happening; is that correct?
10:43:49 15 A. No, not in preparing for
10:43:52 16 this. It was an inspector at our annual
10:43:58 17 inspection in 2016 that suggested that we
10:44:04 18 report everything, then investigate.
10:44:08 19 Q. And no one had ever brought
10:44:11 20 that to your attention before?
10:44:12 21 A. No. Our practice was to
10:44:16 22 investigate and then report.
10:44:19 23 Q. Okay. And we heard already
10:44:24 24 about the incident with the resident who came
10:44:27 25 to your office and had made complaints
10:44:33 26 regarding Ms. Wettlaufer and had threatened
10:44:39 27 her, and you had made a critical incident
10:44:39 28 report on that issue; is that correct?
10:44:39 29 A. Yes.
10:44:39 30 Q. But when you found out that
10:44:41 31 other issues had happened from other staff with
10:44:43 32 respect to Ms. Wettlaufer having threatened

him, you did not make a report; is that correct?

A. Yes.

Q. Thank you. I'm going to move on to the issue around acuity, and you talked quite a bit about acuity this morning.

You talked that there has been an increase in acuity, and I think we heard in your last bit of testimony with Ms. Hughes that you didn't necessarily have the ability to simply go out and hire another nurse just because you thought there should be a better staffing ratio. That was up to head office; is that correct?

A. Yes.

Q. Okay. And so I gather you could move people around within the home, you indicated, and do something -- I believe it was called cross-department? What was the terminology that you used? And so you could move people -- say maybe move an RPN, put two RPNs in, maybe some more PSWs to help support someone; is that correct?

A. Well, you couldn't do that over the night shift. You had to have the RN there, but you could make adjustments, you know, otherwise.

Q. Okay. And can you -- you were asked about the maximum number of staffing in a home earlier this week, the maximum number of staffing. And I think you indicated there is a maximum number of staff; is that correct?

10:46:06 A. I believe what -- the
10:46:07 staffing that was calculated from the funding
10:46:11 that we received from the Ministry of Health
10:46:14 was the maximum that we could use in our home.
10:46:18 Q. So the restriction that you
10:46:21 have is around the funding that you receive,
10:46:23 not around any kind of legislative requirement;
10:46:27 is that correct?
10:46:27 A. I believe so, yes.
10:46:28 Q. Okay. And can you tell us
10:46:32 what minimum staffing there is in a home? So
10:46:32 do you know if there's any legislation, other
10:46:35 than we know there has to be one RN, correct,
10:46:37 on at all times?
10:46:38 A. Yes.
10:46:39 Q. Is there a minimum staffing
10:46:41 number?
10:46:41 A. I'm not aware. I just, you
10:46:47 know, went by the sheet that we received when
10:46:49 there was an increase or decrease in funding.
10:46:52 Q. Okay. And so there's --
10:46:56 you're not aware of anything in the legislation
10:46:59 that says you have to have a certain number of
10:47:01 residents per staff member?
10:47:02 A. Well, I can't recall. I
10:47:10 might have. You know, I know for the
10:47:14 administrator and Director of Nursing, there's
10:47:17 numbers there, but I can't really remember any
10:47:19 further than that.
10:47:20 Q. Okay. Thank you. So as I
10:47:23 said, we've talked about the fact that there
10:47:27 has to be an RN on at all times. Now, that was

10:47:30 1 not the case when you started; is that correct?
10:47:32 2 Do you remember that far back?
10:47:33 3 A. When I first started, I was
10:47:36 4 actually an RN and worked on the floor, and,
10:47:40 5 you know, there was an RN that worked opposite
10:47:43 6 me.
10:47:45 7 Q. Okay. But do you know what
10:47:46 8 the legislative requirements were then?
10:47:49 9 A. No.
10:47:49 10 Q. Okay. Fair enough. But
10:47:51 11 there have certainly been for many, many years
10:47:54 12 a requirement for one RN both under the old
10:47:57 13 legislation as well as the new legislation; is
10:47:59 14 that correct?
10:47:59 15 A. Yes.
10:48:01 16 Q. Okay.
10:48:02 17 MS. MEADUS: Can we bring up
10:48:05 18 Document 04353? And I will pass those up to
10:48:26 19 you. Could I have that marked as an exhibit,
10:48:41 20 please? I do not believe that's an exhibit
10:48:45 21 yet.
10:48:46 22 THE COMMISSIONER: I don't think
10:48:46 23 that there would be any problem
10:48:49 24 with marking this as an exhibit,
10:48:50 25 although it hasn't been really
10:48:52 26 put to the witness.
10:48:54 27 MS. MEADUS: Sorry.
10:48:57 28 THE COMMISSIONER: No, that's
10:48:58 29 fine. So that would be
10:49:00 30 exhibit --
10:49:00 31 MS. MEADUS: I'm afraid that I'm
10:49:01 32 going to forget.

10:49:02 THE COMMISSIONER: That would be
10:49:03 Exhibit 32, Madam Clerk?
10:49:07 Thank you.
10:49:09 THE COURT CLERK: Yes,
10:49:10 Commissioner.
10:49:10 EXHIBIT NO. 32: Inspection
10:49:10 Report dated March 20, 2012
10:49:12 BY MS. MEADUS:
10:49:12 Q. So are you familiar with that
10:49:14 document?
10:49:14 A. Yes.
10:49:15 Q. Okay. And so that was a
10:49:18 finding of noncompliance with respect to having
10:49:22 insufficient staffing; is that correct?
10:49:23 A. Yes.
10:49:23 Q. Okay. So if you can just
10:49:27 scroll down, please. Thank you. So it says
10:49:34 that:
10:49:34 "In March of 2012, in record
10:49:38 review with the administrator
10:49:39 and Director of Nursing, they
10:49:41 confirmed that on November the
10:49:42 14th, there was not a Registered
10:49:44 Nurse on duty or present at the
10:49:45 home."
10:49:46 Is that correct?
10:49:46 A. Yes.
10:49:46 Q. It says that:
10:49:49 "They spoke with the home
10:49:51 administrator, confirmed present
10:49:54 backup plan for replacing
10:49:55 Registered Nurse does not

10:49:57 provide for additional
10:49:59 contingency plan ensuring a
10:50:01 Registered Nurse is on duty and
10:50:01 present in the home at all
10:50:01 times."
10:50:04 Is that correct?
10:50:04 A. Yes.
10:50:04 Q. And so you've got what was
10:50:06 called a VPC or a Voluntary Plan of Correction;
10:50:11 is that correct?
10:50:11 A. Yes.
10:50:11 Q. And that is -- there are
10:50:13 different levels of noncompliances, so you've
10:50:20 got -- and it's up at the top if you want to --
10:50:20 sorry, just scroll to the top of the page just
10:50:23 for ease. The first would be a written
10:50:24 notification?
10:50:25 A. Yes.
10:50:25 Q. And that just says that
10:50:26 you've done something wrong, but it doesn't
10:50:29 require you to do anything; is that correct?
10:50:31 A. Yes.
10:50:31 Q. Okay. And usually that's
10:50:32 because something has already been resolved at
10:50:36 that time. Would you agree?
10:50:37 A. Yes.
10:50:38 Q. And the next one is the
10:50:40 Voluntary Plan of Correction. And that means
10:50:41 that within your home, you have to correct
10:50:43 something, but you don't have to advise the
10:50:45 Ministry of any correction. You just have to
10:50:47 correct it within -- come up with a plan and

10:50:48 1 correct it. Would you agree?
10:50:50 2 A. Yes.
10:50:51 3 Q. And then the next would be --
10:50:51 4 it says "direct referral," but, in fact, the
10:50:53 5 next one would be the compliance order; is that
10:50:56 6 correct? And that's an order that they make,
10:50:57 7 and then they come back and check out. You
10:50:59 8 agree?
10:50:59 9 A. Yes.
10:51:00 10 Q. And then the director
10:51:01 11 referral is something where it's a more serious
10:51:03 12 matter, and the director from the Ministry of
10:51:07 13 Health would make an order herself; is that
10:51:09 14 correct?
10:51:09 15 A. Yes.
10:51:09 16 Q. Okay. So this was a
10:51:10 17 Voluntary Plan of Correction. You were being
10:51:13 18 asked to correct this. You agree?
10:51:15 19 A. Yes.
10:51:15 20 Q. Okay. So it's my
10:51:17 21 understanding this was a period of
10:51:18 22 approximately four hours?
10:51:20 23 A. Yes.
10:51:23 24 Q. Were you involved in the
10:51:24 25 staffing during that time to try to fill that
10:51:26 26 out?
10:51:26 27 A. Yes.
10:51:26 28 Q. Okay. So what was your
10:51:29 29 solution when you came up with this issue for
10:51:35 30 the problem?
10:51:36 31 A. The night that it happened
10:51:37 32 or --

10:51:37 Q. That's correct. What did you
10:51:40 do when you discovered that there was not going
10:51:43 to be an RN, that they were not going to be
10:51:46 available?
10:51:46 A. I went through the schedule
10:51:51 and -- to see if anyone would come in, and
10:51:57 obviously no one could. I asked the day staff
10:52:06 if they would stay. And, you know, that's how
10:52:11 we covered the four hours.
10:52:14 Some -- one of registered nurses
10:52:15 agreed to stay four hours, and then we had an
10:52:19 RN working on the night shift. And I don't
10:52:22 recall who that was. We had, you know, two or
10:52:25 three working.
10:52:27 And no one could either come in
10:52:31 and do the four hours, or the nurse that was
10:52:33 working the full night shift, you know, either
10:52:37 couldn't get ahold of her or she couldn't work
10:52:40 that additional four hours before her shift.
10:52:45 So we were short.
10:52:47 Q. And did you ever use agency
10:52:48 staff?
10:52:48 A. We did over the years now and
10:52:53 again.
10:52:53 Q. And this would be -- can you
10:52:55 explain maybe just what agency staff are?
10:52:57 A. When there was a real
10:53:02 shortage of nurses, we would ask head office if
10:53:06 we could get support from an agency, and they
10:53:11 would approve that. We used a couple different
10:53:18 agencies, I think, over the time.
10:53:21 Q. And do you know what the cost

10:53:22 1 of that -- was it more than you would have to
10:53:25 2 pay?
10:53:25 3 A. It was quite a bit more.
10:53:27 4 Q. Okay. So it was certainly a
10:53:29 5 costly measure that you didn't like to use very
10:53:32 6 often; is that correct?
10:53:32 7 A. Yes. It was, you know, dire
10:53:34 8 straits when we used an agency.
10:53:37 9 Q. And preference, of course, is
10:53:40 10 always to use staff from within the home where
10:53:41 11 they're familiar with the residents as opposed
10:53:44 12 to someone from outside; is that correct?
10:53:44 13 A. Of course.
10:53:45 14 Q. Okay. So you put two RPNs on
10:53:48 15 in that time instead; is that correct?
10:53:49 16 A. Yes.
10:53:50 17 Q. And we heard this morning
10:53:52 18 when you were talking with Ms. Hughes that the
10:53:52 19 College of Nurses talks about the level of
10:54:00 20 acuity, and you need higher levels of staff --
10:54:03 21 of nurses for certain kinds of care; is that
10:54:03 22 correct?
10:54:05 23 A. Yes.
10:54:06 24 Q. Okay. So you would agree
10:54:07 25 that two RPNs don't equal an RN; is that
10:54:11 26 correct?
10:54:11 27 A. No, but we felt they could
10:54:14 28 handle the workload, and I was on call if --
10:54:17 29 and I had, you know, my clothes ready to come
10:54:20 30 in if they needed actual support.
10:54:23 31 Q. So that's my question. Why
10:54:26 32 didn't you fill in that spot for the four

10:54:27 hours?
10:54:28 A. Because it was my
10:54:30 anniversary.
10:54:33 Q. So you decided not to -- that
10:54:36 you weren't able to do it; is that correct?
10:54:37 A. We had plans for the evening.
10:54:39 Q. Were there any other
10:54:43 management staff that could have filled that
10:54:45 spot?
10:54:45 A. I don't recall.
10:54:47 Q. Okay. All right. Thank you.
10:54:50 Yesterday you talked about registered staff
10:54:53 meetings, and there was a question to you about
10:54:55 whether Ms. Wettlaufer attended those. And you
10:54:57 indicated that that was rarely?
10:54:59 A. Yes. She did attend, you
10:55:02 know, a few, but not on a regular basis like
10:55:06 some of the nurses did.
10:55:06 Q. And in those meetings, you
10:55:09 would discuss a whole variety of issues related
10:55:11 to what was going on in the home and to improve
10:55:15 quality; is that correct?
10:55:16 A. Yes.
10:55:17 Q. Okay. Were they mandatory
10:55:19 meetings?
10:55:19 A. No, they weren't mandatory.
10:55:21 Q. And did you ever speak to her
10:55:23 about attending those meetings?
10:55:24 A. Yes, I did.
10:55:25 Q. And why did she not attend?
10:55:28 A. She didn't really give an
10:55:30 answer.

10:55:32 Q. All right. Thank you.
10:55:33 A. But the minutes were posted
10:55:35 in the -- each medication room. There was a
10:55:38 communication binder, and the minutes were
10:55:40 posted for registered staff.
10:55:42 Q. So she could read what had
10:55:45 occurred --
10:55:46 A. Yes.
10:55:47 Q. -- but she wouldn't be
10:55:48 participating in the conversation?
10:55:50 A. That's right. And if she had
10:55:51 any questions, you know, she could ask a
10:55:54 coworker or come to me or one of the other
10:55:57 managers if she needed further explanation.
10:56:00 Q. Okay. But she worked mostly
10:56:02 nights and evenings, so that would have been
10:56:04 more difficult; is that correct?
10:56:05 A. Well, she worked two weeks
10:56:10 evenings and two weeks nights.
10:56:11 Q. So there wouldn't --
10:56:13 A. So the meeting, you know,
10:56:16 usually started around 1:30, so if she were
10:56:19 working evenings, it, you know, could slide in
10:56:23 very nicely with her scheduled shift.
10:56:27 If she were working nights, it
10:56:30 certainly would be more difficult, but when I
10:56:32 was a nurse on the floor, I would be working a
10:56:36 night shift, and I'd make the effort to come
10:56:38 in.
10:56:38 Q. Can I bring up her Affidavit
10:56:43 at paragraph 16 to 18. So in your Affidavit,
10:57:01 you talk about the inspection system, and

10:57:05 you're critical of the new inspection system.
10:57:08 Would you agree?
10:57:08 A. Yes.
10:57:10 Q. Okay. And one of the
10:57:11 concerns that you have are that under the old
10:57:14 system, when they were called compliance
10:57:17 advisors, they provided advice. So if they
10:57:20 came in, they found something, they would
10:57:23 sometimes just discuss it with you and not
10:57:25 leave a noncompliance. Would you agree?
10:57:28 A. Well, it wasn't so much -- if
10:57:32 it was a serious matter, they would certainly
10:57:37 give us a finding, but it was more a team
10:57:40 effort, I think. And we even had a compliance
10:57:46 advisor on at least one occasion give an
10:57:50 in-service, you know, to the staff.
10:57:51 Q. Okay. And under the new
10:57:54 system, so since 2010 and the new legislation,
10:57:58 these are now inspectors who simply inspect.
10:58:01 If they find something, they're required to
10:58:04 leave a finding; is that correct?
10:58:05 A. Mm-hm.
10:58:05 Q. And they no longer provide
10:58:07 that advice to the home?
10:58:08 A. That's correct.
10:58:09 Q. And would you agree that one
10:58:12 recommendation that we might make to this
10:58:15 Commission may be that -- not that the
10:58:18 inspectors would provide advice, but perhaps
10:58:21 there would be a different part of the Ministry
10:58:23 that could provide that advice to the homes so
10:58:28 that you could call up or have people come and

10:58:32 do in-services. Do you think that would be a
10:58:34 good recommendation?
10:58:34 A. I think that is a good
10:58:36 recommendation. Sometimes, you know, it felt
10:58:39 like you were reinventing the wheel, right. So
10:58:42 if someone has something that's working or a
10:58:46 different approach to something, you know, why
10:58:48 not share that information?
10:58:49 Q. Are you familiar with the
10:58:51 long-term care homes net portal that the
10:58:55 Ministry has?
10:58:55 A. Long-term care -- that's
10:59:02 where we reported our compliance.
10:59:05 Q. No, this would have been --
10:59:06 this is a website where they post memorandum,
10:59:10 information about upcoming training sessions
10:59:12 that is available to the homes.
10:59:14 Did you ever go on that site?
10:59:16 It would have had the -- the abuse trees, for
10:59:20 example, are posted on it.
10:59:22 A. I think there was an update
10:59:26 to the critical incident system, and I watched
10:59:29 that webinar, I think.
10:59:32 Q. Okay. But you don't know of
10:59:33 that website that I'm talking about? That
10:59:36 wouldn't have been something you would have
10:59:38 gone to as a Director of Nursing?
10:59:39 A. I wonder if it was through
10:59:41 that website. I don't know.
10:59:42 Q. When the Long-Term Care Homes
10:59:44 Act came in, did you take any webinars through
10:59:46 the Ministry of Health around reporting or

10:59:50 1 abuse or any other subjects?
10:59:53 2 A. I can't really recall. I
10:59:54 3 think what head office did have was a meeting,
11:00:00 4 you know, with the area DOC, the
11:00:06 5 administrators, and resident care coordinators.
11:00:11 6 Q. Okay. But you don't remember
11:00:12 7 taking any webinars or attending sessions put
11:00:15 8 on by the Ministry of Health?
11:00:17 9 A. Not for that. I did go to
11:00:20 10 Toronto for quality improvement, but I don't
11:00:22 11 remember anything about the Long-Term Care Act
11:00:26 12 that way.
11:00:26 13 Q. Okay. Thank you. I'm going
11:00:28 14 to turn your attention to the issue of the
11:00:31 15 Coroner and their relationship with the homes.
11:00:34 16 And, again, you've been in the
11:00:37 17 system for a long time, so you probably recall
11:00:40 18 at one time that the Coroner came in on every
11:00:43 19 death. Do you recall that?
11:00:44 20 A. Every death?
11:00:46 21 Q. Yes.
11:00:46 22 A. I don't -- maybe that's going
11:00:52 23 too far back. I don't know. I remember every
11:00:55 24 tenth death.
11:00:55 25 Q. Okay. So you remember the
11:00:58 26 threshold death, so every tenth death that the
11:01:02 27 Coroner's office would come in?
11:01:03 28 A. Mm-hm.
11:01:04 29 Q. And how was that reported?
11:01:05 30 Did they report and then make an appointment to
11:01:07 31 come and see you, or did the Coroner just show
11:01:10 32 up at every tenth death?

11:01:13 A. No. We would call the
11:01:16 Coroner and say that we've had, you know, the
11:01:18 tenth death. And sometimes he'd come right
11:01:21 away.
11:01:23 You know, we'd always keep the
11:01:24 charts handy so that if he decided to come in,
11:01:30 you know, tomorrow or that day that we'd have
11:01:34 them, you know, at hand.
11:01:36 Q. And would you meet with the
11:01:37 Coroner yourself?
11:01:39 A. We usually put him in an
11:01:43 office, and he reviewed the files himself, and
11:01:48 then if he had any questions, he would either
11:01:53 speak with me, or if the nurse was on that knew
11:01:57 the resident, he would talk to the nurse.
11:01:59 Q. And would he be looking at
11:02:03 just the tenth death file or all ten?
11:02:06 A. All ten.
11:02:07 Q. All ten. All right. And so
11:02:07 he would look at the chart, and if he had
11:02:10 questions, he would ask staff?
11:02:12 A. Yeah.
11:02:14 Q. Did he ever speak to families
11:02:15 about the deaths?
11:02:16 A. I don't recall. He
11:02:18 certainly, you know, would have that
11:02:19 information in the chart. It would be the face
11:02:23 page of the chart.
11:02:23 Q. Okay. And while you've
11:02:28 been -- in the 30 odd years you've been at the
11:02:31 home, how often are you aware that residents
11:02:34 have autopsies after they die?

11:02:38 A. I can't really recall anyone.
11:02:46 There may have been, but...
11:02:47 Q. You don't recall?
11:02:48 A. I don't recall.
11:02:48 Q. Okay. And other than the
11:02:53 tenth-death system, when it was in the tenth
11:02:57 death, would you call at any other times for
11:02:59 the Coroner?
11:03:01 A. Yes, if it was a sudden and
11:03:04 unexpected death.
11:03:05 Q. And who would do that call?
11:03:08 A. It would be the RN on the
11:03:11 shift that the death occurred on.
11:03:14 Q. Okay. And now --
11:03:17 A. Sorry, or the RPN. It could
11:03:20 be either, yeah.
11:03:21 Q. Now the system is to complete
11:03:22 a document online and send that in for every
11:03:26 death; is that correct?
11:03:26 A. Yes.
11:03:27 Q. Okay. And if there's an
11:03:27 issue, do you phone the Coroner? So if you
11:03:34 think there's an unexpected death or something
11:03:36 happens, is it done through the paper on the
11:03:38 computer, or do you actually phone the Coroner
11:03:41 to say, "Hey, we've had something happen. We
11:03:44 think you should come out"?
11:03:45 A. I believe we called a number
11:03:47 and tell them the situation, and they would
11:03:49 call the Coroner, and then I think the Coroner
11:03:52 would call us.
11:03:53 Q. So you don't simply rely on

that paper. You have to make a phone call as well; is that correct?

A. Yes, I believe so.

Q. Okay. Thank you.

THE COMMISSIONER: I just want to make sure I heard your question. Was your question in addition to completing the document online, if the death were sudden and unexpected --

MS. MEADUS: That's correct.

THE COMMISSIONER: -- then did they do something more?

MS. MEADUS: That's right. And she's indicated that they would phone the Coroner's 1-800 number.

BY MS. MEADUS:

Q. Is that correct?

A. Yeah. It was an office number, and they would take a message and call the Coroner, and then the Coroner would call us, I believe.

THE COMMISSIONER: Thank you, Ms. Meadus.

BY MS. MEADUS:

Q. So I'm almost done. You'll be happy to know.

I'm going to get into an area that's a little bit more difficult, and I apologize, but I think we have to look at all

these issues.

So Ms. Hughes brought you to a part in your Affidavit where you had talked about reflecting on some of the deaths around the symptoms of sweating that later on you thought that had been symptoms possibly of insulin overdose; is that correct?

A. Yes. That occurred when I was reviewing the documents that the police officer -- she gave me a list of names, and, you know, I was going through them one by one, and it -- you know, there were three in close succession that had that charting to reflect that.

Q. And we also know that Ms. Pickering went into the hospital, and the doctor, Dr. Urbantke, had said that she had concerns as well around that specific case and that there had been hypoglycaemia, and she was very concerned and said that if Ms. Pickering died, that the Coroner should be called; is that correct?

A. That's right.

Q. Okay. And, sorry, Dr. Urbantke is actually also a Coroner; is that correct?

A. Yes.

Q. Okay. Was not the Coroner obviously on this case because it would have been a conflict?

A. Mm-hm.

Q. Okay. And during that time,

11:05:51 we also heard about an insulin problem where
11:05:56 someone -- where Ms. Wettlaufer had taken the
11:05:58 wrong insulin and put it into the pen and had
11:06:03 used that; is that correct?
11:06:03 A. That occurred after, I
11:06:03 believe.
11:06:09 Q. That was after?
11:06:09 A. Yes.
11:06:10 Q. Okay. All right. So
11:06:11 thank you very much for clarifying that.
11:06:12 So you had at least a number of
11:06:14 times when people are getting symptoms of
11:06:19 hypoglycaemia where they shouldn't have; is
11:06:23 that correct?
11:06:23 A. Well, it wasn't really
11:06:26 apparent, you know, as such at that time.
11:06:29 Q. Okay. And can you tell me,
11:06:34 what do you think could have been done to catch
11:06:39 those? Is there something that nursing staff
11:06:42 should be looking for? Are there any ways, do
11:06:45 you think, of checking for those kind of issues
11:06:49 now that you've sort of reflected on it?
11:06:52 A. Well, you know, if you're
11:06:57 thinking that insulin is going to be the
11:06:59 culprit, you know, in hindsight, you'd almost
11:07:03 have to have a standing PRN order for a blood
11:07:10 sugar check because you weren't to check blood
11:07:15 sugar unless you had an order.
11:07:18 And that was brought to our
11:07:21 attention at one time because we thought maybe
11:07:24 some residents were falling because their --
11:07:27 they were maybe getting up too quickly, you

11:07:31 1 know, light-headed, that maybe their blood
11:07:35 2 sugar was low, so we wondered if that was a
11:07:38 3 problem.
11:07:39 4 But then -- I don't know if it
11:07:41 5 was the nurse consultant, she said, you know,
11:07:43 6 you should be getting a PRN blood sugar order
11:07:47 7 if you want to do that especially -- like, some
11:07:49 8 diabetics even had just a standing blood sugar
11:07:54 9 order. It would be, like, on Mondays and
11:07:56 10 Thursdays, check blood sugar, you know, in the
11:07:59 11 morning or in the afternoon.
11:08:00 12 And that's all changed now. You
11:08:04 13 know, doctors order hemoglobin A1Cs which look
11:08:11 14 at blood sugar over a longer period, say, a
11:08:16 15 month or three months' times.
11:08:18 16 Q. When you're talking about
11:08:20 17 doing the blood sugar check, is that the
11:08:22 18 pinprick?
11:08:23 19 A. Yes, it's a little drop of
11:08:25 20 blood.
11:08:25 21 Q. That's something that could
11:08:27 22 be done within the home itself; is that
11:08:28 23 correct?
11:08:28 24 A. Yes.
11:08:28 25 Q. And you could have something
11:08:30 26 like that if someone had symptoms of
11:08:38 27 hypoglycaemia or hyperglycaemia, you could test
11:08:40 28 that in the home even if they weren't diabetic;
11:08:43 29 is that correct?
11:08:43 30 A. Well, you shouldn't, you
11:08:45 31 know, if you didn't have the doctor's orders.
11:08:47 32 Q. Right, but you'd need a

11:08:49 1 doctor's order, but that is possible to be done
11:08:51 2 within the home?
11:08:52 3 A. Yes, that is possible.
11:08:53 4 Q. And is that something you
11:08:54 5 think might be a recommendation, that there
11:08:57 6 should be more consideration for doing that
11:08:58 7 type of testing?
11:08:59 8 A. I don't know. Do you think
11:09:02 9 this will ever happen again, you know? I
11:09:04 10 certainly hope not. I think it's, you know,
11:09:15 11 hard -- and I've spoken to this before.
11:09:19 12 Yes, insulin was the concern in
11:09:21 13 this case, but there are other medications that
11:09:24 14 could be given that are just as deadly. And,
11:09:29 15 you know, how can you prevent everything?
11:09:37 16 Like, that's --
11:09:37 17 Q. And I think that -- you know,
11:09:39 18 to be fair to you, I think we will hear some
11:09:42 19 evidence later from the experts that insulin is
11:09:45 20 actually one of the drugs of choice in many of
11:09:48 21 these cases, but that's not within your
11:09:50 22 knowledge basis, so I will leave it at that.
11:09:53 23 Thank you very much for your time.
11:09:55 24 A. You're very welcome.
11:09:56 25 THE COMMISSIONER: Thank you,
11:09:58 26 Ms. Meadus.
11:09:59 27 MS. HEWITT: Would this be an
11:10:01 28 appropriate time, Commissioner,
11:10:02 29 for the morning break?
11:10:03 30 THE COMMISSIONER: Yes, it would
11:10:04 31 be. Go ahead if you want to
11:10:05 32 pack up. I just want to make

sure that if there are any documents that I'll need for the next set of cross-examination, over the break perhaps they could be brought up or just -- I just don't want to have a repeat of this morning where there was some confusion over the documents. I don't want to waste anybody's precious time.

MS. HEWITT: We will. Thank you.

THE COMMISSIONER: Thank you.

THE COURT CLERK: The Public Inquiry is on recess until 11:35.

-- RECESSED AT 11:10 A.M.

-- RESUMED AT 11:27 A.M.

MS. HEWITT: Thank you, Commissioner. I have been assured for right now we don't have any additional documents for this witness, and Ms. Binhammer on behalf of the RNAO is here.

THE COMMISSIONER: Thank you very much.

CROSS-EXAMINATION BY MS. BINHAMMER:

Q. Good morning, Helen. May I call you Helen as well?

A. Yes, please.

11:28:05 Q. By name is Lauren Binhammer, and I represent the Registered Nurses Association of Ontario, which is --

11:28:10 A. I'm sorry, I'm having trouble hearing you.

11:28:12 Q. I'm sorry, the Registered Nurses Association of Ontario.

11:28:15 A. Yes.

11:28:15 Q. Which is a professional association dedicated to public policy issues related to nursing and promoting advocacy in nursing. I just have a few questions for you today.

11:28:25 My first question relates to training. You obviously had a leadership position at Caressant Care. Did you have any leadership training provided to you?

11:28:36 A. I -- when I was Assistant Director of Nursing, I took a nursing leadership course that was offered I think through the Canadian Health Care Association or Council. It was a long distance program, and it was like we did a monthly project. We had, you know, to do reading and write an essay and answer questions, that kind of thing.

11:29:12 Q. Okay, and was there any other leadership training either through Caressant or otherwise?

11:29:19 A. Well, we would have meetings, you know, through head office with our regional group and there was training offered there by the Regional Manager.

11:29:39 And we also had a Caressant Care
11:29:43 conference every year. It was a two-day event,
11:29:47 and there would be guest speakers, you know,
11:29:50 talking on different topics.
11:29:52 Q. Okay, and --
11:29:54 A. I would also go to the
11:29:57 geriatric refresher day that was offered at the
11:30:03 university, and then it got so large it had to
11:30:08 be moved off-site. I went every year but did
11:30:17 miss a couple of years because of what was
11:30:19 happening.
11:30:23 And then I also went to the
11:30:29 medical pharmacy in-services when I could that
11:30:32 were offered.
11:30:33 Q. Okay. And we have heard that
11:30:35 Registered Nurses in general and especially on
11:30:38 night shift had a supervisory role with respect
11:30:40 to RPNs and PSWs?
11:30:42 A. Yes.
11:30:43 Q. Was there any leadership
11:30:44 training offered to them?
11:30:45 A. Just through the orientation
11:30:55 process and with our ideals that we wanted, you
11:31:02 know, residents well looked after.
11:31:06 Q. Was any of the orientation
11:31:08 process, though, specifically directed to
11:31:10 supervising, leading and managing other staff?
11:31:13 A. I don't believe so.
11:31:15 Q. Thank you. Now, you have
11:31:19 spoken a bit already today about the
11:31:20 distinction between RNs and RPNs, but I want to
11:31:22 clarify a point on that in your affidavit. So

11:31:25 at paragraph 24 at page 5 of your affidavit,
11:31:37 you have said that RNs are the supervisor and
11:31:43 they are someone who the RPNs can go to for
11:31:45 advice; do you see that sort of in the middle
11:31:48 of paragraph 24?
11:31:54 So am I right that RPNs, the
11:31:57 practice at Caressant, if an RPN has a
11:31:59 situation that maybe she doesn't know quite how
11:32:01 to deal with or is a little out of her depth,
11:32:05 she is supposed to go to an RPN [sic] for
11:32:08 advice on what to do?
11:32:09 A. Yes, she had that option. If
11:32:11 she wasn't sure, she could go and speak with
11:32:13 the Registered Nurse.
11:32:14 Q. And that is because
11:32:15 Registered Nurses generally have more education
11:32:18 and are better able to deal with more complex
11:32:20 cases and situations?
11:32:21 A. Yes.
11:32:22 Q. Okay, and so if you are
11:32:24 dealing with a resident who has complex needs,
11:32:28 you would want to have a Registered Nurse
11:32:30 closely involved in that resident's care?
11:32:32 A. Yes, but that is not to put,
11:32:35 you know, down the Registered Practical Nurses.
11:32:41 Some of them had a lot of experience and were
11:32:45 good critical thinkers and, you know, sometimes
11:32:50 it was just a collaboration between the
11:32:54 Registered Nurse and Registered Practical
11:32:56 Nurse.
11:32:56 Q. Sure, absolutely, but
11:32:58 Registered Nurses had a different skill set

than --

A. Yes.

Q. And so if you were dealing with a complex or an unpredictable situation, you would want a Registered Nurse around to provide supervision and care?

A. Yes.

Q. And now I just want to clarify something about one of the Critical Incident Reports. It is at Exhibit MM to your affidavit, and it is document number 00643.

And I want to take you to page 3 of this report, and you may remember that it is from March 2013 and the issue was there was a missing capsule of a narcotic and Ms. Wettlaufer said it was possible that she had given the resident a double dose.

Now, under "Analysis and follow-up", you can see there is a question:

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

And underneath that it says:

"On going education regarding medication administration, following [narcotics] protocols [...] and prompt reporting of discrepancies."

Was this, the ongoing education that is referred to here, is this the annual training that we have heard about, or was this

11:34:18 a specific program in response to this
11:34:19 incident?
11:34:20 A. Well, the protocols and for
11:34:28 narcotics and, you know, medication
11:34:30 administration would have been reviewed then,
11:34:36 but it was ongoing. As things changed, you
11:34:39 know, the education would need to be ongoing.
11:34:42 Q. Okay, and when you said the
11:34:43 protocols were reviewed then, do you mean
11:34:47 reviewed by you or reviewed by all staff
11:34:50 together? What was the --
11:34:51 A. Reviewed by all staff, yeah.
11:34:53 Q. So there was a review by all
11:34:54 staff --
11:34:55 A. Yes.
11:34:55 Q. -- in response to this?
11:34:56 A. I'm sure there was, yes.
11:34:57 Q. Okay, thank you, those are my
11:35:01 questions.
11:35:02 A. And it was also audited,
11:35:04 because that is when the narcotic was missing,
11:35:06 so, yeah, it was a whole change, you know,
11:35:13 re-emphasizing the process.
11:35:15 MS. BINHAMMER: Thank you.
11:35:15 Those are my questions.
11:35:17 THE COMMISSIONER: Thank you.
11:35:18 MS. HEWITT: Ms. Martin on
11:35:20 behalf of the RPNAO.
11:35:26 CROSS-EXAMINATION BY MS. MARTIN:
11:35:32 Q. Hi, Helen.
11:35:33 A. Hi.
11:35:34 Q. I'm Dianne Martin and I

11:35:36 represent the Registered Practical Nurses of
11:35:38 Ontario. So I just have a couple of nursing
11:35:40 questions for you related to nursing.
11:35:43 RPNs and RNs are both nurses
11:35:48 regulated by the College of Nurses and are
11:35:51 responsible to the same standards of practice;
11:35:55 is that correct?
11:35:55 A. Yes.
11:35:55 Q. Okay. So when you talk about
11:36:00 complexity with your residents, can you
11:36:03 describe what -- because RPNs can manage a
11:36:09 fairly significant level of complexity, can you
11:36:12 describe what an RPN level of complexity that
11:36:16 they could manage is compared to what would
11:36:18 then have to move on to a Registered Nurse?
11:36:21 What does complexity look like that is
11:36:23 appropriate to both categories?
11:36:24 A. I can't really give an
11:36:28 example. You know, if the RPN felt that she
11:36:31 needed advice or wasn't familiar with a certain
11:36:34 situation, she could go to the RN. And
11:36:39 sometimes just talking, you know, with someone
11:36:43 else would help come up with the answers or,
11:36:48 you know, the best way to handle a situation.
11:36:50 I can't really give you an example.
11:36:53 Q. Is that because it would
11:36:55 depend on the individual level of knowledge for
11:36:57 each of those nurses?
11:36:58 A. I believe so, and you know,
11:37:00 what exactly, you know, was the situation. It
11:37:03 is hard to think of something that --
11:37:06 Q. Okay. So I'm just going to

move on to your page 24 of your affidavit which we had up earlier. Thank you.

"There is a significant [...]" --

And I am just going to read it, that:

"There is a significant difference in pay between Registered Nurses and Registered Practical Nurses. In my opinion, in the long-term care setting there is not as much difference in practice. However, the Registered Nurse would do more of the in-depth assessments. At Caressant Care, Registered Practical Nurses do more of the treatments, and Registered Nurses more assessments. In addition, the Registered Nurse is the supervisor, someone who Registered Practical Nurses can go to for advice. However, both Registered Nurses and Registered Practical Nurses administer medications, assess wounds, do treatments, take doctor's orders and process them, speak to families [and] update care plans and lead the residents' team conference, etc."

11:38:07 1 Because they are -- sorry, that
11:38:08 2 is the end of your quote.
11:38:09 3 So a couple of questions about
11:38:11 4 that from your affidavit.
11:38:13 5 When you mention a significant
11:38:15 6 difference in pay on average, approximately
11:38:18 7 what is the difference?
11:38:19 8 A. I can't recall.
11:38:21 9 Q. And you mention that
11:38:24 10 Registered Nurses -- oh, sorry, I was going to
11:38:26 11 ask you about the assessments, but can you --
11:38:30 12 Registered Nurses do assessments, but can you
11:38:32 13 describe some of the assessments that the RPNs
11:38:34 14 are doing?
11:38:34 15 A. They would take blood sugars,
11:38:39 16 blood pressures, temperatures. They would do
11:38:45 17 their own urine dip tests.
11:38:46 18 Q. Okay, and would an RPN be
11:38:50 19 able to recognize the symptoms of hypoglycaemia
11:38:54 20 and react accordingly?
11:38:55 21 A. Yes.
11:38:55 22 Q. You state that both RNs and
11:38:58 23 RPNs administer medications. Would this
11:39:01 24 include the administration of insulin?
11:39:02 25 A. Yes.
11:39:03 26 Q. Okay, and just a couple of
11:39:06 27 questions about the Nurse Consultant that you
11:39:08 28 mentioned in your earlier testimony.
11:39:09 29 In your testimony on Friday, you
11:39:12 30 had mentioned that a Nurse Consultant in
11:39:14 31 relation to the medication -- you had mentioned
11:39:17 32 it in relation to the Medication Administration

Record. Do you know more about who this Nurse Consultant was, such as their background or credentials?

A. I know who she was, but I don't know her credentials.

Q. And in what circumstances would you consult the Nurse Consultant?

A. She would visit the home approximately once a month and do rounds and, you know, talk to staff and talk to me and just see how things were going, talk about any issues. If there was a new process coming that she was working on, she would, you know, give me a heads-up, that kind of thing.

Q. Did the Nurse Consultant ever advise you or the staff on the College of Nurses' Standards of Practice?

A. Yes, I believe it was the Regional Manager -- or not the Nurse Consultant but the Regional Manager.

Q. And did the Nurse Consultant ever advise on continued education, particularly after a series of medication errors or treatment errors were reported?

A. I don't recall. I think we took that upon ourselves.

MS. MARTIN: Okay, and thank you, that ends my questions.

THE COMMISSIONER: Thank you.

MS. HEWITT: I believe that ends those that want to participate at this point in time, but Mr.

11:41:02 Golden is entitled to re-examine
11:41:03 the witness.
11:41:04 THE COMMISSIONER: Thank you.
11:41:05 RE-EXAMINATION BY MR. GOLDEN:
11:41:07 Q. Thank you. Helen, in the
11:41:15 cross-examinations you were asked a number of
11:41:17 questions about funding for staffing, and is it
11:41:22 your understanding that the funding for
11:41:25 staffing for care comes through the Nursing and
11:41:29 Personal Care Envelope?
11:41:29 A. Yes.
11:41:29 Q. And is it your understanding
11:41:32 that the amount that is given for the Nursing
11:41:38 and Personal Care Envelope --
11:41:40 MR. ZIGLER: Commissioner, I
11:41:40 hate to interrupt my friend, but
11:41:42 he shouldn't be leading his own
11:41:44 witness.
11:41:49 MR. GOLDEN: We have been trying
11:41:50 to speed things up and have
11:41:53 adopted a practice that appears
11:41:54 to be, you know --
11:41:58 THE COMMISSIONER: I am going to
11:42:01 let this go ahead. If there is
11:42:02 a problem with the base
11:42:04 assumptions in it -- but in the
11:42:07 interests of time and also we do
11:42:08 have the relaxed rules in the
11:42:11 Rules of Procedure.
11:42:12 So go ahead, Mr. Golden.
11:42:14 BY MR. GOLDEN:
11:42:14 Q. Who sets that Nursing and

11:42:16 Personal Care Envelope, the amount that is in
11:42:18 it?
11:42:18 A. That comes from the Ministry.
11:42:24 Q. And in your experience,
11:42:27 having worked at the home and been responsible,
11:42:30 did you typically spend on nursing and personal
11:42:33 care everything that was in that Nursing and
11:42:36 Personal Care Envelope?
11:42:37 A. Yes, we did.
11:42:38 Q. Now, you were asked in
11:42:44 cross-examination about some of the
11:42:46 difficulties, and you mentioned going to
11:42:49 hospital to make sure, as an example, that
11:42:54 prospective residents were residents that you
11:42:57 actually would have the capability of looking
11:42:59 after.
11:43:01 A. Yes.
11:43:01 Q. And to the best of your
11:43:04 knowledge, what happens if you admit a resident
11:43:08 and then you determine that their needs are too
11:43:11 complex, too unusual, too heavy for your home?
11:43:16 How easy is it for you to discharge that
11:43:19 resident?
11:43:19 A. It is actually very
11:43:23 difficult. We had a resident in that
11:43:26 situation. We had sent her to hospital to the
11:43:30 Mental Health Unit probably two times, and
11:43:36 there was no change in her behaviour. And I
11:43:42 believe the third time we sent her, we told the
11:43:47 hospital that we couldn't take her back because
11:43:49 she was a risk, you know, to others.
11:43:55 And the hospital, the Mental

11:44:04 Health Unit, the Supervisor was adamant that we
11:44:07 were to take her back and we refused. And
11:44:11 there was a big meeting set up. Anita Cole was
11:44:24 there from the CCAC. There was two of her
11:44:26 workers there that worked with her in the
11:44:28 community when she lived in Tillsonburg. There
11:44:32 were two or three representatives there from
11:44:34 the Mental Health Unit in the hospital.
11:44:47 And I had -- Anita had said to
11:44:49 me, Helen, under what circumstances would you
11:44:52 take her back? And I had, you know, drafted an
11:44:56 agreement, and I can't really recall what was
11:45:02 all in it. It would be on her file, I'm sure.
11:45:08 But the hospital would not agree to the
11:45:11 conditions.
11:45:13 And it was a very nasty meeting.
11:45:18 We were berated and Anita Cole sent me an email
11:45:27 afterwards saying that she felt, you know,
11:45:29 badly for us and she could understand our
11:45:35 viewpoint and she was going to work towards not
11:45:38 having this resident admitted back to the home.
11:45:42 And that did happen, but it was
11:45:47 a difficult and, you know, quite a lengthy
11:45:50 process.
11:45:50 Q. Is this an issue that you
11:45:53 think needs an attention?
11:45:54 A. Pardon me?
11:45:55 Q. Is this an issue which you
11:45:56 think needs attention?
11:45:58 A. I'm sorry, I am not catching
11:45:59 what you are saying.
11:45:59 Q. Is this an issue in terms of

11:46:01 1 residents who have needs that are determined to
11:46:06 2 be too high for the nursing homes --
11:46:06 3 A. Yes, this --
11:46:09 4 Q. -- this is an issue?
11:46:10 5 A. Yes, this woman had mental
11:46:12 6 health issues that we could not handle at the
11:46:14 7 home.
11:46:14 8 Q. Helen, there were --
11:46:17 9 THE COMMISSIONER: Sorry, Mr.
11:46:19 10 Golden spoke at the same time as
11:46:20 11 you did, and I understood his
11:46:21 12 question was, do you think this
11:46:23 13 is a problem or a difficulty or
11:46:24 14 a challenge for the homes that
11:46:27 15 there are residents with too
11:46:31 16 difficult or challenging
11:46:32 17 behaviours to be managed in the
11:46:34 18 home? Do you think that that is
11:46:35 19 an issue for the homes?
11:46:37 20 THE WITNESS: I certainly do
11:46:38 21 think that is an issue. Some of
11:46:43 22 these potential candidates I
11:46:47 23 believe, you know, should be in
11:46:48 24 some type of mental health unit
11:46:52 25 or psychiatric facility because
11:47:01 26 their behaviour is
11:47:03 27 uncontrollable, if you will.
11:47:06 28 THE COMMISSIONER: So, Mr.
11:47:07 29 Golden, if I misspoke your
11:47:08 30 question, please --
11:47:10 31 MR. GOLDEN: You did not.
11:47:11 32 THE COMMISSIONER: Thank you.

11:47:12 BY MR. GOLDEN:
11:47:13 Q. Helen, in cross-examination a
11:47:15 number of the counsel specifically asked you
11:47:17 about the incident with the resident whose
11:47:21 finger was bleeding, and that happened at the
11:47:23 same time that Bethe and others were dealing
11:47:26 with a potential hip and a fall; do you
11:47:31 remember that?
11:47:31 A. Yes.
11:47:32 Q. And based on your
11:47:34 investigations of that, did you -- was there
11:47:40 any sense that the resident's finger had been
11:47:44 cut because of neglect on the part of your
11:47:48 staff?
11:47:48 A. No, I think it was probably
11:47:53 an inadvertent accident, you know, maybe caused
11:47:56 by the resident herself or something else, but
11:48:01 it had been bandaged, and I am quite
11:48:08 comfortable in saying that it would have been
11:48:10 looked after.
11:48:10 Q. And as a result of your
11:48:12 seeing that it had been bandaged, did you view
11:48:14 that resident as being at risk?
11:48:16 A. No.
11:48:17 Q. Now, Ms. Hughes on behalf of
11:48:22 the union asked you a number of questions about
11:48:25 potential red flags when you interviewed
11:48:30 Elizabeth Wettlaufer based on her prior work
11:48:33 history; do you remember that?
11:48:35 A. Yes.
11:48:35 Q. And we now know from Exhibit
11:48:40 6, the Overview Report, specifically that prior

11:48:44 to Ms. Wettlaufer being hired at Caressant
11:48:49 Care, that ONA had all of the details about the
11:48:54 horrendous termination and the circumstances --
11:48:57 MS. HUGHES: I am objecting to
11:48:58 this line of questioning.
11:48:59 MR. GOLDEN: Well, I am laying
11:49:01 the foundation for the question.
11:49:03 It is --
11:49:03 THE COMMISSIONER: Can I hear
11:49:03 the objection first, and then
11:49:04 I'll hear your response.
11:49:07 MS. HUGHES: Thank you. A
11:49:07 number of times I have been told
11:49:09 that the witnesses can't speak
11:49:10 to that particular issue. If we
11:49:12 are going to any issue about
11:49:14 another workplace, other than
11:49:16 Christian Horizons where she did
11:49:17 speak to them and got a
11:49:18 reference letter, that this
11:49:21 witness could not speak to this
11:49:22 issue, and I have been cut off a
11:49:23 number of times on that issue.
11:49:25 And if Mr. Golden is going to go
11:49:26 into another area that is just
11:49:28 simply trying to be prejudicial
11:49:30 when this witness can't assist
11:49:32 you, Madam Commissioner, I am
11:49:34 objecting.
11:49:35 MR. GOLDEN: Okay, well, I
11:49:36 hadn't finished the question.
11:49:37 That is not where I was going.

11:49:38 I was simply noting that in
11:49:41 Exhibit 6 it has already been
11:49:43 put into evidence that ONA fully
11:49:46 participated and was fully aware
11:49:48 of the mental health
11:49:49 circumstances, the deceptions,
11:49:52 the overdoses that happened at
11:49:54 Geraldton.
11:49:54 And I simply wanted to ask this
11:49:56 witness whether over the entire
11:49:58 period of Ms. Wettlaufer's
11:50:00 employment, from the time she
11:50:02 was hired until she was fired,
11:50:05 including when information about
11:50:08 bipolar and OCD was passed on to
11:50:10 the union, did the union ever
11:50:12 come and say, well, we actually
11:50:15 have additional information
11:50:17 about a mental health issue that
11:50:21 happened prior to her employment
11:50:24 at Caressant Care?
11:50:25 MS. HUGHES: And I am still
11:50:27 objecting to that question. Mr.
11:50:29 Golden hasn't laid the
11:50:30 foundation with respect to
11:50:31 whether or not ONA had any
11:50:33 knowledge. At that time, she
11:50:35 was going under a different
11:50:36 name, which you may recall,
11:50:39 Madam Commissioner, of Bethe
11:50:40 Parker as opposed to Wettlaufer.
11:50:42 So there is absolutely no

11:50:43 1 evidence with respect to that
11:50:45 2 there was any connection on
11:50:47 3 behalf of ONA.
11:50:49 4 THE COMMISSIONER: The Overview
11:50:51 5 Reports and Foundational
11:50:53 6 Documents were entered into
11:50:54 7 evidence and admitted into
11:50:55 8 evidence at the beginning, at
11:50:56 9 the outset. If you are
11:50:59 10 suggesting that he has to build
11:51:03 11 that --
11:51:04 12 MR. GOLDEN: I am happy to refer
11:51:06 13 to the paragraphs.
11:51:07 14 THE COMMISSIONER: Yes. I mean,
11:51:08 15 it is in evidence.
11:51:09 16 MS. HUGHES: I understand that
11:51:10 17 that's in evidence, Madam
11:51:12 18 Commissioner, but I don't see
11:51:14 19 how that would arise then in
11:51:15 20 terms of this witness can now
11:51:18 21 lead -- or, sorry, this counsel
11:51:20 22 can now lead it through this
11:51:22 23 particular witness. And in
11:51:23 24 fact, why is he doing it now at
11:51:24 25 this point?
11:51:25 26 THE COMMISSIONER: Well, I
11:51:26 27 understand that but --
11:51:27 28 MS. HUGHES: Because I have no
11:51:28 29 chance now to respond with this
11:51:30 30 witness.
11:51:30 31 THE COMMISSIONER: Well, you may
11:51:31 32 have a chance to respond at some

11:51:33 other point. But it does seem
11:51:34 to me that many, many times you
11:51:38 were trying to suggest through
11:51:40 the cross-examination that there
11:51:40 were opportunities for CCW or
11:51:42 this witness to speak to the
11:51:44 union. In this case, what he is
11:51:47 trying to elicit is whether
11:51:49 there was an opportunity or in
11:51:51 fact whether the union had in
11:51:52 fact shared information the
11:51:53 other way.
11:51:54 I am not sure why I see that as
11:51:56 unfair when the document is
11:51:58 entered into evidence showing
11:52:00 that you had that evidence --
11:52:01 MS. HUGHES: Well, Madam
11:52:02 Commissioner, when we are
11:52:03 talking about the union, we are
11:52:04 talking about completely
11:52:05 different locals. If you are
11:52:07 going to talk about unions as if
11:52:08 like CUPE knows everything
11:52:12 across or ONA would know
11:52:13 everything, these are in
11:52:14 different locals. And to
11:52:15 suggest, for instance, that
11:52:16 Karen Routledge as the local rep
11:52:17 would know that, for instance, I
11:52:20 just think that is unfair.
11:52:22 THE COMMISSIONER: All right,
11:52:23 there was no suggestion that it

11:52:24 was Karen Routledge.
11:52:24 I am going to rule that the
11:52:26 question is in order, but if you
11:52:27 can, Mr. Golden, please refer
11:52:30 to the --
11:52:30 MR. GOLDEN: Yes, I will.
11:52:30 MS. HUGHES: But, Madam
11:52:31 Commissioner, if I could just
11:52:33 clarify, my objection is that
11:52:34 why are we asking this witness?
11:52:36 How can this witness say what
11:52:38 ONA knew or didn't know?
11:52:39 THE COMMISSIONER: It wasn't a
11:52:40 question about what ONA knew or
11:52:42 didn't know. The question is --
11:52:45 I agree there is a based
11:52:46 assumption in the evidence,
11:52:48 which we are going to go to, but
11:52:49 based on the evidence that has
11:52:50 already been admitted into this
11:52:52 hearing that it appears that ONA
11:52:55 was well aware of certain
11:52:57 information about Elizabeth
11:52:59 Wettlaufer. And the question to
11:53:00 her was, did any of the union
11:53:04 come and present that
11:53:05 information to her. That I rule
11:53:08 to be an acceptable question,
11:53:10 particularly in light of the
11:53:11 line of questioning which
11:53:13 continually asked her what she
11:53:15 shared with the union.

11:53:16 MS. HUGHES: All right, and,
11:53:17 Madam Commissioner, I would just
11:53:18 ask you to take judicial notice
11:53:20 with respect to that in terms of
11:53:22 that unions are organized by
11:53:24 locals, and so to suggest that
11:53:26 somehow that the individuals who
11:53:28 were servicing Caressant Care
11:53:30 knew something, there is no
11:53:31 foundation to that.
11:53:32 THE COMMISSIONER: All right,
11:53:33 thank you.
11:53:33 Go ahead, Mr. Golden, and to the
11:53:36 specifics in the --
11:53:37 BY MR. GOLDEN:
11:53:38 Q. All right, so the specifics
11:53:38 are contained in Exhibit 6, in the Overview
11:53:43 Report, and they start at paragraph number
11:53:45 19 -- sorry, you know, we can go right to
11:53:53 paragraph 27.
11:53:55 Paragraph 27 is a summary of a
11:53:58 meeting that took place with E.W., Elizabeth
11:54:03 Wettlaufer, a representative of the Geraldton
11:54:05 Hospital and the ONA representative. And it
11:54:08 describes in some detail what was discussed and
11:54:12 the circumstances surrounding Elizabeth
11:54:15 Wettlaufer taking Lorazepam 5 mg. before her
11:54:18 shift, 25 tablets at the end of her shift,
11:54:21 and so on, and then if we --
11:54:23 THE COMMISSIONER: All right,
11:54:26 and shall we just get that up on
11:54:27 the screen I wonder there, Mr.

11:54:29 Golden, in fairness to everyone.
11:54:30 MR. GOLDEN: Sure.
11:54:31 THE COMMISSIONER: All right,
11:54:31 so --
11:54:43 MS. HEWITT: It is in Volume 1
11:54:45 of that Overview Report,
11:54:48 paragraph 27.
11:54:49 THE COMMISSIONER: So it is
11:54:49 Exhibit 6, which is the Overview
11:54:51 Report on the Facilities and
11:54:56 Agencies.
11:54:56 MR. GOLDEN: Yes.
11:54:57 THE COMMISSIONER: And we are
11:54:58 talking about paragraph --
11:55:00 MR. GOLDEN: 27.
11:55:01 THE COMMISSIONER: -- 27 in
11:55:03 Volume 1, and the Foundation
11:55:05 Documents, if we need them, are
11:55:07 set out there.
11:55:09 BY MR. GOLDEN:
11:55:15 Q. So paragraph 27 describes the
11:55:19 meeting that happened after the incident at
11:55:23 Geraldton Hospital which was described on the
11:55:26 first day.
11:55:27 And then in paragraph 29, I'll
11:55:33 just read that:
11:55:34 "The Ontario Nurses'
11:55:37 Association, on behalf of
11:55:40 [Elizabeth Wettlaufer] files a
11:55:40 grievance as a result of her
11:55:42 dismissal."
11:55:43 And then if we go over to

paragraph 42, it says:

"[Geraldton District Hospital] and ONA settle [Elizabeth Wettlaufer's] grievance and enter into Minutes of Settlement. The terms of the settlement include amending [Elizabeth Wettlaufer's] personnel file to reflect that she resigned from the [Geraldton District Hospital] for 'health reasons' as a result of a medical condition for which she has since sought medical treatment. As part of the settlement, [Geraldton District Hospital] agrees to respond to any reference requests by advising that she resigned her employment for health reasons."

And I simply wanted to know from Helen whether over the seven-year period that Bethe Wettlaufer worked at Caressant Care, whether anyone from ONA ever advised you of the prior mental health issues with Bethe Wettlaufer?

A. No.

Q. All right. Now, Ms. Hughes when she was cross-examining you did choose to put to you notes from a Registered Nurses staff meeting of March 25, 2014. Those are the notes that she selected, and one of the issues that

she drew your attention to was a shortage of nurses.

I don't need to pull that up on the screen, but if we can pull up Exhibit QQ from your affidavit in Exhibit 16, my question is just about the timing. Helen, what was happening in terms of your RN staffing the day after March 25, 2014? And if you can look at QQ and the document specifically --

A. Sorry, P?

Q. Sorry, QQ.

A. QQ.

Q. And the doc ID is 16756. And if you go to the second page of 16756, on March the 26th, is this the meeting where Ms. Wettlaufer was sent home and then terminated?

A. Yes.

Q. Thank you. Now, Helen, counsel for the College of Nurses asked you a number of questions about a document that summarized your telephone conversation, and I would like to pull that up on the screen, 36847.

Thank you. At the very top it says:

"Please note: The following is a summary of the investigator's conversation with the contact. It is not a statement of the contact and has not been reviewed, or approved as accurate by the contact."

11:59:39 1 Did you ever receive any
11:59:41 2 follow-up in order to verify what your
11:59:47 3 conversation was?
11:59:48 4 A. No, I did not.
11:59:50 5 Q. And did anyone from the
11:59:55 6 College ever share with you the prior history
11:59:58 7 before the employment at Caressant Care of
12:00:04 8 Bethe Wettlaufer's mental health issues?
12:00:06 9 A. No.
12:00:06 10 Q. Thank you. Now, Helen, there
12:00:22 11 were three documents, Exhibits 28, 29 and 30,
12:00:28 12 that were ONA forms related to overwork that
12:00:36 13 were put to you. We don't need to look at
12:00:40 14 them, but I would like to know other than the
12:00:43 15 boxes that were ticked that we could use more
12:00:46 16 staff, were there any discussions with ONA
12:00:49 17 practically about what could be done to add
12:00:54 18 staffing?
12:00:54 19 A. I can't recall. I don't
12:01:02 20 think so.
12:01:04 21 Q. And you were also asked by
12:01:10 22 Ms. Hughes about inappropriate interactions
12:01:14 23 between Ms. Wettlaufer and people working under
12:01:19 24 her. I would like you to look at your
12:01:23 25 Exhibit L, document number 16862.
12:01:30 26 If we could just scroll down.
12:01:49 27 Now, Helen, you'll see in the middle of the
12:01:52 28 page there is a paragraph starting with the
12:01:54 29 words "You are an RN [...]"
12:01:57 30 A. Yes.
12:01:59 31 Q. "[...] you have a position of
12:02:00 32 power and you need to be careful

of what you say and how you say it."

Were issues regarding boundaries between Ms. Wettlaufer and staff and her behaviour, were they things that were actually raised by you?

A. Raised by me?

Q. In discussion with her.

A. Yes.

Q. All right, thank you. Now, you were also asked a question by the lawyer for the Residents' Councils about neglect, and she took you to a section which said that you must report immediately if you have reasonable grounds to suspect.

What was your understanding of your obligation to report if you did not feel there were reasonable grounds that there had been neglect or abuse?

A. Then I thought it wasn't necessary to report.

Q. Now, Helen, a number of the counsel kept coming back to Exhibit No. 32, that is 04353, the citation from the Ministry regarding the four hours on a night in 2012 when there was no RN, if we can pull that document up.

To the best of your recollection, over the period that the documentation from this Commission covers for Caressant Care, and that would be 2005 through to 2016, is this the -- do you know if this is

12:04:11 1 the only time you were cited for not having
12:04:13 2 someone there for four hours?
12:04:15 3 A. Yes.
12:04:15 4 Q. And you explained in
12:04:23 5 cross-examination the steps you took to try and
12:04:27 6 fill that missing four-hour gap. Did anyone
12:04:35 7 from the Ministry, when they wrote you up for
12:04:37 8 this, suggest that you had put residents at
12:04:40 9 risk?
12:04:40 10 A. No.
12:04:41 11 Q. Did you believe that?
12:04:42 12 A. No.
12:04:43 13 Q. You were also asked about
12:05:04 14 ways to go back and note patterns, for example,
12:05:09 15 if residents had been charted as being cold and
12:05:13 16 clammy. For residents who are diabetic and on
12:05:19 17 insulin and residents who are not on insulin,
12:05:23 18 are there a number of reasons why someone might
12:05:27 19 present as cold and clammy?
12:05:29 20 A. It could be a night sweat.
12:05:36 21 You know, there are -- or they are having, you
12:05:40 22 know, a fever and then got chilled because, you
12:05:42 23 know, they were damp from the perspiration.
12:05:53 24 MR. GOLDEN: Okay. Thank you, I
12:05:56 25 have nothing further.
12:05:57 26 THE COMMISSIONER: Thank you.
12:06:01 27 MS. HEWITT: Commissioner, that
12:06:02 28 ends the testimony and all the
12:06:04 29 questions, I believe, of Helen,
12:06:07 30 and so we are finished this
12:06:09 31 aspect of the testimony.
12:06:11 32 THE COMMISSIONER: Let me then

12:06:14 thank the witness.
12:06:15 Thank you very much for coming
12:06:16 to help the Inquiry. We
12:06:17 appreciate all your candour and
12:06:19 your help. You are free to go
12:06:21 now. You don't have to come
12:06:23 back. Everybody is finished
12:06:24 asking you their questions.
12:06:25 THE WITNESS: Very good, thank
12:06:27 you.
12:06:27 THE COMMISSIONER: Thank you.
12:06:28 THE WITNESS: And thank you to
12:06:29 everyone present.
12:06:40 THE COMMISSIONER: I just
12:06:41 thought that the witness would
12:06:42 like to get away from that chair
12:06:44 as soon as possible, and
12:06:45 therefore, I will now let you go
12:06:46 on, Ms. Hewitt.
12:06:47 MS. HEWITT: Commissioner, I
12:06:49 have a proposal, and that is we
12:06:51 are starting a whole different
12:06:53 witness now which will not
12:06:55 entail all of the many exhibits
12:06:56 that you have in front of you.
12:06:58 We have additionally got, while
12:07:00 we were here this morning, an
12:07:02 additional document that I wish
12:07:03 to go over with that particular
12:07:06 witness.
12:07:06 And I was wondering if we could
12:07:09 take the lunch break now and

12:07:11 then come back after the lunch
12:07:14 break and then just take the
12:07:15 witness through her evidence.
12:07:17 THE COMMISSIONER: Have you had
12:07:18 a chance to canvass this with
12:07:20 your friends?
12:07:22 MS. HEWITT: No, not during the
12:07:23 morning break.
12:07:24 THE COMMISSIONER: All right.
12:07:25 Does anybody have a problem with
12:07:28 us breaking now and coming back?
12:07:31 I guess that would be about
12:07:33 1:30? Is that a difficulty?
12:07:34 MS. HUGHES: I have no problem
12:07:35 breaking, Madam Commissioner.
12:07:37 I was wondering if I could ask
12:07:38 also to meet with this witness?
12:07:39 I understand that this witness
12:07:40 is the person who has now been
12:07:43 identified as the ONA rep. It
12:07:45 was not identified earlier to us
12:07:47 that way. And we would like a
12:07:48 chance to speak with her for a
12:07:50 few minutes too. And I trust
12:07:52 that can be accommodated?
12:07:54 MS. HEWITT: I am not quite sure
12:07:55 what my friend is indicating
12:07:58 about wasn't indicated about the
12:08:00 ONA rep because it has always
12:08:02 been, I believe, in her summary,
12:08:03 which was provided to everyone,
12:08:04 but as long as I get an

12:08:06 1 opportunity to speak to the
12:08:07 2 witness, the witness is free to
12:08:09 3 speak to anyone else. We have
12:08:10 4 never stopped any witness from
12:08:12 5 speaking to anyone else.
12:08:12 6 THE COMMISSIONER: All right.
12:08:13 7 So I think that that takes care
12:08:14 8 of that. But she is your
12:08:16 9 witness, so I would direct that
12:08:19 10 you deal with her first, and
12:08:20 11 then if she is prepared to meet
12:08:21 12 with Ms. Hughes, go ahead,
12:08:28 13 but --
12:08:28 14 MS. HEWITT: Well, counsel for
12:08:28 15 Caressant Care is her lawyer.
12:08:29 16 MS. HUGHES: Well, that is,
12:08:29 17 Madam Commissioner, why I am
12:08:30 18 confused, because I have not --
12:08:32 19 the affidavit has been reviewed
12:08:34 20 by counsel for the Commission or
12:08:36 21 counsel for the employer, and we
12:08:38 22 have not seen any drafts of it.
12:08:40 23 We have had no -- she has had a
12:08:45 24 chance to vet it and make
12:08:46 25 changes, and we have not. And
12:08:47 26 they are characterizing her as a
12:08:48 27 witness for the employer, and so
12:08:49 28 I am naturally confused.
12:08:51 29 THE COMMISSIONER: Well --
12:08:54 30 MS. HUGHES: So I would like an
12:08:55 31 opportunity.
12:08:55 32 THE COMMISSIONER: I thought

12:08:56 1 that the witnesses -- I saw the
12:08:58 2 witness list some time ago.
12:09:00 3 Were you not aware that this
12:09:01 4 witness was going to be called?
12:09:03 5 MS. HUGHES: It was not
12:09:04 6 characterized as an ONA witness.
12:09:06 7 THE COMMISSIONER: Sorry, it is
12:09:07 8 not an ONA witness.
12:09:08 9 MS. HUGHES: So I never had a
12:09:09 10 chance. We only got -- so maybe
12:09:11 11 you don't know this,
12:09:12 12 Commissioner, but we only get
12:09:13 13 the affidavits a very short
12:09:16 14 period of time and the notes a
12:09:17 15 short period of time.
12:09:17 16 And so I am a bit worried by the
12:09:19 17 tenor of the criticism of ONA
12:09:22 18 that we are seeing throughout
12:09:24 19 these proceedings, and I feel
12:09:25 20 that ONA is at a disadvantage if
12:09:27 21 this witness who is a, quote,
12:09:30 22 "ONA representative", we weren't
12:09:32 23 given the affidavit to vet it.
12:09:33 24 I did ask for that opportunity
12:09:35 25 earlier and --
12:09:35 26 THE COMMISSIONER: Sorry, Ms.
12:09:36 27 Hughes, I'm just going to have
12:09:38 28 to cut you off there. I have
12:09:39 29 never understood this to be an
12:09:41 30 ONA representative in the sense
12:09:42 31 that she is being produced as an
12:09:44 32 ONA witness. My understanding

12:09:45 1 of the witness list is that she
12:09:47 2 is being produced because of her
12:09:48 3 work at the facility. She was
12:09:51 4 the RN and she was present at
12:09:53 5 meetings, including in the
12:09:55 6 capacity of being a union
12:09:56 7 representative, which I think is
12:09:59 8 different than an ONA
12:10:00 9 representative.
12:10:02 10 So if you can just -- so my
12:10:04 11 understanding, and correct me,
12:10:06 12 is she is being produced as a
12:10:08 13 witness by Commission Counsel
12:10:12 14 because of her employment period
12:10:14 15 at Caressant Care during which
12:10:16 16 she did certain things,
12:10:17 17 including serving as a union
12:10:19 18 representative.
12:10:20 19 MS. HEWITT: Yes, and if I may,
12:10:22 20 Commissioner, that is correct.
12:10:24 21 She is being called as a nurse
12:10:26 22 at Caressant Care who happened
12:10:27 23 to be the ONA rep and has
12:10:29 24 information.
12:10:30 25 And with all due respect to Ms.
12:10:32 26 Hughes, this witness's summary
12:10:34 27 as part of the process was
12:10:35 28 posted and available to counsel
12:10:37 29 quite some time ago, with the
12:10:39 30 document IDs. The affidavits
12:10:41 31 followed those summaries. We
12:10:42 32 were very detailed. We don't

12:10:44 have property in the witness.
12:10:47 And so, you know, as I said, she
12:10:50 is not being tendered as an ONA
12:10:51 witness. She is being tendered
12:10:54 as a Registered Nurse who
12:10:55 happened to be the ONA
12:10:56 representative who was sitting
12:10:57 in on some of the meetings in
12:11:00 that capacity.
12:11:01 THE COMMISSIONER: We do need to
12:11:03 have it sorted out, because
12:11:04 otherwise I won't know whether
12:11:06 you are cross-examining her or
12:11:08 not.
12:11:08 MS. HUGHES: Well, my concern
12:11:09 is, Madam Commissioner, with
12:11:12 respect to if there is going to
12:11:13 be criticism of ONA and if Mr.
12:11:16 Golden is going to have sort of
12:11:17 the last word after all the
12:11:18 witnesses to come around, as we
12:11:22 have seen in this one, you know,
12:11:23 I am concerned, and perhaps I'll
12:11:25 wait and see if those concerns
12:11:26 come to fruition. And I would
12:11:27 ask that if something comes out
12:11:29 after I do the cross-examination
12:11:32 that I am not able to explore
12:11:34 with this witness, that I have
12:11:36 another opportunity, if it is a
12:11:37 criticism of ONA.
12:11:38 THE COMMISSIONER: I singularly

12:11:41 question whether or not that
12:11:43 would be a proper or a valid
12:11:45 process.
12:11:49 The facilities are putting in
12:11:51 the evidence that they need to
12:11:52 call. There is no property in a
12:11:55 witness. You have the
12:11:56 opportunity to speak to the
12:11:58 witness, if she chooses to do
12:12:00 that. And you have, of course,
12:12:01 the opportunity to
12:12:04 cross-examine.
12:12:04 But the normal process is chief,
12:12:07 cross-examination and
12:12:08 re-examination. And of course,
12:12:11 you will have an opportunity
12:12:12 again to -- I assume you have
12:12:18 already indicated whether or not
12:12:19 you want witnesses of your own
12:12:21 to be put forward and so on.
12:12:22 But I don't see how we could in
12:12:26 conscience, in dealing with fair
12:12:28 process, alter that approach to
12:12:32 the hearing of evidence.
12:12:34 MS. HUGHES: All right, well,
12:12:35 I'm just putting it on the
12:12:37 record, because there seems to
12:12:39 be an inordinate amount of
12:12:40 criticism of ONA that I
12:12:41 certainly wasn't made aware of
12:12:43 before we started these
12:12:44 proceedings that that would be

12:12:45 the case, and so I raise that
12:12:47 because I have concerns about
12:12:48 fairness.
12:12:49 THE COMMISSIONER: At any stage,
12:12:50 if there is an objection that
12:12:53 you wish to raise, please stand
12:12:55 and give it to me and I will
12:12:57 deal with it. But I don't think
12:12:59 I will, unless someone can
12:13:02 disabuse me of this, I don't
12:13:04 think that it would be wise or
12:13:06 available to me to alter the
12:13:07 normal process by which we call
12:13:10 a witness.
12:13:12 MS. HEWITT: And I would just
12:13:13 say that there is -- I am
12:13:17 assuming there is a lot of
12:13:19 people and organizations here
12:13:20 that feel that their processes
12:13:21 and procedures are under
12:13:22 scrutiny, and we are here to
12:13:24 find the facts and that is what
12:13:26 we are attempting to do.
12:13:28 THE COMMISSIONER: All right.
12:13:29 So if I can then, it is like
12:13:33 about 12:15. And so nobody else
12:13:35 has a health concern or other
12:13:37 problem that would affect me
12:13:39 calling the lunch recess at this
12:13:41 time?
12:13:41 All right, so then by my watch
12:13:44 it is about 12:15. We have now

12:13:46 agreed that the lunch recess
12:13:48 will be an hour and 15 minutes,
12:13:51 and I understand from you that
12:13:53 that will give you sufficient
12:13:55 time to deal with the later
12:13:56 document that has come in and
12:13:57 get your witness ready to start
12:14:01 promptly at 1:30?
12:14:03 MS. HEWITT: That's correct,
12:14:04 Commissioner.
12:14:04 THE COMMISSIONER: All right,
12:14:05 thank you very much.
12:14:05 -- RECESSED AT 12:14 P.M.
13:30:20 -- RESUMED AT 1:30 P.M.
13:30:20 MS. HEWITT: Thank you,
13:30:21 Commissioner. We would like to
13:30:22 now call Karen Routledge to the
13:30:24 stand.
13:30:25 KAREN DIANE ROUTLEDGE; SWORN.
13:31:16 MS. HEWITT: Perhaps, Madam
13:31:34 Clerk, if we can move those
13:31:35 documents away from the witness
13:31:37 to make it a little more
13:31:39 spacious for now.
13:31:41 THE WITNESS: Thanks.
13:31:44 EXAMINATION IN-CHIEF BY MS.
13:31:44 HEWITT:
13:31:44 Q. And we do have an affidavit
13:31:46 to pass up to Ms. Routledge.
13:31:50 And we have been asking or some
13:31:52 people have said they would rather be called by
13:31:54 their first name, some people not. What is --

13:31:56 do you have a preference?
13:31:57 A. First name is good.
13:31:59 Q. Okay. And it is Karen;
13:31:59 correct?
13:32:00 A. Yes.
13:32:12 Q. All right.
13:32:12 THE COMMISSIONER: Thank you
13:32:12 very much.
13:32:15 BY MS. HEWITT:
13:32:16 Q. Now, in front of you, Karen,
13:32:17 is a document that says "Affidavit of Karen
13:32:21 Routledge", and if I could just take you to the
13:32:23 last page of that affidavit, so before you get
13:32:26 to tab "A", the last page there, and is that
13:32:33 your signature?
13:32:33 A. Yes, it is.
13:32:34 Q. All right. Now, my
13:32:35 understanding is that there is a correction to
13:32:38 be made in terms of the date that you believed
13:32:44 that you were an ONA rep; is that correct?
13:32:46 A. Yes.
13:32:46 Q. All right. So what I propose
13:32:47 to do is when we get to that part of my
13:32:49 questioning that talks about ONA, we'll clarify
13:32:52 it then; is that okay with you?
13:32:53 A. Yes.
Q. All right, so subject --
THE COURT REPORTER: I'm sorry,
I'm having some trouble hearing
the witness.
THE WITNESS: Okay?
THE COMMISSIONER: Is that

better?
THE COURT REPORTER: Yes.
13:33:03 BY MS. HEWITT:
13:33:03 Q. All right, so subject to the
13:33:04 one correction that we'll make, other than that
13:33:07 date, Karen, were there any other corrections
13:33:11 to be made at this time?
13:33:12 A. No.
13:33:12 MS. HEWITT: Okay, so could we
13:33:13 make this the next exhibit,
13:33:14 please, Commissioner?
13:33:15 THE COMMISSIONER: Yes, we can.
13:33:17 Is it Exhibit 32, Madam Clerk?
13:33:19 THE COURT CLERK: Yes,
13:33:20 Commissioner.
13:33:20 THE COMMISSIONER: Thank you
13:33:20 very much.
13:33:21 Is it subject to redactions, or
13:33:22 it is fine as is?
13:33:24 MS. HEWITT: It has been
13:33:25 redacted.
13:33:25 THE COMMISSIONER: All right, so
13:33:26 Exhibit 32 then is the affidavit
13:33:28 of Karen Routledge, thank you.
13:33:29 THE COURT CLERK: Pardon me,
13:33:31 Commissioner, 33.
13:33:32 THE COMMISSIONER: Is it? Okay,
13:33:33 there we go, 33. Sorry, Exhibit
13:33:35 33. Thank you, Madam Clerk.
13:33:36 EXHIBIT NO. 33: Affidavit of
13:33:38 Karen Routledge.
13:33:38 BY MS. HEWITT:

13:33:38 Q. Thank you. Now, before we
13:33:40 get started, Karen, can you just give us a bit
13:33:43 of your background, your history of employment?
13:33:47 A. I graduated in 1976. I was
13:33:49 employed at Alexandra Hospital in Ingersoll. I
13:33:53 worked in various positions there. I was a
13:33:57 Registered Nurse. I was a Coordinator for the
13:34:00 Acute Care Unit, and I also worked Emergency,
13:34:04 some OR, and basically all areas.
13:34:09 At the same time, I was employed
13:34:11 at Woodstock General Hospital in the Emergency
13:34:15 Department mainly, and some in ICU, some in OR.
13:34:21 During the year 2001 and 2002, I
13:34:26 took a leave of absence from Alexandra Hospital
13:34:28 to work in Banff Springs, Alberta.
13:34:32 Q. And when did you come to
13:34:36 Caressant Care?
13:34:36 A. 2005.
13:34:38 Q. And was that -- at the time
13:34:41 that you were at Caressant Care, was that your
13:34:42 first foray into long-term care?
13:34:45 A. Yes, it was.
13:34:46 Q. In all the rest of your
13:34:48 significant experience in the hospital setting?
13:34:51 A. Uhm-hmm.
13:34:52 Q. And so what differences, if
13:34:54 any, did you find when you went from being a
13:34:57 hospital Registered Nurse to a long-term care
13:35:00 Registered Nurse, if any?
13:35:03 A. Well, I went to long-term
13:35:08 care thinking it would be a nice precursor to
13:35:10 retirement, but I found that, such as the

13:35:17 1 workload is, I have really never worked harder
13:35:20 2 in my life or used the amount of skill that I
13:35:23 3 had, and I was so glad that I had that
13:35:26 4 emergency background to be able to apply it to
13:35:28 5 this area in order to do my assessments
13:35:31 6 correctly.
13:35:34 7 And the introduction of RAI/MDS
13:35:36 8 to long-term care sometime around 2011, I am
13:35:41 9 not sure, you know, doubled the paperwork from
13:35:47 10 the Nursing Care Plan aspect. And there was a
13:35:54 11 lot more interaction with families.
13:35:58 12 Q. Let's go to your affidavit,
13:36:01 13 because at paragraph 6, starting at paragraph 6
13:36:05 14 you talk about your daily routine, and I notice
13:36:09 15 that that is in quotes, so --
13:36:10 16 A. Which page are you on?
13:36:11 17 Q. Page number 2.
13:36:11 18 A. All right.
13:36:13 19 Q. And if we could put this
13:36:14 20 affidavit up.
13:36:15 21 A. Uhm-hmm.
13:36:16 22 Q. If we could just go through
13:36:19 23 to educate both the Commissioner and the
13:36:22 24 general public as to what a typical day in the
13:36:25 25 life would be of a Registered Nurse in
13:36:28 26 long-term care.
13:36:30 27 Now, my understanding is that
13:36:32 28 what you are describing in paragraph 6 is your
13:36:35 29 shift on days; is that correct?
13:36:37 30 A. Yes.
13:36:38 31 Q. All right. So just take us
13:36:40 32 through, and you don't have to read it, but

take us through what would -- when you came on shift, what time would that be?

A. The off-going nurse and I would do a narcotic count, and then she would give me the highlights of what she had experienced on her shift, the report. And then I would do an initial assessment of any patients that I felt required extra attention, you know, eyes on first thing in the morning, and you know, any falls that happened during the night, palliative care patient, residents.

And then I would start actually medications.

Q. All right, let me stop you there, because what I am going to do is as we go through one part of your routine, I am just going to ask some questions to just flesh that out a bit.

So the narcotic count -- let me ask first, what wing or what section in Caressant Care would you normally have worked in when you were on days?

A. I rotated through all three sections, but mainly toward the end Level 2, Section A.

Q. And is that towards the end of your career at Caressant Care --

A. Yes, the end of my career.

Q. Do you remember, let's go back a bit to Elizabeth Wettlaufer. In 2014, approximately, would you have still been in Level 2, Section A or Section A, Level 2?

13:38:14 A. Mainly, but I did, you know,
13:38:17 shifts on Section B.
13:38:19 Q. Okay. Now, in Section A,
13:38:22 Level 2, how many residents on days would you
13:38:24 be --
13:38:26 A. 32.
13:38:27 Q. And do you remember whether
13:38:30 or not you had any assistance from RPN staff in
13:38:34 that section?
13:38:35 A. No.
13:38:35 Q. So you were totally in charge
13:38:37 of 32?
13:38:38 A. Yes.
13:38:41 Q. And then you said that you
13:38:46 would come on shift, and what were your shift
13:38:49 hours? What were your shift hours?
13:38:53 A. 7:00 to 3:00, 3:00 to 11:00,
13:38:58 11:00 to 7:00.
13:38:59 Q. So the day shift you would be
13:39:01 starting at 7:00 a.m.?
13:39:03 A. Uhm-hmm.
13:39:03 Q. You have to say "yes" or
13:39:04 "no".
13:39:04 A. Yes.
13:39:05 Q. It is okay, you'll get to
13:39:06 used to it. We do it all the time.
13:39:09 So you come on shift at 7:00
13:39:10 a.m., and you indicated that you would have to
13:39:12 do the narcotic count with the off-going nurse?
13:39:15 A. Yes.
13:39:15 Q. And again, would that have
13:39:17 been an RN going off the evening or the night

13:39:22 shift?
13:39:23 A. RPN or RN.
13:39:24 Q. And that narcotic count, is
13:39:30 that just for the residents in your wing?
13:39:32 A. Yes.
13:39:33 Q. And briefly, if you can take
13:39:35 us through what is the process that you and the
13:39:39 off-going shift nurse would undertake to do
13:39:42 that narcotic count?
13:39:43 A. The -- one would count the
13:39:49 actual count of the medications, going through
13:39:53 and visually looking at the number of
13:39:55 medications left, and the other nurse would
13:40:00 record the numbers on a narcotic count sheet.
13:40:06 Now, that did change whereby
13:40:09 both nurses were to visualize the narcotics
13:40:15 and, you know, agree on the number.
13:40:19 Q. And the narcotics that you
13:40:22 are counting, did those come from the
13:40:24 medication cart?
13:40:25 A. They were in a separate
13:40:27 drawer in the medication cart. It was a
13:40:28 double-lock system.
13:40:30 Q. And that double-lock system,
13:40:35 was it the drawer that was locked or was there
13:40:38 a locked box within the drawer?
13:40:39 A. A locked box within the
13:40:41 drawer.
13:40:41 Q. Okay. And the cart itself is
13:40:44 locked; is that correct?
13:40:45 A. If it is in the medication
13:40:49 room, no, because you are the only one with a

13:40:51 1 key to that medication room. It is locked by
13:40:55 2 the medication door. Outside of that, if you
13:40:58 3 are not in front of the cart or observing the
13:41:00 4 cart, then the medication cart was locked.
13:41:04 5 Q. And the medication room would
13:41:06 6 be locked and you would have the key?
13:41:08 7 A. Yes.
13:41:08 8 Q. And would the Registered
13:41:11 9 Nurse then have the key to the medication cart
13:41:14 10 as well?
13:41:15 11 A. Yes.
13:41:15 12 Q. And the key to the narcotic
13:41:17 13 bin?
13:41:17 14 A. Separate.
13:41:18 15 Q. All right, so three keys?
13:41:19 16 A. Three, three keys, yeah.
13:41:21 17 Q. So you are -- you do the
13:41:28 18 narcotic count, and assuming that all goes
13:41:31 19 well, you indicate that you would get a report
13:41:35 20 from the off-going nurse?
13:41:37 21 A. Uhm-hmm.
13:41:37 22 Q. You have to say "yes" or
13:41:38 23 "no".
13:41:38 24 A. Yes.
13:41:39 25 Q. It is okay, we'll get there.
13:41:42 26 Now, you then talk about medications. So
13:41:48 27 within long-term care, and we'll take your
13:41:50 28 experience in Section A, Level 2, 32 residents,
13:41:58 29 would all of those residents be on medications
13:42:01 30 or a majority or a minority?
13:42:02 31 A. Almost all. It would be rare
13:42:05 32 not to have someone on anything. I can't think

of a time when there was someone that came in on no medications. There was usually, you know, with osteoporosis or something like that, there is a vitamin even, vitamin D, calcium.

Q. And would, in your experience, would the residents in long-term care, and let's talk about towards the end of Ms. Wettlaufer's time there, 2014, would they be on fewer than five, more than five --

A. More than five.

Q. More than five medications? You have to say "yes" or "no".

A. Yes.

Q. It's okay.

A. More than five.

Q. And is that more than five a day, or is that more than five each time you are giving medications?

A. The morning med pass is the heaviest med pass, and five to ten would be the average.

Q. Per resident?

A. Uhm-hmm.

Q. Yes?

A. Yes. And outside of that, there is the insulin is given before medication, before breakfast.

Q. So if you --

A. It is scheduled as a separate med pass.

Q. Okay. So when we are talking about your regular med pass in the morning,

13:43:36 1 that doesn't include things like insulin?
13:43:38 2 A. Right.
13:43:39 3 Q. Okay. And so approximately
13:43:41 4 then how many medications would you be giving
13:43:44 5 out during your morning med pass?
13:43:46 6 A. Between 4- and 600. That is
13:43:54 7 on Level 1. I remember at one time looking at
13:43:58 8 just how many medications are we giving out and
13:44:02 9 in the time frame that we are looking at, and
13:44:04 10 there was a place on EMAR where it totalled all
13:44:10 11 of the medications you had given that day and
13:44:14 12 what was complete and what was incomplete, so
13:44:15 13 that that data was from there.
13:44:16 14 Q. All right, and when you say
13:44:17 15 "EMAR", you are talking about the Electronic
13:44:21 16 Medication Administration Record?
13:44:21 17 A. Uhm-hmm.
13:44:22 18 Q. Yes?
13:44:22 19 A. Yes.
13:44:23 20 Q. Okay. Now, we have heard
13:44:30 21 some talk throughout this Inquiry as to how the
13:44:33 22 medications are placed in the medication cart,
13:44:36 23 and we heard about cycle strips.
13:44:38 24 A. Yes.
13:44:39 25 Q. Were you familiar with what
13:44:40 26 cycle strips were?
13:44:41 27 A. Yes.
13:44:42 28 Q. And just refresh our memory
13:44:44 29 as to what types of medications come in those
13:44:46 30 cycle strips?
13:44:47 31 A. All the routine medications,
13:44:50 32 blood pressure medications, Tylenol, your oral

13:44:54 hypoglycaemics, your calcium channel blockers,
13:45:01 entero-coated aspirin, all kinds of arthritic
13:45:06 medications, vitamins.
13:45:07 Q. And would those types of
13:45:11 medications constitute the majority that you
13:45:14 would be giving out to each resident?
13:45:16 A. Yes.
13:45:16 Q. And then on top of that, you
13:45:19 would have narcotics; correct?
13:45:22 A. Yes.
13:45:22 Q. So you talked about the
13:45:29 medication cart being in the medication room.
13:45:32 Is that where it would normally be when you
13:45:34 would come on shift?
13:45:34 A. Yes.
13:45:35 Q. And would you have to do
13:45:36 anything to prepare the medication cart to
13:45:39 start your medication pass?
13:45:41 A. Well, just place the water on
13:45:47 there and make sure you had enough apple sauce
13:45:50 if residents' medications needed to be crushed.
13:45:55 Any extra supplement fluids like Ensure or
13:46:01 Resource needed to be placed on there. You
13:46:05 would check your insulin syringes and make sure
13:46:07 that you have enough of the dose once you get
13:46:10 into giving out those medications.
13:46:13 Q. Do you recall, and I know you
13:46:19 have been retired for some time, but do you
13:46:22 recall how the medication carts at Caressant
13:46:25 Care were actually organized in terms of what
13:46:29 would have been found, for instance, in the top
13:46:30 drawer or --

13:46:32 A. They were organized by room.
13:46:37 On Level 1 and Level 2 it was all private
13:46:40 rooms, so you would start at 101 and you would
13:46:42 go down through the cart and the end one would
13:46:45 be room 132. That would be the index card on
13:46:49 top. And all of the residents' medications
13:46:51 would be in that particular area.
13:46:53 Q. Would this be -- which drawer
13:46:55 is this?
13:46:56 A. Level 1 and Level 2.
13:46:57 Q. So in the medication cart,
13:47:00 where would the cycle strips, for instance, be
13:47:02 located?
13:47:03 A. The first and second drawer.
13:47:04 Q. All right, and are they in
13:47:06 separate containers per residents or just --
13:47:09 A. They are in the strip
13:47:10 packaging from pharmacy with the label on them.
13:47:14 Q. And they are organized you
13:47:15 said from room to -- the first room to the last
13:47:18 room?
13:47:19 A. Yes.
13:47:19 Q. And the narcotics are in the
13:47:22 separate drawer at the bottom?
13:47:24 A. Yes.
13:47:24 Q. Now, you start your
13:47:26 medication pass, and so do you just simply go
13:47:29 down to the first room and find the resident
13:47:31 and give him or her their medication? You are
13:47:34 shaking your head no?
13:47:35 A. No, because at that point
13:47:39 everybody is getting up for breakfast, so

13:47:42 1 residents aren't in their rooms at that time.
13:47:46 2 On the evening shift, it is a
13:47:47 3 little different because maybe after they have
13:47:49 4 gone or retired for bed, you can do that
13:47:53 5 chronologically.
13:47:54 6 But in general, I would start in
13:47:55 7 the dining room and basically supervise the
13:48:00 8 admission or the transfer of people into the
13:48:03 9 dining room, and as they came in, then you
13:48:06 10 would give the medications, unless that
13:48:09 11 medication needed to be given after a meal.
13:48:11 12 Q. And when --
13:48:17 13 A. But by 8 o'clock or 8:15,
13:48:20 14 everybody was in the dining room, so you
13:48:21 15 certainly weren't finished by any means at that
13:48:25 16 point.
13:48:25 17 Q. When would you typically
13:48:26 18 start your med pass? You have come on shift at
13:48:28 19 7:00, and by what time would you start --
13:48:30 20 A. 7:30.
13:48:35 21 Q. So you anticipate, and it is
13:48:41 22 totally normal, you anticipate the questions I
13:48:43 23 am going to ask, and like any witness, you
13:48:45 24 probably want to get done and out. But I get
13:48:49 25 evil eyes if we interrupt each other, so if you
13:48:53 26 can just wait until I finish the question, I'll
13:48:56 27 try to make them as short as I can.
13:48:56 28 A. Okay.
13:48:59 29 Q. So you start your medication
13:49:03 30 pass by 7:30, and you indicated you are trying
13:49:05 31 to catch residents as they are transferring
13:49:07 32 into the dining room; is that fair?

13:49:08 A. Yes.
13:49:08 Q. And so you said that you
13:49:11 wouldn't be able to complete that pass by 8
13:49:13 o'clock?
13:49:14 A. No.
13:49:14 Q. And what would happen then if
13:49:16 you weren't completed it by 8 o'clock?
13:49:18 A. I never completed a med pass
13:49:21 by 8 o'clock.
13:49:22 Q. All right.
13:49:23 A. 9 o'clock would be the
13:49:24 earliest.
13:49:24 Q. So would you continue your
13:49:27 medication pass while the residents were
13:49:30 sitting in the dining room?
13:49:31 A. Yes.
13:49:32 Q. Okay. And refresh our memory
13:49:43 as to when you go to give a medication to a
13:49:47 resident, what process do you have to go
13:49:51 through to make sure it is the right medication
13:49:53 to the right resident?
13:49:54 A. Well, you would check that
13:49:56 what is in the pharmacy strip is what the
13:49:59 medication is on your EMAR. You also check the
13:50:03 dose. You check the time. And you make sure
13:50:06 you have the right resident.
13:50:08 Q. So when you indicate check
13:50:11 what is in the pharmacy strip, that is the
13:50:13 cycle strips you are talking about?
13:50:14 A. Yes, they are labelled.
13:50:15 Q. And you would check the
13:50:17 Electronic Medication Administration Record.

13:50:20 Is that what would give you the dose and the
13:50:22 time?
13:50:23 A. Both would have dose and
13:50:24 time.
13:50:24 Q. The strip as well?
13:50:26 A. Yes.
13:50:26 Q. And you make sure that you
13:50:29 have the right resident?
13:50:30 A. Uhm-hmm, yes.
13:50:32 Q. What do you do to make sure
13:50:33 you have the right resident?
13:50:34 A. If I wasn't familiar with
13:50:40 that floor, as what happens as I rotate and new
13:50:44 residents come in, I would make sure that I
13:50:46 checked with the PSWs and made certain that
13:50:49 that was the resident I was giving the
13:50:51 medication to.
13:50:52 Q. And there has been some
13:50:57 indication, I believe, that there is a picture
13:51:02 of the resident on the electronic medication --
13:51:04 A. Yes, there is.
13:51:05 Q. All right, so that is another
13:51:06 check for you?
13:51:07 A. Yes.
13:51:07 Q. And you are shaking your
13:51:09 head?
13:51:09 A. No, yes, when they first
13:51:11 come, the picture isn't always there for a
13:51:13 week, so you really do need to know your
13:51:15 residents or make sure that your PSW --
13:51:20 Q. Knows the resident?
13:51:21 A. -- knows the resident, if,

you know --

Q. All right, and I think you indicated that you would start the med pass by 7:30, and you may be done by 9 o'clock; is that correct? You have to say "yes" or "no".

A. Yes, and I was just thinking it depends on what might happen during that medication pass, as it is never not interrupted, so it may be 9:30.

Q. What are the types of interruptions that you may have while you are trying to give out your medications?

A. Well, one of the most critical ones is a choking spell. The other thing is you are supervising textures. You are supervising the PSWs. There may be a problem with a resident still on the floor and your attention is needed there.

Q. And when you talk about you are looking at texture, is that the textures the residents are eating?

A. Yes, someone with a stroke may be on thin fluids. Someone with no dentures or a chewing problem might be on a minced or a pureed texture. So you are supervising those things as well.

Q. And are you responsible for making sure that the right texture gets to the right resident?

A. Well, in general that should be a dietary responsibility, but you oversee it as the RN.

13:52:56 Q. All right.
13:52:57 A. And you make -- you identify
13:52:59 if there should be any changes either in their
13:53:04 ability to eat, as in do they need more
13:53:08 assistance or, you know, do they need to go
13:53:11 down to a different texture, they are having
13:53:13 difficulty with this.
13:53:14 Q. So you mean if that is
13:53:20 something you notice that a resident is having
13:53:22 difficulty with a certain texture?
13:53:23 A. Uhm-hmm.
13:53:25 Q. What would you do if that
13:53:26 came to your attention?
13:53:27 A. I would trial them on a
13:53:28 different texture. Or if they were complaining
13:53:31 that I don't like this stuff, you know, why are
13:53:32 you giving it to me, if there was no choking
13:53:35 issue and the dietitian would get a referral,
13:53:38 then you could go up a texture. It is not
13:53:40 always moving down.
13:53:42 Q. And when you are giving the
13:53:44 medications at Caressant Care for the morning
13:53:48 med pass, where is your medication cart
13:53:51 situated?
13:53:52 A. It is situated off to the
13:53:57 side in front of the sink, or it is mobile.
13:54:01 Different nurses put it in different places.
13:54:03 Now, for the supper and the noon
13:54:05 meal, the medication pass is not as intensive,
13:54:08 so at noon the cart would be outside of the
13:54:13 dining room.
13:54:13 Q. And if you are not with your

13:54:17 cart, is it expected to be locked?
13:54:19 A. Yes.
13:54:19 Q. And so what happens if you
13:54:23 are in the middle of giving a resident
13:54:28 medication and then there is a choking spell?
13:54:31 A. You have already locked it
13:54:32 when you walk away giving the medication.
13:54:34 Q. So every time that you
13:54:35 actually go to a resident to give a medication,
13:54:38 you have locked your medication --
13:54:39 A. It is a button you push.
13:54:41 Q. So it is an automatic lock?
13:54:42 A. Uhm-hmm.
13:54:42 Q. Okay, I think we were --
13:54:44 A. Yes.
13:54:44 Q. Or at least I was thinking
13:54:45 the old lock and key.
13:54:46 A. No, you didn't have to use a
13:54:48 key to -- well, you had to use a key to open
13:54:50 it, but --
13:54:51 Q. So when you leave your
13:54:52 medication cart to administer the medication,
13:54:54 you can push a button and it automatically
13:54:56 locks?
13:54:57 A. Yes.
13:54:57 Q. But when you come back to get
13:54:59 the next medication for the next resident, it
13:55:02 is a key; is that correct?
13:55:03 A. Yes.
13:55:04 Q. And you do that for each of
13:55:07 your residents?
13:55:07 A. Yes.

13:55:08 Q. On each of your medication
13:55:10 passes?
13:55:10 A. Yes.
13:55:11 Q. Okay.
13:55:18 A. I have trialed it other ways.
13:55:21 I have taken my medication cart right with me
13:55:24 for a certain table.
13:55:27 Q. And how did that work?
13:55:29 A. A little smoother.
13:55:30 Q. And did you continue to use
13:55:34 it that way then after it went a little
13:55:36 smoother?
13:55:37 A. It varied. You know, it
13:55:40 depended on the day, where I was in my
13:55:43 medication pass and how quickly residents came
13:55:47 into the dining room or when the food was being
13:55:51 served, that kind of thing. You didn't want to
13:55:53 be interfering with the food service either.
13:55:56 Q. Now, you said that you are
13:56:00 responsible or you are supervising the PSWs; is
13:56:03 that correct?
13:56:03 A. Yes.
13:56:03 Q. And how many PSWs would you
13:56:05 have had on the day shift in or around 2014; do
13:56:08 you recall?
13:56:09 A. Three.
13:56:09 Q. And what types of things are
13:56:16 you looking for when you are supervising PSWs?
13:56:19 A. Making sure that they
13:56:21 interact with the residents appropriately and,
13:56:24 you know, that they are engaging the residents
13:56:27 and providing, you know, time for the food to

13:56:39 get there basically to the mouth and providing,
13:56:43 you know, a friendly environment, a dining
13:56:48 environment.
13:56:48 Q. Now, the medication pass is
13:56:54 over, you know, at approximately 9 o'clock you
13:56:59 indicated, depending upon interruptions, and
13:57:03 you say in your affidavit at paragraph (d) that
13:57:06 you would start treatments after breakfast.
13:57:09 And so are treatments then different than
13:57:12 medications?
13:57:13 A. Yes, they are. There is a
13:57:15 treatment cart that is separate from the
13:57:16 medication cart, and this would be all of your
13:57:18 dressings, possibly eye treatments, wound care.
13:57:24 Q. And how would you determine
13:57:32 which residents needed treatment on any
13:57:34 particular day?
13:57:35 A. Well, a new treatment -- like
13:57:39 it would be on what they call a TAR or a
13:57:42 Treatment Administration Record, much the same
13:57:44 as an EMAR.
13:57:46 Q. So you have your medications
13:57:50 on the Electronic Medication Administration
13:57:52 Record and the residents' treatments on what
13:57:55 you call a TAR, a Treatment Administration
13:57:57 Record?
13:57:57 A. And that Treatment
13:58:00 Administration Record, the computer for that is
13:58:01 on top of the treatment cart.
13:58:03 Q. How long -- in general, how
13:58:16 long would it take for you to complete this
13:58:20 treatment pass?

13:58:20 A. Usually an hour, but that can
13:58:26 vary.
13:58:26 Q. And are all residents or the
13:58:30 majority of residents on treatment, or no?
13:58:33 A. No, you try to minimize the
13:58:35 number of treatments that you have because you
13:58:37 are trying to prevent wounds or heal them.
13:58:46 Q. All right. Now, in paragraph
13:58:51 (e) of your affidavit, you talk about the
13:58:56 different charting that you have to do as a
13:58:58 Registered Nurse, and perhaps you can just give
13:59:03 us an overview of some of them. You indicate
13:59:06 Nursing Care Plan revisions. What is a Care
13:59:09 Plan?
13:59:09 A. A Care Plan is an overall
13:59:11 picture of the patient's care in the nursing
13:59:15 home. It deals with all of your ADLs or
13:59:18 activities of daily living. It deals with any
13:59:21 behaviour problems, any mental issues, anything
13:59:26 specific to that resident. It deals with
13:59:31 bladder control, bowel control.
13:59:36 Q. And what is the type of
13:59:39 information -- for instance, you indicated that
13:59:41 a Care Plan would reference behaviour problems.
13:59:45 What kind of information would you find on a
13:59:47 Care Plan for behaviour problems?
13:59:50 A. Behaviour problems would
13:59:53 be -- well, there is a number of different
13:59:55 behaviour problems, but aggression and how you
13:59:59 would deal with that and how -- what triggers
14:00:02 it, maybe sexual inappropriateness and, you
14:00:09 know, everything that you can try to prevent

14:00:13 that from happening, or you know, with
14:00:16 Alzheimer's disease, wandering is another
14:00:20 behaviour, and just the different strategies
14:00:22 that have been developed that seem to work for
14:00:26 that particular resident.
14:00:27 Q. And are those care plans
14:00:31 revised?
14:00:32 A. Ongoing, all the time, not --
14:00:37 they are reviewed specifically with the family
14:00:39 every three months, but if there is a change in
14:00:44 the resident's care, there needs to be a change
14:00:48 in the Care Plan.
14:00:48 Q. Now, you mentioned earlier,
14:00:50 you talked about texture and that if a resident
14:00:52 was having some difficulty with a certain
14:00:54 texture, you may refer and go down to a
14:00:57 different texture; is that correct?
14:00:58 A. Yes.
14:00:58 Q. And would that change, is
14:01:00 that something that would be reflected on the
14:01:03 Care Plan?
14:01:04 A. That initiates -- a trial
14:01:08 texture change initiates a dietitian's
14:01:11 referral, and the dietitian would come in and
14:01:12 do her assessment of that particular resident
14:01:14 to see what is most appropriate.
14:01:15 Q. And then would that end up
14:01:17 eventually in the Care Plan if it was changed?
14:01:19 A. Yes.
14:01:19 Q. Okay. Now, you talk about
14:01:23 daily Progress Notes on any change in a
14:01:26 resident's condition. So when you are charting

14:01:31 your Progress Notes, do you chart on every
14:01:33 resident every day?
14:01:34 A. No. You just -- you chart on
14:01:38 the highlights of what is happening on the
14:01:41 floor, any changes, anything significant that
14:01:46 you see behaviour-wise or any critical incident
14:01:53 that may have happened during that shift, as in
14:01:57 a fall or someone hits someone else, that kind
14:02:03 of thing.
14:02:04 Q. And we have got a lot of
14:02:08 Progress Notes that have been entered in
14:02:12 evidence within the Overview Reports. So if a
14:02:15 resident has a good day, no issues, would we
14:02:18 expect to see a Progress Note on that
14:02:20 particular --
14:02:22 A. You would need to see a
14:02:23 Progress Note at least weekly for every
14:02:25 resident, even if it is just a summary that,
14:02:27 you know, things haven't changed and this is
14:02:30 ongoing, or there is, you know, something to
14:02:35 strive for, maybe we could look at a
14:02:38 restorative care program or make some changes.
14:02:41 Q. And there is more charting on
14:02:47 here, including I just want to talk about if a
14:02:50 resident fell. Is that something that you may
14:02:54 be interrupted with with your medication pass?
14:02:56 A. Definitely, yes.
14:02:57 Q. And so what would happen,
14:02:59 what is the process if a resident falls?
14:03:01 A. The PSWs are not to move them
14:03:07 until they have contacted a registered staff,
14:03:13 and you go in and you do an initial assessment

14:03:15 of that resident.
14:03:17 You do -- well, first of all, if
14:03:21 it is critical, if you are suspecting a severe
14:03:25 head injury or cervical injury or say a hip
14:03:29 fracture, which occurs in a nursing home, you
14:03:31 don't move them and you call 911. That starts
14:03:36 the whole process. You administer first aid.
14:03:39 You make sure they are as comfortable as
14:03:41 possible, but --
14:03:44 Q. Are there any type of tests
14:03:46 that you do? If you suspect that perhaps
14:03:49 someone has broken their hip, is there any
14:03:51 assessment that you do at the time to determine
14:03:53 whether or not it is a reasonable assessment or
14:03:55 just call 911?
14:03:58 A. Well, you suspect a fractured
14:04:02 hip if they are having an extreme pain there,
14:04:04 if there is shortening or turning of that hip,
14:04:06 if there is some kind of a deformity, but you
14:04:08 are not the physician and you definitely can't
14:04:12 diagnose it by just looking. But if there is a
14:04:17 suspicion of that, pain is the main thing.
14:04:20 Q. And you talked about if there
14:04:22 is pain, and then you talked about a shortening
14:04:24 or a turning of the hip. Is that something
14:04:26 that you are visualizing? Is that --
14:04:28 A. Yes.
14:04:28 Q. Or is there anything hands-on
14:04:31 that you do to determine that?
14:04:33 A. No. You could ask them, if
14:04:41 they are cognizant, if they can move their --
14:04:44 you know, what can you move? Can you move your

14:04:46 1 lower extremities? Can you point your toe up
14:04:50 2 and down? That kind of thing, just to see what
14:04:52 3 kind of range of motion they have, or even with
14:04:56 4 a fractured arm or anything. You know, you can
14:04:59 5 assess circulation for sure, make sure they
14:05:02 6 have a pedal pulse or a radial pulse.
14:05:05 7 Q. And have there been
14:05:08 8 circumstances where you have responded to a
14:05:10 9 fall and initially thought there might be a
14:05:13 10 fractured hip and then, after continued
14:05:17 11 reassessment, have determined there probably
14:05:19 12 wasn't, or --
14:05:20 13 A. It can happen both ways.
14:05:22 14 Q. And under what circumstances
14:05:26 15 would you move a resident from the floor back
14:05:30 16 into a bed?
14:05:31 17 A. If they had good range of
14:05:34 18 motion, if they weren't in any extreme pain and
14:05:37 19 they didn't seem to have an altered level of
14:05:39 20 consciousness which would indicate some kind of
14:05:42 21 a head injury or any major head trauma, obvious
14:05:48 22 head trauma by bruising or bleeding or --
14:05:52 23 Q. Okay, thank you. Now, it is
14:05:55 24 all in your affidavit, and I am going to leave
14:05:57 25 the rest of the charting for now.
14:05:59 26 And then you talk about that you
14:06:02 27 start the medication pass, and this is
14:06:04 28 paragraph (g), again between 11:00 and 11:30,
14:06:10 29 and I think you said earlier that those
14:06:12 30 medication passes, that that medication pass
14:06:15 31 would not be as intensive in terms of the
14:06:18 32 number of medications; is that correct?

14:06:21 A. That's right.
14:06:21 Q. And did you ever estimate how
14:06:29 many medications would be given out on an
14:06:32 average basis during the afternoon or the lunch
14:06:35 med pass?
14:06:35 A. I don't know. It would be in
14:06:41 the system.
14:06:42 Q. The morning you said was five
14:06:47 to ten per resident. Do you have an
14:06:49 estimate --
14:06:50 A. At least.
14:06:50 Q. Do you have an estimate for
14:06:52 the --
14:06:52 A. Yeah, not all residents would
14:06:54 have medication at noon. Quite often they
14:06:55 would just have them at breakfast and supper,
14:06:57 or even breakfast and bedtime, twice a day.
14:07:00 Q. And you would follow the same
14:07:02 routine; is that fair?
14:07:03 A. No, at noon we wouldn't move
14:07:05 the med cart into the dining room.
14:07:07 Q. Okay, and why is that?
14:07:12 A. To give them a better dining
14:07:15 experience, you know, there is no cart in there
14:07:20 handing out medication. But it is just too
14:07:22 intensive to accommodate that I guess in the
14:07:25 morning.
14:07:25 Q. Now, you talk in paragraph
14:07:31 (i) of your affidavit, and so that is 6, Roman
14:07:37 numeral "i", about there could be potential
14:07:39 admissions to do, and you indicate in your
14:07:42 affidavit:

14:07:43 "If I did them correctly, it
14:07:44 would be four hours of my time."
14:07:49 And so what is time-intensive
14:07:50 about admissions?
14:07:52 A. There is an Admission
14:07:57 Checklist Package.
14:07:57 Q. Uhm-hmm?
14:07:58 A. And I believe you had that as
14:08:04 a reference.
14:08:06 Q. Did I? I don't think it made
14:08:11 it into your -- just on average, give us what
14:08:14 you do on an admission?
14:08:15 A. Well, you would greet the
14:08:17 family and the resident, and then you would
14:08:18 start your assessments. You would do your
14:08:20 temperature, blood pressure, pulse, pulse-ox.
14:08:28 You would ask them about all of their
14:08:30 activities of daily living, you know, what can
14:08:33 they do for themselves; what do they need help
14:08:35 with; what diet they are on.
14:08:37 You investigate what appliances
14:08:43 that they are using, whether they have, you
14:08:44 know, a -- whether they have dentures. You do
14:08:48 continence assessments. You find out if they
14:08:51 need a product or not, or if they need an OT or
14:08:54 a PT referral.
14:08:58 A lot of time is spent with the
14:08:59 family asking questions, and it is nice to have
14:09:04 the time to do that without interruption but
14:09:08 that rarely happened when the RN was
14:09:11 responsible for the full admission.
14:09:17 I tried to -- if they hadn't had

14:09:20 1 a tour of the actual floor, I would try to, you
14:09:26 2 know, take them around and show them the dining
14:09:29 3 area, the activity area, the things that could
14:09:33 4 be done there. And you know, I would explain a
14:09:36 5 little bit about the routine and what time
14:09:38 6 meals are and things like that.
14:09:41 7 Q. And at the time that you are
14:09:43 8 doing that, are you still in charge of the 32
14:09:46 9 residents?
14:09:46 10 A. Yes.
14:09:47 11 Q. And we have heard within the
14:09:51 12 Inquiry to date a couple of different names, a
14:09:57 13 Head-to-Toe Assessment and a 24-hour Care Plan.
14:10:02 14 So what is the Head-to-Toe
14:10:05 15 Assessment?
14:10:05 16 A. The Head-to-Toe Assessment
14:10:08 17 is, well, basically that. You look at any
14:10:10 18 scars or any surgical scars or otherwise. You
14:10:14 19 would look at any breaks in the skin or any
14:10:16 20 reddened areas. You would look at any
14:10:18 21 deformities or is there any amputations. You
14:10:25 22 would look at the foot care; is there bunions,
14:10:28 23 is there calluses. Basically look at the
14:10:35 24 resident as a physician might for a physical.
14:10:37 25 Q. And then on admission, we
14:10:41 26 have heard talk about the 24-hour Care Plan.
14:10:45 27 What does that involve?
14:10:47 28 A. 24 hours is the time limit
14:10:49 29 you have for the Care Plan, and the Care Plan
14:10:53 30 has about 13, maybe 12 or 13 areas that need to
14:10:58 31 be addressed and these - I think I mentioned
14:11:01 32 them before - they include all your activities

14:11:03 1 of daily living like your mobility, your
14:11:06 2 eating, your diet, your bowel control, your
14:11:13 3 bladder control, any behaviours, anything
14:11:19 4 specific to that resident.
14:11:20 5 Q. And when you say you had 24
14:11:22 6 hours to do it, was that --
14:11:24 7 A. It was to be completed in 24
14:11:25 8 hours. The day nurse was to start it as she
14:11:31 9 did, you know, an initial assessment, so she
14:11:33 10 would have the information to be able to start
14:11:35 11 it.
14:11:37 12 Q. Is that 24 hours from
14:11:38 13 admission?
14:11:39 14 A. From time of admission, yes.
14:11:41 15 Q. And so you indicate that the
14:11:43 16 day nurse would start it. Were there occasions
14:11:46 17 when it would be finished by the evening or
14:11:48 18 night nurse?
14:11:48 19 A. Yes.
14:11:49 20 Q. And how would you communicate
14:11:52 21 then to the evening or night nurse that, you
14:11:54 22 know, there is --
14:11:55 23 A. At report time you would say
14:11:58 24 this is what this resident can do, but there
14:12:00 25 are these things still left that need to be
14:12:02 26 done.
14:12:02 27 Q. Okay, thank you. You
14:12:09 28 indicate that in the afternoon there is a
14:12:12 29 half-hour med pass?
14:12:14 30 A. Approximately. And during
14:12:18 31 the day too there is also what we call PRN
14:12:24 32 medications, which are medications that the

14:12:29 1 patient may request or that you identify as
14:12:31 2 needed by the resident. They are an as-needed
14:12:35 3 medication, so they are also given throughout
14:12:37 4 the day.
14:12:37 5 Q. And we have seen reference in
14:12:40 6 the materials and the testimony to date about
14:12:43 7 can a resident ask for a pain pill? Is that --
14:12:46 8 A. Oh, yes, yes.
14:12:47 9 Q. Would that be a type of PRN?
14:12:49 10 A. That is, yeah, that is a PRN.
14:12:53 11 Q. And so how often or how
14:12:55 12 timely should your response be if a resident
14:12:58 13 has asked for a PRN pain medication?
14:13:02 14 A. I would say within five to
14:13:03 15 ten minutes.
14:13:04 16 Q. Now, did you have breaks
14:13:13 17 during the day?
14:13:14 18 A. Yes, short ones.
14:13:19 19 Q. So let me ask you --
14:13:20 20 A. Not lunch.
14:13:20 21 Q. -- were you supposed to have
14:13:22 22 time for a break?
14:13:22 23 A. Yes, half an hour for lunch,
14:13:26 24 15 minutes in the morning and 15 in the
14:13:28 25 afternoon, but there were nurses that -- it was
14:13:30 26 rare that an RN was able to have her breaks on
14:13:34 27 time and a full break.
14:13:35 28 Q. When you are on break, who
14:13:41 29 replaces you on the floor?
14:13:42 30 A. No one, basically. If -- I
14:13:51 31 suppose if it was an emergency and you were
14:13:54 32 absolutely unavailable, the nurse from the

other floor would cover, and you do between first and second floor try to cover each other that way, you know, I am going on break, and try to alternate your breaks that way.

On Section B there is three RPNs, or there is now on days. There wasn't. There was only two. But that is how you would get covered there.

Q. All right. But where you were, if you went off on break for that 15 minutes in the morning, there is not somebody that comes and says --

A. Well, they have a full workload themselves downstairs, so there really wasn't an extra 15 minutes for that person to physically come up. That didn't happen. In an emergency, your PSWs were there and they were able to identify that, gee, this is something that we need further assessment on or this is critical.

Q. Okay. And you indicated that this half hour med pass in the afternoon would be approximately 2 o'clock?

A. Yes.

Q. And your shift ends at 3:00?

A. Yes.

Q. And so where would the time come from to chart everything that we have talked about in paragraph --

A. Bits and pieces during the day, possibly between your medication and your treatment pass, possibly between the treatment

14:15:15 pass and the next pass. The majority of
14:15:20 charting is done after your 2 o'clock med pass,
14:15:22 but then it is a catch-up kind of thing.
14:15:27 Q. Where do you do your
14:15:32 charting? I know you have got a -- you said
14:15:35 you had a computer on top of the medication
14:15:37 cart?
14:15:37 A. No, that is not the one you
14:15:38 chart on. You would chart on the one at the
14:15:40 desk at the nursing station.
14:15:41 Q. So you had to physically go
14:15:50 to the nurses station and sit and be able to
14:15:53 chart there; is that correct?
14:15:54 A. Yes, that's correct.
14:15:55 Q. Is that where the PSWs - and
14:15:57 we are going to hear from PSWs - is that where
14:15:59 they chart as well?
14:16:00 A. No. They had portable units
14:16:02 that were throughout the hallway, one fairly
14:16:07 close to the nursing desk, one halfway down and
14:16:10 one at the end. So there would be call bells
14:16:13 as well, and they would be able to answer those
14:16:18 in between charting.
14:16:22 They were trying to allow the --
14:16:24 you know, it is best to do charting right at
14:16:26 the time; as you get the fluid intake, then you
14:16:30 enter it. To do all of the PSW charting at the
14:16:34 end of the day is unreasonable.
14:16:40 Q. Sorry, and in terms of fluid,
14:16:43 is it the PSWs then that chart what each --
14:16:46 A. Yes.
14:16:47 Q. Or the fluid volume that each

14:16:49 1 resident has taken --
14:16:50 2 A. Every meal the fluid volume,
14:16:52 3 plus the snacks the fluid volume is entered
14:16:55 4 into the resident's chart, as well as their
14:16:58 5 meal is charted, whether or not they took 25
14:17:03 6 percent, 50 percent, 75 or 100 percent. It was
14:17:09 7 a numerical system.
14:17:11 8 Q. Now, I interrupted you at the
14:17:14 9 very beginning, because you made a comment
14:17:17 10 about RAI/MDS and I wanted to start at the
14:17:19 11 beginning of your day.
14:17:20 12 But you did have some comments
14:17:24 13 in your affidavit about the change to the
14:17:28 14 workload when this system came on board, and
14:17:30 15 what was your experience with the change in
14:17:32 16 that workload?
14:17:33 17 A. Well, every resident was to
14:17:37 18 have a RAI/MDS assessment every three months,
14:17:42 19 and it was a very complex data system that
14:17:49 20 mimicked the Care Plan in some respects, but we
14:17:54 21 were still expected to do both.
14:17:58 22 Q. So for the Care Plan, you
14:18:06 23 indicated that you would do assessments and you
14:18:08 24 would implement changes, if there was a change
14:18:10 25 to a resident's status, et cetera. On the
14:18:14 26 RAI/MDS side of things, what type of job or
14:18:23 27 task did you have to do for that particular
14:18:27 28 system?
14:18:28 29 A. Two different things. Your
14:18:30 30 Care Plan is ongoing, and it changes throughout
14:18:33 31 the three months. An MDS is a snapshot of what
14:18:39 32 that resident is like right at the time for

14:18:41 data in order to receive funding.
14:18:46 So the MDS would -- oh, and
14:18:50 there was people in place to do the coding.
14:18:53 Like we did the initial hands-on assessment:
14:18:56 do they have dentures; do they have glasses;
14:18:59 how is their vision; what is their mental
14:19:00 capacity; is there any behaviour problems? All
14:19:02 kinds of those things. What is their range of
14:19:05 motion; what is their mobility status; can they
14:19:09 walk or can they ambulate -- all of that is
14:19:12 data that is collected in MDS coding. And then
14:19:15 it goes to the RAI coordinators, and they
14:19:18 complete it and send it off to the Ministry.
14:19:21 Q. And when you are doing -- so
14:19:29 you said these assessments have to be done
14:19:32 every three months?
14:19:32 A. Uhm-hmm.
14:19:33 Q. Yes or --
14:19:34 A. The MDS, yes.
14:19:35 Q. The MDS assessments. And are
14:19:37 those assessments, are they part of your
14:19:40 regular day, like you have to get them done and
14:19:43 get everything else that we have just chatted
14:19:45 about done as well?
14:19:46 A. Yes.
14:19:46 Q. And --
14:19:49 A. And they weren't getting
14:19:51 done. When they first came in, it was very
14:19:53 difficult to fit them in, and so they started
14:19:56 looking at every nurse, you know, how much they
14:20:00 have done RAI/MDS. And it was a huge workload.
14:20:05 Q. We have seen and I think you

might have sat in on one of the meetings with Bethe Wettlaufer where there was a discussion about how many RAI/MDS assessments that she had done, and do you remember that?

A. Uhm-hmm.

Q. Yes?

A. Yes, I do.

Q. Was she the only one at that point in time that was getting spoken to about not completing those assessments; do you recall?

A. I think we reached a point where, yes, we were getting most of it completed, but Bethe was not with the rest of us as far as that she was below that standard and I believe that's why she was spoken to.

And there could have been others too, but I was not -- I did not sit in on that.

Q. All right, we'll get to that in just a moment.

Now, just briefly, on the evening shift, could you tell us what the difference would be between what you are doing on a day shift and potentially what somebody is doing on an evening shift? The number of medications to be handed out, for instance, is that the same, less than, more than?

A. It is less medications. There is more family interaction. A lot of families would visit in the evening, and so, you know, you needed to spend some time doing that. Day shift covered two meals, and the

14:21:46 1 evening shift covered just the one.
14:21:54 2 Q. The RAI --
14:21:56 3 A. But you could still have the
14:21:57 4 amount of interruption, I guess. Like the
14:22:01 5 falls, the palliative, that didn't change
14:22:05 6 between days -- well, maybe in the evenings
14:22:07 7 there was more falls, but I'm not sure why, but
14:22:11 8 that was tracked and trended.
14:22:13 9 Q. And the night shift, what
14:22:22 10 would be the difference -- or let me go back to
14:22:24 11 the evening shift. Would the evening shift
14:22:26 12 have to do hospital admissions or
14:22:30 13 re-admissions?
14:22:30 14 A. No, but there would be pieces
14:22:32 15 of a hospital admission or even a routine
14:22:35 16 admission that needed to be done on the
14:22:42 17 evening, plus finish the Care Plan for that
14:22:44 18 resident.
14:22:44 19 Q. And how about the RAI/MDS
14:22:46 20 assessments?
14:22:47 21 A. That had to be completed
14:22:50 22 within the week.
14:22:51 23 Q. So would there be more than
14:22:54 24 one nurse potentially working on that
14:22:57 25 particular assessment during the week?
14:22:58 26 A. Yes.
14:22:59 27 Q. And I take it in your
14:23:08 28 section, which was Level A -- or Section A,
14:23:11 29 Level 2, that would only be two other nurses,
14:23:15 30 an evening nurse and a night nurse that would
14:23:17 31 be involved?
14:23:18 32 A. Yes, that's right.

14:23:18 Q. When would medications be
14:23:25 received within the home?
14:23:26 A. They would be received toward
14:23:29 the end of the pharmacy day, which was
14:23:33 approximately 5 o'clock, so on the evening
14:23:36 shift.
14:23:36 Q. And so on days, would you be
14:23:39 responsible at all for taking those medications
14:23:42 and making sure they got to the right cart or
14:23:46 narcotic drawer?
14:23:47 A. No.
14:23:47 Q. Thank you. All right, now I
14:23:52 want to talk next about the handling of insulin
14:23:55 at Caressant Care, and my understanding from
14:23:58 your affidavit was that the residents were on a
14:24:05 pen and cartridge system at the time that
14:24:08 Elizabeth Wettlaufer would have been there?
14:24:09 A. Yes.
14:24:09 Q. And let's talk about how to
14:24:17 order insulin. So let's take a resident that
14:24:22 is already there and diabetic. How would you
14:24:26 re-order insulin that is needed for one of your
14:24:29 residents?
14:24:29 A. Well, one of the things with
14:24:31 insulin is you wouldn't know by EMAR as to
14:24:36 whether that medication was low or not. You
14:24:39 would actually have to visualize it in the
14:24:41 fridge.
14:24:42 So if there was, say, a long
14:24:44 weekend or something coming up or even as you
14:24:48 are taking out the last of the vials, then you
14:24:50 would re-order that medication. There really

14:24:53 wasn't a system for that.
14:24:56 Q. So when the insulin is
14:24:58 ordered and comes in, where is it stored?
14:25:02 A. It is stored in the fridge.
14:25:03 MS. HEWITT: Okay, so we are
14:25:04 going to -- Commissioner, we
14:25:07 have some examples. We think
14:25:09 that Ms. Hughes actually had
14:25:11 some examples of these, and I
14:25:13 would like to enter them as an
14:25:14 exhibit, this and the insulin
14:25:15 pen when we get to it, just so
14:25:17 that you can have some reference
14:25:21 to what we are going to talk to
14:25:23 today.
14:25:24 THE COMMISSIONER: All right,
14:25:24 thank you.
14:25:26 MS. HEWITT: And I have one that
14:25:27 has been marked as Exhibit "A"
14:25:29 to the affidavit of Karen
14:25:30 Routledge, and I just have an
14:25:31 empty package for the other one.
14:25:42 THE COMMISSIONER: Thank you.
14:25:46 BY MS. HEWITT:
14:25:48 Q. And if we could give one of
14:25:50 those to the witness.
14:25:52 A. Thanks.
14:25:52 Q. And do you recognize this
14:25:53 type of box, Karen?
14:25:54 A. Yes, I do.
14:25:55 Q. And would you have -- is this
14:25:58 the type of insulin that some of the residents

would have been on at Caressant Care?

A. Yes.

Q. And when that -- in that box what would we find?

A. Five vials of NovoRapid insulin. They are usually in a foil package.

Q. All right. And when that box of insulin comes in, what would you see, if anything, on the actual box?

A. On the box would be a label with the resident's name and the dose of insulin, the type of insulin, date of birth, doctor.

Q. When that comes in, and I know you weren't on the evening shift, but what would -- do you understand what the evening shift would do when they received insulin in terms of making sure it was the proper insulin, et cetera?

A. It would be scanned into the EMAR section. Whether it would be evenings or nights, it would depend on whether or not that insulin was required for a 5 o'clock med pass. But it uses a scanner similar to your price scanner at Walmart and takes it off of the EMAR system. And if you don't get it off, it will tell you that you can't deliver that medication until you have checked this insulin into the fridge.

Q. And what will tell you, the EMAR?

A. Your EMAR won't let you.

14:27:39 1 There is a -- it will be all red, and your
14:27:42 2 medication check won't be complete until you do
14:27:45 3 that properly.
14:27:47 4 Q. So you have to get the
14:27:49 5 insulin in and you have to scan it in to
14:27:51 6 confirm that it has been received?
14:27:53 7 A. Yes.
14:27:53 8 Q. And is that an online system
14:27:57 9 then?
14:27:58 10 A. Yes.
14:27:59 11 Q. And the information in that
14:28:02 12 scan, where would that go to? How would you
14:28:05 13 know it matches what has been ordered?
14:28:08 14 A. Can you repeat that?
14:28:13 15 Q. Yeah. If I get in a box of
14:28:15 16 insulin and I scan it through the system, what
14:28:19 17 is that scan doing? Is it alerting somebody
14:28:21 18 that I have received it, or is it just being
14:28:24 19 computerized?
14:28:25 20 A. It has been computerized, as
14:28:27 21 far as I know.
14:28:27 22 Q. Okay. Does the pharmacy ever
14:28:29 23 get confirmation that that particular box of
14:28:33 24 insulin has been received; do you know?
14:28:37 25 A. Yes.
14:28:37 26 Q. And how do they get that
14:28:39 27 confirmation?
14:28:40 28 A. Well, I'm assuming it is
14:28:48 29 online and it goes to pharmacy, but I could be
14:28:51 30 wrong on that.
14:28:51 31 Q. All right, well, the --
14:28:53 32 A. If it is in the manual

14:28:54 system, like sometimes insulin is ordered in a
14:28:57 book and then it is done manually. The better
14:29:03 way to do it, though, is the EMAR system.
14:29:08 Sometimes I would have phoned pharmacy and say
14:29:11 that, you know, I can't say that I have signed
14:29:13 this medication off because I can't get it
14:29:14 scanned in, so yes, they do have some record of
14:29:17 that.
14:29:17 Q. All right. So you said it
14:29:19 can be ordered through the computer system; is
14:29:23 that correct?
14:29:23 A. Yes, that is the better way.
14:29:25 Q. And then when it comes in, it
14:29:27 gets scanned and it gets matched up to what has
14:29:29 been ordered through the computer system?
14:29:31 A. Yes.
14:29:32 Q. And you have indicated that
14:29:33 there could be a manual way to order it as
14:29:35 well?
14:29:35 A. Yes.
14:29:35 Q. And the manual way, do you
14:29:37 recall what the manual way was?
14:29:39 A. There was a pharmacy order
14:29:41 book.
14:29:43 Q. All right. And what would
14:29:45 you do if you were ordering --
14:29:48 A. You would write the
14:29:49 resident's name, the insulin required, the date
14:29:54 that you ordered it and your initials. When it
14:30:02 is received, it is received and signed off by
14:30:05 the nurse receiving.
14:30:06 Q. Okay. But when you are

14:30:08 actually ordering it, you filled out this drug
14:30:13 record book, and then how does it get to the
14:30:15 pharmacy?
14:30:15 A. It is faxed.
14:30:16 Q. And then when that is
14:30:25 received, how does it determine that it has
14:30:28 actually been received? What is the check on
14:30:30 that?
14:30:30 A. The check on that is simply
14:30:33 the nurse that has received it has signed it
14:30:36 off. It does not go back to pharmacy to say
14:30:38 that that circle has been complete.
14:30:45 Q. And when you were at
14:30:46 Caressant Care, were both systems being used or
14:30:49 did one supplement the other?
14:30:50 A. We went mainly to EMAR, but
14:30:56 there were certain medications that required --
14:31:02 say stock medications or some kind of like say
14:31:07 some kind of fluid that, you know, it was
14:31:09 extra, or stock medications would be like maybe
14:31:15 a PRN allergy medication or things like that,
14:31:23 they could be put on that record.
14:31:24 Q. But for insulin, were both
14:31:27 systems --
14:31:28 A. For insulin, initially it was
14:31:29 all manual. When EMAR came out, it was a
14:31:34 blend. Toward the end, I believe -- I hit the
14:31:38 microphone -- toward the end it was all EMAR.
14:31:46 Q. So the ordering --
14:31:46 A. So I don't know when it
14:31:47 changed over exactly, but --
14:31:49 Q. By the time that Ms.

Wettlaufer left, would it have been all EMAR or still on some manual?

A. I believe all EMAR.

Q. Okay.

A. That was -- yeah.

Q. So the ordering and the receipt would be electronic; is that fair to say at that point?

A. Yes.

Q. So you received that little package of cartridges that you have in front of you and the Commissioner has in front of you.

MS. HEWITT: Now, Commissioner, it is marked as Exhibit "A" to the affidavit of Ms. Routledge. Do you want it marked as a separate exhibit, or is that satisfactory for you?

THE COMMISSIONER: No, no, that is satisfactory.

BY MS. HEWITT:

Q. Okay. So what then would be done with that package of cartridges once it is received at Caressant Care? Where would it be stored?

A. In the fridge.

Q. And where were the fridges located?

A. In the medication room.

Q. So where you worked, which is Section A, Level 2?

A. Yes.

14:32:51 Q. Was there a fridge in that
14:32:53 medication room?
14:32:54 A. Yes.
14:32:54 Q. And was the fridge locked?
14:32:58 A. It was behind the medication
14:33:00 door.
14:33:01 Q. All right.
14:33:02 A. The fridge itself was not
14:33:03 locked, so it was under a single lock.
14:33:05 Q. And who was allowed in the
14:33:09 medication room? We hear that you have the key
14:33:13 as the Registered Nurse, but would other people
14:33:15 be -- would you leave the door open? Would
14:33:17 other people be able to go in and get into the
14:33:19 fridge?
14:33:19 A. No.
14:33:20 Q. So --
14:33:24 A. The only thing that I would
14:33:25 like to say here is that every medication key
14:33:28 was the same for each section.
14:33:29 Q. In terms of the medication
14:33:32 door?
14:33:32 A. Yes.
14:33:33 Q. So you could go --
14:33:35 A. I could go to first floor and
14:33:36 get into her medication fridge. I could go to
14:33:39 Section B and get into their medication fridge
14:33:41 with the same key.
14:33:42 Q. And was that throughout your
14:33:44 experience at Caressant Care?
14:33:45 A. Yes.
14:33:45 Q. Was that ever discussed, do

14:33:48 you recall, at any time as to whether that was
14:33:50 best practice or did anyone have any views as
14:33:54 to at that time the fact that you could go to
14:33:58 any other floor and get into his or her
14:34:02 medication room?
14:34:02 A. Concerns were not raised on
14:34:03 that.
14:34:03 Q. Okay. And when you are not
14:34:06 in the medication room, is that door locked at
14:34:09 all times?
14:34:10 A. Yes.
14:34:10 Q. Is there any reason for
14:34:12 anyone else to gain entry to that room?
14:34:15 A. No. Wait, cleaning staff,
14:34:22 but you stayed in the medication room, like not
14:34:27 in the medication room on the wet floor, but
14:34:29 you stayed right there when cleaning staff were
14:34:32 in your medication room.
14:34:32 Q. All right, so the cleaning
14:34:34 staff didn't have their own set of keys and
14:34:36 would just simply go in and clean it?
14:34:38 A. Exactly, and the medication
14:34:41 cart at that time could be locked.
14:34:42 Q. Okay.
14:34:46 A. But not the fridge.
14:34:47 Q. Not the fridge. So in the
14:34:49 fridge, how are these -- and let me ask you
14:34:52 this first. The residents that had diabetes
14:34:56 and were on insulin, would they be on one type
14:35:00 of insulin or could they be on more than one
14:35:03 type?
14:35:03 A. They could be on more than

14:35:05 1 one. They could be on it once a day. They
14:35:07 2 could be on it four times a day. It depends on
14:35:10 3 their diabetes.
14:35:13 4 Q. So if a resident is on two
14:35:19 5 different types of insulin, how were they
14:35:22 6 stored in the fridge? Like what do you do when
14:35:27 7 you put them in --
14:35:27 8 A. There is no segregation.
14:35:28 9 Insulin is just -- there is no organization to
14:35:34 10 how insulin is stored in the fridge as the med
14:35:37 11 carts.
14:35:38 12 Q. So the med carts you talked
14:35:41 13 about earlier had these --
14:35:42 14 A. Index card.
14:35:44 15 Q. And in the fridge, are
14:35:46 16 they -- is each resident stored together, or is
14:35:48 17 it just all you have to search through every
14:35:51 18 single insulin until you get the right one?
14:35:53 19 A. The latter.
14:35:53 20 Q. The latter. Were they
14:35:56 21 elasticized together at least for each
14:35:59 22 resident, their different types of insulin?
14:36:01 23 A. Not necessarily.
14:36:02 24 Q. Okay, and was that the
14:36:05 25 case --
14:36:06 26 A. So you didn't have that much
14:36:08 27 of a supply ahead of time.
14:36:10 28 Q. And on average within your
14:36:14 29 section, because I don't want to give a
14:36:16 30 misimpression that the whole fridge is full of
14:36:18 31 insulin, but on average in your section how
14:36:21 32 many of your residents would be on injectable

14:36:25 1 insulin?
14:36:26 2 A. Five to six on Level 2, six
14:36:30 3 to eight on Level 1, and approximately ten to
14:36:36 4 fourteen on B.
14:36:38 5 Q. Now, when it is -- so it gets
14:36:47 6 stored in the fridge, and my understanding is
14:36:56 7 that those cartridges are then used in a pen
14:36:58 8 system; is that correct?
14:36:59 9 A. Yes.
14:37:00 10 MS. HEWITT: All right, so,
14:37:02 11 Commissioner, we have a pen for
14:37:03 12 each of you, and I have had it
14:37:05 13 pre-filled with a cartridge so
14:37:07 14 that neither of you had to
14:37:09 15 attempt to do that on live TV.
14:37:14 16 THE COMMISSIONER: I am sure
14:37:15 17 Karen would have no problem, but
14:37:16 18 I might.
14:37:17 19 MS. HEWITT: That is what I was
14:37:18 20 concerned about.
14:37:19 21 So there is one that is labelled
14:37:20 22 Exhibit "B" to the affidavit of
14:37:23 23 Karen Routledge and then a
14:37:24 24 second one for you,
14:37:29 25 Commissioner.
14:37:30 26 THE COMMISSIONER: Thank you.
14:37:33 27 BY MS. HEWITT:
14:37:33 28 Q. Now, in terms of the pens,
14:37:40 29 would you have different pens for the
14:37:42 30 residents, or would you use one pen typically?
14:37:45 31 A. Different pens.
14:37:47 32 Q. And those pens, would you

14:37:55 1 have to re-order them on occasion?
14:37:57 2 A. Yes.
14:37:58 3 Q. And what was the shelf life
14:38:00 4 of a pen, approximately? How long could a pen
14:38:03 5 last?
14:38:03 6 A. I really don't know.
14:38:06 7 Q. Did you ever have to re-order
14:38:09 8 one?
14:38:09 9 A. Yes.
14:38:09 10 Q. And what type of
14:38:10 11 circumstances would cause you to re-order a
14:38:12 12 pen?
14:38:12 13 A. They wouldn't connect quite
14:38:17 14 right, your connections would wear down a
14:38:20 15 little bit. It is a plastic part. It wouldn't
14:38:23 16 dial up, it wouldn't click quite right. Or
14:38:30 17 sometimes the cap might be lost.
14:38:33 18 But they are a cost to the
14:38:35 19 residents, so you don't set it up as I'm going
14:38:38 20 to have a pen every week. I mean, at home they
14:38:41 21 would have them for a lot longer than that, and
14:38:45 22 they were a lot longer than that.
14:38:47 23 Q. All right. And we see the
14:38:49 24 pens here being delivered in boxes. Would the
14:38:52 25 pens be kept in the boxes for the residents or
14:38:56 26 the --
14:38:57 27 A. No.
14:38:58 28 Q. All right. So if we can open
14:38:59 29 up a box, do you have one there?
14:39:03 30 A. Uhm-hmm.
14:39:04 31 Q. So we can just open up the
14:39:05 32 box and remove the -- now, is that like a glass

14:39:14 case, Ms. Routledge?
14:39:15 A. This is a plastic case, much
14:39:18 like luggage, with a place to insert your pen.
14:39:24 Q. All right. Now, when it
14:39:26 would come -- is this the pen that you are
14:39:29 familiar with?
14:39:30 A. Yes.
14:39:30 Q. And is this the packaging
14:39:32 that you are familiar with?
14:39:33 A. Yes.
14:39:33 Q. When it would come for a
14:39:35 resident, would the resident's name be on the
14:39:38 actual blue package, the blue case?
14:39:42 A. No. And in fact, that would
14:39:46 be something that would still need to be
14:39:47 ordered on a manual pharmacy requisition,
14:39:51 because it is not something that you deliver,
14:39:52 basically. You would need to order that from
14:39:55 pharmacy separately. There is no EMAR that
14:39:58 says, yes, I need to order a pen. It is done
14:40:01 manually.
14:40:02 Q. All right, so if the pen, for
14:40:03 whatever reason, is worn down or not working
14:40:07 appropriately, you would go through the system
14:40:09 that you told us earlier with writing it down
14:40:12 on the drug record sheet and faxing it to the
14:40:15 pharmacy; is that correct?
14:40:15 A. Yes.
14:40:16 Q. All right. So when it comes
14:40:18 in and it doesn't have the resident's name on
14:40:24 the particular -- I guess would it have the
14:40:27 resident's name on the actual cardboard box the

pen came in; do you recall?

A. Yes.

Q. Okay.

A. Because you would need to know which resident you ordered it from -- or for.

Q. And then when you remove the actual casing, I think you indicated that the case --

A. Neither this or this is labelled.

Q. All right, so neither the package, the eyeglass type of case or the pen itself is labelled?

A. Correct.

Q. And when it would be stored in the medication cart, would it be kept in the case or separately simply as the pen; do you recall?

A. I recall it separately as a pen in its own little blue box right beside that patient's medication.

Q. So it is taken out of the case and the pen itself is stored in the medication cart; that is your recollection?

A. Yes.

Q. Now, is there any labelling that occurs at the home before it goes into the medication cart?

A. Yes. The nurse would label the pen with the resident's name. We used to do it manually, and then they got a label maker

14:41:49 and we had labels for every patient.
14:41:51 Q. And you indicated that that
14:42:00 pen would then be located and I think you said
14:42:04 beside the resident's bin; is that correct?
14:42:06 A. Two different things.
14:42:09 On Level 2 it would be beside in
14:42:12 a little blue bin, like your little plastic
14:42:15 blue bin beside the resident's medication.
14:42:19 Section B was a little
14:42:21 different. They were -- no, they were the
14:42:24 little blue bins too, so yes.
14:42:26 But they went with various ways
14:42:28 to separate out the medication pens.
14:42:34 Q. Okay, let's just backtrack.
14:42:37 A. Okay.
14:42:37 Q. You said beside the blue bins
14:42:39 with the resident's medications. Are you
14:42:41 talking about the cycle strips?
14:42:43 A. Yes.
14:42:43 Q. So there would be a bin with
14:42:45 the resident's cycle strip?
14:42:47 A. Yes.
14:42:47 Q. And then you said beside it
14:42:49 would be --
14:42:50 A. Yes, if someone was on
14:42:52 insulin, there would be a separate bin right
14:42:54 beside that resident's --
14:42:56 Q. All right, and are the bins
14:42:57 labelled at all; do you recall?
14:43:00 A. Yes, room number, name.
14:43:05 THE COMMISSIONER: Sorry, is the
14:43:06 bin the same as the little blue

box?
THE WITNESS: Yes.
THE COMMISSIONER: Okay.
MS. HEWITT: Sorry, Commissioner.
THE COMMISSIONER: No, that is fine. I just wanted to make sure I understood.
BY MS. HEWITT:
Q. Now, we have pre-loaded cartridges in these particular pens, but if a pen had come in for a new admission, for instance, with a resident on insulin and you needed to put a cartridge in the pen, the cartridge would be located in the fridge, is that correct, if you are just starting off?
A. Yes.
Q. And when you take a cartridge from the fridge, is there any type of recording that you have removed one cartridge from a box of five?
A. No.
Q. So no tracking of insulin that way?
A. No.
Q. Now, maybe you can take apart your pen and just re-insert the cartridge and just demonstrate how the cartridge goes in.
A. There is the cap, and then there is two parts to this pen. You click it, and it comes out. And there is your cartridge.
Q. All right, and so --

14:44:30 A. There is no way to put it in
14:44:31 wrong. It just doesn't fit. So that you put
14:44:34 it back into your dosage meter here, and then
14:44:39 click it back into the delivery system. When
14:44:44 you go to give your insulin, you dial it and
14:44:48 you --
14:44:48 Q. All right, before you get --
14:44:50 A. You are not there yet, okay.
14:44:52 Q. I am not going to force you
14:44:54 to --
14:44:54 A. I got 600 medications to give
14:44:56 here.
14:44:56 Q. True, true, and I am sure
14:44:59 everybody else wants me to hurry up, but I
14:45:01 think this is very important.
14:45:02 So, Commissioner, I don't want
14:45:03 you to test your skills in terms of taking it
14:45:06 apart, but maybe just take the cap off the pen.
14:45:08 There you go.
14:45:10 THE COMMISSIONER: Without
14:45:11 mistake.
14:45:13 BY MS. HEWITT:
14:45:13 Q. Now, in terms of just simply
14:45:16 the cartridge, Karen, do you recall how many
14:45:21 units that single cartridge contains? It is 3
14:45:29 ml, if that helps.
14:45:32 A. If I can cheat.
14:45:34 Q. Yes, you can cheat and look
14:45:36 at your affidavit. I think --
14:45:37 THE COMMISSIONER: Or just look
14:45:38 at the cartridge.
14:45:39 BY MS. HEWITT:

14:45:39 Q. I think it is 300. Do you
14:45:41 recall?
14:45:42 A. I believe so. It will tell
14:45:45 you -- no, 100 units per ml, so it is 3 ml and
14:45:50 so that is 300.
14:45:51 Q. All right. And so if you are
14:45:52 looking at that cartridge, 300 units. And the
14:45:59 individuals who would be on this particular
14:46:02 type of insulin, do you have an average of the
14:46:06 number of units that they would be injected
14:46:10 with at any given time?
14:46:11 A. No, it varies so much from
14:46:14 resident to resident, there is really --
14:46:18 somebody could be on up to 50; somebody could
14:46:21 be on as low as 2 to 5; or somebody could be on
14:46:26 insulin according to test, you know, depending
14:46:28 on what their blood sugar was, this is the
14:46:32 number of units that he would or she would get.
14:46:36 Q. All right. Now, you are
14:46:37 talking about on a test. Is that a sliding
14:46:39 scale?
14:46:39 A. Yes, that is what is called a
14:46:41 sliding scale.
14:46:42 Q. And just explain for a moment
14:46:45 what is a sliding scale?
14:46:47 A. A sliding scale is if a
14:46:49 resident, let's say they are on it four times a
14:46:52 day, that their morning blood sugar at 7:30 is
14:46:55 such and such, so you would go to the EMAR and
14:46:59 you would say, okay, with this blood sugar,
14:47:01 this is the insulin I give. There would be
14:47:04 parameters.

14:47:05 Q. And so between a certain
14:47:06 range is --
14:47:07 A. There would be a range, and
14:47:10 whatever range you fell into, there would be
14:47:12 the amount of insulin that you would give for
14:47:14 that resident.
14:47:14 Q. All right. So some residents
14:47:16 would be on a sliding scale, and would some
14:47:18 residents be on a fixed dose per --
14:47:21 A. Most residents in the nursing
14:47:25 home are pretty stabilized and they are on a
14:47:25 fixed dose, but we would get new admissions and
14:47:29 residents that were not so stable that would be
14:47:31 on a sliding scale.
14:47:32 Q. And are you able without the
14:47:39 dial-up mechanism - and we'll talk about that
14:47:42 in a moment - are you able to visualize 5 units
14:47:45 at all?
14:47:46 A. No.
14:47:46 Q. And so there is a part of the
14:47:50 pen that rotates and the numbers go up; is that
14:47:53 correct?
14:47:53 A. Yes.
14:47:54 Q. Is that what you mean by
14:47:55 "dial up a dose"?
14:47:56 A. Yes.
14:47:57 MS. HEWITT: So, Commissioner,
14:48:00 there should be on your pen a
14:48:01 little dial.
14:48:03 THE COMMISSIONER: Is that the
14:48:04 orange thing at the bottom?
14:48:05 MS. HEWITT: No, on the

14:48:07 actual --
14:48:07 THE COMMISSIONER: The black
14:48:09 thing at the top?
14:48:09 MS. HEWITT: Correct, there
14:48:10 should be a little window.
14:48:11 THE COMMISSIONER: Yes.
14:48:12 MS. HEWITT: Maybe, Karen, if
14:48:15 you could just show the
14:48:16 Commissioner where the window is
14:48:18 for the dial-up.
14:48:20 THE WITNESS: Yeah, there is
14:48:20 your window there, the end of
14:48:23 that, the end of the --
14:48:25 THE COMMISSIONER: Oh, where
14:48:27 the --
14:48:27 THE WITNESS: That is the dose,
14:48:28 but this is how you dial it up,
14:48:30 here.
14:48:32 THE COMMISSIONER: Okay.
14:48:32 THE WITNESS: The wrong end.
14:48:33 There you go.
14:48:34 THE COMMISSIONER: Okay.
14:48:35 MS. HEWITT: All right, and
14:48:36 so --
14:48:36 THE COMMISSIONER: Oh, yes,
14:48:37 thank you.
14:48:38 BY MS. HEWITT:
14:48:38 Q. And so if somebody is on 5
14:48:40 units, does that record 5? Can you dial it up
14:48:45 to 5?
14:48:46 A. Yes. I thought you meant
14:48:49 could I visualize 5. I could definitely

14:48:52 visualize 5 units here.
14:48:53 Q. I did ask you that, in part
14:48:56 to determine why you have that dial-up. Would
14:48:59 you be able as a nurse to actually visualize 5
14:49:02 units?
14:49:03 A. Not at 100 units a ml, which
14:49:08 is a fifth of a teaspoon.
14:49:10 Q. All right. And so is it safe
14:49:12 to say that one of the control measures there
14:49:16 is is this mechanism that dials up the dose for
14:49:18 you?
14:49:19 A. Yes.
14:49:19 Q. And where do you get, for any
14:49:29 particular resident, where do you get the dose
14:49:31 that the resident is on?
14:49:32 A. The dose comes initially from
14:49:35 the doctor's orders. Then it is transcribed to
14:49:40 pharmacy and it is on the EMAR system. It is
14:49:43 entered in the EMAR system with a time, dose
14:49:54 and type of insulin under that resident's name.
14:49:59 Q. So if you come to the time
14:50:02 where a resident needs 5 units, you would dial
14:50:08 up 5 units; is that correct?
14:50:09 A. Yes.
14:50:10 Q. All right. Now, was there
14:50:12 any independent double-check that you, Karen,
14:50:16 you have dialled up 5? Was there anybody else
14:50:18 that would come along and say, yes, you have
14:50:20 dialled up 5?
14:50:21 A. No.
14:50:21 Q. And I will get back to that
14:50:32 in a moment, but the rest of -- you have

14:50:35 dialled it up to 5 and you are ready to give
14:50:39 it. What would you do next with this
14:50:41 particular pen in terms of does it have a
14:50:46 needle on it?
14:50:47 A. You would put the needle on
14:50:50 first. Then you would prime it. Then you
14:50:56 would dial your dose. Then you would inject
14:51:00 it, after you have checked that you have got
14:51:03 the right resident, the right time, the right
14:51:06 insulin.
14:51:12 Q. And what you mean "prime it"?
14:51:14 What would you be doing when you primed it?
14:51:16 A. Make sure that the end of the
14:51:17 needle forms a drop so that there is no air in
14:51:20 the needle or the tunnel going to the needle,
14:51:22 so that you are giving exactly that amount of
14:51:25 units.
14:51:26 Q. And does that then waste a
14:51:28 little bit of the insulin?
14:51:29 A. A touch, very, very little.
14:51:31 Q. Now, if you had an
14:51:36 independent double-check, if somebody watched
14:51:39 you dial that dose up to 5, when you walked
14:51:42 away from that individual, does that dose lock
14:51:45 in at 5 such that you can't dial anything else
14:51:48 up?
14:51:49 A. No. No, you could top it up
14:51:50 any time you wanted.
14:51:53 THE COMMISSIONER: Sorry, I need
14:51:55 to hear that question and answer
14:51:55 again.
14:51:56 BY MS. HEWITT:

14:51:56 Q. So if there was an
14:51:57 independent double-check, and so let's take you
14:52:01 two, you both, and so, Karen, you dial up 5,
14:52:04 and an independent double-check with another
14:52:06 nurse would require them to look at the pen; is
14:52:09 that correct?
14:52:09 A. Yes.
14:52:10 Q. Would they also look at
14:52:12 anything else to make sure that it is the right
14:52:14 dosage?
14:52:15 A. Well, if it is an independent
14:52:16 check and they are going to be thorough, they
14:52:18 better be looking at what kind of insulin I am
14:52:20 giving and who I am giving it to and that I
14:52:22 have got the proper number of units on EMAR.
14:52:26 Q. And so now both of you
14:52:28 determined the right resident, the right dose,
14:52:30 and the pen is dialled up to the correct
14:52:32 amount?
14:52:33 A. Yes.
14:52:33 Q. That is an independent
14:52:35 double-check; is that correct?
14:52:36 A. Yes.
14:52:37 THE COMMISSIONER: And the step
14:52:37 doesn't involve you watching --
14:52:40 me watching you deliver it,
14:52:42 administer it?
14:52:43 I just want to make sure that an
14:52:45 independent double-check is only
14:52:48 that what is dialled up on the
14:52:51 pen is for the right resident
14:52:53 and right type and right amount,

but it does not include a visual watching of the administration?

BY MS. HEWITT:

Q. No, we haven't got to the administration yet, but an independent double-check of the medication would be that; is that correct?

A. Yes.

THE COMMISSIONER: All right, that is what I needed to be clear on. Thank you so much.

BY MS. HEWITT:

Q. Thank you. And my question, Commissioner, to Karen was the two of you do that and agree it is the right resident, et cetera, and is there anything on the pen itself that would prevent a nurse from walking away and dialling up more at any time?

A. No.

Q. And so to the second question or comment that the Commissioner had, is there any -- does anybody watch you administer the insulin?

A. When --

Q. When you were at Caressant Care?

A. When I was at Caressant Care, which was until 2016, there was no double-check on insulin. Physically, geographically, there was one nurse on the second floor for 32 residents. You didn't have that availability of another registered staff. There was three

14:54:12 in the building; one was on Section B, one was
14:54:15 on Level 1, and one was on Level 2, and you are
14:54:17 all doing the same thing, your morning med pass
14:54:24 and insulin.
14:54:28 Q. And so if there was going to
14:54:30 be an independent double-check, you would have
14:54:33 to go to one of those other nurses while they
14:54:35 are in the middle of their medication pass; is
14:54:39 that what you are saying?
14:54:39 A. While you are in the middle
14:54:42 of both, yours and theirs, yes.
14:54:44 Q. And do you have any knowledge
14:54:47 of in the sector at the time, and not in
14:54:52 hindsight, but at the time that Elizabeth
14:54:55 Wettlaufer was at your long-term care home, do
14:54:56 you have any knowledge as to whether or not
14:55:02 there with insulin was that independent
14:55:05 double-check at other long-term care homes?
14:55:06 A. No. Oh, in other long-term
14:55:10 care homes?
14:55:11 Q. Yes.
14:55:11 A. I wouldn't know.
14:55:12 Q. You wouldn't know, okay. But
14:55:14 certainly at Caressant Care there was no
14:55:15 requirement for that second set of eyes on the
14:55:17 dosage?
14:55:19 A. No.
14:55:19 Q. And there was no requirement
14:55:20 for a second set of eyes on the administration?
14:55:22 A. No.
14:55:23 Q. Now, once you administer the
14:55:28 insulin, what happens to the dial? Does it

14:55:33 stay at 5 and you go up from there?
14:55:36 A. It goes to zero, once you
14:55:39 have administered.
14:55:39 Q. So is there any way, if you
14:55:49 were going to go back to another nurse and show
14:55:51 him or her the pen, any way that they could
14:55:53 actually see --
14:55:57 A. There is no memory, no
14:55:59 indicator that would tell me that, yes, you
14:56:01 have just given 5 units.
14:56:03 Q. And would you have to record
14:56:19 anywhere how many units you have just given?
14:56:21 A. Not the number specifically,
14:56:27 but the number would be on your EMAR and you
14:56:30 would click that yes, you have given this
14:56:31 medication.
14:56:32 Q. And so what is found on the
14:56:34 EMAR then, is that simply John Smith 5 units,
14:56:41 and you are just clicking "yes" or "no" given?
14:56:43 A. Yes.
14:56:43 Q. Okay, AND does that change if
14:56:49 somebody is on a sliding scale?
14:56:51 A. Yes.
14:56:51 Q. And how do you do a sliding
14:56:52 scale? How do you document?
14:56:55 A. Then you would put in the
14:56:57 number of units that you had given.
14:56:58 Q. And would you have to
14:56:59 document the blood sugar as well?
14:57:02 A. The blood sugar would be
14:57:09 documented on a separate EMAR. Yes, they are
14:57:17 both documented, but it is on a separate input.

14:57:20 1 Q. All right. And you said for
14:57:21 2 a sliding scale you would take the resident's
14:57:24 3 blood sugar and then that would depend the --
14:57:27 4 that would then tell you how many units to
14:57:30 5 administer; is that correct?
14:57:30 6 A. Yes.
14:57:30 7 Q. And what instrument do you
14:57:33 8 use to take a resident's blood sugar?
14:57:36 9 A. The glucometer.
14:57:38 10 Q. And at the time that you were
14:57:40 11 at Caressant Care, is the glucometer per
14:57:45 12 resident? Does each resident that needs blood
14:57:48 13 sugars taken have their own, or was it used for
14:57:51 14 all people on your section?
14:57:54 15 A. Both.
14:57:54 16 Q. Is that a private cost to the
14:57:58 17 resident, the glucometer?
14:57:59 18 A. Yes, it is.
14:57:59 19 Q. And --
14:58:00 20 A. The pharmacy introduced
14:58:09 21 individual glucometers for residents.
14:58:10 22 Q. And do you remember when they
14:58:12 23 started to introduce that?
14:58:14 24 A. Sorry, no, no.
14:58:15 25 Q. And so to test the blood
14:58:22 26 sugar of a resident, what is the process using
14:58:23 27 this glucometer?
14:58:24 28 A. It is a finger prick.
14:58:26 29 Q. And then what happens? So
14:58:31 30 you prick a finger?
14:58:32 31 A. And then you put it on your
14:58:33 32 strip which is inserted into a small oval

machine, and it reads it out on a screen.
Q. So it actually reads what the blood sugar level is?
A. Yes.
Q. And is there at the time --
A. It gives you a numerical value.
Q. All right. And you would have to take that numerical value and determine where on the sliding scale it falls?
A. Yes.
Q. And then that would tell you the number of units to administer?
A. Yes.
Q. And the glucometer itself at the time that you were there, does it hold a memory?
A. Some of the newer ones I think do, but we never used that feature or we didn't have it.
Q. All right. And do you know whether or not, and I am just asking your experience because we are going to hear from pharmacists, et cetera, but do you know for those glucometers that had a memory, was it ever reviewed in terms of somebody checking the glucometer's memory to say, yes, the blood sugar on the glucometer is 10.2 and, yes, on the EMAR it has been recorded as 10.2?
A. No.
Q. At the time that you were there, did anything prevent a nurse with bad

14:59:54 intentions from taking somebody's blood sugar
14:59:58 but entering whatever number they wanted on the
15:00:00 EMAR?
15:00:01 A. Repeat the question, please?
15:00:03 Q. Does anything prevent a nurse
15:00:06 from taking the resident's blood sugar and it
15:00:10 is 10.2, does anything prevent the nurse with
15:00:13 bad intentions from recording a different sugar
15:00:16 level on the medication?
15:00:17 A. No, no.
15:00:18 Q. And I shouldn't say not with
15:00:24 just bad intentions, but could that be an error
15:00:27 as well transcribing?
15:00:29 A. Yes.
15:00:30 Q. So in your experience, the
15:00:33 glucometer doesn't hook up to the -- I'm not
15:00:38 very techie, I must admit that.
15:00:44 A. I'm worse.
15:00:44 Q. The glucometer doesn't get
15:00:45 hooked up to the system, the EMAR system, and
15:00:47 automatically transfer the blood sugar; is that
15:00:49 correct?
15:00:49 A. Correct.
15:00:50 Q. It still has to be manually
15:00:51 inputted?
15:00:52 A. Yes.
15:00:52 Q. So that could be subject to
15:00:53 human error?
15:00:54 A. Yes.
15:00:54 Q. Or it could be subject to bad
15:00:56 intentions?
15:00:56 A. Yes.

15:00:56 Q. Now, let's talk about a
15:01:11 situation when you have continued to give the
15:01:16 resident their insulin, and now you are coming
15:01:18 to the end of the amount that is in the
15:01:22 cartridge. Do you visualize or are you able to
15:01:27 visualize how much is left in the cartridge to
15:01:29 determine whether you need to replace it?
15:01:31 A. No.
15:01:32 Q. So how do you know when to
15:01:35 replace a cartridge?
15:01:36 A. You would dial and you
15:01:40 wouldn't have enough -- well, you could --
15:01:42 there is a point that you can tell a little
15:01:45 bit, but if you dial up, and then the dial
15:01:52 won't go any further once you are out of
15:01:55 insulin.
15:01:57 Q. So if you needed 30 units and
15:02:00 could only dial to 10, does that tell you there
15:02:02 is not sufficient --
15:02:04 A. That tells me my -- I need to
15:02:06 replace my insulin.
15:02:08 Q. All right. Now, in that
15:02:10 situation, if you could dial up to 10, would
15:02:16 you give 10 units to the resident and then go
15:02:19 get another cartridge and give another 20?
15:02:21 A. I would never do that.
15:02:22 Q. Why not?
15:02:22 A. That is two pokes where they
15:02:24 could just have one.
15:02:25 Q. In terms of that would be two
15:02:28 injections for the resident?
15:02:29 A. Yes.

15:02:29 Q. And so if you needed 30 units
15:02:32 for a resident and only have 10, are you saying
15:02:36 that you would replace the cartridge?
15:02:38 A. Yes.
15:02:38 Q. What would you do with the
15:02:41 cartridge that contained 10 remaining units?
15:02:44 A. It would go in the sharps
15:02:46 container.
15:02:46 Q. Where would the sharps
15:02:50 container be located?
15:02:51 A. Well, there is several.
15:02:53 There is one in the medication room. There is
15:02:55 one on the medication cart.
15:03:02 Q. And are those containers --
15:03:04 sorry, in your experience, which one would you
15:03:07 use or would you use both, the one in the
15:03:10 medication room or the one on the cart?
15:03:12 A. The one on the medication
15:03:14 cart would be used most frequently.
15:03:15 Q. Is there an ability for you,
15:03:18 once you deposit that insulin cartridge, to get
15:03:24 it back out of the sharps container?
15:03:26 A. You could, but you would be
15:03:28 putting yourself at risk for HIV, I guess,
15:03:33 because that is where all the glass and the
15:03:35 syringes are located, or hepatitis.
15:03:40 Q. But if you were that
15:03:44 risk-taker, you could attempt to get a
15:03:48 cartridge out of a sharps box?
15:03:49 A. You could get the top off of
15:03:53 the biohazard container and possibly use a pair
15:03:58 of forceps or something, but --

15:04:00 Q. Would you damage the box in
15:04:01 the process?
15:04:02 A. No, it is very hard plastic.
15:04:04 Q. Okay. Now, when you are
15:04:07 depositing that cartridge with its leftover 10
15:04:10 ml in the sharps box, do you record anywhere
15:04:14 that you have disposed of a cartridge?
15:04:16 A. No.
15:04:16 Q. So you don't record when you
15:04:21 take a cartridge out of the box to put in the
15:04:24 pen and you don't record when you throw out the
15:04:28 cartridge with some amount remaining; is that
15:04:31 correct?
15:04:31 A. Correct.
15:04:32 Q. And do you know whether or
15:04:51 not the pharmacy audits insulin use within the
15:04:55 home?
15:04:55 A. I am not sure.
15:04:57 Q. Is there anything, other than
15:05:05 confirming that insulin has been received,
15:05:09 ordered and received, from your experience is
15:05:11 there anything that goes back to the pharmacy
15:05:14 which talks about how many units are being used
15:05:18 on a daily basis or a weekly basis?
15:05:20 A. You would be able to
15:05:23 calculate that but not coordinate it with the
15:05:29 actual amount that was used.
15:05:30 Q. And explain that for us.
15:05:33 A. You could calculate it by the
15:05:35 dosage, how much insulin you should be going
15:05:38 through. For example, if somebody is getting
15:05:42 50 units a day, that equals a number of cc's,

15:05:48 and there is so many cc's, so you should be
15:05:50 using 'x' number per week.
15:05:53 But to compare it or to also
15:05:59 count the actual amount used and the actual
15:06:02 amount thrown away, you couldn't with the
15:06:07 present system.
15:06:08 Q. And why couldn't you with the
15:06:10 present system?
15:06:11 A. Because I'm not charting that
15:06:15 I have taken a cartridge out. I'm not charting
15:06:18 that I have thrown it away. I'm not charting
15:06:20 that there is 10 units left that I just wasted.
15:06:25 Q. And if somebody is on a
15:06:33 sliding scale, is it fair to say that that nice
15:06:37 mathematical calculation isn't available?
15:06:39 A. Not by me, anyway. Maybe
15:06:44 pharmacy.
15:06:44 Q. You would have to actually
15:06:46 look at --
15:06:47 A. Yes, you would have to
15:06:48 actually look at the dosage given.
15:06:50 Q. On each occasion.
15:06:53 A. Yes.
15:06:54 Q. And to the best of your
15:06:56 knowledge, that is not the system that was in
15:06:57 place with Caressant Care?
15:06:58 A. No.
15:07:12 MS. HEWITT: All right, I'm
15:07:13 moving to a different area now,
15:07:16 Commissioner.
15:07:16 Would you like to take a break
15:07:18 now or later?

15:07:18 THE COMMISSIONER: No, I think
15:07:20 now would be the right time.
15:07:21 Thank you.
15:07:21 -- RECESSED AT 3:07 P.M.
15:07:21 -- RESUMED AT 3:24 P.M.
15:24:15 MS. HEWITT: Thank you,
15:24:17 Commissioner. As usual, when
15:24:20 you break, you go, "Oh, I didn't
15:24:22 ask this question." So I'm not
15:24:24 moving to a new area quite yet.
15:24:24 BY MS. HEWITT:
15:24:27 Q. Just a couple of questions
15:24:28 for you, Karen, still on insulin, and that is
15:24:33 insulin is not a controlled drug; is that
15:24:33 correct?
15:24:36 A. Correct.
15:24:36 Q. So it wouldn't have to go
15:24:38 into the controlled-drug destruction box;
15:24:38 correct?
15:24:41 A. Correct.
15:24:42 Q. Now, would there be an
15:24:44 ability or would someone use the noncontrolled
15:24:48 destruction box if they wanted to as an
15:24:51 alternative to the sharps container?
15:24:52 A. Repeat that question.
15:24:55 Q. We have heard testimony that
15:24:58 within the medications rooms, there's a
15:25:02 noncontrolled drug destruction box, so
15:25:06 leftover -- if a Tylenol has fallen on the
15:25:09 floor, et cetera.
15:25:09 A. Yes.
15:25:09 Q. So would it be anyone's

15:25:11 practice to get rid of insulin cartridges in
15:25:17 that container versus the sharps in your
15:25:21 experience?
15:25:21 A. No.
15:25:21 Q. So it's the sharps container
15:25:23 from your experience?
15:25:24 A. Yes.
15:25:24 Q. And does anything prevent
15:25:29 someone who has that leftover cartridge with
15:25:32 ten units from simply putting it in their
15:25:34 pocket?
15:25:34 A. No.
15:25:35 Q. We've been dealing with
15:25:42 NovoRapid cartridges which have an orange band
15:25:47 around them -- do you recall that -- in the
15:25:49 pen?
15:25:50 A. Yes.
15:25:51 Q. Are there other types of
15:25:52 insulin that your residents may be on?
15:25:55 A. They may be on Lantus, which
15:25:58 is a long-acting drug, usually given in the
15:26:01 evening or at night, bedtime. There's also
15:26:05 Humalog. There's also Humalog Mix, which has a
15:26:09 milkiness to it and different colour.
15:26:10 Q. And for Lantus, would it --
15:26:13 in your experience at Caressant Care, was it
15:26:16 the same type of system, the pen and the
15:26:20 cartridge system?
15:26:20 A. No. It was a separate,
15:26:23 prefilled syringe.
15:26:26 Q. Syringe or pen?
15:26:28 A. Pen.

15:26:29 Q. And what's the difference
15:26:32 between the two? It's prefilled, so it already
15:26:36 has a cartridge in it. Is that what you mean?
15:26:39 A. Yes.
15:26:39 Q. And then is that the only
15:26:40 difference? Would you get extra cartridges to
15:26:43 put in it?
15:26:43 A. No. You would just simply
15:26:45 replace that pen.
15:26:47 Q. It's a disposable pen?
15:26:49 A. Yes.
15:26:50 Q. Okay. So that was for the
15:26:52 Lantus. The Humalog and the Humalog Mix, were
15:26:55 they the disposal-pen system, or were they the
15:26:58 pen-and-cartridge system we've been talking
15:27:00 about?
15:27:00 A. They were the same as the
15:27:04 NovoRapid.
15:27:05 Q. Would there be any
15:27:08 distinguishing factors, features about the
15:27:09 cartridge that you could tell it's one from the
15:27:12 other?
15:27:13 A. Humalog Mix25 would, say,
15:27:17 have a milkiness to it and a different colour
15:27:24 of tip on it.
15:27:25 Q. And the band, we see the
15:27:27 orange band on NovoRapid. Would it be a
15:27:29 different colour on the other?
15:27:32 A. Yes.
15:27:32 Q. Okay. Now, I know you
15:27:36 weren't the ONA representative, I think you
15:27:42 said in your Affidavit, until approximately

15:27:44 2009?
15:27:44 A. Yes.
15:27:45 Q. But I just want to ask you a
15:27:47 question about an incident that had occurred
15:27:49 with Ms. Wettlaufer in 2008. There was a
15:27:57 medication incident that's found at Tab Number
15:28:02 HH. I'm not going to turn you to it. HH of
15:28:08 Ms. Crombez's Affidavit. And she's written:
15:28:10 "To remedy this, she is taking
15:28:13 med cards for insulin, putting
15:28:16 them on top of the cart. I
15:28:18 asked her to use the MAR as her
15:28:20 bible."
15:28:21 Do you know at all what Ms. Crombez would be
15:28:23 referring to when she's talking about there
15:28:25 being little cards for the insulin? Was there
15:28:33 any different type of storage for insulin at
15:28:35 some point?
15:28:35 A. The cards were used as an
15:28:37 identification system when we didn't even have
15:28:39 the med card. It was a tray. And the med card
15:28:45 would have the resident's name, the insulin,
15:28:47 and the dosage on it, and it would be put in a
15:28:54 holder on this medication tray, and the insulin
15:29:02 would be with it.
15:29:03 But as well, on the MAR, M-A-R,
15:29:08 not EMAR but MAR, there would be a manual
15:29:12 system to sign off your insulin, that you gave
15:29:15 that insulin. So there would be two
15:29:19 identifications.
15:29:23 Q. So there was a tray, and you
15:29:25 said you'd have this card with various

15:29:30 information on it, and then you'd also have the
15:29:32 medication administration record as a check?
15:29:34 A. Yes.
15:29:34 Q. All right. And when you say
15:29:37 "tray," is it like -- I'm imagining a serving
15:29:40 tray. How would you describe it?
15:29:43 A. It was a tray, a metal tray,
15:29:48 approximately 1 foot by 1 foot with a handle
15:29:53 overtop that was portable. And the medication
15:30:00 cards had a little insert that you could stick
15:30:03 them in.
15:30:06 Q. Would the pen --
15:30:08 A. A very old system compared to
15:30:11 the EMAR.
15:30:12 Q. Right. And how long ago
15:30:14 would that have been in use?
15:30:15 A. I don't know exactly.
15:30:19 Q. So by 2008, was it your
15:30:24 experience that most nurses were still using
15:30:28 these cards or not, or do you recall at all?
15:30:30 A. I worked very hard at getting
15:30:34 rid of those cards and using strictly the MAR
15:30:39 or EMAR system.
15:30:41 Q. And why do you say that you
15:30:43 worked very hard at getting rid --
15:30:44 A. They were just not
15:30:46 reliable -- as reliable as the -- definitely
15:30:51 not as reliable as the EMAR, but the MAR was
15:30:55 your reference. That was where new orders were
15:31:00 processed.
15:31:03 Q. And was it eventually phased
15:31:06 out, this system, then?

15:31:07 A. Yes, definitely.
15:31:07 Q. Completely?
15:31:08 A. Yes.
15:31:08 Q. Now, before we get to my next
15:31:17 section, I didn't ask you whether or not, in
15:31:19 your experience, you had seen a change in the
15:31:25 residents come into long-term care.
15:31:27 You told me that you'd seen a
15:31:29 change in the workload, but how about the
15:31:32 residents? Was there a change in the level of
15:31:35 acuity of the residents, in your experience?
15:31:36 A. Yes. The complexity of the
15:31:40 residents definitely went up. We had tube
15:31:45 feedings. We had vac dressings that required
15:31:51 quite a high level of care. And also in the
15:31:57 mix was more psychiatric -- psychogeriatric
15:32:04 residents that definitely increased acuity and
15:32:11 vigilance for the nurses.
15:32:14 Q. One of the things you just
15:32:15 talked about -- I got most of that except for
15:32:19 vac dressing. What's that?
15:32:20 A. It's a very complicated
15:32:24 vacuum dressing that needs to be sealed over
15:32:26 the wound and drained into a system. It's a
15:32:32 closed system, but you have to create that
15:32:34 vacuum over the wound with your dressings.
15:32:38 Q. Did you see any change in the
15:32:42 mobility of residents over the years that came
15:32:45 into long-term care?
15:32:46 A. You know, not necessarily
15:32:54 because we were -- we went from a facility with
15:33:00 restraints, with, you know, total care to a

15:33:04 facility that encouraged restorative care and
15:33:08 no restraint. So patients were encouraged to
15:33:12 be mobile, if anything else.
15:33:16 I did supervise a restorative
15:33:20 care program, which is a very intensive program
15:33:23 brought in for the residents. They had to, you
15:33:28 know, have the ability to rehabilitate.
15:33:31 But we would take on patients
15:33:33 with hip fractures and strokes and increase
15:33:36 their ability to do their activities of daily
15:33:39 living, whether it's eating, whether it's
15:33:41 walking, whether it's transferring.
15:33:49 Q. When you went from the
15:33:50 restraint type of a system to the more
15:33:52 restorative care, did that increase the risk of
15:33:57 falls?
15:33:57 A. I think so, yes, but it also
15:34:02 decreased complications associated with
15:34:04 restraints, which was a major plus.
15:34:09 Q. And is that something that
15:34:11 happened industry-wide?
15:34:13 A. Industry-wide, yes.
15:34:14 Q. Okay. Now, you told us
15:34:21 earlier in your evidence about the number of
15:34:24 medications that nurses are giving out on a
15:34:31 daily basis.
15:34:31 Can you tell me whether or not
15:34:36 there's a possibility of a medication error
15:34:39 when you're administering medications?
15:34:43 A. Definitely.
15:34:43 Q. What type of errors, in your
15:34:45 experience, may you see in terms of

15:34:48 1 administering medications?
15:34:50 2 A. Well, the most obvious one
15:34:54 3 would be the wrong resident. Another one would
15:34:57 4 be a wrong time. Another one would be the
15:35:01 5 wrong dose.
15:35:07 6 Q. And we've seen some errors in
15:35:09 7 the evidence to date about missing -- signing
15:35:16 8 for having given a medication, and it's
15:35:22 9 still --
15:35:22 10 A. A missed medication would be
15:35:25 11 another error.
15:35:26 12 Q. In your experience, what is
15:35:29 13 the philosophy in terms of medication error
15:35:34 14 around --
15:35:34 15 A. A nurse -- a nurse is always
15:35:38 16 normally, you know, devastated by a medication
15:35:43 17 error. And you try to review all of the
15:35:46 18 circumstances that surrounded that regarding,
15:35:49 19 you know, time, place, any factors that would
15:35:52 20 have contributed to that medication error and
15:35:54 21 try to encourage proper protocol and try to put
15:36:03 22 things in place to avoid those medication
15:36:06 23 errors in the future, whether it be education,
15:36:09 24 whether it be process, whether it be policy.
15:36:14 25 Q. And did you see that being
15:36:16 26 done at Caressant Care?
15:36:17 27 A. Yes. That was encouraged,
15:36:20 28 and self-reporting was encouraged.
15:36:23 29 Q. Would medication errors be
15:36:28 30 used at staff meetings to discuss what's going
15:36:35 31 on in educational purposes?
15:36:37 32 A. In order for that to happen,

15:36:38 I thought that there should have been more
15:36:38 tracking and trending of, you know, look at
15:36:40 your medication errors over a six-month period
15:36:43 and determine what your staffing levels were at
15:36:46 the time, what day of the week it was at the
15:36:48 time, what time are you -- you know, are these
15:36:50 errors occurring, and possibly pulling some
15:36:53 conclusions from that. And then it should be
15:36:56 brought forward as policy or changes that we
15:37:02 could do ourselves.
15:37:03 Q. And did you see that
15:37:05 occurring from your experience in
15:37:07 Caressant Care?
15:37:07 A. No.
15:37:15 Q. If there was a medication
15:37:17 error -- sorry, let me ask you this: What was
15:37:23 discussed at staff meetings in respect of
15:37:25 medication errors?
15:37:25 A. I think if you look at the
15:37:29 minutes of the registered staff meetings that
15:37:32 happened monthly, you would see that a report
15:37:37 would be given as to, you know, there is X
15:37:42 number of incidents this month, and medication
15:37:44 errors are on the rise. And there was some
15:37:47 discussion as to what we can do for it, but I
15:37:51 don't believe that we had all of the data that
15:37:53 was required for continuous change.
15:38:03 Q. And do you think that that
15:38:06 type of data or tracking and trending would be
15:38:08 useful within the system?
15:38:09 A. I would hope so, yes.
15:38:11 Q. In terms of how

15:38:21 Caressant Care dealt with the individual nurse
15:38:23 that had made an error, what would happen in
15:38:27 those situations?
15:38:28 A. It would be investigated at a
15:38:31 meeting and reviewed by that nurse, and she
15:38:35 would be reinstructed verbally to be more
15:38:40 careful, find out what factors may have
15:38:45 contributed to that singular incident.
15:38:46 Q. So one-on-one, there would be
15:38:54 more of that discussion regarding the errors?
15:38:56 A. Yes.
15:38:57 Q. Did medication errors result
15:39:02 in discipline at Caressant Care?
15:39:07 A. Sometimes.
15:39:07 Q. And under what circumstances,
15:39:19 from your experience, would a medication error
15:39:21 reach the level of discipline?
15:39:23 A. Repetitive, frequent errors
15:39:28 by one -- any particular nurse would be cause
15:39:33 for alarm.
15:39:42 Q. All right. Let's just talk
15:39:44 about -- we talked about earlier that your
15:39:49 recollection is that you were a representative
15:39:52 of ONA commencing in or about 2009; is that
15:39:56 correct?
15:39:56 A. Yes.
15:39:56 Q. All right. Now, can you tell
15:40:01 us, what is the process by which you would have
15:40:04 been chosen to become the representative
15:40:08 on-site?
15:40:09 A. Mirian Wright was the union
15:40:17 representative before me, and I believe she

15:40:19 1 went ahead and asked all of the nurses, you
15:40:24 2 know, who's interested in taking on this
15:40:27 3 responsibility.
15:40:33 4 Q. Then what happened?
15:40:34 5 A. Then I inherited it by
15:40:38 6 default.
15:40:42 7 Q. So you were -- did you
15:40:46 8 volunteer originally or after no one else had
15:40:49 9 come forward?
15:40:50 10 A. The latter.
15:40:50 11 Q. And in 2009, was that the
15:40:56 12 first time that you were an ONA representative?
15:40:58 13 A. Yes.
15:40:58 14 Q. What type of training, if
15:41:02 15 any, were you provided with to be an ONA
15:41:07 16 representative in terms of understanding
15:41:09 17 duties, responsibilities?
15:41:10 18 A. ONA did offer a number of
15:41:13 19 programs. I did not attend those, but I was --
15:41:21 20 I had access to Jane Holmes at the time who was
15:41:27 21 the liaison officer, and she was my source of
15:41:32 22 information. That and also the contract that
15:41:39 23 ONA puts out --
15:41:43 24 Q. Collective agreement?
15:41:45 25 A. -- was a guideline. The
15:41:45 26 collective agreement.
15:41:45 27 Q. Now, you indicated that ONA
15:41:49 28 offered a number of programs, but you didn't
15:41:52 29 take those. Was there any particular reason
15:41:54 30 you didn't take them?
15:41:56 31 A. I don't remember.
15:42:07 32 Q. And what was the process if

there was going to be a meeting with a Registered Nurse that potentially could lead to discipline? Take us through what the regular process would be while you were the ONA representative.

A. I would be called usually that day and told that we are going to have a meeting with so-and-so, and she needs a union representative.

Q. And who would call you?

A. Either Brenda or Helen. If I were on shift, it would happen just after my shift. If I was on a day off, it would be someone else in my stead as a witness. But basically what we would do at those meetings would be to taken minutes.

Q. So when you were on shift and would attend, you indicated that it would be done after your shift?

A. Usually, yes.

Q. All right. And then you indicated that there were times when there was a discussion taking place when you weren't on shift?

A. Yes.

Q. So at that point in time, someone else would stand in your place?

A. Yes.

Q. Do you know how that individual would be chosen?

A. Well, on afternoons, there was only two RNs in the building, so it would

15:43:47 1 be the other RN in the building. On days, it
15:43:50 2 would be one of three.
15:43:52 3 Q. Was there any particular
15:43:58 4 person that was identified as your delegate, or
15:44:01 5 would it simply be anyone that was on shift at
15:44:05 6 that time?
15:44:05 7 A. Anyone that was on shift at
15:44:07 8 that time.
15:44:07 9 Q. And do you know what, if any,
15:44:11 10 training those individuals would have in terms
15:44:13 11 of the duties and responsibilities of an ONA
15:44:16 12 rep?
15:44:16 13 A. None.
15:44:17 14 Q. They wouldn't have any.
15:44:19 15 And you indicated just a moment
15:44:21 16 ago that your -- the duties would be to take
15:44:24 17 minutes?
15:44:26 18 A. Yes.
15:44:26 19 Q. And would those -- where
15:44:33 20 would those minutes go?
15:44:34 21 A. They would go in Bethe's
15:44:37 22 file.
15:44:37 23 Q. Now, by "Bethe's file," are
15:44:41 24 you talking about the employer's -- her
15:44:44 25 employment file kept by Caressant Care or a
15:44:47 26 different file?
15:44:47 27 A. There was an ONA file.
15:44:57 28 Q. Where would that be kept at
15:44:58 29 Caressant Care?
15:44:58 30 A. When I left, there was a
15:45:00 31 filing cabinet in a storage area in the
15:45:02 32 basement.

15:45:03 Q. While you were the ONA rep,
15:45:15 would you put those minutes into a file?
15:45:17 A. Yes.
15:45:18 Q. And would you -- is that
15:45:21 where it was kept when you were an ONA rep?
15:45:24 You'd have to go down to the basement to the
15:45:27 filing cabinet?
15:45:29 A. Yes.
15:45:30 Q. Was that in a locked room?
15:45:32 A. Yes. And the file itself was
15:45:33 locked.
15:45:33 Q. So the room would be locked
15:45:38 and the filing cabinet locked?
15:45:39 A. Yes.
15:45:39 Q. Who would have access to the
15:45:41 room?
15:45:41 A. Just myself. And I gave the
15:45:43 key to Jennifer Hague, who was another
15:45:47 full-time RN on Section B.
15:45:52 Q. Anybody else have access to
15:45:57 that room?
15:45:57 A. No.
15:45:57 Q. Was that dedicated to ONA
15:46:01 then or --
15:46:01 A. No. There was cleaning
15:46:03 supplies in there.
15:46:04 Q. Okay. So would the cleaners
15:46:06 get in there then?
15:46:07 A. Not with the locked filing
15:46:09 cabinet.
15:46:09 Q. Okay. So they could get into
the room --

A. Yes.
Q. -- but not the locked filing cabinet?
A. Yes.
15:46:11 Q. Was that an ONA filing
15:46:12 cabinet then?
15:46:13 A. Yes. But there was no
15:46:23 coordination. I really didn't know when I was
15:46:27 off shift or when I was on a day off. I
15:46:34 wouldn't get that follow-up that this had
15:46:36 happened or even necessarily the minutes.
15:46:39 Q. So when -- let's just talk --
15:46:45 I'll get back to that for sure in a moment, but
15:46:48 when you're taking the minutes, you would put
15:46:50 them in the filing cabinet in Bethe's file.
15:46:52 Would you have any contact
15:46:56 with -- I think you said Jane Holmes?
15:46:58 A. Yes. If there was concerns
15:47:00 or if Bethe had expressed a desire to look at
15:47:05 this further, investigate it or that we felt
15:47:10 there wasn't any fairness to what was
15:47:12 happening, but -- do you want me to elaborate
15:47:16 on that one?
15:47:17 Q. Yeah.
15:47:17 A. Okay.
15:47:18 Q. We want all the information
15:47:19 we can get.
15:47:20 A. But Bethe, in general, at
15:47:22 these meetings would be very contrite and
15:47:28 apologetic. And, you know, "I'm sorry. I
15:47:30 don't know how that happened."
15:47:31 Or, you know, there was X

15:47:32 numbers of things going on at the time, and
15:47:42 there really wasn't any concerns that she
15:47:44 wanted to bring forward to Jane Holmes.
15:47:47 Q. So is it fair to say that
15:47:50 there wasn't an automatic reporting, then, to
15:47:53 Jane Holmes or anybody else at that point in
15:47:55 time?
15:47:55 A. No.
15:47:56 Q. Okay. And so --
15:47:58 A. Automatic though, a five-day
15:48:01 suspension or a termination, according to my
15:48:08 liaison officer, Jane Holmes, said that they
15:48:13 should be automatically investigated. Not
15:48:16 necessarily grieved, but automatically
15:48:18 investigated.
15:48:19 Q. And who would be responsible
15:48:20 for investigating?
15:48:21 A. The liaison officer.
15:48:23 Q. Not yourself?
15:48:24 A. No.
15:48:24 Q. You would have to, I'm
15:48:26 assuming, then notify them that there's been
15:48:28 a --
15:48:29 A. Yes.
15:48:29 Q. And you said earlier there
15:48:40 wasn't much coordination. So with the other
15:48:43 individuals that -- during your time period
15:48:46 that you were ONA rep, if they sat in with
15:48:50 Bethe, would they come to you and identify,
15:48:54 "Was with Bethe yesterday"?
15:48:55 A. Usually.
15:48:58 THE COMMISSIONER: I'm sorry. I

didn't understand your question.
MS. HEWITT: I think Karen indicated that she wouldn't always be the ONA rep there. If she was off shift, somebody else would come in and be a witness.
And my question was whether or not they would communicate that there was a meeting and the results of that meeting to Karen.
THE COMMISSIONER: Okay.
BY MS. HEWITT:
Q. And I think you just said usually; is that correct?
A. Yes.
Q. All right. And typically, would they take minutes of the meetings?
A. Yes.
Q. And where would those be located? Do you know?
A. Some of them were in Bethe's -- wound up in Bethe's file, but I'm pretty sure not all of them did. It wasn't a smooth process or anything cut and dried.
Q. And we've been talking a lot about best practices within this inquiry. Is there, upon reflection, any comment about how that process worked in terms of the communication among yourselves as representatives or witnesses?
A. The question is?

15:50:23 Q. Anything that could be done
15:50:24 better going forward?
15:50:25 A. To do with best practice?
15:50:27 Q. Yeah, or communication. If
15:50:31 you have a witness in one day and another
15:50:34 witness in the next day.
15:50:41 A. I think it -- it needs a
15:50:46 strong, educated union person overseeing that,
15:50:53 whether it's the -- and on-site wasn't working.
15:51:07 Q. Why wasn't it working, in
15:51:09 your opinion?
15:51:09 A. Well, I just felt that I
15:51:12 didn't have all the pieces of the puzzle at any
15:51:15 given time.
15:51:26 Q. And why did you feel that you
15:51:28 didn't have all the pieces of the puzzle?
15:51:34 Where did you expect to get those pieces from?
15:51:37 A. Well, I think that the
15:51:39 minutes could have been shared. For example,
15:51:49 the first time I had heard about different
15:51:52 things in this case were from the London Free
15:51:58 Press, and I'm thinking, wow, I didn't know
15:52:00 that.
15:52:07 Q. You mean things that had
15:52:08 happened with Bethe at the home --
15:52:08 A. Yes.
15:52:12 Q. -- in terms of her
15:52:13 discipline?
15:52:13 A. Yes.
15:52:14 Q. And when you talk about the
15:52:15 minutes, you mean the minutes that were taken
15:52:17 by the various ONA reps that were there?

15:52:20 A. Yes. Even afterwards. There
15:52:21 was no communication afterwards. I was the
15:52:24 union rep until 2011, and then Jane Holmes gave
15:52:32 Brenda a letter stating that all of the minutes
15:52:37 and disciplinary actions should filter through
15:52:41 her -- or should be forwarded to her, rather.
15:52:53 Q. Have you seen this letter?
15:52:54 A. No.
15:52:55 Q. So where's your knowledge of
15:52:57 this letter coming from?
15:53:02 A. From ONA.
15:53:04 Q. Okay. And was that at the
15:53:05 time?
15:53:05 A. No.
15:53:06 Q. Did you see that letter at
15:53:08 the time?
15:53:08 A. I think Jane -- I don't
15:53:11 remember, but Jane -- Jane and I had a good
15:53:14 rapport, and I assume she would have told me
15:53:18 that at the time. I just -- I don't recall
15:53:20 that.
15:53:20 Q. And have you seen that letter
15:53:22 recently then?
15:53:23 A. No.
15:53:23 Q. So how do you know its --
15:53:26 knowledge of it?
15:53:26 A. That's what I was told, so...
15:53:36 Q. By?
15:53:36 A. By ONA.
15:53:38 Q. Okay. So your recollection,
15:53:39 then, is that you would have been the union rep
15:53:43 since 2009 to 2011?

15:53:44 A. Yes.
15:53:45 Q. And so in the material,
15:53:48 that's the correction that you want to make?
15:53:50 A. Yes.
15:53:51 Q. All right. And in the
15:53:53 material in your Affidavit at Tab Number C are
15:53:58 various meetings and discipline that you have
15:54:03 signed off on. If you just go to the last one
15:54:09 at Tab Number C, April 20th, 2012. Do you see
15:54:17 that?
15:54:17 A. I don't think I have what
15:54:21 you -- oh, okay. Yeah. Yeah. Okay, just a
15:54:28 second. The one that's April 19th, 2012?
15:54:33 Q. I think the last page is
15:54:36 April -- yes, the date on the top is
15:54:37 April 20th, but the date incident occurred,
15:54:40 April 19th.
15:54:43 A. Yes.
15:54:43 Q. And you sign on top of union
15:54:46 rep?
15:54:46 A. It should be witness.
15:54:48 Q. Were you just used to
15:54:51 signing --
15:54:51 A. Yes.
15:54:51 Q. So your evidence is that
15:54:57 past -- do you know what month in April this
15:55:01 occurred -- or month in 2011 this occurred?
15:55:01 A. No.
15:55:01 Q. All right. So at some point
15:55:04 past 2011, your evidence is if you continue to
15:55:07 sign these, you were there as a witness?
15:55:10 A. Yes.

15:55:10 Q. All right. And so was there
15:55:13 ever any time after year 2011 that ONA got
15:55:18 another rep in the home?
15:55:19 A. No. Toward the end, Mina
15:55:26 took it on for a short period of time, but then
15:55:29 she left the institution.
15:55:31 Q. What was Mina's last name?
15:55:47 Do you remember?
15:55:48 A. No.
15:55:48 Q. Okay. I think it's in the
15:55:52 documentation, so we'll get to it later.
15:55:55 A. Here it is under November 25,
15:55:58 '13, G-H-A-D-E-R-I.
15:56:03 Q. And so that particular
15:56:05 meeting -- by April 2013, there would have been
15:56:11 another ONA rep?
15:56:12 A. Yes.
15:56:12 Q. So in between when you were
15:56:14 witnesses, what was your process when you were
15:56:19 no longer --
15:56:20 A. When I was no longer union
15:56:22 rep? RNs were brought in similar to when I was
15:56:26 not there as a union rep.
15:56:27 Q. Okay. Now, in these meetings
15:56:34 that you would attend, let's talk about --
15:56:38 let's talk about Bethe Wettlaufer for a second
15:56:41 before we get to her discipline.
15:56:43 Tell me what your involvement
15:56:45 would have been with Ms. Wettlaufer. How much
15:56:48 interaction would you have?
15:56:50 A. As RNs in charge of -- three
15:56:55 RNs in charge of three different units, I never

15:56:57 worked side by side with her. On afternoons,
15:57:02 there was just one RN on Section B and one RN
15:57:04 on nights.
15:57:06 So I never -- never worked with
15:57:09 Bethe to observe any of her care or, you know,
15:57:16 interaction with family or any of that. The
15:57:20 only time I actually had a rapport with Bethe
15:57:26 would be at report time, whether she was coming
15:57:28 off of nights and I was on days or if I was on
15:57:31 days and she was coming on evenings. And that
15:57:33 would be maybe 10, 15 minutes.
15:57:37 Q. And in that particular
15:57:42 interaction, can you -- did you develop an
15:57:46 impression of Bethe Wettlaufer in terms of what
15:57:50 she was like, what her personality was like?
15:57:52 A. For the most part, she came
15:57:54 in smiling and quite bubbly, and she portrayed
15:58:04 herself as a very caring nurse for the
15:58:08 residents. She would even take some of the
15:58:14 most difficult and maybe people that didn't
15:58:16 have family and bring them in special little
15:58:19 treats from home or something like that. I had
15:58:26 no idea.
15:58:27 Q. No idea what brings us here
15:58:32 today?
15:58:33 A. Yeah.
15:58:33 Q. And you indicated, when we
15:58:43 were talking about these particular meetings
15:58:45 that you would be involved in, she would be
15:58:49 contrite?
15:58:49 A. Yes. She was remorseful,
15:58:51 often tearful. I, at one point before the

15:58:56 meeting, said, "Listen, Bethe, I think I know
15:58:59 that you're getting called in." I may have
15:59:01 even written the incident myself, "but you're
15:59:04 not pulling your workload. You know, other
15:59:06 people are having to follow you and pick up on
15:59:09 your slack."
15:59:09 And she would say, "I'm so
15:59:12 sorry. I didn't know." And then she would
15:59:14 burst into tears, and she would say, "I'll try
15:59:18 to do better."
15:59:19 And for a couple of weeks,
15:59:20 whether it was discipline or whether it was
15:59:23 someone talking to her, things would improve
15:59:28 work-wise at least, because that was the most
15:59:31 obvious thing that we could see as coworkers,
15:59:37 the workload.
15:59:38 Q. What were you observing in
15:59:43 terms of the workload?
15:59:47 A. The workload was heavy.
15:59:55 Dealing with the number of issues that you
15:59:57 have, the assessment pieces, the paperwork, the
16:00:00 MDS, the nursing care plans, and all of the
16:00:03 incidentals that would come up during your
16:00:06 shift, rapport with doctors, there was really a
16:00:10 heavy workload.
16:00:12 And when we were short-staffed,
16:00:15 even if it was a PSW that I was short on my
16:00:19 floor -- like, I was working on second floor.
16:00:24 If there was a PSW short, the RN would be doing
16:00:30 PSW duties as well.
16:00:30 Q. But we were talking about
16:00:31 Ms. Wettlaufer, and you said that that's where

16:00:34 you would see the most because you'd be coming
16:00:38 on shift.
16:00:38 A. Mm-hm.
16:00:39 Q. What were you noticing in
16:00:40 respect of what she was doing or not doing in
16:00:42 terms of workload?
16:00:44 A. She wouldn't be completing
16:00:46 nursing care plans within 24 hours. She
16:00:48 wouldn't be doing head-to-toe assessments that
16:00:51 she should be doing. She wouldn't complete
16:00:53 treatments.
16:00:54 Q. Were those some of the things
16:01:01 that were being discussed with her in these
16:01:04 meetings?
16:01:05 A. Yes.
16:01:05 Q. And are those the types of
16:01:11 things you indicated that you'd see improvement
16:01:13 on for a short period of time?
16:01:16 A. For a couple of weeks, for a
16:01:18 short period of time anyway, yes.
16:01:20 Q. All right. Now, you did say
16:01:20 that it could be something that you had
16:01:23 actually complained about; is that correct?
16:01:26 She could be brought into the meeting for
16:01:29 something you'd actually complained about?
16:01:32 A. Yeah.
16:01:32 Q. And so that must have been a
16:01:34 difficult position for you?
16:01:36 A. Well, it was. I did have
16:01:37 words with her, as I said.
16:01:39 Q. And do you remember what's
16:01:42 the type of thing -- do you remember what you

would have brought to management's attention?

A. Workload.

Q. Workload. We heard some comments about her taking breaks with students, et cetera.

A. She would arrange her shift to befriend or be buddies with the student and go for -- you know, go have supper with them or bring in treats. And if she was working the night shift, she'd be buddy buddies with the PSWs and bring in pizza, that kind of thing.

It was -- it wasn't all that professional, in my mind. It wasn't -- like, she was in a position of power and a supervisory role, and this didn't strike me as professional.

Q. Right. Did you bring that to management's attention?

A. Yes.

Q. All right. And do you remember Bethe Wettlaufer -- that being discussed with Bethe?

A. I was not present at that discussion or even aware of it, the discussion or the follow-up.

Q. All right. If I can just turn you to Tab Number C.

MS. HEWITT: It might be easier, Commissioner, for you to see it on the screen. 16862.

BY MS. HEWITT:

Q. This is a document dated

June 17th, 2011. Do you see that document?

A. June 17, yes.

Q. Yes. And at the top, it identifies Bethe Wettlaufer, Brenda Van Quaethem, Helen Crombez, and Karen Rodriguez. Do you know who Karen Rodriguez is?

A. She's the other union rep. It was Karen Routledge. I think that's an error.

Q. And to be fair, you said that in your Affidavit, that you are misidentified in this note as Karen Rodriguez?

A. Yes.

Q. Was she for the PSWs?

A. Yes.

Q. Okay. So it wouldn't make sense in any event that she would be in this meeting?

A. No.

Q. And then if we just scroll down two-thirds of the way down the page, it says:

"You are an RN. You have a position of power, and you need to be careful of what you say and how you say it."

Do you see that?

A. Yes.

Q. And then it goes on:

"Your comments to students at break time are not always appropriate. You rush

16:04:47 1 downstairs at 5:30 to have
16:04:49 2 supper with the students, and
16:04:50 3 your conversation is not always
16:04:52 4 appropriate. You are still an
16:04:54 5 RN and represent the home even
16:05:03 6 when you're on break."
16:05:05 7 Is that the same incident that you're talking
16:05:07 8 about, or is that a different one?
16:05:10 9 A. It could be either.
16:05:15 10 Q. Okay. Do you have any
16:05:16 11 independent recollection of that meeting?
16:05:17 12 A. No.
16:05:18 13 Q. And when we look at a lot of
16:05:20 14 these meetings that you were involved in -- and
16:05:24 15 to be fair, there's quite a number over a
16:05:27 16 number of years. Do you have any independent
16:05:29 17 recollection of those?
16:05:30 18 A. I remember Bethe being very
16:05:38 19 nervous going into these meetings. I remember
16:05:40 20 her being very respectful of authority and
16:05:45 21 management, and she would listen. She did not
16:05:49 22 argue the points that were being brought
16:05:56 23 forward. Sometimes she was tearful and seemed
16:06:01 24 nervous and apologetic.
16:06:12 25 Q. Did you have any view at the
16:06:14 26 time as to whether she appeared genuine in
16:06:18 27 those apologies?
16:06:20 28 A. Well, she fooled me. I -- I
16:06:27 29 had no -- you know, there was no indication
16:06:32 30 that she wasn't being genuine.
16:06:35 31 Q. Now, we've seen as a result
16:06:37 32 of these meetings that there was various levels

16:06:40 of action taken between counselling, written
16:06:46 warnings, verbal warnings, up to suspensions.
16:06:49 Do you recall that?
16:06:49 A. Yes.
16:06:50 Q. And you administered or dealt
16:06:54 with the collective agreement?
16:06:55 A. Yes.
16:06:56 Q. And did you deal with the
16:06:58 policies as well? Would you review any
16:07:03 policies in your role on --
16:07:06 A. The collective agreement?
16:07:07 Q. Yes.
16:07:07 A. No.
16:07:07 Q. Okay. So you would go by the
16:07:09 collective agreement?
16:07:09 A. Yes.
16:07:10 Q. All right. And what was your
16:07:13 understanding of the type of discipline process
16:07:15 that was being used with Bethe Wettlaufer?
16:07:18 A. It was a progressive
16:07:28 discipline. It would start with investigative,
16:07:32 go to written, and then -- or verbal warning,
16:07:37 written warning, and then into suspensions,
16:07:39 whether it be one, five, or -- and then
16:07:43 termination.
16:07:44 Q. And was that process
16:07:46 followed?
16:07:46 A. Yes.
16:07:54 Q. At least while you were the
16:07:56 union rep?
16:07:57 A. Yes.
16:07:57 Q. Okay. Now, we heard some

16:08:04 evidence that it was followed, but it wouldn't
16:08:09 necessarily -- I think the example was if
16:08:12 somebody was at a written warning for
16:08:14 absenteeism and they made a medication error,
16:08:17 it wouldn't go to the next step?
16:08:19 A. That was Caressant Care's
16:08:21 corporate interpretation of that. That was not
16:08:24 in the ONA contract. Anything that was on the
16:08:36 file would be removed after 18 months, if there
16:08:42 was any time that there was 18 months free of
16:08:46 incident, but I don't think that happened.
16:08:47 Q. From your understanding, was
16:08:50 that any incident?
16:08:57 A. Yes.
16:08:59 Q. So 18 months had to pass
16:09:00 between any incident? That was your
16:09:03 understanding?
16:09:04 A. Yes.
16:09:08 Q. You said it's not in the ONA
16:09:14 contract. Was that grieved that they weren't
16:09:17 following it properly?
16:09:18 A. No.
16:09:20 Q. What was your view of the way
16:09:25 that they were handling it?
16:09:27 A. Well, it seemed to be -- it
16:09:35 just seemed to be a repetitive process,
16:09:40 medication errors, absenteeism, workload
16:09:48 problems. Seemed to be a theme there.
16:09:55 Q. Did you have any discussions
16:09:57 with Caressant Care about the way that they
16:10:00 were interpreting it and the pattern that you
16:10:02 were seeing?

16:10:02 A. No.
16:10:05 Q. And any discussions with --
16:10:11 was it Jane Holmes at the time, that there was
16:10:13 anything developing from what you could see?
16:10:15 A. No.
16:10:15 Q. And you do say -- in your
16:10:27 Affidavit at paragraph 44, you say:
16:10:46 "I believe that there was a
16:10:47 number of red flags going on,
16:10:49 and as the ONA representative, I
16:10:50 had to support her, but I also
16:10:53 felt that there was an
16:10:54 opportunity there for management
16:10:55 the say, 'Listen, what's going
16:10:56 on? We need to do something
16:10:58 here. What do you need?'
16:10:59 I thought that perhaps they
16:11:01 should step in and do something.
16:11:04 Disciplinary actions are not
16:11:05 supposed to be a slap on the
16:11:07 hand. They are supposed to be
16:11:09 more productive. Like, let's
16:11:11 get in and change the situation
16:11:14 kind of thing. It should have
16:11:16 been done in a more constructive
16:11:17 manner as opposed to a
16:11:20 disciplinary manner."
16:11:22 Do you have any suggestions in terms of how she
16:11:25 should have been dealt with?
16:11:26 A. No, but I feel that it should
16:11:36 have gone further up.
16:11:39 Q. What do you mean by "gone

16:11:40 1 further up"?
16:11:41 2 A. Well, either on the ONA
16:11:44 3 ladder or the corporate ladder or, you know,
16:11:46 4 just looked at -- not everyone, including
16:11:49 5 management, had every piece of this puzzle.
16:11:53 6 Somehow it needs -- needed to be put together.
16:12:01 7 It was a very fragmented process.
16:12:03 8 Q. You do indicate that she was
16:12:12 9 struggling with her bipolar issues?
16:12:14 10 A. She brought that up at one of
16:12:17 11 the disciplinary meetings.
16:12:18 12 Q. Did she brings it up more
16:12:24 13 than once or just at that one meeting?
16:12:27 14 A. That's all I heard, at that
16:12:28 15 one meeting.
16:12:29 16 Q. Did you have -- when you had
16:12:32 17 any interactions with her, did you notice any
16:12:35 18 issues with what she was struggling?
16:12:39 19 A. Well, sometimes she would
16:12:40 20 come in and she'd be, you know, a little bit up
16:12:43 21 and bubbly, and then there'd be other times she
16:12:47 22 was more quiet and, you know, withdrawn, but it
16:12:53 23 wasn't anything prominent, or it didn't seem to
16:13:01 24 affect her workload -- or her work, I guess.
16:13:07 25 Q. Okay. Any indication from
16:13:10 26 your interaction with her which would be
16:13:15 27 twofold, I'm assuming. One is in your meetings
16:13:18 28 with her, and one is on shift change. Any
16:13:21 29 indication of any alcohol or drug addiction?
16:13:24 30 A. I never smelled any alcohol.
16:13:30 31 I don't remember any change in level of
16:13:33 32 consciousness or slurring of her speech, no --

16:13:37 1 none of that.
16:13:39 2 She interacted appropriately at
16:13:46 3 the time. Her responses were normal. It was a
16:13:51 4 normal conversation, normal rapport, normal
16:13:54 5 change-of-shift reports.
16:14:06 6 Q. Now, I'm not going to take
16:14:08 7 you to all of the underlying incidents, but you
16:14:11 8 did reference in your Affidavit a couple of
16:14:13 9 them. And if I can turn you to paragraph
16:14:27 10 Number 61.
16:14:35 11 Before we get into that, when
16:14:37 12 you're in these meetings, are you actually
16:14:40 13 provided with a copy of the underlying
16:14:43 14 complaint?
16:14:43 15 A. No.
16:14:43 16 Q. All right. Was it the
16:14:44 17 practice of Caressant Care to at least identify
16:14:47 18 what the issue was?
16:14:48 19 A. The management would identify
16:14:51 20 what that issue was, but not prior to the
16:14:53 21 meeting.
16:15:00 22 Q. And in the meeting, they
16:15:02 23 would then identify what the issue was?
16:15:04 24 A. Yes.
16:15:05 25 Q. And was there an opportunity
16:15:07 26 for Ms. Wettlaufer to explain what happened?
16:15:10 27 A. Yes.
16:15:10 28 Q. And from your perspective,
16:15:14 29 going forward, would it be beneficial to know
16:15:20 30 what the issue was before you go into a
16:15:21 31 meeting?
16:15:21 32 A. Yes, I would think so.

16:15:25 Q. And why would that be?
16:15:26 A. Well, you'd be able to review
16:15:32 maybe your charting or remember what was
16:15:35 happening at the time, and you'd be better
16:15:39 prepared.
16:15:40 It's more like a shock factor
16:15:42 when you go in and are presented with something
16:15:46 that you obviously had no reflection or
16:15:53 remembrance of.
16:15:54 Q. Okay. Now, you talk in
16:16:00 paragraph 61 that:
16:16:03 "There was a counselling session
16:16:05 based on not doing the
16:16:08 24-hour-care plan. She'd only
16:16:09 done the head-to-toe assessment
16:16:11 and left it for others to
16:16:13 complete. That happened very
16:16:14 often. This was a reoccurring
16:16:15 and frequent problem with EW."
16:16:19 And that's what you were referring to earlier
16:16:21 in your testimony; is that correct?
16:16:22 A. Yes.
16:16:22 Q. Now, there was also a
16:16:25 situation that developed in January of 2012,
16:16:28 and it involved, as we saw in the last couple
16:16:30 of days, how she handled a fall and a hematoma
16:16:35 on a resident's leg. Do you recall that?
16:16:38 A. I wasn't involved in it --
16:16:44 Q. Right.
16:16:45 A. -- like, the incident itself,
16:16:48 but I do remember the meeting. The first that
16:16:54 I read Wendy MacKnott -- the letter was when

16:17:02 you gave it to me. So I didn't have that
16:17:08 information.
16:17:09 Q. Right. And that's just what
16:17:11 you indicated. When you went into these
16:17:13 meetings, you weren't given a copy of that
16:17:16 underlying complaint?
16:17:17 A. Right.
16:17:18 Q. All right. But you were in
16:17:21 the meeting that discussed those issues?
16:17:22 A. Yes.
16:17:23 Q. And that was in January of
16:17:29 2012? Take my word for it.
16:17:37 A. Okay.
16:17:38 Q. And so your best recollection
16:17:43 at this point is that you were there as a
16:17:44 witness?
16:17:44 A. Yes.
16:17:45 Q. Okay. And so do you have an
16:17:49 independent recollection of discussing the
16:17:51 issue that related to the resident's fall and
16:17:55 the hematoma?
16:17:56 A. Helen reviewed what Wendy had
16:18:01 stated in her letter, that it was an unsterile
16:18:05 procedure and that she shouldn't have moved
16:18:11 this resident if she had suspected a hip
16:18:15 fracture.
16:18:15 Q. And in that same meeting, did
16:18:22 you discuss a situation that was brought
16:18:24 forward by Jennifer Slyfield regarding a
16:18:31 disimpaction of a resident?
16:18:32 A. Yes.
16:18:32 Q. And what was your view of

16:18:33 that particular situation?
16:18:34 A. Again, I didn't have
16:18:40 Jennifer's letter concerning it, but in
16:18:46 general, you try to avoid a disimpaction by
16:18:54 looking at a resident's diet, looking at their
16:18:56 medications, looking at all kinds of other
16:19:00 factors that might contribute to that before
16:19:02 you get into that situation.
16:19:04 But it's usually the resident is
16:19:05 on the toilet and having difficulty passing a
16:19:08 bowel movement and is in quite a bit of pain
16:19:11 prior to a disimpaction.
16:19:17 Q. And so if you find a resident
16:19:20 in that particular situation, what would be the
16:19:26 process? Would you go --
16:19:27 A. You would try to be as gentle
16:19:30 and make it as comfortable as possible, but it
16:19:33 is -- it is an uncomfortable procedure to be
16:19:37 sure, and they're already uncomfortable.
16:19:40 Q. And I know you didn't read
16:19:43 the particular letter, but Jennifer Slyfield,
16:19:50 was she a PSW or an RPN? Do you remember?
16:19:54 A. She started out as a PSW, but
16:19:56 she came an RPN, so I'm not sure which capacity
16:20:00 she was in there at that point. Does she say
16:20:04 in her letter?
16:20:05 Q. No.
16:20:05 A. Okay.
16:20:05 Q. No. And in her letter, she
16:20:08 talks about the fact that the procedure wasn't
16:20:10 stopped, and there's no -- and I think she
16:20:11 indicated there was no pain medication.

16:20:14 And from your experience, if the
16:20:17 resident was in pain, would you stop the
16:20:20 process to give them a pain medication?
16:20:22 A. It would depend on the degree
16:20:25 of pain. I mean, you would -- you would -- you
16:20:28 would stop a procedure if the patient wasn't in
16:20:31 pain at rest, but --
16:20:35 Q. Would you use your assessment
16:20:39 skills as a Registered Nurse?
16:20:41 A. Yes.
16:20:41 Q. Okay. In terms of some of
16:20:57 these incidents that were being reported, was
16:21:03 there education within the home as to the
16:21:05 circumstances under which employees, whether
16:21:10 they be Registered Nurses or PSWs, would have
16:21:12 to report what they viewed as abuse and
16:21:18 neglect?
16:21:18 A. Yes.
16:21:18 Q. And was that --
16:21:20 A. It was renewed annually.
16:21:22 Q. So it was education, and it
16:21:28 was renewed annually?
16:21:30 A. Yes.
16:21:30 Q. What typically would be the
16:21:32 type of education that you would receive in
16:21:35 terms of --
16:21:35 A. It would be an in-service.
16:21:37 I believe at the time it was the Assistant
16:21:41 Director of Nursing who would give us that
16:21:44 in-service. And we would also have educational
16:21:47 materials to work with and they -- like, a quiz
16:21:55 at the end that we needed to complete in order

16:21:59 to get that certification for the year.
16:22:06 Q. And what was your
16:22:08 understanding of the circumstances under which
16:22:09 there would have be a report of abuse or
16:22:12 neglect?
16:22:13 A. You would have to report any
16:22:17 abuse or neglect to management on call, and
16:22:21 then they would report it to Helen and Brenda.
16:22:24 After that, I don't know.
16:22:28 Q. As part of the --
16:22:29 A. I knew that it had to be
16:22:32 taken to the Ministry, but how much
16:22:35 investigation before or after had to be done
16:22:39 I'm unaware of.
16:22:40 Q. And did you understand from
16:22:42 the training that employees could report it
16:22:44 directly to the Ministry as well?
16:22:45 A. Yes, actually.
16:22:48 Q. And was that in any way
16:22:56 discouraged at the home?
16:22:57 A. I wouldn't know.
16:22:58 Q. All right. But what was the
16:23:01 regular practice then? Do you know of any --
16:23:05 A. To report it to the managers.
16:23:06 Q. And did anyone come to you
16:23:15 with any concerns in terms of Bethe
16:23:18 Wettlaufer's care of residents, whether it be
16:23:21 allegations of abuse or neglect?
16:23:23 A. No.
16:23:23 Q. And by that, I mean any
16:23:31 staff. Did any family members express any
16:23:34 concern about her care?

16:23:35 A. No.
16:23:35 Q. Did any residents express any
16:23:41 concern about her care?
16:23:42 A. No.
16:23:42 Q. Now, I'm just going to take
16:23:54 you to another situation, and that is
16:23:58 Maureen Pickering. Do you remember
16:24:00 Ms. Pickering?
16:24:01 A. Yes.
16:24:02 Q. And I apologize again,
16:24:05 friends and family are watching, but it's
16:24:11 relevant that we discuss what happened in this
16:24:13 particular case.
16:24:14 Was Ms. Pickering someone that
16:24:20 was on your section?
16:24:21 A. Yes.
16:24:21 Q. And do you know or do you
16:24:24 recall the circumstances surrounding her
16:24:27 passing away?
16:24:27 A. Yes.
16:24:29 Q. All right. Now, I want to
16:24:35 take you first to some progress notes.
16:24:38 MS. HEWITT: Now, these are,
16:24:40 Commissioner, within Exhibit 6,
16:24:44 but I do have separate copies if
16:24:48 you'd like a separate copy to
16:24:50 have a look at.
16:24:52 THE COMMISSIONER: I have
16:24:52 Exhibit 6, so if it's here, I
16:24:55 can look at it.
16:24:56 MS. HEWITT: There will be a
16:24:58 reference to the note but not

16:24:59 1 the actual source of the
16:25:02 2 document itself.
16:25:18 3 BY MS. HEWITT:
16:25:03 4 Q. So if I can turn to
16:25:04 5 Document 15236, and if we can go down -- scroll
16:25:26 6 down to the entry at March 23rd, 17:21.
16:25:38 7 Now, I think you indicated
16:25:40 8 earlier that these progress notes would reflect
16:25:42 9 if something happened with the resident; is
16:25:46 10 that correct, Karen?
16:25:46 11 A. Yes.
16:25:46 12 Q. And just before this
16:25:49 13 particular entry, we know from Exhibit 6 that
16:25:53 14 Ms. Pickering had been in the hospital and had
16:25:57 15 returned to the home. Do you recall that
16:26:00 16 occurring?
16:26:01 17 A. I wasn't present when she
16:26:04 18 returned from the home, but the morning that
16:26:08 19 she was sent to Woodstock General emergency, I
16:26:12 20 had been told by the PSWs that she didn't seem
16:26:16 21 herself and wasn't coming to breakfast.
16:26:18 22 And so I went and checked on her
16:26:20 23 myself, I don't know, sometime around 8 or, you
16:26:26 24 know, quarter to 8 and found that she had a
16:26:30 25 decreased -- you know, she was drowsy. And
16:26:35 26 I think I charted -- just let me find that.
16:26:41 27 Q. We would have to scroll down
16:26:44 28 earlier in that particular document.
16:26:47 29 A. It was the day before.
16:27:04 30 MR. VAN KRALINGEN: Page 3 of
16:27:04 31 the document.
16:27:04 32 MS. HEWITT: Page 3? Do you

16:27:04 have the time there, Alex?
16:27:05 MR. VAN KRALINGEN: The entry is
16:27:06 10:59 that I think Ms. Routledge
16:27:09 might be speaking about.
16:27:11 BY MS. HEWITT:
16:27:11 Q. 10:59, is that your entry
16:27:12 there?
16:27:12 A. Yes.
16:27:12 Q. All right. And what does it
16:27:16 say?
16:27:16 A. So we were checking on her,
16:27:18 and then at 10:50, I found her unresponsive,
16:27:20 diaphoretic, cold and clammy with deep snoring
16:27:23 sounding respirations and mucus.
16:27:26 So I immediately called 911 and
16:27:31 made arrangements for her to be transferred to
16:27:34 Woodstock General for assessment.
16:27:37 Q. Now, at that point in time --
16:27:40 number one, was Ms. Pickering diabetic?
16:27:43 A. No.
16:27:44 Q. And the symptoms that she was
16:27:47 experiencing, diaphoretic and cold and clammy,
16:27:51 are those symptoms that can be associated with
16:27:56 only hypoglycaemia or --
16:27:59 A. Definitely not. They could
16:28:01 be associated with a heart attack. They could
16:28:04 associated with a neurologic event. There
16:28:07 could be a number of infectious processes going
16:28:10 on. There are multiple clinical scenarios that
16:28:18 would present as such.
16:28:20 And, you know, she definitely
16:28:22 needed hospital attention and some diagnostics

16:28:26 to be able to determine what was causing this.
16:28:31 Q. And you did take some vitals
16:28:34 at the time; is that correct?
16:28:35 A. Yes.
16:28:36 Q. And for --
16:28:37 A. The entry says that I wrote
16:28:39 it -- like, when you chart is usually after the
16:28:44 event, like --
16:28:50 Q. Because during the event,
16:28:51 you're in the middle of the event?
16:28:52 A. Yes.
16:28:53 Q. So you're charting at 10:59
16:28:56 what had happened that particular morning?
16:28:58 A. Yes.
16:28:58 Q. All right. And you charted
16:29:02 some of her vitals. Is it normal practice to
16:29:08 take blood sugars in these types of events if
16:29:09 the individual isn't diabetic?
16:29:11 A. No, not normal, no.
16:29:17 Q. All right. And then she
16:29:19 returned -- she returned to Caressant Care the
16:29:23 next day?
16:29:24 A. I believe it was the same
16:29:27 night -- no, the next day, yeah.
16:29:33 Q. Actually, I think you're
16:29:35 right. So that's at 10 --
16:29:36 A. She returned that same
16:29:38 evening, I believe, and Bethe was the receiving
16:29:40 nurse for her that time.
16:29:41 Q. All right. And so if we go
16:29:44 up, then, to the entry at 17:21, do you see
16:29:54 that, March 23rd? That's that same evening?

16:29:58 A. Yes.
16:29:58 Q. And it indicates that --
16:30:00 Dr. Urbantke mentioned that:
16:30:04 "Maureen's blood sugar was
16:30:06 extremely low when she arrived
16:30:08 at the hospital, and the cause
16:30:09 is unknown. She stated that if
16:30:11 Maureen passes, it might be a
16:30:13 good idea to call the Coroner on
16:30:15 this one."
16:30:16 Do you see that?
16:30:16 A. Yes.
16:30:16 Q. Would you have read that in
16:30:18 this progress notes?
16:30:19 A. Yes.
16:30:20 Q. And it appears, if we just go
16:30:24 up the next entry at 22:46, this is Elizabeth
16:30:29 Wettlaufer again?
16:30:30 A. Yes.
16:30:30 Q. And it says:
16:30:32 "Maureen continues to respond to
16:30:34 voice and touch."
16:30:35 So she's back at the home at this point in
16:30:38 time?
16:30:38 A. Yes.
16:30:39 Q. Is that correct?
16:30:39 And then my understanding is
16:30:42 that -- and I won't go through everything here
16:30:48 for the sake of the family, but if we go up to
16:30:52 the March 28th 09:23 entry, were you on shift
16:31:00 when Ms. Pickering passed away?
16:31:02 A. Yes.

16:31:03 Q. And is this entry on
16:31:08 March 28, 2014, at 09:23 your entry?
16:31:14 A. Yes.
16:31:14 Q. And can you tell us what
16:31:16 steps you took on finding Ms. Pickering
16:31:24 deceased with no respirations or pulse?
16:31:27 A. I put a call in to the
16:31:31 Coroner's office. It's a 1-800 number. As
16:31:35 you're filling out the paperwork, it indicates
16:31:39 that number.
16:31:40 And Dr. George who was on call
16:31:44 that particular day called me back, and I said
16:31:47 that Dr. Urbantke was concerned regarding an
16:31:52 unexplained low blood sugar, and that is why I
16:31:56 was calling him as the Coroner.
16:32:00 I said that she also possibly
16:32:01 may have had a stroke and, you know, went over
16:32:05 her other medical conditions.
16:32:11 And he said, well, I'm -- he was
16:32:15 satisfied with that, and he said, "I think you
16:32:17 need to call Dr. Reddick." So that's what I
16:32:21 did.
16:32:21 Q. And who's Dr. Reddick?
16:32:26 A. I believe he was her GP at
16:32:31 the time, but if her GP wasn't available,
16:32:34 Dr. Reddick was the home's physician. Just --
16:32:39 let me just -- her physician is Dr. Reddick,
16:32:43 yes. It's at the top.
16:32:44 Q. All right. And so is it your
16:32:45 understanding that no autopsy was done?
16:32:46 A. Yes.
16:32:50 MS. HEWITT: Commissioner, I

16:32:51 1 understand that the
16:32:52 2 transcriptionists have to take
16:32:54 3 two minutes and switch out.
16:32:56 4 THE COMMISSIONER: All right.
15:07:24 5 (BRIEF RECESS TAKEN.)
16:33:21 6 BY MS. HEWITT:
16:33:22 7 Q. We are good? Not even two
16:33:25 8 minutes.
16:33:25 9 All right. And what is the
16:33:31 10 process, Karen, if a resident passes away on
16:33:34 11 your shift? What are the steps that you have
16:33:37 12 to take in respect to that particular
16:33:38 13 individual?
16:33:39 14 A. You call the physician. You
16:33:44 15 call the family.
16:33:49 16 Q. Are there any forms to fill
16:33:51 17 out?
16:33:51 18 A. There are Ministry forms on
16:33:55 19 the computer regarding time, date of death,
16:34:05 20 age, and there is also the birth -- or Death
16:34:11 21 Certificate that is filled out by the
16:34:13 22 physician.
16:34:13 23 MS. HEWITT: Okay, and so I'm
16:34:15 24 going to go to those documents.
16:34:18 25 And, Commissioner, those are all
16:34:20 26 referenced in Exhibit No. 6, but
16:34:22 27 for your sake, to have a hard
16:34:24 28 copy in front of you, I have
16:34:27 29 pulled them.
16:34:27 30 THE COMMISSIONER: All right,
16:34:28 31 thank you.
16:34:29 32 BY MS. HEWITT:

16:34:29 Q. So if we can first go to
16:34:31 document 01670, and is this the document you
16:35:17 were just speaking about, the Medical
16:35:20 Certificate of Death?
16:35:20 A. Yes.
16:35:21 Q. And is this a form that the
16:35:27 nursing staff fill out any part of, or is this
16:35:31 simply the physician?
16:35:31 A. We fill out the information
16:35:34 about the deceased, as in name, age, and date
16:35:42 of death, but it is the physician's
16:35:45 responsibility to do the rest.
16:35:46 Q. And when would the physicians
16:35:53 arrive? Did they come right away or did they
16:35:55 come later, or is there a practice?
16:35:57 A. There is no practice. You do
16:36:00 call the physician, and he will give you an
16:36:02 idea of when he might be in. It might be when
16:36:05 office hours are over. It might be, if it is
16:36:07 in the middle of the night, first thing in the
16:36:09 morning. He usually gives you an idea as to
16:36:12 when that happens, but it is not immediate.
16:36:14 Q. And does the deceased remain
16:36:22 in the home until the Medical Certificate of
16:36:24 Death is signed?
16:36:25 A. Yes. It is required by your
16:36:30 funeral home.
16:36:31 Q. They need that medical
16:36:32 certificate before they take the body?
16:36:35 A. Yes.
16:36:35 Q. All right, and then if I can
16:36:37 turn you to document number 15387.

16:36:44 I should ask you this question.
16:36:45 Did you have any discussion with Dr. Reddick
16:36:48 with respect to Mrs. Pickering and what
16:36:50 Dr. Urbantke had said; do you remember?
16:36:53 A. I don't recollect.
16:36:59 Q. All right. Do you even know
16:37:02 whether or not he was in while you were still
16:37:04 on shift?
16:37:04 A. Yes, he was.
16:37:08 Q. And this document identifies
16:37:15 it is from the Office of the Chief Coroner,
16:37:18 Institutional Patient Death Record; do you see
16:37:21 that?
16:37:21 A. Yes, that is the one on the
16:37:22 computer.
16:37:22 Q. Right, and so I was just
16:37:24 going to say we have seen some handwritten
16:37:27 ones, but is this now a computerized form?
16:37:29 A. Yes.
16:37:30 Q. And what training would you
16:37:32 as an RN get on how to fill out these
16:37:35 particular forms?
16:37:37 A. There was no education on how
16:37:40 to fill out the form. It was it is now on
16:37:48 computer, and this is how you fill out -- like
16:37:50 this is the form you need to fill out. If you
16:37:52 have any questions, ask your co-worker, or I'm
16:37:55 sure the managers would be available if we had
16:37:57 questions about it.
16:37:58 Q. And --
16:38:00 A. But no formal education.
16:38:01 Q. All right. And so is it the

16:38:05 1 RN on duty that fills out the answers to the
16:38:09 2 particular questions that are --
16:38:10 3 A. Or the RPN.
16:38:11 4 Q. Or the RPN. And in this
16:38:17 5 particular case, you answered no to all those
16:38:21 6 questions?
16:38:21 7 A. Yes.
16:38:22 8 Q. And you answered no to:
16:38:26 9 "Is the death both sudden and
16:38:28 10 unexpected?"
16:38:29 11 A. Yes.
16:38:29 12 Q. And what is your
16:38:32 13 understanding of when you would identify that
16:38:36 14 something is sudden and unexpected?
16:38:38 15 A. It is not unusual for a
16:38:45 16 long-term care patient to have a stroke, and
16:38:48 17 that was the indicator that Woodstock General
16:38:54 18 Emergency had given us that it was possible she
16:38:57 19 had a stroke and that was what I was basing
16:39:04 20 the -- and the fact that the Coroner wasn't
16:39:05 21 alarmed with any of the information that I had
16:39:09 22 given him, that is why that answer was no.
16:39:12 23 Q. Okay, thank you. And if we
16:39:18 24 could just finish this particular number of
16:39:21 25 documents with going to document 15386. Do you
16:39:38 26 recognize this document?
16:39:39 27 A. Yes.
16:39:39 28 Q. And what is this document?
16:39:41 29 A. That is more or less
16:39:43 30 Caressant Care's checklist to make sure that
16:39:46 31 you have done everything, like that all of the
16:39:49 32 tasks related to a resident's death are

16:39:54 completed.
16:39:55 Q. And so this is an internal
16:39:58 form?
16:39:58 A. Yes, it is.
16:39:59 Q. All right. And is it signed
16:40:01 by both the physician and yourself?
16:40:05 A. It is signed at the top by
16:40:07 the physician, but that is a repeat of the
16:40:10 death certificate. The middle part is being --
16:40:13 is filled out by myself, but the bottom
16:40:15 signature there is the mortician --
16:40:18 Q. Okay.
16:40:18 A. -- who picked up the body.
16:40:21 Q. And where would these forms
16:40:22 be located?
16:40:23 A. They should be at every
16:40:25 nursing station.
16:40:28 Q. And we have heard some
16:40:29 testimony about the Death Registry having to be
16:40:33 signed as well?
16:40:34 A. Not signed, but are you
16:40:40 talking about the Record of Deaths at Caressant
16:40:44 Care?
16:40:44 Q. Correct.
16:40:45 A. It needs to be charted in
16:40:47 there. It is not a signature that is required.
16:40:49 It is a -- basically a list so that we can
16:40:58 identify when we have the tenth or critical
16:41:04 case.
16:41:04 Q. And was that a requirement at
16:41:06 one point in time on this sheet that every
16:41:09 tenth one, the Coroner would have to be

16:41:11 notified?
16:41:12 A. Yes.
16:41:12 Q. And you kept track of that in
16:41:14 this --
16:41:15 A. It was in a manual system and
16:41:17 it was kept on Section B.
16:41:18 Q. Okay, and if we can turn to
16:41:21 document 71978, is this what you were referring
16:41:43 to?
16:41:43 A. Yes.
16:41:44 Q. And if we scroll down, Karen,
16:41:50 in terms of Ms. Pickering's particular passing,
16:41:55 it doesn't appear to be on this Death Registry.
16:41:58 So it was March 28th, 2014, I believe. Do you
16:42:04 see that?
16:42:04 A. Yes.
16:42:05 Q. And so what are the
16:42:10 circumstances under which that may not have
16:42:13 occurred in terms of registering her death on
16:42:17 the death record? You indicated it was located
16:42:28 in Section B.
16:42:29 A. It was -- yes, it was located
16:42:31 in Section B. It wasn't computerized, when we
16:42:35 were all computerized, and it wasn't a
16:42:42 check-off box on the resident's death form.
16:42:46 And maybe that could be corrected. It should
16:42:48 be.
16:42:48 Q. The document that we just saw
16:42:50 didn't have anywhere in that process, you know,
16:42:52 sign off on the death record; is that what you
16:42:54 are saying?
16:42:54 A. Yes.

16:42:54 Q. Okay. And by this time, the
16:42:58 issue of every tenth resident was not -- it was
16:43:03 no longer a concern; is that correct?
16:43:05 A. I think so, yes.
16:43:07 Q. And was there, in Section B
16:43:17 with this death record, was there any other
16:43:19 documents kept with it that helped explain the
16:43:21 process?
16:43:22 A. I think there was another
16:43:27 checklist in there, as well as some forms on
16:43:31 the Medical Certificate of Death there. I
16:43:36 didn't work Section B often.
16:43:41 Q. And if I can just turn you
16:43:43 for a moment to document 72195, this is a
16:44:16 document called "Death of a Resident -
16:44:19 Registered Staff Role", March 2003. Do you
16:44:25 recognize this particular policy, Karen?
16:44:33 And we'll scroll down a bit. It
16:44:35 has "Definitions", what is an "Expected Death":
16:44:37 "Death is expected when the
16:44:40 health care team is of the
16:44:41 opinion that the resident is
16:44:42 irreversible and irreparably
16:44:45 terminally ill, there is no
16:44:47 treatment that will restore
16:44:48 health and that death is
16:44:49 anticipated by the health care
16:44:51 team."
16:44:52 Do you recognize this policy?
16:44:55 A. I probably read it way back.
16:44:58 Q. Any ongoing training at
16:45:00 Caressant Care as to these types of issues, the

16:45:04 end-of-life care and the documentation?
16:45:07 A. No.
16:45:07 Q. And then subsequent to this,
16:45:18 Ms. Wettlaufer was terminated in March 2014; do
16:45:21 you recall that?
16:45:21 A. Yes.
16:45:22 Q. And you actually sat in on
16:45:24 her investigative meeting leading up to that
16:45:32 termination; is that correct?
16:45:34 A. The investigative meeting and
16:45:36 the termination happened all at once. No?
16:45:43 Q. The investigative meeting is
16:45:45 dated March 26th, 2014, and if you just turn -
16:45:52 and I won't get it up on the screen - but if
16:45:55 you could just turn to tab D, the very last
16:45:58 document. Do you see that? It should be
16:46:08 handwritten notes.
16:46:09 A. Yes.
16:46:09 Q. And now are you mistakenly
16:46:12 referred to as Karen Rodriguez again in this
16:46:17 document?
16:46:17 A. Yes.
16:46:18 Q. And my understanding of the
16:46:21 sequence of events is that Ms. Wettlaufer was
16:46:27 put off of work at that point in time; do you
16:46:29 recall that?
16:46:30 A. Yes.
16:46:32 Q. And in fact, at tab number
16:46:36 "F" -- or "E" you have a note that you sent
16:46:41 that you made in terms of this meeting; is that
16:46:44 correct?
16:46:44 A. Yes, yes.

16:46:45 Q. And in that meeting Ms.
16:46:47 Wettlaufer asked:
16:46:48 "Am I going to lose my job?"
16:46:50 A. Yes.
16:46:51 Q. Now, my understanding from
16:46:52 the Overview Report is that the termination was
16:46:55 March the 31st?
16:46:56 A. Right.
16:46:57 Q. So you were in the
16:46:58 investigative meeting?
16:46:59 A. Yes.
16:47:00 Q. And were you aware prior to
16:47:02 her being terminated that she was going to be
16:47:05 terminated?
16:47:05 A. No.
16:47:06 Q. And we'll hear from the nurse
16:47:09 that was actually involved in this particular
16:47:12 situation.
16:47:13 And I know I'm one minute past
16:47:16 the time for break, Commissioner.
16:47:19 I just wanted to finish up,
16:47:22 Karen, by asking you to, if you can, just talk
16:47:27 to us about the impact that these crimes have
16:47:32 had on you when you discovered it or to the
16:47:37 residents or any comments that you would like
16:47:39 to make.
16:47:40 A. It was a shock. It was
16:47:48 horrifying.
16:47:53 Q. Did she ever give any
16:47:55 indication that she was intentionally harming
16:47:57 the residents?
16:47:57 A. No. I have wracked my brain

16:48:02 thinking how could this happen? How could you
16:48:05 not know? And I haven't come up with anything.
16:48:12 It is just I feel my heart goes out to the
16:48:16 families.
16:48:18 Q. And I think --
16:48:19 A. And it is something that is
16:48:20 going to stay with me forever.
16:48:23 Q. And has that been the general
16:48:26 feeling with your colleagues?
16:48:27 A. With my colleagues, I was off
16:48:31 for a year with breast cancer and had every
16:48:35 intention of coming back to work, and this was
16:48:38 January of '16, and I came back for a couple of
16:48:44 days and the apathy in the place was just
16:48:49 palpable and I couldn't handle it. I had had
16:48:53 enough emotional turmoil over the last year,
16:48:56 and I just wanted things to settle down. And
16:48:59 so I retired early.
16:49:01 Q. And you said that was January
16:49:03 '16. Was it January '16 or '17?
16:49:06 A. 2016, right?
16:49:08 Q. These crimes, we became aware
16:49:13 of them in October 2016.
16:49:14 A. Okay, the next year, sorry.
16:49:16 Q. No, no, that is fine. That
16:49:18 is fine. My memory is not perfect either.
16:49:22 And when you say the apathy in
16:49:23 the home, was that at a time when the resident
16:49:30 beds, the admissions had stopped?
16:49:32 A. Yes. The --
16:49:34 Q. Sorry, go ahead.
16:49:35 A. The one thing I would like to

16:49:37 1 say too is that it affected the staff so much
16:49:40 2 there, and there was so many staff that gave
16:49:42 3 excellent care and were so caring, and it is
16:49:46 4 just -- it was horrific for them.
16:49:48 5 Q. Yes.
16:49:49 6 A. My heart goes out to them
16:49:51 7 that are still working there.
16:49:52 8 Q. Yes. And one of the things
16:49:55 9 that you did say earlier was better
16:49:59 10 communication between everybody would help
16:50:02 11 going forward; is that correct?
16:50:03 12 A. The whole system, right from
16:50:05 13 the ground up.
16:50:05 14 Q. Right, and any -- you know,
16:50:07 15 the Commissioner is here to talk about, you
16:50:09 16 know, moving forward, and I know this has been
16:50:12 17 difficult for you as well.
16:50:13 18 But any thoughts about moving
16:50:15 19 forward that you wanted to share at this point
16:50:16 20 in time?
16:50:17 21 A. Not at this time.
16:50:19 22 Q. Okay. And we are always
16:50:23 23 available to share those thoughts, but thank
16:50:25 24 you so much for going through what you have
16:50:27 25 gone through.
16:50:29 26 MS. HEWITT: And those are my
16:50:30 27 questions for today,
16:50:31 28 Commissioner, and I am five
16:50:33 29 minutes past our break time, so
16:50:36 30 I suggest this is a good time to
16:50:38 31 break for the day.
16:50:39 32 THE COMMISSIONER: All right.

16:50:40 And will there be questions from
16:50:42 you in the morning, beginning in
16:50:44 the morning, Mr. Golden?
16:50:46 MR. GOLDEN: Yes.
16:50:46 THE COMMISSIONER: All right,
16:50:47 thank you very much. We know it
16:50:48 is not easy to come to the
16:50:49 Inquiry. I appreciate that very
16:50:50 much.
16:50:50

-- Adjourned at 4:51 p.m.

REPORTER'S CERTIFICATE

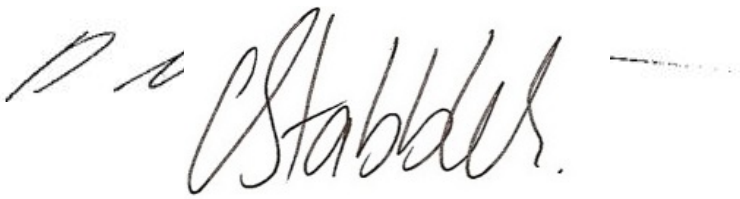
We, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, and CARISSA L. STABBLER, RPR, CSR, Certified Shorthand Reporter, do certify:

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

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by us and were thereafter transcribed;

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

Dated this 11th day of June, 2018.



NEESON COURT REPORTING INC.
PER: DEANA SANTEDICOLA, RPR, CRR, CSR
& CARISSA L. STABBLER, RPR, CSR

(

(d) 1260:7

(e) 1261:9

(g) 1265:28

(i) 1266:29

0

00643 1209:11

01670 1354:2

04353 1187:18 1230:24

09:23 1351:30 1352:2

1

1 1143:29 1147:18 1150:12 1226:5,17 1250:7 1252:2,10 1287:3 1301:2 1314:8

1-800 1200:16 1352:8

10 1147:18 1306:18,23,24 1307:2,6 1308:5 1309:12 1331:11 1350:26

10.2 1304:28,29 1305:7

100 1170:12 1273:6 1294:4 1297:6

101 1252:3

104 1161:3

10:50 1349:12

10:59 1349:3,6 1350:12

11:00 1246:17,18 1265:28

11:10 1205:17

11:27 1205:18

11:30 1265:28

11:35 1205:16

12 1153:3,5 1157:24,29 1162:2 1268:30

12:14 1240:13

12:15 1239:26,32

12th 1157:20 1158:2 1161:19

13 1162:20 1165:2 1268:30 1330:13

132 1252:5

14th 1188:23

15 1240:2 1270:24 1271:10, 15 1331:11

15236 1348:5

15386 1356:25

15387 1354:32

16 1140:18,28 1153:6 1194:31 1228:5 1362:13, 20

163 1142:28,31

164 1143:27

1648 1180:2

16488 1180:3

16756 1228:13, 14

16862 1229:25 1334:30

16917 1157:28

16918 1157:19

17 1166:21 1335:2 1362:20

17:21 1348:6 1350:31

17th 1335:1

18 1166:27 1167:2 1194:31 1338:9,10,15

18-month 1167:5,9

185 1161:13

19 1135:19 1136:17,23 1161:16 1175:26 1225:19

1976 1243:4

19th 1135:26 1159:31 1329:13, 17

1:30 1194:22 1233:13 1240:8, 14

2

2 1142:28 1143:30 1144:15 1145:4,31 1150:13 1244:17 1245:24,32 1246:4 1248:28 1252:2,10 1271:23 1272:2 1276:29 1283:31 1287:2 1291:6 1294:15 1301:2

20 1140:3 1147:23,24,26 1188:7 1306:25

2001 1243:13

2002 1243:13

2003 1359:16

2005 1230:31 1243:18

2007 1153:9 1154:13,31 1157:24,25,29 1159:1,5

2008 1159:31 1313:5 1314:18

2009 1313:1 1319:24 1320:11 1328:32

2010 1137:4 1139:27 1140:3 1160:9 1195:18

2011 1140:7,15 1143:23 1160:19 1244:8 1328:3,32 1329:27,30 1330:2 1335:1

2012 1188:7,19 1230:25 1329:9, 13 1342:24 1343:12

2013 1135:20 1136:17,23 1140:18,28 1145:4 1161:16 1162:2 1209:14 1330:15

2014 1154:10,14, 18 1181:24 1227:31 1228:8 1245:30 1249:8 1259:24 1352:2 1358:14 1360:4, 13

2016 1184:17 1230:32 1300:28 1362:21,23

2017 1157:21

20th 1137:4 1139:27 1329:9, 16

22:46 1351:17

23 1140:6,15

23rd 1348:6 1350:32

24 1208:1,5 1212:1 1268:28 1269:5,7,12 1333:8

24-hour 1268:13,26

24-hour-care 1342:14

248 1152:8,14

25 1138:13 1225:28 1227:31 1228:8 1273:5 1330:12

26 1135:21 1136:6,9,10 1139:17 1160:19

26th 1228:15 1360:13

27 1135:30 1136:18,19,21 1139:17 1153:9 1155:19 1159:1 1175:31 1225:20, 21 1226:7,15,16, 21

28 1139:30,32 1229:11 1352:2

28th 1351:30 1358:14

29 1140:12 1226:25 1229:11

2:30 1175:4

3

3 1143:28 1144:25 1150:14 1209:12 1293:25 1294:4 1348:30, 32

30 1140:20,22,25 1148:27 1155:28 1198:30 1229:11 1306:17 1307:1

300 1294:1,5,7

31 1172:1,11,12

31st 1361:7

32 1188:2,6 1230:23 1242:13, 23 1246:6,12 1248:28 1268:8 1300:30

33 1242:26,28,29, 30

36847 1228:23

3:00 1246:17 1271:25

3:07 1310:4

3:24 1310:5

4

4 1145:18,24
4- 1250:6
40 1159:22
400 1172:26
42 1227:1
43 1162:19 1165:3
44 1339:7
450 1154:6,16
48 1152:9
4:51 1364:11

5

5 1150:8,10 1181:21 1208:1 1225:27 1277:5 1279:23 1294:15 1295:17 1296:28, 29,30,32 1297:1, 4,22,23,27,29 1298:1,23,25 1299:3 1302:1,10, 18
50 1273:6 1294:14 1308:32
54989 1149:25 1150:4
57094 1176:32
5:30 1166:16 1336:1

6

6 1154:6 1177:1 1180:3 1219:32 1221:2 1225:17 1226:9 1244:13, 28 1266:29 1347:24,29 1348:13 1353:26
600 1250:6 1293:11
61 1341:10 1342:11
63 1166:21
65 1168:7
6:30 1175:4

7

70956 1153:4
71978 1358:8
72195 1359:14
72584 1140:8 1143:22
72585 1140:21, 23
72587 1139:29, 31
7285 1145:2
75 1273:6
7:00 1246:17,18, 20,27 1253:19
7:30 1253:20,30 1256:4 1294:28
7th 1160:8

8

8 1253:13 1254:3, 7,9 1348:23,24
8:15 1253:13

9

9 1254:11 1256:4 1260:5
90 1159:25,30
911 1264:6,15 1349:15
93 1160:25
9:29 1135:1
9:30 1256:9
9:34 1139:14
9:46 1139:15

A

a.m. 1135:1 1139:14,15 1205:17,18 1246:20,28
A1cs 1203:13
ability 1185:10 1257:4 1307:20 1310:22 1316:7, 10
absence 1243:14
absenteeism 1338:4,27
absolutely 1137:19 1208:31 1221:32 1270:32
abuse 1177:10 1179:15,18,22,28 1180:5,9,13,14, 15,18,24,25,30 1183:2 1184:7 1196:19 1197:1 1230:19 1345:16 1346:4,7,28
acceptable 1156:15 1224:28
access 1320:20 1323:15,20
accident 1219:16
accommodate 1266:26
accommodate d 1233:25
accordance 1148:20
accurate 1228:32
act 1152:29 1164:22 1173:3,6, 8 1175:26,31 1179:26 1184:2 1196:31 1197:11
action 1146:7 1337:1
actions 1146:1 1209:20 1328:5 1339:19
activities 1261:18 1267:18 1268:32 1316:10
activity 1268:3
actual 1168:20 1177:12 1192:30 1247:11 1268:1 1279:9 1289:13, 32 1290:8 1296:1 1308:27 1309:4 1348:1
acuity 1142:24 1148:25 1185:5,6, 8 1192:20 1315:11,17
Acute 1243:8
adamant 1217:1
add 1229:17
addiction 1340:29
addition 1147:8 1148:1 1165:6 1200:8 1212:20
additional 1189:1 1191:19 1205:22 1221:18 1232:28
additionally 1232:26
addressed 1268:31
Adjourned 1364:11
adjust 1143:10 1144:26 1146:18
adjustments 1185:26
ADLS 1261:17
administer 1212:26 1213:23 1258:22 1264:7 1299:27 1300:22 1301:31 1303:5 1304:13
administered 1302:3 1337:5
administering 1148:3 1316:29 1317:1
administration 1209:26 1210:5 1213:24,32 1250:16 1254:32 1260:20,23,25,28 1300:2,5 1301:29 1314:2
administrator 1160:11 1168:14 1178:31 1181:27 1182:13 1186:27 1188:20,30
administrators 1168:18 1197:5
admission 1253:8 1267:5,12, 31 1268:25 1269:13,14 1276:15,16 1292:12
admissions 1266:31 1267:4 1276:12 1295:12 1362:29
admit 1216:19 1305:17
admitted 1217:21 1222:7 1224:20
adopted 1215:21
Adriano 1159:12
advertising 1147:4
advice 1195:7, 24,29,31 1208:4, 11 1211:20 1212:24
advise 1164:29 1189:30 1214:16, 22

advised 1136:6 1227:24
advising 1227:19
advisor 1195:15
advisors 1195:7
advocacy 1206:11
advocating 1146:30,31
affect 1176:4 1239:28 1340:24
affected 1363:1
affidavit 1152:8, 9,11 1159:25 1160:23 1166:20, 23 1194:30,31 1201:3 1207:32 1208:1 1209:11 1212:1 1213:4 1228:5 1234:19 1235:23 1240:28 1241:11,13 1242:23,30 1244:12,20 1260:7 1261:9 1265:24 1266:29, 32 1273:13 1277:15 1278:20 1283:15 1287:22 1293:29 1312:32 1313:8 1329:6 1335:11 1339:7 1341:8
affidavits 1235:13 1236:30
afraid 1187:31
afternoon 1203:11 1266:4 1269:28 1270:25 1271:22
afternoons 1321:31 1331:1
Agatha 1169:27
age 1353:20 1354:10
agencies 1191:31 1226:11
agency 1191:21, 26,29 1192:8
aggression 1261:29
agree 1141:24 1144:8 1147:13, 18 1149:20 1151:15 1162:21 1163:13 1164:19 1168:32 1169:4, 14 1170:1,10 1177:24 1183:31 1189:25 1190:1,8, 18 1192:24 1195:2,10,26 1217:14 1224:16 1247:17 1300:15
agreed 1167:16 1191:11 1240:1
agreement 1148:4,6,10,11 1153:2,14,18,27 1154:10,18 1166:27 1217:12 1320:24,26 1337:6,11,15
Agreements 1153:29
agrees 1227:17
ahead 1141:15 1204:31 1215:24, 30 1225:13 1234:12 1286:27 1320:1 1362:31
ahold 1191:18
aid 1264:7
air 1298:14
alarm 1319:20
alarmed 1356:21
Alberta 1243:15
alcohol 1340:29, 30
alerting 1280:17
Alex 1349:1
Alexandra 1243:5,14
allegations 1346:28
allergy 1282:21
alleviated 1184:8
allowed 1145:9 1284:10
alter 1238:23 1239:12
altered 1265:19
alternate 1271:4
alternative 1310:24
Alzheimer's 1262:2
ambulate 1274:10
amending 1227:7
amount 1173:26 1215:13 1216:1 1238:28 1244:2 1276:4 1295:5 1298:16 1299:19, 32 1306:4 1308:12,27 1309:4,5
amputations 1268:21
Analysis 1209:18
Anita 1217:3,9, 17
anniversary 1193:3
annual 1184:16 1209:31
annually 1176:13 1345:20, 22
answers 1211:23 1356:1
anticipate 1253:21,22
anticipated 1359:27
anybody's 1205:10
anyone's 1310:32
apathy 1362:14, 27
apologetic 1324:30 1336:24
apologies 1336:27
apologize 1138:6,31 1166:8 1200:32 1347:10
apparent 1202:16
appeared 1336:26
appears 1155:11 1215:21 1224:21 1351:16
apple 1251:20
appliances 1267:21
applied 1153:19
apply 1244:4
appointed 1182:28
appointment 1197:30
approach 1196:7 1238:23
appropriately 1259:30 1289:24 1341:2
approval 1151:31 1152:3
approve 1191:30
approved 1228:31
approximately 1143:28 1165:2 1172:26 1190:22 1213:6 1214:9 1245:31 1250:3 1260:5 1269:30 1271:23 1277:5 1287:3 1288:4 1312:32 1314:8
April 1135:19,25 1136:17,23 1161:19 1162:2 1329:9,13,15,16, 17,26 1330:15
area 1162:12 1175:5,10 1197:4 1200:30 1220:25 1244:5 1252:7 1268:3 1309:29 1310:10 1322:31
areas 1147:30 1243:9 1268:20, 30
argue 1336:22
argument 1155:12,14
arise 1222:19
arm 1265:4
arrange 1334:6
arrangements 1349:16
arrive 1354:14
arrived 1351:5
arthritic 1251:2
as-needed 1270:2
aspect 1231:31 1244:10
aspirin 1251:2
assess 1151:18 1212:27 1265:5
assessed 1152:25
assessment 1149:12 1245:7 1262:25 1263:32 1264:13,14 1268:13,15,16 1269:9 1271:19 1273:18 1274:4 1276:25 1332:21 1342:15 1345:8 1349:17

assessments 1149:20 1151:2 1212:16,20 1213:11,12,13 1244:5 1267:15, 24 1273:23 1274:15,20,21 1275:3,10 1276:20 1333:9

assigned 1142:25 1175:7,9

assist 1220:27

assistance 1172:27 1246:8 1257:5

Assistant 1146:11 1176:22 1206:18 1345:28

association 1172:23,24 1206:3,7,10,21 1226:28

assume 1158:28 1159:4 1173:32 1238:17 1328:19

assuming 1172:29 1239:17 1248:18 1280:28 1325:22 1340:27

assumption 1224:17

assumptions 1215:26

assured 1205:21

attack 1349:26

attempt 1287:15 1307:28

attempting 1239:23

attend 1193:16, 30 1320:19 1321:18 1330:25

attendance 1147:5 1157:29, 30 1158:12

attended 1162:29 1193:14

attending 1193:28 1197:7

attention 1146:11 1179:14 1184:20 1197:14 1202:30 1217:26, 29 1228:1 1245:8 1256:18 1257:13 1334:1,18 1349:32

attitude 1175:14,16

audited 1210:20

audits 1308:16

August 1160:19

authority 1336:20

automatic 1258:12 1325:5, 10

automatically 1258:23 1305:21 1325:13,14

autonomously 1150:21

autopsies 1198:32

autopsy 1352:30

availability 1300:31

average 1213:6 1249:21 1266:4 1267:11 1286:28, 31 1294:9

avoid 1317:22 1344:4

aware 1141:32 1157:16 1161:23 1173:5,7,11 1179:6,17 1186:18,22 1198:31 1221:4 1224:22 1235:3 1238:30 1334:24 1361:12 1362:22

B

back 1167:22 1187:2 1190:7 1197:23 1216:30 1217:2,11,21 1230:23 1231:14 1232:7 1233:1,11 1245:30 1258:26 1265:15 1276:10 1282:11 1293:3,4 1297:31 1302:5 1307:22 1308:22 1324:13 1351:23 1352:12 1359:30 1362:12,13

background 1214:2 1243:3 1244:4

backtrack 1291:14

backup 1188:31

bad 1304:32 1305:8,12,30

badly 1217:19

band 1311:14 1312:26,27

bandaged 1219:18,22

Banff 1243:15

base 1215:25

based 1219:10, 28 1224:16,19 1342:13

basement 1322:32 1323:6

basically 1184:1 1243:9 1253:7 1260:1 1268:17,23 1270:30 1289:18 1321:15 1357:27

basing 1170:29 1356:19

basis 1178:12 1193:17 1204:22 1266:4 1308:24 1316:26

bed 1253:4 1265:16

beds 1362:29

bedtime 1266:17 1311:22

befriend 1334:7

beginning 1222:8 1273:9,11 1364:2

behalf 1205:24 1210:28 1219:25 1222:3 1226:28

behaviour 1216:28 1218:26 1230:5 1261:19, 24,26,27,29 1262:3 1274:7

behaviour-wise 1263:6

behaviours 1149:3 1218:17 1269:3

believed 1166:23 1241:19

bells 1272:21

beneficial 1341:29

berated 1217:17

Beth 1158:11

Bethe 1157:30 1165:8 1166:7,15 1167:11 1168:21 1177:15 1219:6 1221:30 1227:23, 25 1229:8 1275:2, 14 1324:19,28 1325:29,30 1327:25 1330:26 1331:5,7,14 1332:1 1334:21, 22 1335:4 1336:18 1337:19 1346:26 1350:28

Bethe's 1322:21,23 1324:15 1326:23

bible 1313:13

big 1139:2 1151:21 1167:21 1173:29 1217:3

bin 1248:13 1291:4,7,8,20,26, 32

binder 1194:4

Binhammer 1205:24,29 1206:1 1210:24

bins 1291:11,16, 28

biohazard 1307:31

bipolar 1221:15 1340:9

birth 1279:12 1353:20

bit 1158:7 1163:9, 26 1164:7 1174:28 1177:8 1180:8,23 1181:22 1185:6,9 1192:3 1200:31 1207:30 1235:16 1243:2 1245:18, 30 1268:5 1288:15 1298:19 1306:14 1340:20 1344:11 1359:18

Bits 1271:30

black 1296:2

bladder 1261:21 1269:3

bleeding 1219:5 1265:22

blend 1282:27

blockers 1251:1

blocks 1170:4

blood 1152:22 1202:26,27 1203:1,6,8,10,14, 17,20 1213:15,16 1250:32 1267:16 1294:17,28,30 1302:29,30

1303:3,8,12,25 1304:3,27 1305:1, 6,21 1350:17 1351:4 1352:14

blue 1289:13 1290:21 1291:7,8, 11,16,32

board 1273:14

body 1354:29 1357:13

Bonnie 1168:17

book 1281:2,24 1282:2

bottom 1143:1 1145:17,23,28 1252:24 1295:31 1357:10

bought 1170:3

boundaries 1230:3

bowel 1261:21 1269:2 1344:11

box 1170:23 1247:26,27 1278:29 1279:3,7, 9,10 1280:15,23 1288:29,32 1289:32 1290:21 1292:1,20 1307:29 1308:1,6, 10 1310:18,23,28 1358:25

boxes 1229:15 1288:24,25

brain 1361:32

breach 1176:28

break 1138:28 1204:29 1205:4 1232:32 1233:2,8 1270:22,27,28 1271:3,10 1309:31 1310:8 1335:31 1336:6 1361:20 1363:29, 31

breakfast 1249:27 1252:32 1260:8 1266:16, 17 1348:21

breaking 1233:11,15

breaks 1165:13 1268:19 1270:16, 26 1271:4 1334:4

breast 1362:11

Brenda 1147:10 1160:14 1161:9 1166:26 1168:16 1178:30 1182:3,6 1321:11 1328:4 1335:4 1346:8

briefly 1247:6 1275:21

bring 1173:24,25 1174:13 1176:32 1177:29 1180:2 1187:17 1194:30 1325:3 1331:21 1334:9,11,17

bringing 1165:15

brings 1331:24 1340:12

broke 1138:21

broken 1264:12

brought 1146:10 1173:21 1184:19 1201:2 1202:29 1205:5 1316:6 1318:9 1330:22 1333:24 1334:1 1336:22 1340:10 1343:28

bruising 1265:22

bubbly 1331:17 1340:21

buddies 1334:7, 10

buddy 1334:10

build 1222:10

building 1301:1 1321:32 1322:1

bunions 1268:22

burst 1332:9

button 1258:11, 23

buy 1170:1 1171:3

C

cabinet 1322:31 1323:7,13,30 1324:3,6,15

calcium 1249:4 1251:1

calculate 1308:26,29

calculated 1186:2

calculation 1309:15

call 1143:17 1145:32 1147:9 1155:5 1172:19 1192:28 1195:32 1198:1 1199:7,11, 30,31 1200:1,22, 23 1205:31 1238:6 1239:13 1240:17 1260:19, 25 1264:6,15 1269:31 1272:21 1321:10 1346:7 1351:9 1352:7,11, 21 1353:14,15 1354:17

called 1135:17 1136:27 1149:6, 29 1150:9 1153:8, 29 1158:1 1185:19 1189:9 1195:6 1199:28 1201:21 1235:4 1236:21 1240:31 1294:22 1321:6 1332:2 1349:15 1352:12 1359:15

calling 1239:29 1352:15

calls 1143:20

calluses 1268:23

Canadian 1206:21

cancer 1362:11

candid 1167:14

candidates 1218:22

candour 1232:4

canvass 1233:5

canvassed 1163:29 1165:4

cap 1288:17 1292:29 1293:18

capability 1216:15

capacity 1236:6 1237:9 1274:7 1344:24

capsule 1209:15

card 1252:5 1286:14 1313:21, 32

cardboard 1289:32

cards 1313:10, 16,19 1314:10,20, 22

care 1135:16 1136:15,21 1142:29,30 1148:25,28 1150:22,26,30 1151:7,16 1168:8 1173:3,6,8 1175:22,31 1179:1,22,26 1182:29 1184:2 1192:21 1196:10, 12,30 1197:5,11 1206:16,21 1207:1 1208:23 1209:6 1212:11, 16,30 1215:9,10, 14 1216:1,7,8 1220:2 1221:21 1225:8 1227:23 1229:7 1230:31 1234:7,15 1236:15,22 1243:8,17,20,21, 28,31 1244:8,10, 26 1245:11,21,27 1248:27 1249:7 1251:30 1257:22 1260:14 1261:13, 15,16,24,26 1262:6,11,12,21, 28 1263:22 1268:13,22,26,29 1273:20,22,30 1276:17 1277:14 1279:1 1282:14 1283:24 1284:30 1300:26,27 1301:15,18,20,24 1303:11 1309:26 1311:26 1315:7, 15,29,32 1316:1, 5,15 1317:26 1318:13 1319:1, 13 1322:25,29 1331:5 1332:22 1333:8 1338:30 1341:17 1346:27, 32 1347:3 1350:21 1356:16 1357:23 1359:21, 27,32 1360:1 1363:3

Care's 1338:6 1356:30

career 1245:27, 28

careful 1164:5 1229:32 1319:7 1335:25

Caressant 1135:16 1136:15, 21 1151:6 1206:16,27 1207:1 1208:7 1212:16 1220:1 1221:21 1225:8 1227:23 1229:7 1230:31 1234:15 1236:15,22 1243:17,20 1245:21,27 1251:29 1257:22 1277:14 1279:1 1282:14 1283:24 1284:30 1300:25,

27 1301:24 1303:11 1309:26 1311:26 1317:26 1318:13 1319:1, 13 1322:25,29 1338:6,30 1341:17 1350:21 1356:30 1357:22 1359:32

caring 1331:18 1363:3

cart 1247:20,22, 29 1248:3,4,9 1250:22 1251:12, 17 1252:4,11 1257:23,30 1258:1,22 1259:6 1260:12,13,29 1266:21,24 1272:7 1277:9 1285:23 1290:17, 25,29 1307:13,17, 19 1313:11

cartridge 1277:16 1287:13 1292:14,15,18,20, 27,28,31 1293:24, 25,31 1294:7 1306:5,6,10,25 1307:3,6,21,29 1308:5,7,10,12 1309:10 1311:9, 28 1312:3,21

cartridges 1170:14,15 1283:11,23 1287:7 1292:11 1311:1,14 1312:6

carts 1251:29 1286:11,12

case 1147:25 1155:1,5 1163:17 1164:32 1169:31 1187:1 1201:18, 29 1204:13 1223:7 1239:1 1286:25 1289:1,2, 13 1290:9,13,18, 24 1327:21 1347:13 1356:5 1357:29

cases 1181:32 1204:21 1208:18

casing 1290:8

casual 1143:16

catch 1202:18 1253:31

catch-up 1272:3

catching 1217:30

categories 1211:17

caused 1219:16

causing 1350:1

cautioned 1163:32

cc's 1308:32 1309:1

CCAC 1217:4

CCW 1223:5

certificate 1353:21 1354:4, 24,29 1357:9 1359:11

certification 1346:1

cervical 1264:4

cetera 1165:23 1273:25 1279:19 1300:16 1304:24 1310:30 1334:5

chair 1232:16

challenge 1218:14

challenging 1218:16

chance 1166:28 1222:29,32 1233:5,23 1234:24 1235:10

change 1142:24 1152:27 1175:13, 15 1210:22 1216:28 1247:15 1262:10,11,19,23, 31 1273:13,15,24 1276:5 1302:21 1315:6,9,10,27 1318:27 1339:23 1340:28,31

change-of-shift 1341:5

changed 1156:4,8 1162:13 1174:11 1175:30 1177:14,24 1203:12 1210:6 1262:28 1263:19 1282:31

channel 1251:1

chaplain 1178:3

characterized 1235:6

characterizing 1234:26

charge 1246:11 1268:8 1330:31, 32

chart 1198:20, 27,28 1263:1,3 1271:28 1272:9, 13,17,30 1273:4 1350:7

charted 1231:15 1273:5 1348:26 1350:15 1357:25

charting 1201:13 1261:10 1262:32 1263:23 1265:25 1272:2,5, 23,25,27 1309:9, 10,11 1342:3 1350:12

charts 1198:6

chatted 1274:23

cheat 1293:27, 28

check 1144:26 1190:7 1202:27 1203:10,17 1251:24 1254:22, 24,25,27,31 1255:23 1280:2 1282:7,9 1299:12 1314:2

check-off 1358:25

checked 1143:5 1171:4 1255:15 1279:28 1298:8 1348:22

checking 1202:21 1304:26 1349:11

checklist 1267:6 1356:30 1359:10

chewing 1256:24

chief 1238:13 1355:11

chilled 1231:22

choice 1204:20

choking 1256:14 1257:17 1258:5

choose 1227:29

chooses 1238:9

chosen 1319:29 1321:30

Christian 1220:18

chronological 1137:2,16 1139:23

chronologically 1253:5

chummy 1165:23

circle 1282:12

circulation 1265:5

circumstances 1214:6 1217:10 1220:3 1221:6 1225:26 1265:8, 14 1288:11 1317:18 1319:15 1345:14 1346:3 1347:18 1358:18

citation 1230:24

cited 1231:1

clammy 1231:16,19 1349:13,22

clarification 1158:26

clarify 1207:32 1209:9 1224:9 1241:24

clarifying 1202:10

clean 1285:21

cleaners 1323:27

cleaning 1285:14,17,19 1323:25

clear 1146:30 1152:18 1164:2 1177:6 1178:6 1300:11

Clerk 1136:8 1138:6,10,11 1139:12 1140:10 1171:32 1172:2 1188:2,4 1205:14 1240:21 1242:13, 14,25,29

click 1288:16 1292:30 1293:4 1302:15

clicking 1302:19

client 1150:11 1172:9,14

clients 1150:22

clinical 1349:29

close 1201:12 1272:20

closed 1315:25

closely 1208:23

closet 1174:2,3

clothes 1192:29

clothing 1173:28,31

1174:3,11

co-worker 1355:27

coding 1274:3, 11

cognizant 1264:31

coincide 1165:13

cold 1231:15,19 1349:13,22

Cole 1217:3,17

collaboration 1208:28

colleagues 1362:9,10

collected 1274:11

collective 1148:3,5,9,11 1153:2,14,18,27, 28 1154:10 1166:26 1320:24, 26 1337:6,11,15

College 1138:24 1148:18,20 1149:28 1150:1,8 1181:2 1192:19 1211:5 1214:16 1228:19 1229:6

College's 1151:8

colour 1311:24 1312:24,28

comfortable 1219:19 1264:8 1344:17

commencing 1135:1 1319:24

comment 1273:9 1300:21 1326:28

comments 1160:27 1273:12 1334:4 1335:30 1361:25

Commission 1171:1 1195:28 1230:30 1234:20 1236:13

Commissioner 1135:2,5,11,22,31 1136:4,7,19,31 1137:6,11,18,22, 25 1138:5,14,19, 29 1139:10,16,24, 30 1140:9,22,29 1141:11,14,27 1149:26 1153:12 1155:15 1156:1,9, 13,18 1158:25 1163:7,25 1170:31 1171:7, 17,22,29 1172:3,4 1187:22,28 1188:1,5 1200:5, 12,25 1204:25,28, 30 1205:13,20,26 1210:26 1214:29 1215:3,15,23 1218:9,28,32 1220:9,28 1221:30 1222:4, 14,18,26,31 1223:18,31 1224:8,13 1225:2, 11,30 1226:3,8, 13,16 1231:26,27, 32 1232:11,14,20 1233:4,9,15 1234:6,17,29,32 1235:7,12,26 1236:20 1237:10, 16,32 1239:4,24 1240:10,11,16 1241:7,32 1242:11,12,15,16, 22,26,27 1244:23 1278:6,16,23 1283:12,13,19 1287:11,16,25,26 1291:31 1292:3,5, 6 1293:16,20,30 1295:27,30 1296:2,6,9,14,19, 22,25 1298:29 1299:24 1300:9, 14,21 1309:30 1310:1,7 1325:32 1326:12 1334:29 1347:24,28 1352:32 1353:4, 25,30 1361:20 1363:15,28,32 1364:5

communicate 1269:20 1326:8

communication 1194:4 1326:30 1327:4 1328:2 1363:10

community 1217:6

comorbidities 1149:13,18

comorbidity 1149:6

compare 1309:3

compared 1162:22 1211:14 1314:13

complained 1333:23,25

complaining 1257:15

complaint 1163:17 1341:14 1343:6

complaints 1184:25

complete 1142:24 1199:17 1250:12 1254:3 1260:31 1274:13 1280:2 1282:12 1333:10 1342:17 1345:32

completed 1254:7,8 1269:7 1275:14 1276:21 1357:1

completely 1223:20 1315:2

completing 1200:8 1275:10 1333:7

complex 1148:31 1149:1, 20 1150:23,26 1208:17,21 1209:4 1216:21 1273:19

complexity 1150:12 1211:10, 12,13,16 1315:12

compliance 1190:5 1195:6,14 1196:13

complicated 1315:22

complications 1316:18

computer 1199:25 1260:28 1272:6 1281:10, 15 1353:19 1355:15,25

computerized 1280:19,20 1355:18 1358:23, 24

concern 1142:21 1165:28 1166:2,6 1204:12 1237:15 1239:27 1346:32 1347:3 1359:3

concerned 1181:4,5,12 1201:20 1237:23 1287:20 1352:13

concerns 1141:24 1142:20 1157:5 1165:8 1173:21,24 1178:5 1195:5 1201:18 1237:24 1239:2 1285:6 1324:18 1325:2 1346:26

conclusions 1318:8

condition 1152:28 1227:13 1262:32

conditions 1148:32 1152:28 1217:15 1352:18

conduct 1160:27 1183:5

conference 1207:2 1212:32

confession 1159:16

confirm 1280:6

confirmation 1280:23,27

confirmed 1188:22,30

confirming 1308:20

conflict 1201:30

confused 1234:18,28

confusion 1205:8

connect 1288:13

connection 1142:1 1222:2

connections 1288:14

conscience 1238:22

consciousness 1265:20 1340:32

consideration 1204:6

consistent 1175:11

consistently 1146:31

constitute 1251:5

constructive 1339:25

consult 1214:7

consultant 1203:5 1213:27, 30 1214:2,7,15, 19,21

consultation 1150:28

contact 1164:24 1228:28,30,32 1324:16

contacted 1263:31

contained 1225:17 1307:6

container 1307:8,10,22,31 1310:24 1311:2,5

containers 1252:16 1307:14

context 1163:4

continence 1267:24

contingency 1135:18 1136:1, 11 1189:2

continually 1224:31

continue 1159:5 1254:13 1259:10 1329:30

continued 1214:22 1265:10 1306:2

continues 1351:21

continuing 1135:3

continuous 1318:27

continuum 1150:19 1151:3

contract 1320:22 1338:8, 20

contribute 1344:7

contributed 1317:20 1319:8

contrite 1324:29 1331:30

control 1261:21 1269:2,3 1297:9

controlled 1310:14

controlled-drug 1310:18

conversation 1194:10 1228:21, 28 1229:3 1336:3 1341:4

coordinate 1308:26

coordination 1324:8 1325:26

Coordinator 1179:1 1243:7

coordinators 1197:5 1274:12

copies 1138:15 1347:25

copy 1341:13 1343:5 1347:26 1353:28

corner 1143:2

Coroner 1197:15,18,31 1198:2,10 1199:8, 22,25,30 1200:22, 23 1201:21,25,28 1351:9 1352:15 1355:11 1356:20 1357:32

Coroner's 1197:27 1200:16 1352:8

corporate 1338:7 1340:3

correct 1137:10 1142:9,12,17,22, 29 1143:5,6,11,32 1144:1 1146:32 1148:4,21,28,32 1149:8,9,14,15 1150:2 1151:4,9, 10 1152:31,32 1153:11 1156:22, 27 1157:2,8,16 1158:31 1161:6, 18 1162:4 1164:13 1167:6 1168:22,23 1169:9 1170:16 1173:14,15 1174:20 1175:25 1176:29,30 1179:12,23,28 1180:10,15,19,27, 31 1181:14,25 1182:15,16,21,30 1183:8 1184:14, 28 1185:2,14,23, 32 1186:8,13 1187:1,14 1188:14,26 1189:6,10,21,29, 32 1190:1,6,14,18 1191:1 1192:6,12, 15,22,26 1193:5, 22 1194:17 1195:21,25 1199:19 1200:2, 11,19 1201:7,22, 26 1202:4,14 1203:23,29 1209:21 1211:7 1236:11,20 1240:9 1241:4,20 1244:29 1247:30 1251:9 1256:5 1258:28 1259:21 1262:17 1265:32 1272:13,14 1281:11 1287:8 1289:27 1290:15 1291:4 1292:16 1295:22 1296:4 1297:23 1299:6, 18,22 1300:7 1303:5 1305:22, 23 1308:13,14 1310:15,16,19,20 1319:25 1326:15 1333:23 1342:21 1348:10 1350:3 1351:26 1357:24 1359:3 1360:9,31 1363:11

corrected 1358:26

correction 1189:9,28,31 1190:17 1241:18 1242:5 1329:3

corrections 1242:6

correctly 1244:6 1267:1

cost 1191:32 1288:18 1303:16

costly 1192:5

Council 1172:32 1173:2,9,13,18 1174:19 1206:22

Councils 1172:23,25,27,28, 30 1230:12

counsel 1170:21,28 1171:2 1219:3 1222:21 1228:19 1230:23 1234:14, 20,21 1236:13,28

counselled 1159:23

counselling 1159:32 1160:2,5 1178:1 1337:1 1342:12

counsellors 1177:30

count 1245:4,19 1246:29 1247:3,9, 10,11,14 1248:18 1309:4

counted 1162:19

counter 1171:3

counting 1247:19

couple 1135:8 1141:21 1167:27 1173:30 1174:4 1191:30 1207:10 1211:2 1213:3,26 1268:12 1310:12 1332:11 1333:19 1341:8 1342:25 1362:13

Court 1138:11 1139:12 1172:2 1188:4 1205:14 1241:28 1242:2, 14,25

courthouse 1170:5

cover 1271:1,2

covered 1191:9 1271:8 1275:32 1276:1

covers 1230:30

coworker 1194:13

coworkers 1332:15

create 1315:25

credentials 1214:3,5

crimes 1152:13 1361:23 1362:22

crisis 1146:1

critical 1184:27 1195:1 1196:22 1208:27 1209:9 1256:14 1263:6 1264:3 1271:20 1357:28

criticism 1235:17 1237:18, 31 1238:29

Crombez 1158:11 1161:22 1169:20 1313:14 1335:5

Crombez's 1313:8

cross-department 1185:19

cross-examination 1135:4 1138:23 1141:17 1172:7, 16 1205:3,28 1210:29 1216:11 1219:2 1223:4 1231:5 1237:27 1238:14

cross-examinations 1215:6
cross-examine 1155:21 1171:19 1238:12
cross-examining 1227:29 1237:13
crushed 1251:21
culprit 1202:25
CUPE 1223:23
cut 1219:13 1220:22 1235:28 1326:25
cycle 1250:23, 26,30 1252:12 1254:29 1291:18, 21

D

daily 1244:14 1261:18 1262:31 1267:18 1269:1 1308:24 1316:10, 26
damage 1308:1
damp 1231:23
data 1250:13 1273:19 1274:1, 11 1318:26,29
date 1241:19 1242:6 1268:12 1270:6 1279:12 1281:28 1317:7 1329:15,16 1353:19 1354:10
dated 1135:19 1136:16,23 1137:3 1140:6,18 1188:7 1334:32 1360:13
dates 1157:21
day 1145:10 1146:22 1176:5 1191:7 1198:7 1207:7 1226:24 1228:7 1244:24 1246:19 1249:17 1250:11 1259:14, 24 1260:17 1263:2,13 1266:17 1269:8, 16,31 1270:4,17 1271:31 1272:28 1273:11 1274:22 1275:24,32 1277:4 1286:1,2 1294:28 1308:32 1318:5 1321:7,13 1324:9 1327:5,6 1348:29 1350:22, 24 1352:12 1363:31
days 1146:25 1154:16 1244:29 1245:22 1246:4 1271:6 1276:6 1277:7 1322:1 1331:9,10 1342:26 1362:14
deadly 1204:14
deal 1140:32 1142:20 1208:9, 17 1234:10 1239:8 1240:5 1261:30 1337:8
dealing 1208:21 1209:3 1219:6 1238:22 1311:13 1332:20
deals 1261:17, 18,20
dealt 1141:27 1160:12 1173:29 1319:1 1337:5 1339:29
death 1197:19, 20,24,26,32 1198:3,17 1199:7, 10,13,19,23 1200:9 1353:19, 20 1354:4,11,25 1355:12 1356:9, 32 1357:9,19 1358:13,19,20,25, 30 1359:6,11,15, 19,20,26
deaths 1198:24 1201:4 1357:22
deceased 1352:6 1354:10, 23
December 1137:4 1139:27 1140:3 1159:5
deceptions 1221:6
decided 1183:25 1193:4 1198:6
decrease 1186:20
decreased 1316:18 1348:25
dedicated 1206:10 1323:23
deep 1349:13
default 1320:6
definitions 1179:21 1359:19
deformities 1268:21
deformity 1264:19
degree 1345:4
delegate 1322:4
deliver 1279:27 1289:17 1299:26
delivered 1288:24
delivery 1293:4
Demedeiros 1159:12
demonstrate 1292:28
dentures 1256:24 1267:23 1274:5
department 1147:7 1243:12
depend 1211:27 1279:22 1303:3 1345:4
depended 1259:14
depending 1260:6 1294:16
depends 1256:7 1286:2
deposit 1307:21
depositing 1308:5
depth 1208:9
describe 1169:24 1211:11, 13 1213:13 1314:6
describes 1225:25 1226:21
describing 1244:28
designed 1151:6
desire 1324:19
desk 1272:10,20
destruction 1310:18,23,28
detail 1225:25
detailed 1236:32
details 1220:2
determine 1156:26 1216:20 1260:15 1264:13, 29 1282:6 1297:3 1304:9 1306:7 1318:4 1350:1
determined 1218:1 1265:11 1299:17
devastated 1317:16
develop 1331:13
developed 1262:4 1342:24
developing 1339:4
diabetes 1285:28 1286:3
diabetic 1203:28 1231:16 1277:21 1349:19 1350:18
diabetics 1203:8
diagnose 1264:21
diagnostics 1349:32
dial 1288:16 1293:5 1295:25, 29 1296:17,29 1297:22 1298:7, 23,25 1299:3 1301:32 1306:11, 14,18,23
dial-up 1295:16 1296:10 1297:3
dialled 1297:27, 29 1298:1 1299:18,30
dialling 1300:18
dials 1297:10
DIANE 1240:19
Dianne 1210:32
diaphoretic 1349:13,22
die 1198:32
died 1201:21
diet 1267:20 1269:2 1344:5
dietary 1256:31
dietitian 1257:18 1262:24
dietitian's 1262:23
difference 1169:4 1212:8,13

1213:6,7 1275:23 1276:10 1312:1,6

differences 1243:26

difficult 1194:17,26 1200:31 1216:25 1217:23 1218:16 1274:29 1331:20 1333:28 1363:17

difficulties 1216:12

difficulty 1163:26 1171:8 1218:13 1233:13 1257:7,10 1262:15 1344:10

dining 1253:7,9, 14,32 1254:15 1257:31 1259:16 1260:2 1266:21, 23 1268:2

dip 1213:17

dire 1192:7

direct 1190:4 1234:9

directed 1207:26

directly 1175:7, 8 1179:8 1346:17

director 1142:6 1146:11 1147:32 1148:16 1155:28 1176:22 1178:32 1181:26,30 1182:28 1186:27 1188:21 1190:10, 12 1196:27 1206:19 1345:29

disabuse 1239:10

disadvantage 1235:20

discharge 1216:22

disciplinary 1160:3,6 1328:5 1339:19,27 1340:11

discipline 1160:4 1166:25 1167:3,4,23 1319:13,17 1321:3 1327:28 1329:7 1330:27 1332:12 1337:18, 21

discipline-free 1167:5

disciplines 1167:10,15

discouraged 1346:20

discovered 1183:11 1184:12 1191:2 1361:24

discrepancies 1209:29

discuss 1146:4 1193:20 1195:9 1317:30 1343:28 1347:12

discussed 1146:6 1181:16 1225:25 1284:32 1318:17 1333:13 1334:22 1343:9

discussing 1343:19

discussion 1230:8 1275:2 1318:25 1319:10 1321:23 1334:24 1355:2

discussions 1229:16 1338:29 1339:2

disease 1262:2

disimpaction 1343:30 1344:4, 12

dismissal 1226:31

dismissed 1165:27 1166:12

disposable 1312:10

disposal-pen 1312:14

disposed 1308:7

dispute 1161:8

distance 1206:22

distinction 1207:31

distinguishing 1312:20

District 1227:2, 11,16

doc 1197:4 1228:13

doctor 1158:16 1201:17 1279:13

doctor's 1203:31 1204:1 1212:28 1297:17

doctors 1203:13 1332:24

document 1136:14,16,22 1139:29,31 1140:21,23 1141:7 1143:22 1145:2 1149:24, 29 1150:1 1153:4, 20 1157:19,28 1168:11 1172:6, 12 1175:18 1176:21,32 1180:3 1187:18 1188:10 1199:18 1200:9 1209:11 1223:14 1228:9, 20 1229:25 1230:27 1232:28 1236:30 1240:6 1241:11 1302:25, 29 1334:32 1335:1 1348:2,5, 28,31 1354:2,32 1355:10 1356:25, 26,28 1358:8,28 1359:14,15 1360:16,21

documentation 1152:15 1162:16 1165:32 1181:3 1230:30 1330:11 1360:1

documented 1302:31,32

documents 1135:13 1138:25 1139:2 1141:3 1142:12 1201:9 1205:2,9,22 1222:6 1226:18 1229:11 1240:22 1353:24 1356:25 1359:7

DON 1182:12

door 1248:2 1284:6,13,22 1285:9

dosage 1293:3 1299:10 1301:26 1308:30 1309:21 1313:23

dose 1209:17 1251:25 1254:25 1255:1,3 1279:11 1295:9,12,25 1296:16 1297:10, 14,16,19 1298:7, 23,24 1299:17 1317:5

double 1209:17

double-check 1297:26 1298:22 1299:2,4,22,29 1300:6,28 1301:6, 18

double-lock 1247:23,24

doubled 1244:9

downstairs 1166:16,17 1271:14 1336:1

drafted 1217:11

drafts 1234:22

drained 1315:24

drawer 1247:22, 25,26,28 1251:32 1252:8,14,24 1277:10

dressing 1315:21,23

dressings 1260:14 1315:14, 26

drew 1228:1

dried 1326:25

driving 1151:23

drop 1203:19 1298:14

drowsy 1348:25

drug 1282:1 1289:26 1310:14, 28 1311:21 1340:29

drugs 1204:20

drugstore 1170:2,4

due 1236:25

duration 1156:5

Durbidge 1137:5 1139:27 1140:2

duties 1142:25 1320:17 1322:11, 16 1332:30

duty 1188:24 1189:3 1356:1

E

E.W. 1225:22

earlier 1146:29 1185:30 1212:2 1213:28 1233:21 1235:25 1262:13 1265:29 1286:13 1289:25 1316:24 1319:22 1325:25 1342:20 1348:8, 28 1363:9

earliest 1254:12
early 1163:9 1362:18
ease 1189:16
easier 1334:28
easy 1216:22 1364:7
eat 1257:4
eating 1256:21 1269:2 1316:11
educate 1244:23
educated 1327:8
educating 1176:8
education 1176:23 1208:16 1209:25,30 1210:7 1214:22 1317:23 1345:13, 21,25 1355:23,31
educational 1317:31 1345:30
efficient 1138:4
effort 1149:4 1194:28 1195:14
elaborate 1324:22
elasticized 1286:21
electronic 1250:15 1254:32 1255:20 1260:23 1283:7
element 1148:9
elicit 1223:8
Elizabeth 1154:21 1156:21 1165:12 1169:16 1170:11 1219:28 1224:23 1225:22, 26 1226:29 1227:3,8 1245:30 1277:17 1301:14 1351:17
email 1217:17
EMAR 1250:10, 15 1254:24 1260:21 1277:25 1279:21,25,31,32 1281:3 1282:16, 26,28 1283:1,3 1289:19 1294:29 1297:18,19 1299:15 1302:14, 18,31 1304:29 1305:3,20 1313:27 1314:14, 23,28
emergency 1243:8,11 1244:4 1270:31 1271:17 1348:19 1356:18
Emmerson 1137:12,29 1138:9 1140:8,14
emotional 1362:16
employed 1243:5,10
employee 1156:27 1157:5 1161:31
employees 1177:5 1345:14 1346:16
employer 1155:3 1156:26 1234:21,27
employer's 1322:24
employment 1160:21 1221:12, 20 1227:20 1229:7 1236:14 1243:3 1322:25
empty 1278:22
encourage 1317:21
encouraged 1316:1,2 1317:27, 28
end 1159:5 1160:20 1213:2 1225:28 1245:24, 26,28 1249:7 1252:4 1262:27 1272:21,28 1277:4 1282:27, 28 1296:12,13,20 1298:13 1306:4 1330:4 1345:32
end-of-life 1360:1
ends 1214:28,30 1231:28 1271:25
engaging 1259:31
ensure 1148:19 1251:22
ensuring 1189:2
entail 1232:24
enter 1139:18,20 1171:24 1227:5 1272:27 1278:10
entered 1139:17 1222:6 1223:15 1263:11 1273:3 1297:19
entering 1305:2
entero-coated 1251:2
entire 1177:22 1221:10
entitled 1172:13 1215:1
entry 1285:13 1348:6,13 1349:2, 6 1350:6,31 1351:17,30 1352:1,2
envelope 1168:2,8 1215:10, 14 1216:1,8
environment 1172:10,15 1260:2,3
equal 1192:25
equals 1308:32
error 1158:4,9 1166:29 1305:12, 28 1316:28 1317:11,13,17,20 1318:16 1319:2, 16 1335:9 1338:4
errors 1161:15, 16 1214:24 1316:31 1317:6, 23,29 1318:3,7, 18,24 1319:10,12, 18 1338:27
essay 1206:24
establish 1141:31 1169:22
estimate 1266:2,10,12
evening 1193:6 1246:32 1253:2 1269:17,21 1275:22,25,30 1276:1,11,17,30 1277:5 1279:15, 16 1311:22 1350:28,32
evenings 1194:16,19,23 1276:6 1279:21 1331:10
event 1207:2 1335:17 1349:27 1350:8,9,10
events 1177:22 1350:17 1360:24
eventually 1262:28 1314:31
evidence 1147:12 1152:6 1154:12 1161:18 1162:9,31 1166:12,14 1170:22 1204:19 1221:3 1222:1,7, 8,15,17 1223:15, 16 1224:17,19 1233:3 1238:5,24 1263:12 1316:24 1317:7 1329:25, 30 1338:1
evil 1253:25
EW 1342:19
EXAMINATION 1240:26
examination-in-chief 1163:30
examples 1278:7,9
excellent 1363:3
exercise 1177:13
exhibit 1135:15, 21,24,30 1136:5, 8,10,18,19,21 1139:30,32 1140:12,20,22,25 1149:28 1153:3,5 1171:31 1172:1, 11,12 1176:32 1177:1 1180:2,3 1187:19,20,24,30 1188:2,6 1209:10 1219:31 1221:2 1225:17 1226:9 1228:4,5 1229:25 1230:23 1242:10, 13,23,28,30 1278:11,19 1283:14,17 1287:22 1347:24, 29 1348:13 1353:26
exhibits 1135:9 1136:30 1139:17 1229:11 1232:24
expect 1263:14 1327:17
expected 1158:13 1258:1 1273:21 1359:19, 20
experience 1170:28 1208:26 1216:4 1243:24 1248:28 1249:6 1266:24 1273:15 1284:30 1304:23 1305:15 1307:15 1308:21 1311:3,6, 26 1314:19 1315:6,11

1316:32 1317:12 1318:12 1319:16 1345:1

experienced 1245:6

experiencing 1349:22

expert 1170:32

experts 1204:19

explain 1191:26 1268:4 1294:24 1308:28 1341:26 1359:7

explained 1231:4

explanation 1194:14

explore 1237:28

express 1346:31 1347:2

expressed 1178:5 1324:19

extend 1157:7

extended 1157:6,12

extra 1245:8 1251:22 1271:15 1282:20 1312:6

extreme 1264:17 1265:18

extremely 1144:7 1351:5

extremities 1265:1

eye 1260:14

eyeglass 1290:13

eyes 1245:9 1253:25 1301:25, 29

F

F-I-N-E 1178:26

face 1198:27

facilities 1155:20 1226:10 1238:4

facility 1218:25 1236:3 1315:31 1316:1

fact 1168:9 1179:25 1184:12 1186:31 1190:4 1222:24 1223:10, 11 1285:3 1289:14 1344:30 1356:20 1360:28

factor 1342:6

factors 1150:11 1312:20 1317:19 1319:7 1344:7

facts 1183:24,26 1239:22

fair 1167:29 1171:13 1187:10 1204:18 1238:22 1253:32 1266:19 1283:7 1309:14 1325:4 1335:10 1336:15

fairly 1211:12 1272:19

fairness 1226:1 1239:3 1324:21

fall 1151:2 1219:7 1263:8 1265:9 1342:26 1343:20

fallen 1310:29

falling 1202:31

falls 1245:10 1263:29 1276:5,7 1304:10 1316:16

familiar 1148:10,12 1150:1,15 1153:30 1155:6, 30 1170:8 1172:29 1188:9 1192:11 1196:9 1211:20 1250:25 1255:12 1289:6,9

families 1198:23 1212:30 1244:11 1275:30 1362:4

family 1262:9 1267:14,28 1275:29 1331:6, 21 1346:31 1347:11 1351:29 1353:15

family-to-resident 1180:15

fault 1138:31

faxed 1282:4

faxing 1289:26

feature 1304:19

features 1312:20

feedings 1315:14

feel 1230:17 1235:19 1239:19 1327:15 1339:30 1362:3

feeling 1362:9

fell 1263:25 1295:4

felt 1184:6 1192:27 1196:4 1211:19 1217:18 1245:8 1324:20 1327:12 1339:12

fever 1231:22

fewer 1249:9

figure 1168:3

file 1198:17 1217:13 1227:9 1322:22,23,25,26, 27 1323:2,10 1324:15 1326:23 1338:9

filed 1137:5 1139:26 1140:2,7, 14,18,27 1142:17

files 1198:12 1226:29

filing 1145:3 1322:31 1323:7, 13,29 1324:2,5,15

fill 1190:25 1192:32 1231:6 1353:16 1354:7,9 1355:21,24,25,26

filled 1193:8 1282:1 1353:21 1357:10

filling 1352:9

fills 1356:1

filter 1328:5

financial 1180:25

find 1174:2 1195:20 1239:22 1243:27 1252:28 1261:25 1267:24 1279:4 1319:7 1344:13 1348:26

finding 1137:28 1188:13 1195:13, 21 1352:5

fine 1178:20,26 1187:29 1242:19 1292:7 1362:25, 26

finger 1219:5,12 1303:28,30

finish 1253:26 1276:17 1356:24 1361:21

finished 1178:27 1220:31 1231:30 1232:7 1253:15 1269:17

fired 1221:13

fit 1274:29 1293:2

five-day 1162:1 1325:10

fixed 1295:9,12

flags 1219:27 1339:9

flesh 1245:17

float 1143:16,18 1175:10

Float/casual 1143:15

floor 1187:4 1194:27 1255:13 1256:17 1263:5 1265:15 1268:1 1270:29 1271:1,2 1284:25 1285:4, 16 1300:30 1310:30 1332:28

fluid 1272:26,29, 32 1273:2,3 1282:19

fluids 1251:22 1256:23

Fluttert 1178:32 1179:2

foil 1279:6

follow 1148:5 1266:18 1332:5

follow-up 1209:19 1229:2 1324:10 1334:25

food 1165:15,23 1259:16,18,32

fooled 1336:28

foot 1268:22 1314:8

foray 1243:21

force 1293:9

forceps 1307:32

forever 1362:7

forget 1187:32

form 1137:9 1140:6,18 1141:20 1354:6 1355:18,24,26 1357:3 1358:25

formal 1355:31

forms 1142:8 1229:12 1298:14 1353:16,18 1355:22 1357:14 1359:10

forward 1238:20 1318:9 1320:9 1325:3 1327:2 1336:23 1341:29 1343:29 1363:11, 16,19

forwarded 1328:6

found 1152:11 1160:24 1176:27 1184:30 1195:8 1243:32 1251:31 1302:17 1313:6 1348:24 1349:12

foundation 1220:7 1221:25 1225:10 1226:17

Foundational 1222:5

four-hour 1231:6

fourteen 1287:4

fracture 1264:5 1343:26

fractured 1264:16 1265:4, 10

fractures 1316:9

fragmented 1340:7

frailer 1149:2,17

frailty 1149:14

frame 1183:29, 30 1250:9

framework 1150:10

free 1232:5 1234:2 1327:21 1338:10

frequent 1319:18 1342:19

frequently 1307:19

Friday 1177:21 1213:29

fridge 1277:28 1278:4 1279:29 1283:26 1284:1,4, 8,15,26,27 1285:25,26,27 1286:6,10,15,30 1287:6 1292:15, 19

fridges 1283:27

friend 1155:9 1215:16 1233:27

friendly 1260:2

friends 1233:6 1347:11

front 1149:24 1153:3 1232:25 1241:10 1248:3 1257:26 1283:11, 12 1353:28

fruition 1237:25

full 1150:30 1174:7 1191:17 1267:31 1270:27 1271:13 1286:30

full-time 1323:19

fully 1221:3,4

funding 1183:7 1186:2,6,20 1215:7,8 1274:1

funds 1168:4,20

funeral 1354:27

future 1151:14 1317:23

G

G-H-A-D-E-R-I 1330:13

gain 1285:13

gap 1231:6

gastro 1144:4

gather 1185:16

gave 1147:12 1201:10 1313:28 1323:17 1328:3 1343:1 1363:2

gee 1271:18

general 1153:24 1156:15 1176:9 1207:16 1243:11 1244:24 1253:6 1256:30 1260:30 1324:28 1344:4 1348:19 1349:17 1356:17 1362:8

generally 1208:16

gentle 1344:16

genuine 1336:26,30

geographically 1300:29

George 1352:11

Geraldton 1221:8 1225:23 1226:23 1227:2, 10,16

geriatric 1207:7

give 1138:7 1162:9 1170:21 1193:31 1195:13, 15 1211:18,25 1214:13 1239:7 1240:4 1243:2 1245:5 1252:29 1253:10 1254:18 1255:1 1256:12 1258:9 1261:11 1266:23 1267:11 1278:25 1286:29 1293:5,11 1294:31 1295:5 1298:1 1306:2,24, 25 1345:3,29 1354:17 1361:29

giving 1165:22 1169:16 1249:18 1250:4,8 1251:6, 26 1255:16 1257:17,21 1258:4,7 1298:16 1299:14 1316:25

glad 1244:3

glass 1288:32 1307:25

glasses 1274:5

glucometer 1303:9,11,17,27 1304:15,28 1305:16,19

glucometer's 1304:27

glucometers 1303:21 1304:25

goals 1177:10

Golden 1141:26 1153:12 1154:8 1159:15 1162:25 1163:19 1164:9 1169:18 1170:20 1215:1,4,19,30,31 1218:10,29,31 1219:1 1220:6,24, 30 1221:24 1222:12 1224:4,6 1225:13,15 1226:1,2,12,15,20 1231:24 1237:19 1364:3,4

good 1135:6,7 1172:17,18 1175:18 1178:14 1181:8 1196:2,3 1205:30 1208:27 1232:9 1241:2 1263:13 1265:17 1328:18 1351:9 1353:7 1363:30

gosh 1171:32 1173:28

GP 1352:24,25

graduated 1243:4

grateful 1139:8

great 1155:5

greater 1150:27, 28

greet 1267:13

grief 1177:30 1178:1

grievance 1157:2 1226:30 1227:4

grievances 1161:10,30 1162:27

grieve 1159:29 1160:2,4,16,32 1161:27

grieved 1159:32 1160:9,14,19,28, 30 1161:17,24 1162:2 1325:14 1338:20

grieving 1161:5

ground 1363:13

grounds 1182:25 1184:4 1230:15,18

group 1141:29 1206:31

grouping 1160:23

guess 1163:25 1233:12 1266:26 1276:4 1289:31 1307:24 1340:24

guessing 1154:11

guest 1207:3

guideline 1151:9 1171:25, 31 1320:25

guidelines 1148:18 1168:1,3

H

Hague 1323:18

half 1270:23 1271:22

half-hour 1269:29

halfway 1272:20

hallway 1272:19

hand 1138:7 1166:13 1198:8 1339:21

handed 1136:24 1138:18 1275:26
handing 1266:25
handle 1192:28 1211:24 1218:6 1314:8 1362:15
handled 1342:26
handling 1277:13 1338:24
hands-on 1264:28 1274:4
handwritten 1146:21 1355:17 1360:17
handy 1198:6
happen 1177:31 1199:26 1204:9 1217:22 1254:6 1256:7 1263:28 1265:13 1271:16 1317:32 1319:2 1321:12 1362:1
happened 1138:21 1178:12 1184:31 1190:31 1219:5 1221:7,20 1226:22 1236:22 1237:6 1245:10 1263:7 1267:30 1316:21 1318:21 1320:4 1324:11, 31 1327:25 1338:11 1341:26 1342:17 1347:12 1348:9 1350:13 1360:11
happening 1184:14 1207:11 1228:7 1262:1 1263:4 1324:22 1342:4
happy 1200:29 1222:12
hard 1159:8 1204:11 1211:31 1308:3 1314:21, 25 1353:27
harder 1244:1
harming 1361:30
hate 1155:9 1215:16
head 1143:32 1151:32 1160:12 1182:17 1185:13 1191:28 1197:3 1206:30 1252:30 1255:26 1264:4 1265:21,22
head-to-toe 1268:13,14,16 1333:9 1342:15
heads-up 1214:14
heal 1261:7
health 1158:17 1182:29 1186:3 1190:13 1196:32 1197:8 1206:21 1216:27 1217:1,8 1218:6,24 1221:5, 19 1227:11,20,25 1229:8 1239:27 1359:21,26,27
hear 1159:8 1204:18 1220:9, 11 1272:16 1284:11 1298:30 1304:23 1361:16
heard 1152:5,24 1162:6,10 1175:20 1184:23 1185:8 1192:17 1200:6 1202:1 1207:15 1209:32 1250:20,23 1268:11,26 1310:26 1327:20 1334:3 1337:32 1340:14 1357:18
hearing 1206:5 1224:21 1238:24 1241:29
heart 1349:26 1362:3 1363:6
heaviest 1249:20
heavy 1144:7 1216:21 1332:19, 25
Helen 1141:18, 30 1149:32 1153:7 1157:20 1161:21,27 1164:11 1172:19 1205:30,31 1210:30 1215:5 1217:10 1218:8 1219:2 1227:22 1228:6,18 1229:10,27 1230:22 1231:29 1321:11 1335:5 1343:22 1346:8
helped 1359:7
helpful 1138:30 1167:18
helps 1293:26
hematoma 1342:26 1343:21
hemoglobin 1203:13
hepatitis 1307:26
Hewitt 1135:2 1137:21 1155:8 1161:20 1165:4 1168:26 1171:20 1204:27 1205:11, 19 1210:27 1214:30 1226:5 1231:27 1232:19, 20 1233:7,26 1234:14 1236:19 1239:15 1240:9, 15,20,27 1241:9 1242:3,9,20,32 1278:5,18,24 1283:13,21 1287:10,19,27 1292:4,9 1293:22, 32 1295:27,32 1296:4,7,23,27 1298:32 1300:3, 12 1309:28 1310:6,11 1326:2, 13 1334:28,31 1347:23,31 1348:3,32 1349:5 1352:32 1353:6, 23,32 1363:26
Hey 1199:26
HH 1313:7
high 1177:29 1218:2 1315:15
higher 1192:20
highlights 1245:5 1263:4
hindsight 1202:25 1301:14
hip 1219:7 1264:4,12,17,18, 25 1265:10 1316:9 1343:25
hire 1151:20,32 1185:11
hired 1153:9,16, 20,32 1159:2 1220:1 1221:13
hires 1155:29
history 1219:29 1229:6 1243:3
hit 1282:27
hits 1263:8
HIV 1307:24
hold 1304:16
holder 1313:24
holidays 1148:7
Holmes 1320:20 1324:17 1325:3,6, 12 1328:3 1339:3
home 1144:4 1172:32 1173:18, 26 1175:14,23,26 1176:3 1177:22, 23,32 1178:29 1179:30 1180:4, 10 1181:4 1183:4, 11 1185:17,30 1186:4,11 1188:25,29 1189:4,29 1192:10 1193:21 1195:24 1198:31 1203:22,28 1204:2 1214:8 1216:5,21 1217:21 1218:7, 18 1228:16 1261:17 1264:5 1277:2 1288:20 1290:28 1295:11 1301:15 1308:17 1327:25 1330:3 1331:22 1336:5 1345:13 1346:20 1348:15,18 1351:23 1354:24, 27 1362:28
home's 1352:26
homes 1148:26 1173:3,6,8 1175:31 1177:25 1178:12 1179:17, 26 1184:2 1195:31 1196:10, 17,30 1197:15 1218:2,14,19 1301:18,20
hook 1305:16
hooked 1305:20
hope 1204:10 1318:31
Horizons 1220:18
horrendous 1220:3
horrific 1363:4
horrifying 1361:28
hospital 1201:16 1216:13, 26,30,32 1217:8, 14 1225:24 1226:23 1227:2, 11,17 1243:5,11, 14,24,28 1276:12, 15 1348:14 1349:32 1351:6
hour 1240:2 1261:1 1270:23 1271:22
hours 1154:6 1190:22 1191:9, 11,16,19 1193:1

1230:25 1231:2 1246:16 1267:2 1268:28 1269:6,8, 12 1333:8 1354:19

housekeeping 1135:8

HRI 1143:31

huge 1169:1 1274:31

Hughes 1135:3, 6,7,28 1136:3,6, 13,24 1137:1,10, 14,32 1138:16,27, 32 1139:9,19 1140:4,16,32 1141:6,13,17 1142:5 1149:26, 31 1153:23,26 1154:19 1155:15 1156:7,12,17,20 1158:29 1159:17 1161:25 1164:10 1169:26,30 1170:31 1171:13, 27 1172:8 1185:9 1192:18 1201:2 1219:25 1220:4, 12 1221:22 1222:16,28 1223:17 1224:7 1225:1 1227:28 1229:22 1233:14 1234:12,16,30 1235:5,9,27 1236:26 1237:15 1238:25 1278:8

Humalog 1311:23 1312:13, 23

human 1305:28

hurry 1293:14

hyperglycaemia 1203:27

hypoglycaemia 1201:19 1202:13 1203:27 1213:19 1349:24

hypoglycaemics 1251:1

I

ICU 1243:12

ID 1139:28 1140:8,21 1228:13

idea 1175:18 1178:14 1331:23, 24 1351:9 1354:18,21

ideals 1207:23

identification 1313:20

identifications 1313:30

identified 1150:23 1233:20, 21 1322:4

identifies 1335:4 1355:10

identify 1163:20 1257:2 1270:1 1271:18 1325:29 1341:17,19,23 1356:13 1357:28

IDS 1236:30

ill 1158:20 1359:24

imagining 1314:5

imbalance 1180:30 1181:1

immediately 1181:26 1182:12, 27 1184:3 1230:14 1349:15

impact 1361:23

implement 1273:24

implemented 1175:19 1176:2

implementing 1148:3 1176:4

important 1174:7,10 1293:15

impresses 1164:4

impression 1331:14

improper 1183:2

improve 1193:21 1332:13

improvement 1197:10 1333:17

IN-CHIEF 1240:26

in-depth 1212:15

in-service 1176:14,19 1195:16 1345:27, 30

in-serviced 1176:13

in-services 1196:1 1207:13

inadvertent 1219:16

inappropriate 1160:27 1229:22

inappropriately 1165:14

inappropriateness 1261:31

incident 1184:24,27 1196:22 1209:10 1210:2 1219:4 1226:22 1263:6 1313:4,6 1319:8 1329:16 1332:3 1336:7 1338:11, 13,16 1342:30

incidentals 1332:23

incidents 1318:23 1341:7 1345:12

include 1213:24 1227:7 1250:1 1268:32 1300:1

included 1171:6

including 1160:17 1221:14 1236:5,17 1263:24 1340:4

incompetent 1183:2

incomplete 1250:12

increase 1185:8 1186:20 1316:9, 15

increased 1315:17

increasing 1148:26

independent 1297:26 1298:22 1299:2,4,11,21,29 1300:5 1301:6,17 1336:11,16 1343:19

independently 1165:7

index 1252:5 1286:14

indicating 1233:27

indication 1255:19 1336:29 1340:25,29 1361:30

indicator 1302:9 1356:17

individual 1211:27 1298:24 1303:21 1319:1 1321:30 1350:18 1353:13

Individually 1174:24,26

individuals 1225:7 1294:8 1322:10 1325:27

industry 1155:27

industry-wide 1316:21,22

infectious 1349:28

inferences 1142:3

information 1177:7 1182:28 1196:8,16 1198:27 1221:14, 18 1223:11 1224:23,27 1236:24 1261:23, 25 1269:10 1280:11 1314:1 1320:22 1324:26 1343:2 1354:9 1356:21

Ingersoll 1243:5

inherited 1320:5

initial 1174:9 1245:7 1263:32 1269:9 1274:4

initially 1265:9 1282:25 1297:16

initials 1281:29

initiates 1262:22,23

inject 1298:7

injectable 1286:32

injected 1294:10

injections 1306:31

injury 1143:32 1264:4 1265:21

inordinate 1238:28

input 1302:32

inputted 1305:25

inquiry 1151:12 1163:28 1166:18 1205:15 1232:3 1250:21 1268:12 1326:27 1364:8

insert 1289:3 1314:10

inserted 1303:32

inspect 1195:19

inspection 1184:17 1188:6 1194:32 1195:1

inspector 1184:16

inspectors 1195:19,29

instance 1152:7 1165:22 1170:3 1223:27,29 1251:31 1252:12 1261:23 1275:26 1292:13

institution 1330:6

Institutional 1355:12

instrument 1303:7

insufficient 1188:14

insulin 1152:29 1168:25,26 1169:8,17,32 1170:2,4,12 1171:3 1201:7 1202:1,3,24 1204:12,19 1213:24 1231:17 1249:26 1250:1 1251:24 1277:13, 20,22,25 1278:2, 11,32 1279:6,8, 12,17,18,23,28 1280:5,16,24 1281:1,28 1282:23,25 1285:29,30 1286:5,9,10,18, 22,31 1287:1 1291:26 1292:13, 23 1293:5 1294:9, 16,31 1295:5 1297:20 1298:10, 19 1299:13 1300:23,29 1301:4,17,32 1306:3,16,21 1307:21 1308:16, 20,30 1310:13,14 1311:1,19 1313:10,16,17,22, 24,28,29

intake 1272:26

intensive 1257:29 1265:31 1266:26 1316:5

intention 1362:12

intentionally 1361:30

intentions 1305:1,8,12,31

interact 1259:30

interacted 1341:2

interaction 1244:11 1275:29 1330:30 1331:6, 13 1340:26

interactions 1173:17 1229:22 1340:17

interested 1320:2

interests 1215:27

interfering 1259:18

internal 1357:2

interpretation 1338:7

interpreting 1338:31

interrupt 1155:10 1215:16 1253:25

interrupted 1138:22 1155:16 1256:9 1263:26 1273:8

interrupting 1166:9

interruption 1267:29 1276:4

interruptions 1256:11 1260:6

interviewed 1219:27

introduce 1303:23

introduced 1169:20 1303:20

introduction 1244:7

investigate 1183:19 1184:18, 22 1267:21 1324:20

investigated 1184:6 1319:4 1325:13,15

investigating 1325:17

investigation 1183:22 1346:13

investigations 1219:11

investigative 1157:28 1337:21 1360:8,10,12 1361:10

investigator's 1228:27

involve 1147:26 1268:27 1299:25

involved 1168:20 1190:24 1208:23 1276:31 1331:29 1336:14 1342:25,28 1361:17

involvement 1330:28

irreparably 1359:23

irreversible 1359:23

issue 1145:28 1146:5,6 1151:13 1169:6 1173:29 1177:19 1180:5 1184:28 1185:5 1190:29 1197:14 1199:22 1209:14 1217:25,28,32 1218:4,19,21 1220:15,16,22,23 1221:19 1257:18 1341:18,20,23,30 1343:20 1359:2

issues 1144:18 1147:6 1148:2 1151:13,21 1158:3,8,17 1159:31 1173:25 1174:13,15 1180:18 1184:31 1193:20 1201:1 1202:21 1206:10 1214:12 1218:6 1227:25,32 1229:8 1230:3 1261:19 1263:13 1332:20 1340:9, 18 1343:9 1359:32

item 1161:16

J

Jacquelyn 1140:19,27 1145:3

Jane 1172:22 1320:20 1324:17 1325:3,6,12 1328:3,17,18 1339:3

January 1342:24 1343:11 1362:13,19,20

Jennifer 1137:12,28 1138:9 1140:7,14 1323:18 1343:29 1344:21

Jennifer's 1344:3

job 1148:11 1273:26 1361:3

John 1302:18

judicial 1225:3

July 1160:8

June 1140:18,28 1145:4 1153:9 1158:32 1159:31 1335:1,2

K

Karen 1162:14, 29,30 1163:2,14, 21 1164:14,17 1165:1 1166:2 1223:28 1224:1 1240:17,19 1241:3,10,11 1242:6,24,31 1243:2 1278:20, 29 1287:17,23 1293:24 1296:7 1297:26 1299:3 1300:14 1310:13 1326:2,11 1335:5, 6,8,12 1348:10 1353:10 1358:11 1359:17 1360:20 1361:22

key 1248:1,6,9,12 1258:17,19,28 1284:11,19,28 1323:18

keys 1248:15,16 1285:20

kind 1173:16,23 1175:5 1177:12 1178:1 1181:32 1186:7 1202:21 1206:25 1214:14 1259:17 1261:25 1263:8 1264:19 1265:2,3,20 1272:3 1282:18, 19 1299:13

1334:11 1339:24

kinds 1180:9,23 1192:21 1251:2 1274:8 1344:6

knew 1164:27 1168:10 1180:21 1198:14 1224:12, 14 1225:9 1346:11

knowing 1148:17 1152:28

knowledge 1162:5 1204:22 1211:27 1216:19 1221:27 1301:12, 16 1309:25 1328:9,26

KRALINGEN 1348:30 1349:2

L

label 1252:18 1279:10 1290:30, 32

labelled 1254:30 1287:21 1290:11, 14 1291:29

labelling 1290:27

labels 1291:1

Labour 1164:24, 28

Lack 1145:19,25

ladder 1340:3

laid 1221:24

Lantus 1311:20, 25 1312:13

large 1207:8

laundry 1173:32

Lauren 1206:1

lawyer 1230:11 1234:15

laying 1220:6

lead 1212:31 1222:21,22 1321:2

leadership 1206:15,17,20,27 1207:20

leading 1207:27 1215:17 1360:8

learned 1184:8, 9

learning 1175:16

leave 1195:10,21 1204:22 1243:14 1258:21 1265:24 1284:13

leaving 1179:11

left 1142:27 1247:13 1269:25 1283:1 1306:6 1309:12 1322:30 1330:6 1342:16

leftover 1308:5 1310:29 1311:9

leg 1342:27

legal 1155:11

legislation 1179:15 1180:26 1181:2 1186:12, 22 1187:13 1195:18

legislative 1186:7 1187:8

length 1154:23, 25

lengthy 1217:23

letter 1164:29 1220:20 1328:4,7, 10,15,22 1342:32 1343:23 1344:3, 21,26,29

level 1192:19 1211:12,13,27 1245:24,32 1246:4 1248:28 1250:7 1252:2,10 1265:19 1276:28, 29 1283:31 1287:2,3 1291:6 1301:2 1304:3 1305:9 1315:10, 15 1319:17 1340:31

levels 1189:13 1192:20 1318:4 1336:32

liaison 1320:21 1325:12,18

life 1244:2,25 1288:3

lifestyle 1158:15

light 1224:29

light-headed 1203:1

limit 1268:28

list 1201:10 1235:2 1236:1 1357:27

listen 1332:1 1336:21 1339:14

listing 1144:6 1161:14

live 1287:15

lived 1217:6

lives 1177:24

living 1261:18 1267:18 1269:1 1316:11

local 1170:29 1223:28

locals 1223:21, 26 1225:6

located 1252:13 1283:28 1291:3 1292:15 1307:10, 26 1326:21 1357:15 1358:20, 22

lock 1258:12,17 1284:9 1298:24

locked 1169:32 1247:25,26,27,30 1248:1,4,6 1258:1,6,10 1284:4,9 1285:9, 23 1323:9,11,12, 13,29 1324:2

locks 1258:24

Lois 1137:5 1139:26 1140:2

London 1327:21

long 1197:17 1206:22 1233:32 1260:30,31 1277:29 1288:4 1314:15

long-acting 1311:21

long-term 1148:25,28 1151:16 1173:3,6, 8 1175:21,31 1179:22,26 1182:29 1184:2 1196:10,12,30 1197:11 1209:20 1212:11 1243:21, 28,30 1244:8,26 1248:27 1249:6 1301:15,18,19 1315:7,29 1356:16

longer 1195:23 1203:14 1288:21, 22 1330:20,21 1359:3

looked 1168:11 1181:16 1184:10 1207:24 1219:20 1340:4

Lorazepam 1225:27

lose 1361:3

lost 1288:17

lot 1149:3 1168:25 1178:3 1208:26 1239:17 1244:11 1263:10 1267:27 1275:29 1288:21,22 1326:26 1336:13

low 1150:24 1152:22 1203:2 1277:26 1294:15 1351:5 1352:14

lower 1265:1

luggage 1289:3

lunch 1232:32 1233:1 1239:29 1240:1 1266:4 1270:20,23

M

M-A-R 1313:26

machine 1304:1

Macknott 1342:32

Madam 1135:11 1136:8 1138:6,10 1139:23 1140:10 1149:26 1153:12 1155:15 1170:31 1171:32 1188:2 1220:28 1221:30 1222:17 1223:17 1224:7 1225:2 1233:15 1234:17 1237:16 1240:20 1242:13,29

made 1175:8 1178:6,11 1182:1, 2 1184:25,27 1238:30 1241:19 1242:7 1255:15 1267:10 1273:9 1319:2 1338:4 1349:16 1360:30

main 1151:13 1264:22

major 1265:21 1316:19

majority 1248:30 1251:5 1261:4 1272:1

make 1158:14 1169:4 1170:17 1175:11 1183:23 1185:1,26 1190:6, 13 1194:28 1195:27 1197:30 1200:1,6 1204:32

1216:13 1234:24 1240:23 1242:5, 10 1251:20,24 1253:27 1254:20, 25 1255:7,10,14, 30 1257:2 1263:22 1264:8 1265:5 1292:7 1298:13 1299:9, 28 1329:3 1335:16 1344:17 1356:30 1361:26

maker 1290:32

makes 1139:22

making 1142:3 1256:28 1259:29 1277:9 1279:18

manage 1146:2 1211:11,14

managed 1218:17

management 1178:28,30 1179:8 1182:8 1183:15 1193:8 1336:21 1339:13 1340:5 1341:19 1346:7

management's 1334:1,18

manager 1145:32 1146:4,5 1206:32 1214:19, 20

managers 1194:14 1346:24 1355:28

managing 1207:27

mandatory 1173:7,9 1181:23 1182:1,5 1193:24, 26

manner 1339:26,27

manual 1280:32 1281:18,21,22 1282:26 1283:2 1289:16 1313:27 1358:5

manually 1281:2 1289:21 1290:32 1305:24

MAR 1313:12,26, 27 1314:22,28

March 1140:6,15 1161:16 1188:7, 19 1209:14 1227:31 1228:8, 14 1348:6 1350:32 1351:30 1352:2 1358:14 1359:16 1360:4, 13 1361:7

mark 1135:30 1136:17,29 1137:15 1138:3,4 1140:20 1141:9 1144:26

marked 1135:14 1143:11 1144:13, 22 1145:15 1146:19 1149:27 1153:5 1187:19 1278:19 1283:14, 16

marking 1135:9 1136:30 1187:24

Martin 1210:27, 29,32 1214:27

matched 1281:14

matches 1280:13

material 1329:2, 6

materials 1270:6 1345:31

mathematical 1309:15

matter 1155:26 1182:8,9 1190:12 1195:12

matters 1135:8 1157:20 1159:22 1160:16,26 1161:4,28 1162:19,23 1165:2,4

Maureen 1347:7 1351:8,21

Maureen's 1351:4

maximum 1185:29,30,32 1186:4

MDS 1273:31 1274:2,11,19,20 1332:22

Meadus 1171:21 1172:16,22 1187:17,27,31 1188:8 1200:11, 14,18,26,27 1204:26

meal 1253:11 1257:29 1273:2,5

meals 1268:6 1275:32

meaning 1178:26

means 1189:28 1253:15

meant 1296:31

measure 1192:5

measures 1297:9

mechanism 1295:16 1297:10

med 1168:29 1169:2 1249:19, 20,30,32 1250:5 1253:18 1254:8 1256:3 1257:23 1266:5,21 1269:29 1271:22 1272:2 1279:23 1286:10,12 1301:3 1313:10, 21

medical 1148:32 1149:7 1152:28 1207:13 1227:13, 14 1352:18 1354:3,24,28 1359:11

medication 1145:10 1146:24 1158:4,9 1161:14, 15 1194:3 1209:26 1210:4 1213:31,32 1214:23 1247:20, 22,31 1248:1,2,4, 5,9 1249:27 1250:16,22 1251:12,17,18,29 1252:11,27,29 1253:11,29 1254:14,18,20,24, 32 1255:17,20 1256:8 1257:23, 29 1258:5,7,9,10, 22,27 1259:1,6,15 1260:4,13,23 1263:26 1265:27, 30 1266:15,25 1270:3,13 1271:31 1272:6 1277:26,32 1279:27 1280:2 1281:6 1282:21 1283:29 1284:2,5, 11,19,21,26,27 1285:5,9,15,16, 18,22 1290:17,22, 25,29 1291:8,13 1300:6 1301:8 1302:16 1305:9 1307:12,13,17,18 1313:6,24 1314:2, 9 1316:28 1317:8, 10,13,16,20,22,29 1318:3,15,18,23 1319:12,16 1338:4,27 1344:32 1345:3

medications 1204:13 1212:27 1213:23 1245:13 1247:11,13 1248:26,29 1249:2,11,18 1250:4,8,11,22, 29,31,32 1251:3, 5,21,26 1252:6 1253:10 1256:12 1257:22 1260:10, 22 1265:32 1266:3 1269:32 1275:26,28 1277:1,8 1282:17, 18,20 1291:17 1293:11 1310:27 1316:25,29 1317:1 1344:6

meet 1198:9 1233:17 1234:11

meeting 1157:19,29 1164:25 1165:19, 29 1176:9,10 1194:21 1197:3 1217:3,16 1225:22 1226:22 1227:31 1228:15 1319:5 1321:1,8 1326:9,10 1330:15 1332:1 1333:24 1335:18 1336:11 1340:13, 15 1341:21,22,31 1342:31 1343:9, 27 1360:8,10,12, 30 1361:1,10

meetings 1162:18,19,28 1163:15 1164:12 1165:3 1173:20 1193:13,19,25,28 1206:29 1236:5 1237:8 1275:1 1317:30 1318:17, 20 1321:15 1324:29 1326:18 1329:7 1330:24 1331:28 1333:14 1336:14,19,32 1340:11,27 1341:12 1343:5

member 1164:22 1172:26 1183:11 1186:24

members 1174:14,15 1178:18,19 1346:31

memo 1135:16

memorandum 1196:15

memory 1250:28 1254:17 1302:8 1304:17, 25,27 1362:26

mental 1216:27, 32 1217:8 1218:5, 24 1221:5,19 1227:25 1229:8 1261:19 1274:6

mention 1213:5, 9

mentioned 1213:28,30,31 1216:12 1262:13 1268:31 1351:3

message 1200:22

met 1159:22 1175:6

metal 1314:7

meter 1293:3

mg 1225:27

microphone 1282:28

middle 1136:26 1143:14 1208:4 1229:27 1258:4 1301:8,10 1350:10 1354:20 1357:9

milkiness 1311:24 1312:24

mimicked 1273:20

Mina 1330:4

Mina's 1330:7

minced 1256:25

mind 1147:20,22 1334:13

minimize 1261:5

minimum 1186:11,16

Minister 1182:29

Ministry 1168:1, 3 1183:12,18,20 1186:3 1189:31 1190:12 1195:30 1196:11,32 1197:8 1216:3 1230:24 1231:7 1274:13 1346:12, 17 1353:18

minority 1248:30

minute 1135:23 1361:19

minutes 1139:11,13 1194:2,4 1227:5 1233:24 1240:2 1270:15,24 1271:11,15 1318:20 1321:16 1322:17,20 1323:2 1324:11, 14 1326:18 1327:19,31 1328:4 1331:11 1353:3,8 1363:29

Mirian 1158:2 1319:31

misappropriation 1183:5,6

misidentified 1335:11

misimpression 1286:30

missed 1317:10

missing 1158:19 1173:32 1209:15 1210:21 1231:6 1317:7

mission 1177:9

misspoke 1218:29

mistake 1167:17 1293:21

mistakenly 1360:19

misuse 1183:5,6

mix 1311:23 1312:13 1315:16

Mix25 1312:23

ml 1293:26 1294:4 1297:6 1308:6

MM 1209:10

Mm-hm 1175:32 1181:6 1182:19, 22 1195:22 1197:28 1201:31 1333:3

mobile 1257:26 1316:3

mobility 1269:1 1274:9 1315:28

moment 1136:32 1137:7 1275:20 1294:24 1295:17 1297:32 1322:15 1324:13 1359:14

Mondays 1203:9

money 1168:1 1183:6

monies 1168:4

month 1203:15 1214:9 1318:23 1329:26,27

monthly 1173:19 1206:23 1318:21

months 1154:6 1157:14 1166:27 1167:2 1262:10 1273:18,31 1274:16 1338:9, 10,15

months' 1203:15

morning 1135:6,7 1172:17, 18 1185:6 1192:17 1203:11 1204:29 1205:7, 30 1232:27 1233:8 1245:9 1249:19,32 1250:5 1257:22 1266:8,27 1270:24 1271:11 1294:28 1301:3 1348:18 1350:13 1354:21 1364:2,3

Morris 1140:19, 27 1145:3

mortician 1357:11

motion 1265:3, 18 1274:9

mouth 1260:1

move 1143:2 1159:20 1162:11 1169:27,29 1185:4,17,21 1211:15 1212:1 1240:21 1263:30 1264:6,31,32 1265:15 1266:20

moved 1207:9 1343:24

movement 1344:11

moving 1257:20 1309:29 1310:10 1363:16,18

mucus 1349:14

multiple 1149:7 1349:29

murdered 1159:13

N

names 1201:10 1268:12

narcotic 1209:15 1210:21 1245:4,19 1246:29 1247:3,9, 14 1248:12,18 1277:10

narcotics 1209:27 1210:4 1247:16,18 1251:9 1252:23

nasty 1217:16

naturally 1234:28

nature 1156:14

necessarily 1185:10 1286:23 1315:30 1324:11 1325:14 1338:2

need?' 1339:16

needed 1147:11 1148:14 1183:24 1192:30 1194:14 1211:20 1251:21, 23 1253:11 1256:18 1260:16 1270:2 1275:31 1276:16 1277:22 1292:14 1300:10 1306:17 1307:1 1340:6 1345:32 1349:32

needle 1298:4,5, 14,15

negative 1149:19 1150:14, 25

neglect 1179:28 1180:5,30 1183:3 1219:13 1230:12, 19 1345:17 1346:5,7,28

nervous 1336:19,24

net 1196:10

neurologic 1349:27

newer 1304:18

nice 1243:31 1267:28 1309:14

nicely 1194:24

night 1152:1 1185:25 1190:31 1191:12,17 1194:28 1207:17 1230:25 1231:20 1245:11 1246:32 1269:18,21 1276:9,30 1311:22 1334:10 1350:24 1354:20

nights 1194:16, 19,25 1279:22

1331:3,9

noncompliance 1188:13 1195:10

noncompliances 1189:13

noncompliant 1176:28

noncontrolled 1310:22,28

noon 1257:28,30 1266:15,20

normal 1238:13 1239:13 1253:22 1341:3,4 1350:16, 19

note 1137:21 1228:26 1231:14 1263:14,17 1335:12 1347:32 1360:29

notes 1157:19 1227:30,31 1235:14 1262:31 1263:1,11 1347:22 1348:8 1351:14 1360:17

notice 1225:3 1244:14 1257:9 1340:17

noticing 1333:4

notification 1189:17

notified 1145:32 1182:17 1358:1

notify 1182:12, 14 1325:22

noting 1221:1

November 1157:20,24,29 1158:2 1188:22 1330:12

Novorapid 1170:13 1279:5 1311:14 1312:18, 27

number 1140:8 1150:3 1159:30 1162:22 1163:3 1185:29,30,32 1186:17,23 1199:28 1200:17, 21 1202:11 1209:11 1215:6 1219:3,26 1220:13,23 1225:18 1228:20 1229:25 1230:22 1231:18 1244:17 1247:12,17 1261:6,28 1265:32 1275:25 1291:30 1294:10, 18 1299:15 1302:13,14,27 1304:13 1305:2 1308:32 1309:2 1313:6 1316:24 1318:23 1320:18, 28 1329:6,9 1332:20 1334:27 1336:15,16 1339:9 1341:10 1349:19,28 1352:8,10 1354:32 1356:24 1360:28

numbers 1186:28 1247:14 1295:21 1325:1

numeral 1266:30

numerical 1273:7 1304:6,9

nurse 1152:1 1154:5 1158:30 1159:3 1172:9,14 1185:11 1188:24, 32 1189:3 1191:16 1194:27 1198:14,15 1203:5 1208:14, 22,29,30 1209:5 1211:15 1212:14, 21 1213:27,30 1214:1,7,15,19,21 1236:21 1237:5 1243:7,28,29 1244:25 1245:3 1246:29 1247:8, 13 1248:9,20 1261:11 1269:8, 16,18,21 1270:32 1274:30 1276:24, 30 1281:31 1282:10 1284:12 1290:30 1297:4 1299:5 1300:17, 30 1302:5 1304:32 1305:5,7 1317:15 1319:1,5, 19 1321:2 1331:18 1345:9 1350:29 1361:16

nurse/patient 1144:30 1147:16

nurse/resident 1147:16

nurses 1142:21 1143:16,17 1146:29,31 1147:5,9,26 1148:4 1149:29 1150:21 1151:27, 29,32 1154:1 1155:28,29 1169:9 1191:10, 28 1192:19,21 1193:18 1206:2,7 1207:16 1208:16, 25,32 1211:1,4,5, 28 1212:9,10,17, 19,23,25,26 1213:10,12 1227:30 1228:2, 19 1247:16 1257:27 1270:25 1272:12 1276:29 1301:7 1314:19 1315:18 1316:25 1320:1 1345:15

Nurses' 1181:3 1214:17 1226:27

nursing 1142:7 1144:4 1146:12, 32 1147:6 1148:1, 17 1150:9 1168:8 1172:32 1173:20, 23 1175:26 1176:22 1178:32 1181:26,30 1186:27 1188:21 1196:27 1202:19 1206:11,12,19 1211:2,3 1215:9, 13,32 1216:6,7 1218:2 1244:10 1261:13,16 1264:5 1272:10, 20 1295:10 1332:22 1333:8 1345:29 1354:7 1357:17

O

objecting 1220:4,29 1221:23

objection 1220:10 1224:9 1239:5

obligation 1230:17

observe 1331:5

observing 1248:3 1332:17

obvious 1265:21 1317:2 1332:15

occasion 1195:15 1288:1 1309:22

occasions 1269:16

occur 1182:26

occurred 1157:15 1182:26 1194:7 1199:13 1201:8 1202:5 1313:4 1329:16, 27 1358:19

occurring 1318:7,12 1348:16

occurs 1264:5 1290:28

OCD 1221:15

October 1362:23

odd 1198:30

off-going 1245:3 1246:29 1247:8 1248:20

off-site 1207:9

offer 1320:18

offered 1206:20, 31 1207:7,14,21 1320:28

office 1151:32 1160:12 1174:22, 25 1182:18 1184:25 1185:13 1191:28 1197:3, 27 1198:12 1200:20 1206:30 1352:8 1354:19 1355:11

officer 1164:24, 28 1201:10 1320:21 1325:12, 18

on-site 1319:30 1327:9

ONA 1137:7 1160:31 1164:24 1166:2 1220:2 1221:3,26 1222:3 1223:24 1224:12, 14,21 1225:24 1227:3,24 1229:12,16 1233:20,29 1235:6,8,17,20, 22,30,32 1236:8, 23 1237:3,6,18,31 1238:29 1241:20, 24 1312:31 1319:24 1320:12, 15,18,23,27 1321:4 1322:11, 27 1323:1,5,23 1324:5 1325:28 1326:4 1327:32 1328:11,29 1330:2,16 1338:8, 19 1339:10 1340:2

one-day 1160:18 1161:17

one-on-one 1319:9
ongoing 1143:4 1144:12,17 1145:15 1209:30 1210:6,7 1262:8 1263:20 1273:30 1359:31
online 1199:18 1200:9 1280:8,29
Ontario 1171:4, 5,6 1172:23,25, 28,30 1206:3,7 1211:2 1226:27
open 1258:19 1284:13 1288:28, 31
opinion 1212:11 1327:11 1359:22
opportunities 1223:5
opportunity 1223:9 1234:1,31 1235:24 1237:30 1238:8,11,16 1339:13 1341:25
opposed 1154:13 1192:11 1221:31 1339:26
opposite 1187:5
option 1208:12
oral 1250:32
orange 1295:31 1311:14 1312:27
order 1137:2,16 1138:25 1139:23 1147:18 1152:24 1190:5,6,13 1202:26,28 1203:6,9,13 1204:1 1224:3 1229:2 1244:5 1274:1 1277:20 1281:18,23 1289:18,20 1317:32 1345:32
ordered 1278:3 1280:13 1281:1, 10,15,29 1289:16 1290:5 1308:21
ordering 1281:26 1282:1, 29 1283:6
orders 1203:31 1212:28 1297:17 1314:29
organization 1286:9
organizations 1239:18
organized 1137:26 1225:5 1251:30 1252:1, 19
orientation 1177:5 1207:22, 25
originally 1320:8
osteoporosis 1249:3
OT 1267:25
outbreak 1144:4
outcome 1150:14
outcomes 1149:19 1150:25
outset 1222:9
oval 1303:32
overdose 1152:30 1201:7
overdosed 1159:11
overdoses 1221:7
overly 1181:11
oversee 1142:30 1256:31
overseeing 1327:8
overtime 1135:26 1136:16, 22 1145:9
1146:25
overtop 1314:9
overview 1152:6 1219:32 1222:4 1225:17 1226:6,9 1261:12 1263:12 1361:6
overwork 1229:12

P

p.m. 1240:13,14 1310:4,5 1364:11
pack 1204:32
package 1139:2 1267:6 1278:22 1279:6 1283:11, 23 1289:13 1290:13
packaging 1252:18 1289:8
pain 1264:17,22, 24 1265:18 1270:7,13 1344:11,32 1345:2,3,5,7
pair 1307:31
palliative 1143:29 1245:11 1276:5
palpable 1362:15
paper 1199:24 1200:1
paperwork 1244:9 1332:21 1352:9
paragraph 1150:20 1152:8, 14 1158:10 1159:25,30 1160:25 1161:3, 13 1166:21 1168:6 1194:31 1208:1,5 1225:18, 20,21 1226:7,14, 21,25 1227:1 1229:28 1244:13, 28 1260:7 1261:8 1265:28 1266:28 1271:29 1339:7 1341:9 1342:11
paragraphs 1222:13
parameters 1294:32
Pardon 1164:16 1166:8 1178:23 1217:27 1242:25
Parker 1221:31
part 1148:11 1165:31 1195:30 1201:3 1219:13 1227:15 1236:27 1241:23 1245:16 1274:21 1288:15 1295:20 1297:2 1331:16 1346:10 1354:7 1357:9
part-time 1143:19 1154:4 1158:30 1159:3
participate 1214:31
participated 1221:4
participating 1194:10
parts 1292:30
partway 1163:10
pass 1145:11 1146:24 1187:18 1240:29 1249:19, 20,30,32 1250:5 1251:18 1252:27 1253:18,30 1254:3,8,14 1256:3,8 1257:23, 29 1259:15 1260:4,32 1263:26 1265:27, 30 1266:5 1269:29 1271:22, 32 1272:1,2 1279:23 1301:3,8 1338:15
passed 1143:30 1221:15 1351:31
passes 1259:2 1265:30 1351:8 1353:10
passing 1344:10 1347:19 1358:12
past 1329:26,30 1361:19 1363:29
patient 1142:24 1245:11 1270:1 1291:1 1345:6 1355:12 1356:16
patient's 1261:16 1290:22
patients 1147:23 1245:8 1316:2,8
pattern 1338:31
patterns 1231:14
pay 1192:2 1212:8 1213:6
pedal 1265:6
pen 1202:3 1277:16 1278:12 1287:7,11,30 1288:4,12,20 1289:3,5,20,22 1290:1,13,18,21, 24,31 1291:3 1292:12,14,27,30 1293:18 1295:21, 28 1298:3 1299:5, 18,31 1300:16 1302:6 1308:11 1311:16,27,31,32 1312:9,10 1314:12
pen-and-cartridge 1312:15
Penfill 1170:13
pens 1287:28,29, 31,32 1288:24,25 1291:13 1292:11

people 1143:30 1149:12 1185:17, 21 1195:32 1202:12 1229:23 1239:18 1240:31, 32 1253:8 1274:3 1284:12,14 1303:14 1331:20 1332:5

percent 1273:6

percentage 1163:16

perfect 1362:26

performance 1161:6

period 1153:8, 10,30 1154:2,6, 21,23,31 1155:2, 4,18,26 1156:25, 32 1157:6,11 1158:22,27 1159:4,11,14,19, 21 1164:15,18 1166:26 1167:5, 10 1190:21 1203:14 1221:11 1227:22 1230:29 1235:14,15 1236:14 1318:3 1325:27 1330:5 1333:18,20

person 1146:6 1171:18 1182:24 1233:19 1271:15 1322:4 1327:8

personal 1168:8 1215:10,14 1216:1,6,8

personality 1331:15

personnel 1227:9

perspective 1176:3 1341:28

perspiration 1231:23

pharmacist 1170:24

pharmacists 1304:24

pharmacy 1170:29 1207:13 1252:18 1254:23, 28 1277:4 1280:22,29 1281:4,23 1282:3, 11 1289:16,19,27 1297:18 1303:20 1308:16,22 1309:17

phased 1314:31

philosophy 1174:29,32 1175:1 1317:13

phone 1146:7 1178:4 1199:22, 25 1200:1,16

phoned 1281:4

physical 1180:24 1268:24

physically 1271:16 1272:11 1300:29

physician 1264:20 1268:24 1352:26,27 1353:14,22 1354:8,17 1357:6, 8

physician's 1354:11

physicians 1354:13

pick 1332:5

picked 1357:13

Pickering 1201:16,20 1347:7,8,14 1348:14 1349:19 1351:31 1352:5 1355:3

Pickering's 1358:12

picture 1167:21 1255:19,28 1261:16

piece 1173:21 1340:5

pieces 1167:27 1271:30 1276:14 1327:13,16,17 1332:21

pill 1270:7

pinprick 1203:18

pizza 1334:11

place 1151:20 1153:15 1154:25, 31 1169:12 1225:22 1250:10 1251:19 1274:3 1289:3 1309:26 1317:19,22 1321:23,27 1362:14

places 1257:27

plan 1135:18 1136:1,11 1188:31 1189:2,9, 28,32 1190:17 1244:10 1261:13, 14,15,24,26 1262:12,21,28 1268:13,26,29 1273:20,22,30 1276:17 1342:14

planned 1209:21

plans 1193:6 1212:30 1262:6 1332:22 1333:8

plastic 1288:15 1289:2 1291:7 1308:3

pocket 1311:11

point 1158:31 1207:32 1214:32 1222:25 1223:1 1252:31 1253:16 1265:1 1275:9,12 1283:8 1306:13 1313:18 1321:26 1325:6 1329:29 1331:32 1343:15 1344:25 1349:18 1351:23 1357:31 1360:25 1363:19

points 1336:22

pokes 1306:28

police 1152:17 1201:9

policies 1148:18 1177:12 1179:31 1180:4 1337:9,10

policy 1177:10, 16 1180:27 1181:13 1183:32 1206:10 1317:24 1318:9 1359:17, 29

pool 1143:15,16, 19

portable 1272:18 1314:9

portal 1196:10

portrayed 1331:17

position 1142:15 1165:30 1206:16 1229:31 1333:28 1334:14 1335:24

positions 1243:6

possibility 1316:28

possibly 1201:6 1260:14 1271:31, 32 1307:31 1318:7 1352:16

post 1196:15

posted 1175:23 1194:2,5 1196:20 1236:28

potential 1218:22 1219:7, 27 1266:30

potentially 1275:24 1276:24 1321:2

power 1180:31 1181:1 1229:32 1334:14 1335:24

Practical 1208:25,29 1211:1 1212:10, 17,23,26

practically 1229:17

practice 1149:30 1150:5 1169:7,19,23 1171:25,30 1172:9,13 1183:10 1184:21 1208:7 1211:6 1212:13 1214:17 1215:21 1285:2 1311:1 1327:3 1341:17 1346:23 1350:16 1354:15, 16

practices 1326:27

pre-filled 1287:13

pre-loaded 1292:10

precious 1205:10

precursor 1243:31

Predictability 1150:13

predictable 1149:13 1150:24

preference 1182:7 1192:9 1241:1

prefilled 1311:30 1312:2

prejudicial 1220:26

prepare 1251:17

prepared 1234:11 1342:5

preparing 1184:11,15

prescription 1170:2,5

present
1188:24,30 1189:4 1224:26 1231:19 1232:13 1236:4 1309:6,8 1334:23 1348:17 1349:30

presented
1342:7

Press 1327:22

pressure
1250:32 1267:16

pressures
1213:16

pretty 1295:11 1326:24

prevent 1151:14 1169:15 1204:15 1209:22 1261:7, 32 1300:17 1304:32 1305:5,7 1311:8

prevention
1179:15,18

previous
1153:28 1166:24

price 1279:24

prick 1303:28,30

prime 1298:6,11

primed 1298:12

prior 1173:2,6 1174:32 1219:28, 32 1221:20 1227:25 1229:6 1341:20 1344:12 1361:12

private 1252:2 1303:16

PRN 1202:26 1203:6 1269:31 1270:9,10,13 1282:21

proactive
1178:12

probation
1153:29 1154:21 1156:22,25

probationary
1153:8,10 1154:1, 5,22,30 1155:2,4, 25 1156:32 1157:6,11 1158:22,27 1159:4,21

problem
1140:31 1141:3 1143:4 1144:12 1145:16 1156:2,3, 19 1169:15 1187:23 1190:30 1202:1 1203:3 1215:25 1218:13 1233:10,14 1239:28 1256:16, 24 1287:17 1342:19

problems
1149:7 1157:15 1261:19,24,26,27, 29 1274:7 1338:28

procedure
1215:29 1343:24 1344:18,30 1345:6

procedures
1168:27 1239:20

proceeding
1147:13

proceedings
1235:19 1238:32

process
1207:23,26 1210:23 1212:29 1214:12 1217:24 1236:27 1238:3, 13,23 1239:13 1247:7 1254:19 1263:29 1264:7 1303:26 1308:2 1317:24 1319:28 1320:32 1321:4 1326:25,29 1330:19 1337:18, 26 1338:26 1340:7 1344:15 1345:3 1353:10 1358:29 1359:8

processed
1314:30

processes
1239:19 1349:28

produced
1235:31 1236:2, 12

product 1267:25

productive
1339:22

profession
1150:9

professional
1136:27 1137:8 1139:20,32 1140:5,12,17,25 1141:19,23 1142:7 1158:13 1206:9 1334:13, 16

program
1179:18 1206:22 1210:1 1263:22 1316:5

programs
1320:19,28

progress
1262:31 1263:1, 11,14,17 1347:22 1348:8 1351:14

progressive
1337:20

project 1206:23

prominent
1340:23

promoting
1206:11

prompt 1209:28

promptly
1240:8

proper 1238:2 1279:18 1299:15 1317:21

properly 1280:3 1338:21

property 1237:1 1238:6

proposal
1232:21

propose
1241:22

prospective
1216:14

protocol
1317:21

protocols
1209:27 1210:3,9

provide 1150:29 1182:20 1189:1 1195:23,29,31 1209:6

provided
1171:1 1195:7 1206:17 1233:31 1320:15 1341:13

providing
1259:32 1260:1

PSW 1255:30 1272:27 1332:27, 29,30 1344:22,23

PSWS 1151:26 1165:16,22 1185:22 1207:18 1255:15 1256:16 1259:20,23,28 1263:30 1271:17 1272:15,16,30 1334:11 1335:14 1345:15 1348:20

psychiatric
1218:25 1315:16

psychogeriatric 1315:16

psychological
1180:25

PT 1267:26

public 1205:14 1206:10 1244:24

pull 1228:3,4,22 1230:26

pulled 1158:7 1353:29

pulling 1318:7 1332:4

pulse 1265:6 1267:16 1352:6

pulse-ox
1267:16

pureed 1256:25

purpose
1183:22

purposes
1317:31

push 1258:11,23

put 1137:23 1139:1 1147:6 1153:21 1154:1, 14 1156:3,22 1162:26 1163:4 1166:5 1167:29 1169:7,12 1174:1 1178:20,22,25 1185:21 1187:26 1192:14 1197:7 1198:11 1202:3 1208:24 1221:3 1227:30 1229:13 1231:8 1238:20 1244:19 1257:27 1282:22 1286:7 1292:14 1293:1,2 1298:5 1302:26 1303:31 1308:10 1312:7 1313:23 1317:21 1323:2 1324:14 1340:6 1352:7 1360:25

puts 1320:23

putting 1155:12 1160:15 1238:4, 26 1307:24 1311:10 1313:10

puzzle 1167:28, 29 1327:13,16 1340:5

Q

QQ 1228:4,9,11, 12

Quaethem
1178:31 1335:5

quality 1193:22

1197:10

quarter 1348:24

question 1163:5,9,12,18 1164:1 1171:10 1192:31 1193:13 1200:7 1206:14 1209:19 1218:12, 30 1220:7,31 1221:23 1224:3, 14,15,24,28 1228:5 1230:11 1238:1 1253:26 1298:30 1300:13, 20 1305:4 1310:9, 25 1313:4 1326:1, 7,32 1355:1

questioning 1153:17 1164:7 1220:5 1224:30 1241:24

questions 1141:19,30 1153:25 1155:23 1156:14 1159:28 1164:5 1168:26, 27 1170:6,30 1171:16 1194:12 1198:13,21 1206:12,25 1210:19,25 1211:3 1213:3,27 1214:28 1215:7 1219:26 1228:20 1231:29 1232:8 1245:17 1253:22 1267:28 1310:12 1355:27,29 1356:2,6 1363:27 1364:1

quickly 1138:2 1152:29 1162:3 1202:32 1259:15

quiet 1340:22

quiz 1345:31

quote 1159:29 1163:3 1213:2 1235:21

quotes 1244:15

quoting 1154:9 1155:9,10

R

radial 1265:6

RAI 1274:12 1276:2

RAI/MDS 1244:7 1273:10, 18,26 1274:31 1275:3 1276:19

raise 1239:1,6

raised 1158:8 1165:8 1166:3 1230:6,7 1285:6

raising 1145:27 1158:3

ran 1182:10

random 1175:3

range 1265:3,17 1274:8 1295:2,3,4

rapport 1328:19 1331:7 1332:24 1341:4

rare 1248:31 1270:26

rarely 1193:15 1267:30

ratio 1144:30 1145:20,26,27 1147:16,20,21 1185:13

re-admissions 1276:13

re-emphasizing 1210:23

re-examination 1215:4 1238:15

re-examine 1215:1

re-insert 1292:27

re-order 1277:22,32 1288:1,7,11

reach 1319:17

reached 1275:12

react 1213:20

read 1146:3 1175:17 1194:6 1212:5 1226:26 1244:32 1342:32 1344:20 1351:13 1359:30

reading 1154:17 1176:18 1177:11 1206:24

reads 1304:1,2

ready 1192:29 1240:7 1298:1

real 1191:27

reason 1137:27 1285:12 1289:23 1320:29

reasonable 1182:25 1184:4 1230:14,18 1264:14

reasons 1227:20 1231:18

reasons' 1227:12

reassessment 1265:11

recall 1142:13 1146:13 1154:20, 23,32 1157:13,21, 23,25,26 1161:7 1165:10,11,17 1168:28,29 1169:10,11 1174:16 1181:19 1186:25 1191:13 1193:10 1197:2, 17,19 1198:25 1199:1,3,4 1213:8 1214:25 1217:12 1221:29 1229:19 1251:27,29 1259:25 1275:11 1281:22 1285:1 1290:1,19,20 1291:29 1293:24 1294:2 1311:15 1314:20 1328:20 1337:3 1342:27 1347:18 1348:15 1360:5,26

receipt 1283:7

receive 1142:7 1186:6 1229:1 1274:1 1345:25

received 1174:17 1186:3, 19 1277:2,3 1279:17 1280:6, 18,24 1281:30 1282:6,7,10 1283:10,24 1308:20,21

receiving 1281:31 1350:28

recent 1167:22, 24

recently 1328:23

recess 1139:13 1205:15 1239:29 1240:1 1353:5

RECESSED 1139:14 1205:17 1240:13 1310:4

recognize 1213:19 1278:28 1356:26 1359:17, 29

recollect 1355:5

recollection 1230:29 1290:25 1319:23 1328:30 1336:11,17 1343:14,19

recommendation 1178:10 1195:27 1196:2,4 1204:5

recommendations 1143:8 1144:25 1146:17, 18

record 1139:28 1188:19 1214:1 1238:27 1247:14 1250:16 1254:32 1260:20,24,26,28 1281:7 1282:2,22 1289:26 1296:29 1302:11 1308:6,9, 11 1314:2 1355:12 1357:22 1358:20,30 1359:6

recorded 1304:29

recording 1292:19 1305:8

recurrence 1209:23

red 1219:27 1280:1 1339:9

redacted 1242:21

redactions 1242:18

reddened 1268:20

Reddick 1352:21,23,26,27 1355:2

refer 1148:14 1222:12 1224:4 1262:16

reference 1220:20 1227:18 1261:24 1267:9 1270:5 1278:13 1314:29 1341:8 1347:32

referenced 1353:26

referral 1190:4, 11 1257:18 1262:24 1267:26

referred 1135:12 1137:30, 32 1140:30 1172:6 1209:31 1360:20

referring 1141:7 1313:15 1342:20

1358:8

reflect 1201:13 1227:9 1348:8

reflected 1202:22 1262:20

reflecting 1201:4

reflection 1326:28 1342:8

refresh 1250:28 1254:17

refresher 1207:7

refused 1217:2

regard 1135:9

regional 1206:30,32 1214:19,20

registered 1135:17,32 1136:10 1151:26 1181:7 1188:23, 32 1189:3 1191:10 1193:12 1194:5 1206:2,6 1207:16 1208:14, 16,22,25,29,32 1209:5 1211:1,15 1212:9,14,17,19, 21,23,25 1213:10, 12 1227:30 1237:5 1243:7,28, 29 1244:25 1248:8 1261:11 1263:31 1284:12 1300:32 1318:20 1321:2 1345:9,15 1359:16

registering 1358:19

Registry 1357:19 1358:13

regular 1193:17 1249:32 1274:22 1321:3 1346:23

regulated 1148:19 1211:5

regulations 1148:20

rehabilitate 1316:7

reinstructed 1319:6

reinventing 1196:5

related 1193:20 1206:11 1211:3 1229:12 1343:20 1356:32

relates 1206:14

relation 1213:31,32

Relations 1164:24,28

relationship 1181:8 1197:15

relaxed 1163:27 1215:28

relevant 1347:12

reliable 1314:27, 28

rely 1166:24 1199:32

remain 1354:23

remaining 1307:6 1308:12

remedy 1144:16 1313:9

remember 1135:24 1175:27 1186:28 1187:2 1197:6,11,23,25 1209:13 1219:8, 29 1245:29 1246:7 1250:7 1275:4 1303:22 1320:31 1328:18 1330:8 1333:31, 32 1334:21 1336:18,19 1340:31 1342:3, 31 1344:22 1347:7 1355:4

remembrance 1342:9

remorseful 1331:31

remove 1288:32 1290:7

removed 1292:20 1338:9

renewed 1345:20,22

reoccurring 1342:18

rep 1158:1 1162:12,13 1164:15,17 1166:2 1223:28 1233:20,29 1236:23 1241:20 1322:12 1323:1,5 1325:28 1326:4 1328:3,31 1329:20 1330:3, 16,22,23 1335:7 1337:30

repeat 1154:27 1178:24 1182:4 1205:6 1280:14 1305:4 1310:25 1357:8

repetitive 1319:18 1338:26

replace 1306:7, 10,21 1307:3 1312:9

replaces 1270:29

replacing 1188:31

report 1137:9 1140:1,13 1141:20 1142:8 1145:3 1165:24 1170:32 1181:25 1182:27 1183:1, 12,13,14,17,20,27 1184:3,18,22,28 1185:1 1188:7 1197:30 1209:13 1219:32 1225:18 1226:6,10 1230:14,17,21 1245:6 1248:19 1269:23 1318:21 1331:8 1345:16 1346:4,6,8,16,24 1361:6

reported 1143:23 1181:25 1183:7,17 1196:13 1197:29 1214:24 1345:12

REPORTER 1241:28 1242:2

reporting 1181:23 1182:1,5 1196:32 1209:28 1325:5

reports 1136:28 1139:21 1140:26 1152:7 1209:10 1222:5 1263:12 1341:5

represent 1206:2 1211:1 1336:5

representative 1225:23,24 1235:22,30 1236:7,9,18 1237:7 1312:31 1319:23,29,32 1320:12,16 1321:5,9 1339:10

representatives 1217:7 1326:31

representing 1172:22

reps 1162:17,32 1327:32

request 1270:1

requests 1227:18

require 1189:21 1299:5

required 1169:17 1195:20 1245:8 1279:23 1281:28 1282:17 1315:14 1318:27 1354:26 1357:26

requirement 1186:7 1187:12 1301:25,28 1357:30

requirements 1150:26 1179:14 1187:8

requires 1149:11,19

requisition 1289:16

resident 1172:31 1175:6 1179:1 1183:3,4 1184:24 1197:5 1198:15 1208:21 1209:17 1216:19, 23,25 1217:21 1219:4,17,23 1249:22 1251:6 1252:28 1254:19, 21,26 1255:8,11, 16,20,31,32 1256:17,29 1257:9 1258:4,9, 27 1261:20 1262:5,14,25 1263:2,13,18,25, 29 1264:1 1265:15 1266:9 1267:14 1268:24 1269:4,24 1270:2, 7,12 1273:1,17,32 1276:18 1277:20 1286:4,16,22 1289:12 1290:5 1292:13 1294:13, 27 1295:6 1297:14,15,22 1298:9 1299:17, 31 1300:15 1303:12,17,26 1306:3,24,31 1307:2 1317:3 1343:25,30 1344:9,13 1345:2 1348:9 1353:10 1359:2,15,22 1362:28

resident's 1174:3 1183:6 1208:23 1219:12

1262:11,32 1273:4,25 1279:11 1281:28 1289:12,30,32 1290:31 1291:4,8, 17,21,27 1297:20 1303:2,8 1305:6 1313:22 1342:27 1343:20 1344:5 1356:32 1358:25

resident-family-to-staff 1180:14

resident-first 1174:29

resident-to-resident 1180:13

resident/nurse 1145:27

residents 1142:28 1143:28, 29 1144:5 1147:24 1148:24, 25,31 1149:2,6 1151:18 1152:20, 25 1173:13 1174:2,5 1175:12 1177:25,32 1178:6 1181:9 1186:24 1192:11 1198:31 1202:31 1207:24 1211:10 1216:14 1218:1, 15 1231:8,15,16, 17 1245:11 1246:4 1247:4 1248:28,29 1249:6 1252:16 1253:1,31 1254:14 1255:14, 30 1256:21 1258:31 1259:15, 30,31 1260:16 1261:3,4 1266:14 1268:9 1277:15, 23 1278:32 1285:28 1286:32 1287:30 1288:19, 25 1295:7,9,10,13 1300:31 1303:21 1311:19 1315:7, 10,11,13,17,28 1316:6 1331:19 1346:27 1347:2 1361:25,31

residents' 1172:23,25,27,28, 29 1173:2,9,12,18 1174:19 1175:21, 22 1176:13,15 1212:31 1230:12 1251:21 1252:6 1260:24

residents/nurse 1145:20, 26

resigned 1227:10,19

Resolution 1145:31

resolved 1144:21 1189:24

Resource 1251:23

respect 1142:19,26 1152:11 1155:2 1156:30 1157:10 1159:30 1160:24, 27 1161:5,15,26 1168:1,19 1169:6 1180:5 1184:32 1188:13 1207:17 1221:25 1222:1 1225:4 1236:25 1237:17 1318:17 1333:5 1353:12 1355:3

respectful 1336:20

respects 1273:20

respirations 1349:14 1352:6

respond 1222:29,32 1227:17 1351:21

responded 1265:8

response 1166:1 1210:1,16 1220:11 1270:12

responses 1341:3

responsibilities 1320:17 1322:11

responsibility 1136:28 1137:8 1139:21 1140:1,5, 13,17,26 1141:20, 23 1142:8 1256:31 1320:3 1354:12

responsible 1142:16 1143:27 1148:2,17 1211:6 1216:5 1256:27 1259:20 1267:31 1277:8 1325:16

rest 1243:23 1265:25 1275:14 1297:32 1345:7 1354:12

restorative 1263:22 1316:1,4, 15

restore 1359:25

restraint 1316:2,14

restraints 1315:32 1316:19

restriction 1186:5

result 1149:10 1167:20 1219:21 1226:30 1227:12 1319:12 1336:31

results 1326:10

RESUMED 1139:15 1205:18 1240:14 1310:5

retired 1251:28 1253:4 1362:18

retirement 1243:32

returned 1348:15,18 1350:21,27

reverse 1152:29

review 1144:30 1166:28 1176:10, 21 1177:17 1188:20 1210:13 1317:17 1337:9 1342:2

reviewed 1152:15 1166:18 1168:3 1198:12 1210:5,9,10,12 1228:31 1234:19 1262:9 1304:26 1319:5 1343:22

reviewing 1136:26 1201:9

revised 1262:7

revisions 1261:13

rid 1311:1 1314:22,25

rights 1175:21, 22,26 1176:2,4,6, 13,15,18,29

rise 1153:13 1154:8 1318:24

risk 1149:18 1150:14,24 1216:31 1219:23 1231:9 1307:24 1316:15

risk-taker 1307:28

RN 1137:5 1139:26 1140:2,7, 14,19,27 1142:27 1143:10,22 1144:26 1145:3, 18 1146:18 1147:23 1149:29 1150:5,29 1151:3 1152:2 1165:21 1171:25 1172:8, 13 1185:25 1186:13,32 1187:4,5,12 1191:3,12 1192:25 1199:12 1211:21 1228:7 1229:29 1230:26 1236:4 1246:32 1247:2 1256:32 1267:30 1270:26 1322:1 1323:19 1331:2 1332:29 1335:23 1336:5 1355:21 1356:1

RNAO 1205:24

RNS 1143:19 1147:11 1207:31 1208:2 1211:4 1213:22 1321:32 1330:22,31,32

Rodriguez 1335:5,6,12 1360:20

role 1207:17 1334:15 1337:10 1359:16

Roman 1266:29

room 1194:3 1247:32 1248:1,5 1251:12 1252:1,5, 20,21,28 1253:7, 9,14,32 1254:15 1257:31 1259:16 1266:21 1283:29 1284:2,11 1285:5, 9,13,15,16,18 1291:30 1307:12, 17 1323:9,12,16, 21,32

rooms 1168:29 1169:2 1170:1 1252:3 1253:1 1310:27

rose 1163:8

rotate 1255:13

rotated 1245:23

rotates 1295:21

rounds 1214:9

routine 1244:14 1245:16 1250:31 1266:19 1268:5 1276:15

Routledge 1162:14 1163:2, 14,21 1164:11

1165:1,7 1166:2 1223:28 1224:1 1240:17,19,29 1241:12 1242:24, 31 1278:21 1283:15 1287:23 1289:1 1335:8 1349:3

RPN 1145:10 1149:30 1150:5 1151:3 1171:26 1172:8,13 1185:21 1199:15 1208:7,10 1211:13,19 1213:18 1246:8 1247:2 1344:22, 24 1356:3,4

RPNAO 1210:28

RPNS 1146:23 1185:22 1192:14, 25 1207:18,31 1208:3,6 1211:4, 11 1213:13,23 1271:6

rule 1224:2,27

rules 1163:27 1215:28,29

run 1173:13

rush 1335:32

rushed 1166:16

rushing 1166:15

S

safe 1297:8

safety 1142:21, 23

sake 1351:29 1353:27

Sandra 1178:32 1179:2,3,4,5

sat 1275:1 1325:28 1360:7

satisfactory 1283:18,20

satisfied 1352:20

sauce 1251:20

scale 1294:21, 23,25,26 1295:8, 14 1302:22,25 1303:2 1304:10 1309:14

scan 1280:5,12, 16,17

scanned 1279:20 1281:7, 14

scanner 1279:24,25

scars 1268:18

scenarios 1349:29

schedule 1175:12 1178:27 1191:5

scheduled 1194:24 1249:29

scheduling 1165:13

school 1177:29

screen 1150:5 1225:32 1228:4, 22 1304:1 1334:30 1360:14

scroll 1177:7 1180:8,22 1181:22 1188:17 1189:15 1229:26 1335:20 1348:5, 27 1358:11 1359:18

scrutiny 1239:21

sealed 1315:23

search 1286:17

section 1142:28 1143:2 1145:4,18, 24 1153:8 1154:25,30 1183:32 1230:13 1245:20,25,32 1246:2,3,9 1248:28 1271:5 1276:28 1279:21 1283:31 1284:20, 27 1286:29,31 1291:9 1301:1 1303:14 1315:5 1323:19 1331:2 1347:15 1358:6, 21,23 1359:5,12

sections 1245:24

sector 1301:13

segregation 1286:8

selected 1227:32

self-reporting 1317:28

send 1164:29 1199:18 1274:13

sense 1139:22 1219:12 1235:30 1335:17

separate 1247:21 1248:14 1249:29 1252:16, 24 1260:12 1283:17 1291:13, 26 1302:31,32 1311:29 1347:25, 26

separately 1289:19 1290:18, 20

sequence 1360:24

series 1214:23

served 1259:17

service 1259:18

servicing 1225:8

serving 1236:17 1314:5

session 1342:12

sessions 1196:16 1197:7

set 1151:6 1152:1 1160:16 1180:26 1205:3 1208:32 1217:3 1226:19 1285:20 1288:19 1301:25,29

sets 1150:10 1182:32 1215:32

setting 1212:12 1243:24

settle 1227:3 1362:17

settlement 1168:4,7,20,21 1227:6,7,16

seven-year 1227:22

severe 1264:3

sexual 1180:30 1261:31

shaking 1252:30 1255:25

share 1196:8 1229:6 1363:19, 23

shared 1223:11 1224:32 1327:19

sharps 1307:7,9, 22,29 1308:6 1310:24 1311:2,5

she'd 1334:10 1340:20 1342:14

sheet 1186:19 1247:14 1289:26 1357:31

shelf 1288:3

shift 1147:12,27 1169:3 1185:25 1191:12,17,19 1194:24,28 1199:13 1207:17 1225:28 1244:29 1245:2,6 1246:15, 16,19,27 1247:1,8 1251:14 1253:2, 18 1259:24 1263:7 1271:25 1275:22,24,25,32 1276:1,9,11 1277:6 1279:15, 17 1321:12,13,17, 19,24 1322:5,7 1324:9 1326:5 1332:24 1333:2 1334:6,10 1340:28 1351:30 1353:11 1355:8

shifts 1175:4,7 1246:2

shock 1342:6 1361:27

short 1138:28 1141:24 1142:22 1155:17,18 1191:20 1235:13, 15 1253:27 1270:18 1330:5 1332:27,29 1333:18,20

short-staffed 1135:19 1136:2, 12 1143:24,26 1144:8 1145:5 1332:26

Short-staffing 1144:17

shortage 1151:29 1191:28 1228:1

shortening 1264:18,24

show 1197:31 1268:2 1296:8 1302:5

showing 1223:15

sic 1208:10

sick 1147:9,10

side 1257:26 1273:26 1331:1

sign 1313:28 1329:19,31 1358:30

signature 1241:15 1357:11, 26

signed 1169:8 1281:5,30 1282:10 1329:8 1354:25 1357:5,7, 20,21

significant 1211:12 1212:3,7 1213:5 1243:24 1263:5

signing 1317:7 1329:23

signs 1151:24, 25

Silcox 1159:13

similar 1151:14 1170:19 1279:24 1330:22

simply 1156:31 1185:11 1195:19 1199:32 1220:26 1221:1,9 1227:21 1252:27 1282:9 1285:21 1290:18 1293:23 1302:18 1311:10 1312:8 1322:5 1354:8

single 1147:27 1284:9 1286:18 1293:25

singular 1319:8

singularly 1237:32

sink 1257:26

sit 1164:25 1272:12 1275:18

site 1196:18

sitting 1237:7 1254:15

situated 1257:24,25

situation 1199:29 1208:8 1209:4,22 1211:21,24,30 1216:26 1306:2, 23 1339:23 1342:24 1343:28 1344:1,8,14 1347:6 1361:18

situations 1151:14 1174:5 1208:18 1319:3

six-month 1159:13 1318:3

skill 1208:32 1244:2

skills 1151:17 1293:17 1345:9

skin 1268:19

slack 1332:6

slap 1339:20

slide 1194:23

sliding 1294:20, 23,25,26 1295:8, 14 1302:22,24 1303:2 1304:10 1309:14

slightly 1147:19

slurring 1340:32

Slyfield 1343:29 1344:21

small 1162:22 1163:3,16 1303:32

smelled 1340:30

smiling 1331:17

Smith 1302:18

smooth 1326:25

smoother 1259:9,12

snacks 1273:3

snapshot 1273:31

snoring 1349:13

so-and-so 1321:8

socializing 1165:14

solution 1190:29

somebody's 1305:1

someone's 1159:28

sort 1202:22 1208:4 1237:19

sorted 1237:11

sought 1227:14

sounding 1349:14

source 1320:21 1348:1

southwestern 1171:6

spacious 1240:24

spare 1138:15

speak 1193:27 1198:14,23 1208:13 1212:29 1220:14,19,21 1223:6 1233:23 1234:1,3 1238:8

speakers 1207:3

speaking 1234:5 1349:4 1354:3

special 1178:1 1331:21

specific 1174:14,15 1175:5 1201:18 1210:1 1261:20 1269:4

specifically 1151:25 1161:24 1179:10,27 1207:26 1219:3, 32 1228:9 1262:9 1302:13

specifics 1156:4 1225:14, 16

specks 1164:1

spectrum 1150:30 1151:22

speech 1340:32

speed 1215:20

spell 1256:14 1258:5

spend 1216:6 1275:31

spent 1267:27

spoke 1177:20 1188:29 1218:10

spoken 1204:11 1207:30 1275:9, 16

spot 1192:32 1193:9

spreadsheet 1167:16

Springs 1243:15

stabilized 1295:11

stable 1295:13

stack 1140:11

staff 1135:17,32 1136:11 1146:30, 32 1147:4 1148:19 1151:17, 20 1152:30 1174:14,15 1176:8,9,12 1177:23 1178:18, 19 1179:8 1181:8, 17 1183:4,11 1184:31 1185:32 1186:24 1191:7, 22,26 1192:10,20 1193:8,12 1194:5 1195:16 1198:21 1202:19 1207:27 1210:10,12,14 1214:10,16 1219:14 1227:30 1229:16 1230:4 1246:8 1263:31 1285:14,17,20 1300:32 1317:30 1318:17,20 1346:31 1354:7 1359:16 1363:1,2

staff-to-resident 1180:13

staffing 1143:10 1144:26 1146:18 1148:1 1173:25, 26 1175:2 1185:13,29,31 1186:2,11,16 1188:14 1190:25 1215:7,9 1228:7 1229:18 1318:4

stage 1239:4

stand 1239:6 1240:18 1321:27

standard 1155:6,27 1156:30 1275:15

standards 1148:18 1211:6 1214:17

standing 1202:26 1203:8

start 1135:10 1139:25 1141:28 1171:23 1225:18 1240:7 1245:12 1251:18 1252:3, 26 1253:6,18,19, 29 1256:3 1260:8 1265:27 1267:15 1269:8,10,16 1273:10 1337:21

started 1187:1,3 1194:22 1238:31 1243:2 1274:29 1303:23 1344:23

starting 1170:21 1229:28 1232:22 1244:13 1246:20 1292:16

starts 1264:6

starving 1166:17

state 1213:22

stated 1343:23 1351:7

statement 1228:29

statements 1177:10
stating 1328:4
station 1272:10, 12 1357:17
status 1273:25 1274:9
statutory 1148:6
stay 1146:23,24 1191:8,11 1302:1 1362:7
stayed 1285:15, 17
stays 1167:6
stead 1321:14
step 1299:24 1338:5 1339:18
steps 1231:5 1352:5 1353:11
stick 1314:10
stock 1282:18, 20
stop 1245:14 1345:2,6
stopped 1234:4 1344:31 1362:29
storage 1313:17 1322:31
stored 1278:3,4 1283:25 1286:6, 10,16 1287:6 1290:16,24
strain 1147:6
straits 1192:8
strategies 1262:3
strictly 1314:22
strike 1334:15
strip 1252:17 1254:23,28 1255:5 1291:21 1303:32
strips 1250:23, 26,30 1252:12 1254:29 1291:18
strive 1263:21
stroke 1256:22 1352:17 1356:16, 19
strokes 1316:9
strong 1327:8
struggling 1340:9,18
student 1334:7
students 1165:14,15 1177:30 1334:4 1335:30 1336:2
stuff 1257:16
subject 1241:27 1242:4,18 1305:27,30
subjects 1197:1
subsequent 1360:3
succession 1201:13
sudden 1199:9 1200:10 1356:9, 14
sufficient 1240:4 1306:19
sugar 1152:23 1202:27,28 1203:2,6,8,10,14, 17 1294:17,28,30 1302:29,30 1303:3,8,26 1304:3,28 1305:1, 6,8,21 1351:4 1352:14
sugars 1213:15 1303:13 1350:17
suggest 1154:16 1163:1 1223:3,27 1225:6 1231:8 1363:30
suggested 1184:17
suggesting 1222:10
suggestion 1223:32
suggestions 1339:28
suitable 1156:27
summaries 1236:31
summarized 1228:21
summary 1225:21 1228:27 1233:30 1236:26 1263:18
supervise 1253:7 1316:4
supervising 1165:21 1207:27 1256:15,16,26 1259:20,28
supervision 1209:6
supervisor 1208:2 1212:22 1217:1
supervisory 1207:17 1334:15
supper 1257:28 1266:16 1334:8 1336:2
supplement 1251:22 1282:15
supplies 1323:26
supply 1286:27
support 1178:2 1182:20 1185:22 1191:29 1192:30 1339:11
suppose 1270:31
supposed 1208:10 1270:21 1339:20,21
surgical 1268:18
surrounded 1317:18
surrounding 1225:26 1347:18
Susan 1179:3
suspect 1182:25 1184:5 1230:15 1264:11, 16
suspected 1343:25
suspecting 1264:3
suspension 1160:18 1161:17 1162:2 1325:11
suspensions 1337:2,23
suspicion 1182:27 1184:7 1264:22
sweat 1231:20
sweating 1152:21,27 1201:5
switch 1353:3
swore 1166:23
SWORN 1240:19
symptom 1152:22
symptoms 1144:6 1152:21 1201:5,6 1202:12 1203:26 1213:19 1349:21,23
syringe 1311:30,31
syringes 1251:24 1307:26
system 1179:21, 22 1194:32 1195:1,6,18 1196:22 1197:17 1199:6,17 1247:23,24 1266:7 1273:7,14, 19,28 1277:16 1278:1 1279:26 1280:8,16 1281:1, 3,10,15 1287:8 1289:24 1293:4 1297:18,19 1305:20 1309:6,8, 25 1311:27,28 1312:14,15 1313:20,28 1314:13,23,32 1315:24,25 1316:14 1318:30 1358:5 1363:12
systems 1282:14,24

T

tab 1137:20 1241:14 1313:6 1329:6,9 1334:27 1360:15,28
table 1259:7
tablets 1225:28
takes 1149:3 1234:7 1279:25
taking 1197:7 1225:27 1277:8, 31 1293:17 1305:1,6 1313:9 1320:2 1321:23 1324:14 1334:4
talk 1142:23 1152:10 1158:15 1166:7 1169:31 1178:7 1194:32 1198:15 1211:9 1214:10,11 1223:22 1244:14 1248:26 1249:7 1250:21 1256:19 1261:9 1262:30 1263:24 1265:26 1266:28 1268:26 1277:13,19 1278:14 1295:16 1306:1 1319:21 1324:12 1327:30

1330:25,26 1342:10 1361:22 1363:15

talked 1166:15 1174:28 1177:9, 20 1185:5,7 1186:31 1193:12 1201:3 1251:11 1262:14 1264:23, 24 1271:29 1286:12 1315:20 1319:22

talking 1170:16, 18 1173:31 1192:18 1196:25 1203:16 1207:4 1211:22 1223:19, 20 1226:14 1249:31 1250:15 1254:29 1291:18 1294:20 1312:15 1313:15 1322:24 1326:26 1331:28 1332:13,31 1336:7 1357:22

talks 1180:9,12, 29 1181:21,22 1182:24 1192:19 1241:24 1308:23 1344:30

TAR 1260:19,25

task 1273:27

tasks 1356:32

team 1195:13 1212:31 1359:21, 28

tearful 1331:32 1336:23

tears 1332:9

teaspoon 1297:7

techie 1305:17

telephone 1228:21

tells 1306:20

temperature 1267:16

temperatures 1213:16

ten 1161:4 1198:17,18,19 1249:20 1266:9 1270:15 1287:3 1311:10

tendered 1237:3,4

tenor 1235:17

tenth 1197:24, 26,32 1198:3,17 1199:6 1357:28, 32 1359:2

tenth-death 1199:6

terminally 1359:24

terminate 1156:31

terminated 1228:16 1360:4 1361:13,14

termination 1178:16,17 1179:6 1220:3 1325:11 1337:25 1360:9,11 1361:6

terminology 1185:20

terms 1148:23 1151:1,11 1162:17 1170:27 1217:32 1222:20 1225:4 1227:6 1228:7 1241:19 1251:30 1265:31 1272:29 1279:18 1284:21 1287:28 1293:17,23 1298:3 1304:26 1306:30 1316:32 1317:13 1318:32 1320:16 1322:10 1326:29 1327:27 1331:14 1332:18 1333:6 1339:28 1345:11,26 1346:26 1358:12, 19 1360:30

test 1203:27 1293:17 1294:16, 20 1303:25

testimony 1185:9 1213:28, 29 1231:28,31 1270:6 1310:26 1342:21 1357:19

testing 1204:7

tests 1213:17 1264:10

texture 1256:20, 25,28 1257:6,10, 15,19 1262:14,16, 17,23

textures 1256:15,20

theme 1338:28

there'd 1340:21

thin 1256:23

thing 1206:25 1214:14 1245:9 1256:15 1259:17 1263:9 1264:22 1265:2 1272:3 1284:18 1295:31 1296:3 1301:3 1332:15 1333:32 1334:11 1339:24 1354:20 1362:32

things 1165:24 1174:12 1177:20 1183:1,7 1210:6 1214:11 1215:20 1230:5 1236:16 1250:1 1256:26 1259:27 1263:19 1268:3,6 1269:25 1273:26,29 1274:8 1277:24 1282:21 1291:5 1315:19 1317:22 1325:1 1327:21, 24 1332:13 1333:12,17 1362:17 1363:8

thinkers 1208:27

thinking 1202:24 1243:31 1256:6 1258:16 1327:22 1362:1

thought 1139:3 1147:11,15,17,23 1150:16 1158:17 1165:16 1167:7 1175:18,28 1180:21 1181:7 1185:12 1201:6 1202:30 1230:20 1232:15 1234:32 1265:9 1296:31 1318:1 1339:17

thoughts 1363:18,23

threatened 1184:26,32

three-factor 1150:10

threshold 1197:26

throw 1308:11

thrown 1309:5, 11

Thursdays 1203:10

ticked 1229:15

Tillsonburg 1217:6

time 1141:1 1147:10 1148:6 1149:3 1150:17 1152:13 1154:23, 25,26 1155:17,19 1156:5,8,25 1158:23 1159:11, 19 1164:23 1166:32 1175:1 1178:4,15,29 1183:29,30 1189:25 1190:25 1191:31 1192:15 1197:17,18 1201:32 1202:16, 30 1204:23,28 1205:10 1214:32 1215:27 1216:29 1218:10 1219:6 1221:12,27 1231:1 1235:2,14, 15 1236:29 1239:30 1240:5 1242:7 1243:10, 19 1245:2 1246:26 1249:1,8, 17 1250:7,9 1251:28 1253:1, 19 1254:25 1255:2,4 1258:8 1259:32 1262:8 1264:13 1267:2, 27,29 1268:5,7,28 1269:14,23 1270:22,27 1271:27 1272:26 1273:32 1275:9, 31 1277:16 1282:32 1285:1,3, 23 1286:27 1294:11 1297:19, 21 1298:9,28 1300:18 1301:13, 14 1303:10 1304:5,16,31 1310:2 1317:4,19 1318:5,6 1320:12, 20 1321:26 1322:6,8 1325:1, 7,27 1327:14,20 1328:13,16,20 1330:2,5 1331:7,8 1333:18,20 1335:31 1336:26 1338:10 1339:3 1341:3 1342:4 1345:28 1349:1, 18 1350:3,29 1351:24 1352:25 1353:19 1357:31 1359:1 1360:25 1361:20 1362:28 1363:20,21,29,30

time-intensive 1267:3

timely 1270:12

times 1173:30 1186:14,32 1189:5 1199:7 1202:12 1203:15 1216:27 1220:13, 23 1223:2 1285:10 1286:2 1294:27 1321:22 1340:21

timing 1228:6
tip 1312:25
today 1151:23 1166:12 1206:13 1207:30 1278:15 1331:25 1363:27
toe 1265:1
toilet 1344:10
told 1148:24 1151:30 1158:11 1166:10 1168:12 1178:17,18,20 1179:8,10 1216:29 1220:13 1289:25 1315:8 1316:23 1321:7 1328:19,27 1348:20
tolerance 1179:27
tomorrow 1198:7
top 1144:29 1189:14,15 1228:24 1251:8, 31 1252:6 1260:29 1272:6 1296:3 1298:27 1307:30 1313:11 1329:15,19 1335:3 1352:28 1357:7
topics 1207:4
Toronto 1197:10
total 1142:28 1161:29 1315:32
totalled 1250:10
totally 1246:11 1253:22
touch 1298:20 1351:22
tour 1268:1
track 1167:15 1358:3
tracked 1276:8
tracking 1292:23 1318:2, 29
tragedy 1177:28 1178:12
trained 1180:18
training 1176:25 1177:13 1181:18 1196:16 1206:15, 17,27,31 1207:21 1209:32 1320:14 1322:10 1346:16 1355:20 1359:31
transcribed 1297:17
transcribing 1305:13
transcriptionists 1353:2
transfer 1253:8 1305:21
transferred 1349:16
transferring 1253:31 1316:12
trauma 1265:21, 22
traumatic 1177:21
tray 1313:21,24, 31 1314:5,6,7
treating 1141:29
treatment 1183:2 1214:24 1227:15 1260:12, 16,18,20,25,27, 29,32 1261:4 1271:32 1359:25
treatments 1212:18,28 1260:8,9,14,24 1261:6 1333:11
treats 1331:22 1334:9
trees 1196:19
trended 1276:8
trending 1318:2,29
trial 1257:14 1262:22
trialed 1259:5
triggers 1261:30
trouble 1206:4 1241:29
true 1152:19 1161:12 1165:26 1293:13
trust 1233:24
tube 1315:13
tunnel 1298:15
turmoil 1362:16
turn 1150:7 1153:1,4,5 1161:2 1168:24 1179:13 1197:14 1313:7 1334:27 1341:9 1348:4 1354:32 1358:7 1359:13 1360:13,15
turning 1264:18, 25
TV 1287:15
twenty 1144:5
two-day 1207:2
two-thirds 1335:21
twofold 1340:27
Tylenol 1250:32 1310:29
type 1204:7 1218:24 1261:22 1264:10 1270:9 1273:26 1278:29, 32 1279:12 1285:29,31 1288:10 1290:13 1292:19 1294:9 1297:20 1299:32 1311:27 1313:17 1316:14,31 1318:29 1320:14 1333:32 1337:18 1345:25
types 1151:2 1180:18 1250:29 1251:4 1256:10 1259:27 1286:5, 22 1311:18 1333:16 1350:17 1359:32
typical 1244:24
typically 1216:6 1253:17 1287:30 1326:17 1345:24

U

Uhm-hmm 1243:25 1244:21 1246:21 1248:21 1249:23 1250:17 1255:9 1257:11 1258:13 1267:7 1274:17 1275:5 1288:30
umbrella 1172:24
unable 1142:24
unavailable 1270:32
unaware 1346:14
uncomfortable 1344:18,19
uncontrollable 1218:27
undergo 1176:25
underlying 1341:7,13 1343:6
underneath 1143:1 1145:14 1209:24
understand 1135:20 1153:28 1154:5,24,29 1165:1 1169:7 1217:19 1222:16, 27 1233:18 1240:3 1279:16 1326:1 1346:15 1353:1
understanding 1158:21 1166:32 1181:24 1190:21 1215:8,12 1230:16 1235:32 1236:11 1241:18 1244:27 1277:14 1287:6 1320:16 1337:18 1338:12, 17 1346:3 1351:27 1352:30 1356:13 1360:23 1361:5
understands 1155:14
understood 1218:11 1235:29 1292:8
undertake 1247:8
underwent 1177:13
unexpected 1199:10,23 1200:10 1356:10, 14
unexplained 1352:14
unfair 1155:25, 31 1223:14,30
union 1157:7 1158:1 1159:28 1161:27 1162:12, 13,17,32 1164:14, 17 1219:26 1221:16 1223:7, 10,19 1224:25,32 1236:6,17 1319:31 1321:8 1327:8 1328:3,31 1329:19 1330:21, 23 1335:7 1337:30
unions 1223:22 1225:5
unit 1216:27 1217:1,8 1218:24 1243:8
units 1170:13 1272:18 1293:25

1294:4,7,10,18 1295:17 1296:29 1297:1,5,6,22,23 1298:17 1299:15 1302:10,12,18,27 1303:4 1304:13 1306:17,24 1307:1,6 1308:23, 32 1309:12 1311:10 1330:32

university 1207:8

unknown 1351:7

unlawful 1183:4

unpredictable 1209:4

unprofessional 1165:17,20

unreasonable 1272:28

unresponsive 1349:12

unsterile 1343:23

unsuitable 1157:1

unsure 1164:2

unusual 1216:21 1356:15

upcoming 1196:16

update 1196:21 1212:30

Urbantke 1201:17,25 1351:3 1352:13 1355:4

urine 1213:17

usual 1310:7

V

vac 1315:14,21

vacation 1148:6

vacuum 1315:23,26

valid 1238:2

Van 1178:31 1335:4 1348:30 1349:2

varied 1259:13

varies 1294:12

variety 1193:20

vary 1261:2

verbal 1159:23 1160:8,17 1166:6 1337:2,22

verbally 1319:6

verify 1229:2

versus 1151:3 1311:2

vet 1234:24 1235:23

vials 1277:31 1279:5

view 1219:22 1336:25 1338:23 1343:32

viewed 1345:16

viewpoint 1217:20

views 1285:2

vigilance 1315:18

violence 1177:10

vision 1274:6

visit 1214:8 1275:30

visual 1300:1

visualize 1247:16 1277:27 1295:17 1296:32 1297:1,4 1306:5,6

visualizing 1264:26

visually 1247:12

vitals 1350:2,16

vitamin 1249:4

vitamins 1251:3

voice 1351:22

volume 1226:5, 17 1272:32 1273:2,3

Voluntary 1189:9,28 1190:17

volunteer 1320:8

VPC 1189:9

vulnerable 1151:18

W

wait 1141:10,11 1237:24 1253:26 1285:14

walk 1258:7 1274:10

walked 1298:23

walking 1300:17 1316:12

Walmart 1279:25

wandering 1262:2

wanted 1207:23 1221:9 1227:21 1273:10 1292:7 1298:28 1305:2 1310:23 1325:3 1361:21 1362:17 1363:19

warning 1160:8 1337:22,23 1338:3

warnings 1160:17,18 1337:2

waste 1205:10 1298:18

wasted 1309:12

watch 1239:31 1300:22

watched 1196:22 1298:22

watching 1299:25,26 1300:2 1347:11

water 1251:19

ways 1176:8 1202:20 1231:14 1259:5 1265:13 1291:12

wear 1288:14

webinar 1196:23

webinars 1196:31 1197:7

website 1196:15,25,29

week 1185:30 1255:29 1276:22, 25 1288:20 1309:2 1318:5

weekend 1277:30

weekly 1263:17 1308:24

weeks 1194:18, 19 1332:11 1333:19

Wendy 1342:32 1343:22

wet 1285:16

Wettlaufer 1153:9,15,19 1154:21 1156:21 1157:12,30 1165:8 1167:11 1168:21 1169:16 1170:11 1178:16 1179:10 1184:26, 32 1193:14 1202:2 1209:16 1219:28 1220:1 1221:31 1224:24 1225:23,27 1226:29 1227:23, 26 1228:16 1229:23 1230:4 1245:30 1275:2 1277:17 1283:1 1301:15 1313:5 1330:26,29 1331:14 1332:32 1334:21 1335:4 1337:19 1341:26 1351:18 1360:4, 24 1361:2

Wettlaufer's 1152:13 1221:11 1227:4,8 1229:8 1249:8 1346:27

wheel 1196:5

whichever 1154:7

window 1296:5, 9,12

windows 1168:29 1169:1,3

wing 1245:20 1247:4

wise 1239:11

withdrawn 1162:3 1340:22

witness's 1236:26

witnesses 1155:19 1220:14 1235:1 1237:21 1238:19 1326:31 1330:19

woman 1218:5

wondered 1203:2

wondering 1232:31 1233:16

Woodstock 1135:16 1136:15, 22 1243:11 1348:19 1349:17 1356:17

word 1146:3 1237:20 1343:12

words 1229:29 1333:30

work 1144:7 1158:19 1161:5 1183:30 1191:18 1217:20 1219:28 1236:3 1243:15 1259:8 1262:4 1340:24 1345:31 1359:12 1360:25 1362:12

work-wise 1332:14

worked 1154:6 1157:15 1187:4,5 1194:15,18 1216:5 1217:5 1227:23 1243:6,8 1244:1 1245:21 1283:30 1314:21, 25 1326:29 1331:1,4

workers 1217:5

working 1135:18 1136:1, 12 1141:24 1142:22 1148:19 1191:12,14,17 1194:23,25,27 1196:6 1214:13 1229:23 1276:24 1289:23 1327:9, 10 1332:28 1334:9 1363:7

workload 1136:28 1137:9 1139:21 1140:1,6, 13,26 1141:20 1142:8 1144:7 1149:11 1192:28 1244:1 1271:14 1273:14,16 1274:31 1315:9 1332:4,16,18,19, 25 1333:6 1334:2, 3 1338:27 1340:24

workplace 1177:11 1220:17

worn 1289:23

worried 1235:16

worse 1305:18

would've 1181:16

wound 1260:14 1315:24,26 1326:23

wounds 1212:27 1261:7

wow 1327:22

wracked 1361:32

Wright 1158:2 1319:31

write 1206:24 1281:27

writer 1143:27

writing 1166:6 1289:25

written 1145:18 1159:23 1160:17 1189:16 1313:8 1332:3 1337:1,22, 23 1338:3

wrong 1174:2 1189:20 1202:3 1280:30 1293:2 1296:20 1317:3,4, 5

wrote 1231:7 1350:6

Y

year 1166:24 1207:2,9 1243:13 1330:2 1346:1 1362:11,16,24

years 1148:27 1155:29 1161:28 1177:14 1187:11 1191:23 1198:30 1207:10 1315:28 1336:16

yesterday 1135:12,24 1137:31 1139:3 1141:21,28 1159:27 1174:28 1193:12 1325:30

Z

ZIGLER 1215:15