PUBLIC INQUIRY INTO THE SAFETY AND SECURITY OF RESIDENTS IN THE LONG-TERM CARE HOMES SYSTEM

OVERVIEW REPORT:

THE FACILITIES AND AGENCIES

June 5, 2018

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VOLUME 1: GERALDTON DISTRICT HOSPITAL CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") began her nursing career at Geraldton District Hospital ("GDH"), working first as a student nurse and then as a Registered Nurse after she was granted registration by the College of Nurses of Ontario (the "CNO"). EW's employment at GDH was terminated in October, 1995 following an investigation in which it was determined that EW had stolen from GDH, and then consumed, "Lorazepam". GDH reported EW's termination to the CNO. The Chronology below outlines EW's work history at GDH and the circumstances surrounding her termination and GDH's report to the CNO.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	January 1995	EW (known as Bethe or Beth Parker at the time), commences working at GDH as a Student Nurse as part of the practical experience of her nursing course.	LTCI00054889
2.	March 31, 1995	EW applies for a position as a Registered Nurse at GDH, indicating that she will complete her course as of May 5, 1995 and will immediately be available for employment.	LTCI00054888 LTCI00054889
3.	April 11, 1995	GDH offers EW a position as a Casual Part-time Graduate Nurse subject to her obtaining her registration with the CNO. EW accepts the offer on April 13, 1995.	LTCI00054885
4.	May, 1995	EW requests a Temporary Registration with the CNO. GDH executes a form identifying that EW has been offered employment as a Registered Nurse as of June 8, 1995. She is granted same	LTCI00054883 LTCI00036270 LTCI00036273
5.	June 12, 1995	GDH records identify EW's date of hire as a Registered Nurse as June 12, 1995.	LTCI00054890
6.	June 30, 1995	The Canadian Nurses Association issues a Candidate Examination Report indicating that EW had passed her Comprehensive Examination.	LTCI00054882
7.	August 28, 1995	EW applies for a position as a Part-time Registered Nurse at GDH.	LTCI00054881
8.	August 31,	EW is advised that her application for a Temporary Regular Part-time Nursing	LTCI00054880

	DATE	EVENT	SOURCE DOC ID
	1995	position had been received but the positions had been filled.	
9.	Week of September 11, 1995	GDH receives a copy of EW's CNO Certification.	LTCI00054878
10.	September 13, 1995	According to a GDH Nurses Assessment and Treatment Report, EW started to feel unwell as she was completing her shift [which had commenced the evening of September 12, 1995]. She went to the bathroom and threw up. On leaving the bathroom, she was very unsteady and was swaying side to side when she started to fall forward. Two staff members supported her and assisted her to a chair. She was very weak and then transferred to a hospital bed in Room 361 where she was very groggy and difficult to arouse.	LTCI00037195
11.	September 13, 1995	Dr. J.G.S. Gomide was called to see EW. Dr. Gomide's Admission Note indicates that EW initially denied having taken any medications but after Marlene Pavletic ["Pavletic" - Director of Nursing] arrived, EW admitted that she took 2 Ativan (Lorazepam) out of the medication cabinet and took them "to take the edge off 'because she was very nervous since she had not worked here very often'".	LTCI00037194
12.	September 13, 1995	Notes by Pavletic indicate that at approximately 08:10 she was summoned to Room 361 by the Staff Health Nurse and, in the presence of Dr. Gomide and S. Parameswaren, RN, EW reports to her that she had obtained Lorazepam from the acute care medication cupboard and had taken 2 (1mg) tablets at 22:00 on September 12, 1995. Pavletic's notes indicate that EW took them to take "the edge off and to get her through the night". EW is admitted to GDH for observation by Dr. Shiu. After being admitted, EW's account of what happened varies. For instance, she tells Pavletic at approximately 16:00 that she took 0.5 mg Lorezapam shortly after coming on shift at 19:30 September 12 because she was nervous and another 2 mg at approximately 07:15 on September 13 before going home to get some sleep.	LTCI00037216 LTCI00037196 LTCI00037208
13.	September 13, 1995	Typed and handwritten notes by K. Harasym, RN, regarding September 13, 1995 shift with EW.	LTCI00037226 LTCI00037227
14.	September 13, 1995	Typed and handwritten notes by S. Parameswaren, RN, Staff Health Nurse, re shift of September 13, 1995	LTCI00037228 LTCI00037229
15.	September 13, 1995	Typed and handwritten notes by M. Gagne, RPN, regarding shift of September 13, 1995	LTCI00037230 LTCI00037231

	DATE	EVENT	SOURCE DOC ID
16.	September 13, 1995	Typed and handwritten notes by D. Lawson, RN, regarding shift of September 13, 1995	LTCI00037232 LTCI00037233
17.	September 14, 1995	EW tells Dr. Gomide that she actually took 25 Ativan (Lorazapam) as a suicide attempt and had been treated for depression in the past. Dr. Gomide's Discharge Summary indicates that a drug screen was performed and the results were not compatible with having taken 25 tablets. EW undergoes a Mental Health Consult. Notes of this assessment indicate that EW "gives the impression she is extremely lonely, she related she must hide a lot of things from her family", but that she does not want to take her own life. EW undergoes an initial assessment with the Social Services Department at her request. Pavletic meets with EW again, this time in Room 372, who tells her that she is unable to remember the events of the previous day and that "she knows she was hallucinating." She repeats what she told Dr. Gomide; i.e. that she took 25 tablets at the end of her shift (after taking .5 mg at the start of her shift). EW denies drug problems but states that she had a small depressive episode five years ago. Pavletic advises EW that she will be in touch within a week, after speaking with the CNO. In the interim, EW will not be called for any shifts. EW is discharged from GDH.	LTCI00037209 LTCI00037217 LTCI00037198 LTCI00037260 LTCI00037199 LTCI00037202 LTCI00037203 LTCI00037204
18.	September 14, 1995	Handwritten note prepared by I. Ciabatti, RN, regarding the shift of September 12 – 13, 1995 with EW.	LTCI00037219
19.	September 14, 1995	Notes produced by the CNO indicate that a conversation took place between Pavletic and a staff member reporting that EW had admitted to taking Lorazepam from hospital stock. Pavletic is told that if a decision is made to terminate, mandatory reporting is required and is encouraged to report. Pavletic is told of two options, letter of report and letter of complaint.	LTCI00037185
20.	September 15 and 17, 1995	Handwritten and typed notes by B. Kyro, RN, regarding shift of September 13, 1995 with EW.	LTCI00037224 LTCI00037225
21.	September 18, 1995	GDH records are changed to reflect an increase in EW's pay rate as a result of producing her Certification.	LTCI00054879

	DATE	EVENT	SOURCE DOC ID
22.	September 20, 1995	Pavletic meets with EW and her union representative. Pavletic advises GDH that the incident will be reported to the CNO as soon as GDH's internal investigation is complete. Pavletic also advises that she will not be offering EW work until the incident is thoroughly investigated. EW reports that she returned to work with her other employer, Geraldton and District Association for Community Living, on September 16, 1995. EW reports that she continues to have no memory of what happened on September 13, 1995, except that she removed Lorazepam from the cupboard.	LTCI00037217 LTCI00037260
23.	October 4, 1995	Typed statements received from A. Rossignol, RPN, regarding shift of September 13, 1995 with EW	LTCI00037220 LTCI00037221
24.	Undated	Handwritten and typed statements from J. Morneau, RPN, regarding shift of September 13, 1995 with EW.	LTCI00037222 LTCI00037223
25.	October 4, 1995	Pavletic phones EW to arrange a meeting, but EW is unable to meet until after October 11, 1995. They agree to meet on October 12, 1995.	LTCI00037217 LTCI00037260
26.	October, 1995	Pavletic's investigation indicates that an RN and an RPN had reported to her the following: *While working with the member [EW] on Sept. 12, the member could not be found for approx. 1 hour. The RN and the Dr. On-Call had noticed that the member appeared very tired all night. They had offered her coffee to perk her up. An RPN has reported that early on Sept. 13 the member got an admission from the Emerg Dept., and the RN had to assist the member in applying oxygen cannula. The members' medication tray was found at a clients bedside by an RPN at approx. 0720 hours*	LTCI00037216
27.	October 12, 1995	A meeting is held with EW. In attendance are Pavletic, Suzanne Marion (Human Resources), and EW's ONA representative. The meeting is to allow EW the opportunity to present her facts concerning the incident. During the meeting, EW acknowledges that she took the Lorazepam. She reports that she ingested .5mg of Lorazepam prior to her shift and 25 tablets at the end of her shift, prior to completing her charting, with the intent of ending her life. EW returned to the ward to finish her charting. She then felt sick and vomited. She can remember nothing else. EW cannot recall the hour between 23:00h and 24:00h; nor can she recall leaving the floor. EW is advised that she has given conflicting accounts of what took place. EW is told by Pavletic that there are serious concerns because EW took	LTCI00054875 LTCI00037260

	DATE	EVENT	SOURCE DOC ID
		medication from a drug cabinet, took the medication while on duty, and did not have a prescription for the medication. Pavletic states that the incident is very serious and could result in her termination. EW states that she is seeking help, she accepts what she did was wrong, and that she feels like it would never happen again.	
28.	October 13, 1995	A second meeting about the incident is held. In attendance are Pavletic, Suzanne Marion, EW and her ONA representative. EW is verbally informed that she is terminated from her employment at GDH "as a result of the incident that occurred during the course of [her] shift on September 12 and 13, 1995." Pavletic advises EW that she is obligated to report the termination to the CNO. EW receives a letter of termination.	LTCI00054874 LTCI00054873 LTCI00037260
29.	October 19, 1995	The Ontario Nurses' Association ("ONA"), on behalf of EW, files a grievance as a result of her dismissal.	LTCI00054872
30.	October 25, 1995	Notes produced by the CNO indicate that a conversation took place between Pavletic and a staff member re termination, grievance of termination, confidentiality etc.	LTCI00037184
31.	November 2, 1995	GDH (Pavletic) writes to the CNO, reporting EW's termination as follows: *Member was completing a 12 hour night tour at 0730 hours. Two oncoming RN's reported that the member, who was coming out of the staff bathroom, appeared dazed, was grossly unsteady on her feet and had difficulty communicating verbally. Subsequently, it was ascertained from the member that she had removed Lorazepam (2mg) from the ward medication stock without authorization and had ingested it during her working hours. The history given by the member changed several times over the 24 hour period (September 13 to September 14/95)* Pavletic provides the CNO with the staff schedule and a list of witnesses.	LTCI00037176 LTCI00037177
32.	November 7, 1995	The CNO acknowledges receipt of the letter of November 2, 1995 and advises that since all the information pertaining to this matter is confidential, they will be unable to inform GDH of the proceedings or outcome of any ensuing investigation.	LTCI00037183
33.	November 24, 1995	Notes produced by the CNO indicate that a conversation took place between Pavletic and Dinah Wong, CNO Investigator, wherein Pavletic indicated that there were no concerns with EW until this incident, though while EW was a student she was "a little bit different" in that she did not socialize with other staff. The notes indicate that Pavletic would like her Letter of Report of	LTCI00037218

	DATE	EVENT	SOURCE DOC ID
		termination to be considered a Letter of Complaint.	
34.	November 27, 1995	GDH (Pavletic) writes to the CNO, informing the CNO of GDH's intention to change the November 2, 1995 letter from a Letter of Report to a Letter of Complaint.	LTCI00037214
35.	December 4, 5 and 13, 1995	The CNO requests various documents from GDH, including a copy of EW's complete health record for her admission on September 13, 1995, as well as all information related to the incident of September 12 – 13, 1995.	LTCI00037164 LTCI00037178 LTCI00037162
36.	December 20, 1995	GDH (Irene Pelletier, Director, Health Records) responds to the CNO's request for EW's health records.	LTCI00037165
37.	December 21, 1995	Notes produced by the CNO indicate that a conversation took place between Pavletic and a CNO staff member discussing Pavletic's notes. Pavletic is recorded as indicating that the night shift could not determine how many Lorazepam EW took.	LTCI00037166
38.	December 27, 1995	GDH (Pavletic) responds to the CNO's request for information.	LTCI00037161
39.	January 2, 1996	The CNO writes to GDH (Pavletic), advising that the Complaints Committee will be considering the GDH's Complaint on March 20-22, 1996 and that GDH would receive notification of the Committee's disposition within one week following the meeting and that the decision, along with its reasons, would follow within approximately 8 weeks.	LTCI00037160
40.	March 22, 1996	The CNO writes to GDH (Pavletic), advising that a panel of the Complaints Committee considered the matter on March 20, 1996 and referred the matter to the Executive Committee for incapacity proceedings. GDH is advised that the matter will be reviewed by the Executive Committee on April 25, 1996 and that a written submission from Pavletic would be considered provided it receives her submission by April 16, 1996.	LTCI00037152
41.	April 3, 1996	The CNO writes to GDH (Pavletic), enclosing a copy of the decision of the panel of the Complaints Committee referring the matter to the Executive Committee for incapacity proceedings. GDH is advised that: *The role of the Executive Committee is to identify a potentially incapacitated member and take steps to ensure the protection of the public. Upon referral to the Executive Committee, the College of Nurses of Ontario has no continuing authority to keep you advised of any further decisions which may be made in relation to this matter. This letter represents our final notice to you.*	LTCI00037148 LTCI00036822 LTCI00037318

	DATE	EVENT	SOURCE DOC ID
42.	November 15, 1996	GDH and ONA settle EW's grievance and enter into Minutes of Settlement. The terms of the settlement include amending EW's personnel file to reflect that she resigned from GDH for "health reasons" as a result of a medical condition for which she has since sought medical treatment. As part of the settlement, GDH agrees to respond to any reference requests by advising that she resigned her employment for health reasons.	LTCI00054872
43.	November 18, 1996	GDH sends a copy of its Minutes of Settlement to ONA.	LTCI00054871

VOLUME 2: GERALDTON AND DISTRICT ASSOCIATION FOR COMMUNITY LIVING

CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") worked at Geraldton and District Association for Community Living ("GDACL"), located in Geraldton, Ontario, between approximately April, 1995 and March, 1996 as a support worker. Accordingly, for a period of time, EW was working shifts at both Geraldton District Hospital and GDACL. Documents relating to her employment at GDACL have been searched for by the current operator but could not be located. The chronology below is based upon information contained in a resume EW submitted to Christian Horizons in 1996 and in a resume she submitted to Caressant Care in 2007.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	April, 1995	EW, then known as Beth or Bethe Parker, becomes employed with Geraldton and District Association for Community Living ("GDACL"). In her resume submitted to Christian Horizons in 1996, EW states that she started with GDACL in May, 1995 and describes her position with GDACL as a "Direct Care Worker"as follows: - *duties included writing and implementing teaching programs and planning and participating in recreational activities for developmentally handicapped clients both high and low functioning* - *became familiar with the challenge of meeting client needs while working within the constraints of a budget.* In her resume submitted to Caressant Care in June, 2007, EW states that she started with GDACL in April, 1995 and describes her position with GDACL as a "Support Worker" as follows: *Job Title – Support Worker: I worked in several different group homes within the organization. I assisted individuals with their daily care including developing life skills, hygiene, meal preparation and clean up, laundry and community outings. I worked closely with 2 individuals who were seeking to develop the skills needed to live independent of daily support. While doing*	LTCI00060351 LTCI00057084

	DATE	EVENT	SOURCE DOC ID
		so, I taught them budgeting, cooking skills and fire safety skills.	
2.	February or March, 1996	EW's resume to Christian Horizons indicates that she leaves her employment with GDACL in February, 1996. In her resume to Caressant Care, she indicates that she leaves her employment with GDACL in March, 1996.	LTCI00060351 LTCI00057084

VOLUME 3: VICTORIA REST HOME CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") worked at Victoria Rest Home, located in Woodstock, Ontario between approximately April, 1996 and November, 1996 as a Registered Nurse. Documents relating to her employment there have not been located. The chronology below is based upon EW's resume from that time period and information obtained by the CNO during its investigation of the incident that occurred at Geraldton District Hospital in September, 1995.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	April, 1996	EW, then known as Elizabeth Parker, becomes employed with Victoria Rest Home. In her resume submitted to Christian Horizons in 1996, EW states that she started with Victoria Rest Home in April, 1996 as a "Charge Nurse" and describes her duties as including "assessing the ongoing physical and mental needs of my patients – Have sought to meet some of those needs by planning and including patients in recreational activities". In her resume submitted to Caressant Care in 2007, EW states that she started with Victoria Rest Home in March 1996 and describes her duties as follows: *Job Title – Staff Nurse: My duty was to provide nursing care for the 21 residents of the home as part of a team of care givers. I was responsible for administering medications several times each shift. I also administered Ventolin treatments, changed sterile and non sterile dressings, checked clients vital signs, and coordinated treatment approaches with other members of the team including family doctors.*	LTCI00060351 LTCI00057084
2.	October or November, 1996	EW leaves her employment with Victoria Rest Home. EW's resume to Caressant Care indicates that she left in October, 1996. Other information, obtained by the CNO in 1997 as noted below, indicates that she left in	LTCI00057084

	DATE	EVENT	SOURCE DOC ID
		November, 1996.	
3.	February 10, 1997	During the CNO proceedings arising from the incident at Geraldton District Hospital, EW's lawyers identify the proprietor of Victoria Rest Home at the time as Jane Windmill, and indicate that EW is in agreement that the CNO can speak to Ms. Windmill but EW "has some concerns about her employment with this facility".	LTCI00037115
4.	February 17, 1997	Notes taken by Michelle Gill, CNO, of a telephone conversation with Jane Windmill, indicate that Ms. Windmill reports that EW was employed as an RPN between April 18, 1996 and November 17, 1996, at which time she left voluntarily. In terms of EW's performance, Windmill reports that they "thought she was a good nurse. They did feel, however, that she was a little quick to make a decision on her own". The example cited is that EW thought that a patient was very close to death so she called the patient's family without taking any vital signs. Ms. Windmill further reports that EW did not show up for her midnight shifts on May 12, 1996 and October 8, 1996 and when called indicated that she didn't realize she was scheduled and refused to come in.	LTCI00037114
5.	March 19, 1997	EW's solicitors are provided with, among other things, a copy of the notes taken of the conversation between Michelle Gill and Windmill.	LTCI00037105
6.	April 2, 1997	EW's solicitors respond to the comments made by Windmill: (a) Ms. Windmill was not at the facility when the facts to which she refers occurred; her information is obviously second hand. (b) Ms. Parker did check the vital signs on the patient, who was close to death, prior to calling the patient's family. (c) On May 12th, while it is true that Ms. Parker did not realize that she was scheduled to work, she did attend once being contacted by the facility. (d) With respect to October 8th, Ms. Parker was not scheduled to work, rather, one of her colleagues failed to report to work. On this occasion, Ms. Parker was contacted to see if she was available to come in. She was not and did not do so.	LTCI00037099

VOLUME 4: CHRISTIAN HORIZONS CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") was hired by Christian Horizons ("CH") as a Support Worker in 1996. The evidence indicates that EW was not employed as a Registered Nurse while with CH, although in her position she administered medication and did assist in medication training.

As a result of the College of Nurses' ("CNO") investigation in 1997 regarding an incident at Geraldton District Hospital, EW must disclose to CH the CNO decision. CH agrees to notify the CNO if EW's chemical dependency is affecting her ability to practice nursing or if she has failed to comply with any of the conditions.

In December, 1995 EW made 3 medication errors [failure to sign], and ultimately received a three day suspension from administering medications. EW is employed by CH for a period of 11 years. During that time period there are indications of additional medication errors such as failure to sign, wrong person, wrong time etc. but no further disciplinary action is noted.

EW resigns her position with CH in June, 2007, noting that she was intending to move to New Brunswick. The Chronology below outlines EW's work history at CH.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	Unknown (presumably June, 1996)	EW, then known as Elizabeth Parker applies for a position as "Day Support Worker" at one of the homes operated by CH. EW's resume does not reference her employment with Geraldton District Hospital but under "Related Experience" does indicate that she is currently a Charge Nurse at Victoria Rest Home in Woodstock, Ontario as well as a relief counsellor with Christian Horizons. EW is hired and commences employment in June, 1996.	LTCI00060350 LTCI00060351
2.	December 9, 1996	CH's records indicate that EW was involved in a medication related incident - A medicated shampoo was used but not signed for.	LTCI00069422
3.	December 25, 1996	CH's records indicate that EW was involved in a medication related incident – A topical cream was not signed for.	LTCI00069422
4.	December 27, 1996	CH's records indicate that EW was involved in a medication related incident – A medicated shampoo was used but not signed for.	LTCI00069422

5.	December 31, 1996	David Petkau, Program Manager ("Petkau"), writes a memo to EW regarding Medication Errors she has made on: December 9 – Did not sign December 25 – Did not sign December 27 – Did not sign Petkau reports that he had verbally warned EW about the first two errors and suspends her from administering medications for three days after the last error, in accordance with the policy. Petkau writes: *Note that should a further error occur in the next 3 months an additional suspension would be required as well as a meeting with Rob Grimes, Regional Manager would be arrange, to discuss the nature and reason for the reoccurring errors.* *I cannot emphasis enough the importance of keeping our medication records accurate and free from error, not only for the safety of our clients but the team members we work with.* *In summary I expect you to remove yourself from the administering of medication for your next 3 working days. Note that this expectation does not supersede the well being of our clients. Following this I will arrange a time with you to discuss solutions and future expectation regarding the administering of medication.*	LTCI00060395
6.	January 19, 1997	CH's records indicate that EW was involved in a medication related incident - A partially dissolved Propranolol was found on the floor under the individual.	
7.	February 28, 1997	EW takes part in "Performance Planning and Development". The following responsibilities and/or goals, among others, are listed: • *To make only comment to clients in a way and in a place that I would want make to myself* • *To operate as a team member assigning value to those I work with in the following ways: Keep humour appropriate. Respectful of others feelings. Listen to concerns brought to me.* The following Core Competencies are noted as needing improvement: • *Monitor and carry out procedures related to Pharmacology;*	LTCI00060397

- *Respect privacy and dignity of clients, including the area of sexuality*
- *Conduct reflects professional ethics*
- *Model expected behaviours*
- *Effectively manages conflict and confrontation*
- *Respects viewpoints/decisions of others*

Petkau makes the following notes in "Comments of Appraiser":

As this is a review of your performance in the past 8 months or so, there are several areas that I look forward to reviewing and seeing improvement on. Note areas #1 above. Those of particular concern are in the areas of professional behaviour and teamwork. I believe your goals for the next year address these issues. Keep them foremost in your mind.

EW makes the following notes in "Comments of Employee":

I believe this is, for the most part, an accurate assessment of my performance and the areas needing improvement.

8.	June, 1997	Petkau receives a copy of the Decision of the Fitness to Practice Committee of the CNO dated May 9, 1997.	LTCI00036808
9.	June 19, 1997	Petkau signs Acknowledgement that he has received a copy of the Decision of May 9, 1997 and agrees, among other things, to notify the CNO if, in CH's opinion, EW's chemical dependency is affecting her ability to practice nursing or if she fails to comply with any of the conditions.	LTCI00037062
10.	July 2, 1997	Tracy Raso, Incapacity Coordinator, Investigations and Hearings with the CNO, writes to Petkau, enclosing a release form signed by EW dated June 17, 1997, authorizing him to provide information to the CNO as necessary in its monitoring of Conditions imposed on EW's certificate. She notes that the Conditions are outlined in the Agreement dated May 9, 1997. Petkau is advised that throughout the monitoring period the CNO will be contacting him approximately four times during the year.	LTCI00060399 LTCI00060400
11.	September 16, 1997	CH's records indicate that EW was involved in a medication related incident – Docusate for evening before was not punched out and given.	LTCI00069422
12.	October 19, 1997	CH's records indicate that EW was involved in a medication related incident – A dose of Amoxicillin was not administered.	LTCI00069422
13.	March 4, 1998	CH's records indicate that EW was involved in a medication related incident – Medications were given but not signed for.	LTCI00069422
14.	March 29, 1998	EW completes "Performance Planning and Development – Self-Appraisal". She notes that she feels that she has become more team-oriented. EW notes her habit of procrastinating. She wants to use more of her nursing	LTCI00060296

skills, “especially in the areas of assessment & client health”. EW further notes that she wants to “develop more consistancy in my approach to the cients, my teammates & my job”.

15.	March - May, 1998	EW’s co-workers complete peer reviews for EW.	LTCI00060297 LTCI00060298 LTCI00060299 LTCI00060300 LTCI00060301 LTCI00060302 LTCI00060303 LTCI00060304 LTCI00060305 LTCI00060306 LTCI00060307 LTCI00060308
16.	June 2, 1998	CH’s records indicate that EW was involved in a medication related incident – Medications given but not signed for.	LTCI00069422
17.	July 9, 1998	A “Performance Planning and Development – Direct Support Staff” is completed for EW.	LTCI00060295

In terms of her goals, the following is noted as being partially met:

- *To operate as a team member assigning value to those I work with in the following ways: Keep humour appropriate. Respectful of others feelings. Listen to concerns brought to me.*

Comments related to that goal are as follows:

Improvement has been made in this area with Bethe working hard at appropriate responses, use of humour and dealing more professionally with conflicts within team. However peer input still reflects need for growth with such comments as needing to be more tactful, rude, enjoying the mistakes of others. This will remain a goal to review in the next period.

The following goal is also noted as being met:

- *To make only comment to clients in a way and in a place that I would want make to myself*

Comments related to that goal are as follows:

Great improvement had been made in the support of the individuals we serve. I believe that this area is one to be aware of in the future and needs to be constantly guarded against. Personality type and humour preferences

are never an acceptable reason for disrespect to the individuals that we serve.

Among the noted core competencies needing improvement are the following:

- *Display professional behaviour*
- *Respects confidentiality*
- *Models expected behaviour*
- *Demonstrates ability to set priorities*
- *Manages time effectively*
- *Effectively managers conflict and confrontation*
- *Respects viewpoint/decision of others*

Reviewing Manager makes the following notes on EW's performance:

1. *Professional Behaviour: It is alarming to see terms like rude, not tactful, and enjoying the mistakes of others as input that your peers have had into your job duties. Certainly these types of behaviours are far from acceptable and need to be changed despite personality types, etc. . . . Note that these ratings have virtually not changed from the last review.*
2. *Self-Management: Setting priorities and managing time effectively are also a concern raised by team members. Again it is concerning to have you described as taking a long time to complete tasks, need to prioritized better, do more share of work, and works slow. The expectation for the next review period will see that peer input has greatly changed indicating that you accomplish tasks timely.*
3. *Team work: Managing conflict and respecting view of others. It is noted that progress has been made in this area from the last review and scores are higher than last review as well. But again needs still exist in order to see you continue to grow professionally within this team. Examples of this are comments such as needing to be more tactful (related to above) the attitude of asking forgiveness rather than permission. This has been discussed in the past as partially a humour issue. It may best to put it aside for the purpose of furthering in this area.*

18.	January 7, 1999	CH's records indicate that EW was involved in a medication related incident - Medication missed.	LTCI00069422
19.	January 19, 1999	CH's records indicate that EW was involved in a medication related incident – A dose of Ducolax was missed.	LTCI00069422
20.	February 22, 1999	CH's records indicate that EW was involved in a medication related incident – Serax was given at the wrong time of day	LTCI00069422

21.	May 17, 1999	EW completes "Performance Planning and Development – Self Appraisal". She notes that she has sought feedback from others who are tactful. She has made a conscious effort to listen to others' points of view. One of her objectives is to "confront people appropriately and use the situation so that differences in opinion or work style are settled in a mutually acceptable way."	LTCI00060311
22.	May, 1999	EW's co-workers complete peer reviews for EW. They are later summarized.	LTCI00060312 LTCI00060313 LTCI00060314 LTCI00060315 LTCI00060318 LTCI00060317L TCI00060318 LTCI00060319L TCI00060321 LTCI00060322 LTCI00060323 LTCI00060324 LTCI00060325 LTCI00060326 LTCI00060327
23.	June 1, 1999	CH's records indicate that EW was involved in a medication related incident - Gave but did not sign for Gaviscon.	LTCI00069422
24.	August 31, 1999	A "Performance Planning and Development – Direct Support Staff" is completed for EW. She has met her objectives. No "Improvement Required" is noted. Reviewing Manager's notes on EW's performance indicate that EW has accomplished what she set out to do and grown since her last appraisal. Her professional behaviour has improved and she has used "her sense of humour and tongue wisely." Her self-management has improved and she is described by her teammates as a hard worker, a good advocate, and open to praise and criticism. Her teamwork has improved and she is more respectful of her teammates; despite personality differences, experiences, and education.	LTCI00060309
25.	October 31, 1999	CH's records indicate that EW was involved in a medication related incident – An iron supplement was not given.	LTCI00069422
26.	April 15, 2000	CH's records indicate that EW was involved in a medication related incident – dose of Hexavitamin was given late.	LTCI00069422
27.	June, 2000	EW's co-workers complete peer reviews for EW.	LTCI00060355 LTCI00060356 LTCI00060357 LTCI00060358

			LTCI00060359 LTCI00060360 LTCI00060361 LTCI00060362 LTCI00060363 LTCI00060364
28.	June 21, 2000	CH's records indicate that EW was involved in a medication related incident - Vitamin signed for but not given.	LTCI00069422
29.	August 15, 2000	A "Performance Planning and Development – Direct Support Staff" is completed for EW. She has met her objectives. No "Improvement Required" is noted. Reviewing Manager's Notes indicate that EW has "continued to grow in the team and in responsibilities that you have in the team'. Further noted that she has taken more responsibility with conflicts or concerns, kept her manager informed and sought good solutions. Areas that EW should be aware of for her own personal/professional growth include "self-direction, self-motivation, procrastination" and "conflict resolution".	LTCI00060328
30.	September 2, 2000	CH's records indicate that EW was involved in a medication related incident - gave one individual another's eye drops of the same kind.	LTCI00069422
31.	October 10, 2000	CH's records indicate that EW was involved in a medication related incident – Did not give a topical cream.	LTCI00069422
32.	February 9, 2001	CH's records indicate that EW was involved in a medication related incident – topical cream not signed for.	LTCI00069422
33.	August, 2001	EW's co-workers complete peer reviews for EW.	LTCI00060367 LTCI00060368 LTCI00060369 LTCI00060370 LTCI00060371 LTCI00060372 LTCI00060373 LTCI00060374 LTCI00060375 LTCI00060376 LTCI00060377 LTCI00060378
34.	September 2001	EW completes a "Performance Planning & Development – Self-Appraisal". She indicates that one of her major accomplishments included the development of a med training program. Further notes that the only objective she did not fully achieve was to complete all tasks on time. She wants more opportunities to use her nursing skills.	LTCI00060368

35.	August, 2001	"Performance Planning and Development – Direct Support Staff 2001" completed for EW. She has met her objectives. No "Improvement Required" is noted. Reviewing Manager's Notes indicate that EW has "demonstrated a keen desire to carry out your responsibilities with a very high degree of professionalism and integrity. You have proven yourself to be very professional and sensitive in your interactions with teammates, family members and the people she supports. Your teammates have described you as being kind, caring, compassionate and as possessing a good sense of humour". The following is also noted: *Bethe, your skills in nursing and your attention to details regarding the over seeing of the med. Procedures and training are appreciated. I would simply ask that you continue to strive for the level of excellence that comes through in your work. It would appear that you have addressed the areas of self motivation and completion of duties in a timely fashion. Thank you for your hard work and continued efforts in growing professionally.*	LTCI00060329
36.	November 20, 2001	CH's records indicate that EW was involved in a medication related incident – Medications given late.	LTCI00069422
37.	January 14, 2002	CH's records indicate that EW was involved in a medication related incident Morning and evening dosage of Fluvoxamine reversed due to misreading label.	LTCI00069422
38.	July, 2002	EW's co-workers complete peer reviews of EW.	LTCI00060379 LTCI00060380 LTCI00060381 LTCI00060382 LTCI00060383 LTCI00060384 LTCI00060385 LTCI00060386
39.	February 4, 2003	CH's records indicate that EW was involved in a medication related incident – gave wrong individual Gaviscon medication.	LTCI00069422
40.	August 29, 2003	CH's records indicate that EW was involved in a medication related incident – Did not give medication.	LTCI00069422
41.	October 29, 2003	Serious Occurrence Noted involving EW – Resident fell to the floor and was unconscious. At one point he stopped breathing for about 30 seconds. Started again when he was shaken by staff. Resident was admitted to hospital and tests were done. Doctor indicated it may have been a "drop seizure". Seemed to be doing well.	LTCI00060410
42.	December 2,	EW completes a Worksheet – Team/Individual Goals	LTCI00060330

	2003		
43.	January 1, 2004	CH's records indicate that EW was involved in a medication related incident – Mislabelling of medications led to wrong dose of Fluvoxamine.	LTCI00069422
44.	February 18, 2004	CH's records indicate that EW was involved in a medication related incident – Gave but did not sign for Claritin.	LTCI00069422
45.	February 27, 2005	CH's records indicate that EW was involved in a medication related incident – Gave wrong person Tegretol.	LTCI00069422
46.	October 5, 2005	EW takes a Leave of Absence ("LOA") for a burst appendix.	LTCI00060332 LTCI00060333
47.	October 11, 2005	"Tammy" writes in the Communication Book; *Staff-Mark* *I dropped Beth's shifts till beginning of November on a pre-emptive move. Sorry – it should not have been done until Thursday (when Beth would receive dr.'s note). If there is any problems/concerns please let me know as I picked up some of her shifts as well.*	LTCI00060387
48.	November 7, 2005	EW returns to work on modified hours.	LTCI00060393
49.	January 31, 2006	CH's records indicate that EW was involved in a medication related incident – Dose of Gaviscon missed.	LTCI00069422
50.	April 3, 2006	CH's records indicate that EW was involved in a medication related incident – Did not sign for noon Gaviscon.	LTCI00069422
51.	July, 2006	EW takes a LOA . Her last day worked is noted as July 6, 2006 and the reason is noted as "psyche".	LTCI00060322 LTCI00060333 LTCI00060393
52.	July 13, 2006	"Mark" writes in the Communication Book: *Update re Bethe – (This is the soonest I was able to write this note).* *Just wanted to let everyone know some details regarding Bethe. I spoke with Dan yesterday. Bethe is currently struggling with some emotional issues and is hospitalized at this time. She will be in the hospital for at least another week. I will be dropping shifts one week at a time as I continue to hear from Dan. If I get a more specific date I will drop the appropriate # of shifts. I am staying in contact with Dan and will continue to update everyone.* *Please know we will send flowers to Bethe as a team. Also please note Dan has indicated visits are NOT a good thing just now. I will talking with Dan weekly or more and providing updates as I can.* *Please keep Bethe and Dan in your prayers during this time. Please also keep our team in prayer as we support Bethe as we can. Thanks Mark.*	LTCI00060388

		P.S. Please wait till Dan gives an OK for phone calls to him or Bethe – he will let us know. Thanks Mark	
53.	July 31, 2006	EW returns to work on modified duties.	LTCI00060394
54.	August 9, 2006	EW returns to full duties.	LTCI00060394
55.	November 23, 2006	CH's records indicate that EW was involved in a medication related incident – 20 :00 Nystatin was given but not signed for.	LTCI00069422
56.	January 1, 2007	CH's records indicate that EW was involved in a medication related incident- Medications given but not signed for.	LTCI00069422
57.	January 18, 2007	CH's records indicate that EW was involved in a medication related incident – Medications given but not signed for.	LTCI00069422
58.	March 30, 2007	CH's records indicate that EW was involved in a medication related incident – Amoxicillin signed for but still in blister pack.	LTCI00069422
59.	May 28, 2007	EW takes a leave of absence - the reason noted is "sick".	LTCI00060332 LTCI00060333 LTCI00060334 LTCI00060394
60.	June 2, 2007	EW returns to full duties.	LTCI00060394
61.	June 2, 2007	CH's HR\Payroll Employee Information Form identifies that EW has returned to work on regular duties as of June 2, 2007.	LTCI00060341
62.	June 2, 2007	EW leaves a hand-written note in the Communications Book: *Hey everyone. I just wanted to thank everyone for their prayers & concern. I wanted to let you know that I will be moving to Fredericton, New Brunswick on June 27th. My last day of work here will be Tuesday June 26th. I have thoroughly enjoyed my time working here & hope we can keep in touch.*	LTCI00060406
63.	June 16, 2007	CH's records indicate that EW was involved in a medication related incident – A dose of Phenobarbital was missed.	LTCI00069422
64.	June 26, 2007	Mark Lambley, Program Manager, ("Lambley") writes reference letter for EW, noting that she had "solid concern and dedication to the individuals for whom she has provided service". Lambley notes that EW functioned as the medication trainer and coordinator for the home, and was able to provide training for staff at times during her employment and around special medical needs, drawing on her nursing background to do this. He wishes her the best in all her future endeavours.	LTCI00051957

VOLUME 5: CARESSANT CARE CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") was hired as a Registered Nurse by Caressant Care Nursing and Retirement Homes Limited to work its location in Woodstock, Ontario commencing June, 2007 ("Caressant Care"). During her employment with Caressant Care, EW was disciplined multiple times (ranging from verbal warnings to suspensions) for various matters, including harassment, failing to complete required duties, not meeting the needs of the residents in a timely manner, inappropriate comments and various medication errors. The Chronology below outlines EW's employment history with Caressant Care and the basis upon which disciplinary action was taken.

EW was terminated on March 31, 2014 as a result of giving the wrong medication (insulin) to a resident, resulting in an adverse reaction to the resident. Caressant Care reported EW's termination to the College of Nurses on Ontario ("CNO"). EW grieved her termination, as well as an earlier 5-day suspension that she had received. Caressant Care settled those grievances in June, 2014. As part of the settlement, Caressant Care provided EW with a letter of reference, the contents of which had been negotiated between the parties.

EW has admitted to 7 counts of 1st Degree Murder, 2 counts of Aggravated Assault and 2 counts of Attempted Murder of residents of Caressant Care. A separate Chronology has been prepared for each of the victims.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	Undated	Note "to whom it may concern" from EW attaching her resume and indicating that she is available for work as of June 27, 2007.	LTCI00057083 LTCI00057084
2.	June 11, 2007	Letter "To whom it may concern" from Mark Lambley, Program Manager, Christian Horizons, indicating that EW had demonstrated a solid concern for and dedication to the individuals for whom she had provided service. Also notes that she functioned as the medication trainer and co-coordinator for the home and provided training to staff.	LTCI00057088
3.	June 27, 2007	EW's commences her employment at Caressant Care	LTCI00057092 LTCI00057098
4.	June 27, 2007	EW signs a Caressant Care form titled "Work Reference", providing an authorization for release of information from Mark Lambley,	LTCI00057085

	DATE	EVENT	SOURCE DOC ID
		Program Manager (Christian Horizons) related to her employment, position and reason for leaving. No answers recorded on form.	
5.	June 27, 2007	EW receives General Orientation for All Employees. EW signs various forms related to reporting work related injuries, the Employee Attendance Program, Confidentiality Agreement and receives WHMIS training.	LTCI00016920 LTCI00057087 LTCI00057088 LTCI00057091 LTCI00057094 LTCI00057109
6.	June – December 2007	EW admitted to having committed Aggravated Assault on Clotilde Adriano and Albina deMedeiros during this time period. *[For details, see Volume 5(i) - Chronology related to Clotilde Adriano]* *[For details see Volume 5(ii) - Chronology related to Albina deMedeiros]*	LTCI00057683
7.	August, 2007	EW admitted to having committed 1st Degree Murder of James Silcox on August 11, 2007. *[For details, see Volume 5(iii) - Chronology related to James Silcox]*	LTCI00057683
8.	November 5 and 7, 2007	Doctor's note – EW off work due to injury until November 8, 2007 and then to November 11, 2007.	LTCI00016919
9.	November 12, 2007	Email from Marie Buckrell, Director of Nursing ("Buckrell"), re November 11, 2007 – EW signed for a room that had not received their pills yet. Staff found these pills at 0230 hrs in a med cup – too late to give them, plus staff had no way of knowing when they were poured.	LTCI00016918
10.	November 12, 2007	Investigative meeting with EW. Noted that EW did not deny that she indeed did not give out resident's medication, and realized immediately that she had made an error. EW also signed for another room that had not received their pills. EW responded that she signs for the pills, pours them and then goes into the room with the medication. States that she was doing this when another staff member came in and she did not finish what she was doing. EW states that to prevent further occurrences she would leave a note to herself on top of the medication cart. EW told she must change her procedure to signing after giving the medication. Also spoken to about her attendance.	LTCI00016917

	DATE	EVENT	SOURCE DOC ID
11.	November 20, 2007	EW signs off on having read various documents including the Employee Handbook, Least Restraint Booklet, the Elder Abuse and Neglect Educational package and policies.	LTCI00057089 LTCI00057090 LTCI00057097 LTCI00057098
12.	December 22 – 23, 2007	EW admitted to having committed the 1st Degree Murder of Maurice Granat on December 22 – 23, 2007 *[For details, see Volume 5(iv) - Chronology related to Maurice Granat]*	LTCI00057683
13.	January 11, 2008	Typed notes re EW's preparation of a Care Plan and Nursing Quarterly Summary regarding a resident. Various issues noted re EW's completion of the care plan for resident.	LTCI00016916
14.	February 25, 2008	Medication error reported by B. Schultz re resident V – No Furosemide 40mg given @0800 because there was none in cyclefill pack.	LTCI00016915
15.	March 7, 2008	Investigatory meeting with EW re complaints about inappropriate behaviour. When asked whether EW had any idea of why she was called into the meeting her response was – "because I'm an 'out' lesbian?" EW denies every saying or doing anything sexually that would make other staff uncomfortable.	LTCI00016914
16.	March 23, 2008	Medication error reported by Shelly Clark, RN, and Lois Durbidge, RN, re resident LC- During narcotic count on March 23, 2008 HS Tylenol #3 signed for as given [by EW] but it was not given.	LTCI00016910 LTCI00016911 LTCI00016912
17.	March 24, 2008	Medication error reported by Lois Durbidge, RN, re resident CH. Resident reported that she had not received her HS insulin @0005hr. Report indicates that EW was called and said she gave the insulin. She was called again later and said "maybe I didn't give it", after the resident insisted she hadn't had it. Resident's Blood sugar – 17.2 at 00:10	LTCI00016909
18.	March 24, 2008	Medication Error reported re resident Wayne Hedges (victim) Lois Durbidge, RN, states that she was notified by Res 3 – 11 that she [sp] had not received HS insulin. 1500 – 2300 RN [EW] telephoned at home and confirmed that Wayne Hedge's insulin had not been given	LTCI00016908

	DATE	EVENT	SOURCE DOC ID
		Mr. Hedges' blood sugar was [greater than] 26.	
19.	March 28, 2008	Discussion with EW regarding medication error re Tylenol #3 being signed for as given but not given. EW said that she was in a hurry and didn't follow her usual process. Asked to give meds correctly and sign as she went even if it took her past the end of her shift and to ask for o/t.	LTCI00016910
20.	April 7, 2008	Discussion with EW about medication error re Wayne Hedges (March 24, 2008) – noted that to remedy this EW will take med cards for insulin & put on top of med cart.	LTCI00016908
21.	April 30, 2008	Caressant Care receives a letter from the Canada Revenue Agency seeking to locate EW	LTCI00057110
22.	June 19, 2008	Counselling letter to EW re her poor attendance record.	LTCI00016913
23.	June 22, 2008	Medication Error reported by Agatha Krawczyk, RN ("Krawczyk"), that a 20:00 Hydromorph Contin 3 mg was not given by EW.	LTCI00016907
24.	December 17, 2008	EW Performance Appraisal – indicates that EW knows the residents well, interacts well with residents and their families and is an asset to Caressant Care.	LTCI00016903
25.	September, 2008 – December 31, 2008	EW admitted to having committed the Attempted Murder of Wayne Hedges during this time period. *[For details, see Volume 5(v) - Chronology related to Wayne Hedges]*	LTCI00057683
26.	January 2008 – December, 2009	EW admitted to having committed the Attempted Murder of Michael Priddle during this time period. *[For details, see Volume 5(vi) - Chronology related to Michael Priddle]*	LTCI00057683
27.	Feb. 27, 2009	EW given letter of counselling re eating at the desk, taking and eating nursing home food, leaving the building on her break and not following through on her nursing duties.	LTCI00016886
28.	March 22, 2009	Handwritten note from EW reporting that a PSW had reported to EW what she felt was abuse of a resident by another RN.	LTCI00016884
29.	August 20, 2009	EW files Employee Incident Report regarding one resident striking another. EW then grabbed the resident's forearms and he pulled	LTCI00016902

	DATE	EVENT	SOURCE DOC ID
		free and struck her twice in left shoulder using his right fist.	
30.	September 2, 2009	Typed letter from Libby Gunter, RN, regarding EW telling her of comments made by another staff member, Jill Fletcher, RN, about her. EW alleged to have said to Libby Gunter: • I have no people skills • Registered staff are complaining about me to her for various issues • PSWs are complaining about me to her • Residents dislike me • That I receive more shifts than her • Why the part time one weekend only per month get shifts that she should have • That there are many changes that should be made and she wants to see them come to fruition • That I am too old to work here and should retire Libby Gunter reports "I am deeply hurt by these nasty unkind remarks and discrimination".	LTCI00016898
31.	September 11, 2009	Investigatory meeting with EW regarding what she had told Libby Gunter. States that she did not want to come to administration and felt that Libby Gunter should solve the issues. EW "seemed at a loss to understand how to handle this kind of situation". EW apologized at the end of the meeting for handling this poorly.	LTCI00016897 LTCI00016899 LTCI00016901
32.	December 3, 2009	EW receives verbal warning regarding discrimination and harassment of a co-worker. Order to apologize to the worker with a manager or union representative present.	LTCI00016895
33.	December 3, 2009	EW advised that her attendance is to be monitored for the next three months and she may be asked to bring in a doctor's note for each absence.	LTCI00016896
34.	January 5, 2010 (Have assumed this was incorrectly dated 2009)	Handwritten note to Brenda Van Quaethem, Administrator (Van Quaethem") from Helen Crombez (Director of Nursing ("Crombez") regarding asking EW for a doctor's note.	LTCI00016894
35.	January 19, 2010	Handwritten note from Jill Fletcher, RN, regarding a number of issues with EW:	LTCI00016888

	DATE	EVENT	SOURCE DOC ID
		• EW constantly arriving late for work. • Leaning over Jill Fletcher's shoulder during report and saying 'do it in order'. • When Jill Fletcher is reading off medications (using last names) EW started talking "Annie Annie", "Ben Ben" followed by "you are so cold" "you are so insensitive" "how would you like it Fletcher, Fletcher". I told her it did not bother me & just ignored her after that. • EW indicates she has a boil and pulls down the right side of her uniform bottoms so she could show it to Jill Fletcher. Additional notes indicate that EW was spoken to about this incident (though mistakenly referred to as Leslie) and that she feels Jill Fletcher is very cold. EW states that she will not show her boil.	
36.	January 21, 2010	Investigative meeting with EW re concerns raised by Jill Fletcher. EW states that if she is late, it is only by a few minutes and that sometimes she reads the communication book before going to the nurses' station. Claims that Jill Fletcher rhyming off people's last name sounds very impersonal. Acknowledges she showed her boil to Jill Fletcher.	LTCI00016890
37.	July 7, 2010	EW receives verbal warning for her poor attendance record.	LTCI00016883 LTCI00016884
38.	February 2, 2011	EW applies for Resident Care Coordinator position. Notified that she didn't meet criteria.	LTCI00016879
39.	February 8, 2011	Investigatory meeting with EW regarding no treatments being done on Level 2. EW claims that she did the treatments but did not sign for them. She acknowledges she did not do one treatment. In terms of RIA/MDS assignments, indicated that EW got 0 out of 105. Reminded that she is frontline staff and expected to be part of this for their funding. Told she is getting a verbal warning.	LTCI00016877
40.	February 8, 2011	EW receives verbal warning re scoring 0/105 on Rai-MDS audit during period December 25, 2010 – February 7, 2011 and a verbal warning for no treatments being done on Level 2 including a treatment for a Stage 4 ulcer	LTCI00016875

	DATE	EVENT	SOURCE DOC ID
41.	March 5, 2011	Handwritten note from Shelly Clark, RN, that resident MC admitted on March 4, 2011 @ 1359 and by March 5 @ 1500 care plan totally blank. Not started x 3 shifts. EW one of those shifts. Care Plan items per Ministry standard are to be completed within 24 hrs.	LTCI00016873
42.	March 8, 2011 (Have assumed this was incorrectly dated Mar 8/08)	Meeting with EW re 24 Care Plan on resident MC not being started. EW states that she started and finished the assessment but acknowledged that she did not tell the oncoming shift that the Care Plan must be done.	LTCI00016873
43.	March 8, 2011	EW was to receive counselling regarding not starting a 24 hour care plan and only doing a Head to Toe assessment. Handwritten notes – not given as completed 24 hr trigger & head to toe assessment. Did not give specific instructions to May to complete 24 hr CP.	LTCI00016872
44.	March 31, 2011	EW receives a written warning for calling in with a headache. Notified by manager/supervisor to take medication and report for work.	LTCI00016870
45.	May 25, 2011	Disciplinary meeting with EW regarding missed shifts.	LTCI00016868 LTCI00016871
46.	May 25, 2011	EW receives a written warning for being absent on May 23, 2011 with no notification.	LTCI00016867
47.	June 15, 2011	Handwritten note that 2 nitro patches had been found on a resident (JC) and one should have been removed	LTCI00016864
48.	Undated	Appears to be prep notes for June 17 meeting.	LTCI00016866
49.	June 17, 2011	Investigative meeting with EW re a complaint regarding an inappropriate comment, talking to someone outside of work re confidential issues, comments to students and failure to note fentanyl patch on the back of a resident.	LTCI00016862
50.	June 17, 2011	Email from Van Quaethem to Cheryl MacDonald and Crombez, re follow-up to complaint regarding inappropriate comments by EW. EW did not think her comments were inappropriate and she felt that it is because she is gay. EW advised to leave work issues at work, and not to go there outside the workplace. EW said she would	LTCI00016861

	DATE	EVENT	SOURCE DOC ID
		Van Quaethem asks whether there is further follow-up she needs to do.	
51.	July 14, 2011	Emergency Hospital note re EW off work for 72 hours.	LTCI00016860
52.	August 26, 2011	Meeting with EW. EW is told that she needs to "step up and take some overtime" Absent the other night [assume August 24, 2011] with short notice. EW told that they need to staff the home and if she has personal commitments she needs to take a LOA. EW indicates issue with taking care of her Dad, who she says has Alzheimers.	LTCI00016859
53.	August 26, 2011	EW given I day suspension re absence on August 24, 2011 due to personal reasons.	LTCI00016858
54.	October 3 – 4, 2011	Doctor's note – EW unable to work due to illness.	LTCI00016857
55.	October 13 – 14, 2011	EW admitted to having committee the 1st Degree Murder of Gladys Millard on October 13 – 14, 2011 *[For details, see Volume 5(vii) - Chronology related to Gladys Millard]*	LTCI00057683
56.	October 23, 2011	Doctor's note from the Emergency Department of WGH re EW seen that night and unable to work. Can return on October 25, 2011	LTCI00057112
57.	October 25 - 26, 2011	EW admitted to having committed the 1st Degree Murder of Helen Matheson on October 25 – 26, 2011 *[For details, see Volume 5(viii) - Chronology related to Helen Matheson]*	LTCI00057683
58.	November 6 - 7, 2011	EW admitted to having committed the 1st Degree Murder of Mary Zurawinski on November 6 – 7, 2011 *[For details, see Volume 5 (ix) - Chronology related to Mary Zurawinski]*	LTCI00057683
59.	November 28, 2011	Doctor's note re absence November 28 – November 29, 2011	LTCI00057111

	DATE	EVENT	SOURCE DOC ID
60.	January 12, 2012	A resident [CH] reports to Crombez that that EW has slapped her as she [CH] was leaving the building. In a Critical Incident Report filed on January 30, 2012 [CIR# 2636-000006-12], Crombez notes: *Incident investigated immediately. Resident interviewed. [CH] stated that she was slapped when telling me. During our discussion, B. VanQuaethem asked [CH] to demonstrate how and where she was hit with the same force as best she could. [CH] closed her fist and punched Brenda in the front of her shoulder which indicated her shoulder which had the surgery.* *N. Brown, PSW interviewed.* *B. Wettlaufer, RN interviewed.*	LTCI00000522 LTCI00059485
61.	January 13, 2012	Caressant Care files a Critical Incident Report regarding an injury to a resident [BK] that resulted in her being transferred to the hospital. EW was on shift at the time and responded to the resident having been found sitting on the floor. The details of EW's care are noted in a handwritten note submitted to Caressant Care on January 16, 2012 – found at #63 herein	LTCI00017015
62.	January 14, 2012	Caressant Care receives a handwritten note from Jennifer Slyfield, PSW, regarding EW and her work ethic: • *PRNs are not given in a timely matter Room 1, Bed 1 I have seen wait for up to 2 hours* • *On Jan 4, 2012 – Rm 21 was disempacted. The resident was in pain and stated so. The commode had more bright red blood than feces.* • *It was awful to see a resident in agony and instead of the nurse stopping to give the resident a PRN for pain she just kept digging farther and farther up while resident was in the air attached to the lift & me, Wendy & Beth all present in the room.* • *On January 6 resident fell while I was on break – Manju paged EW for help. When no one came for 15 minutes he asked me to leave my only break taken early to assist.* *We had the resident standing/walking towards wheelchair before Tamara Mott had come over. Why couldn't EW have walked over? What happens if a resident is in crisis? EW always sits at the nurses' station and eats instead of stocking or helping like I've see other nurses do. I have even been asked to take*	LTCI00016852

	DATE	EVENT	SOURCE DOC ID
		residents' temperatures as EW would just claim to be busy. I should be able to rely on my nurse.	
63.	January 16, 2012	Caressant Care receives handwritten notes by Wendy MacKnott, PSW, dated January 15, 2012 regarding what occurred on shift with EW on January 12 - 13, 2012. Notes relate to a resident's fall and a cut on another resident's finger and provide, in part: *Registered staff was washing right leg, which had a Hemmatoma on her left shin that was tore open. She also had a Hemmatoma on her left shin that was closed.* *After washing resident's right shin Registered staff (B.W.) wrapped wound and proceeded to look at left leg.* *Registered staff stated she suspected resident had broken her hip (Rt) she proceeded to take a pair of small scissors off treatment cart and stated to staff that she was going to (pop) as she said the Hemmatoma to drain and relieve pressure. PSW staff just looked at each other as we didn't feel this was a good thing.* *Registered staff proceeded to puncture the Hemmatoma and it squirted blood out. B.W. then proceeded to keep wiping it until the skin was flat on shin then dressed wound. PSW continued to wash the blood off resident* *PSW voiced our concerns among ourselves and expected management would contact us and they have.* *Also that evening while Registered Staff (B.W.) was preparing for resident to transfer to hospital, I asked (B.W.) to check a resident. She was calling out and was found holding onto her bedrail stating she was going to fall and I noticed her index finger dripping blood on the floor.* *I ask registered staff (B.W.) to look at it and dress it, she stated she would have to do it later she was busy preparing resident to transfer to hospital.* *(B.W.) told me to open treatment cart, take some gauge pads and place them on her finger and she would look at it later, so that is what I did.* *I do not believe she got there to look at it or dress it properly. It was still the same way at 7:10 a.m. when I went to see how she was.*	LTCI00016843
64.	January 16, 2012	Caressant Care receives a handwritten note dated December 16, 2011 from Dawn Pike regarding issues with EW between December	LTCI00016848

	DATE	EVENT	SOURCE DOC ID
		5 and 7, 2011. • *On December 5, 6, 7 found resident VT having difficulty breathing.* • *Went to EW – on all three nights she said "resident is COPD 'I think'" and went about her business.* • *December 8 – working with Donna K – checked on VT – same symptoms. Told DK same symptoms for last three days – she reported to EW – EW decided to check on resident. After checking decided that VT was COPD level 2 and gathered an oxygen machine for resident.* • *I feel that VT was neglected by Beth and suffered for 3 days with shortness of breath and labored breathing.* • *December 5 – GP started ringing bell at around 2:25 a.m. I approached EW where she was found sleeping in the chapel to tell her that GP wanted some pain meds. She told me it would have to wait until 3:00 a.m. when she was finished her break. This meant that GP would have to be uncomfortable for at least an hour until her meds would even become in effect.* • *Jan 2 – 8 GP started ringing her bell around 2:15 for her adavane (sleeping aid) EW was approached on her break for this. I was told she would get it shortly.* • *GP rang bell x2.* • *Rang last time at 3:45 because she said she wanted her adavan and if she was not going to get it to just tell her because she had been waiting a long time and can't sleep. GP was very upset about this and wanted an explanation.* • *These have been bothersome.* • *As I explained, I knew the right thing to do but was hesitant due to fear. I am not a rat or a trouble maker but have known that by not telling anyone I was only hurting the residents of CC.* *I feel that it will be properly dealt with and I feel in my heart that now I have done the correct thing by bringing this to your attention.*	
65.	Undated	Investigative meeting with EW regarding January 12, 2012 shift. Did not complete work re post fall. EW indicates that she was exhausted. Explains what happened. Acknowledges that they moved resident to a wheelchair, thinking that she had hurt her hip.	LTCI00016853

	DATE	EVENT	SOURCE DOC ID
		Did take unsterile scissors and poke hematoma. Did not look at resident GH's finger. Did not get to it. In terms of disempacting the resident, EW indicates that the resident was uncomfortable and saying "OW, OW, OW but not screaming". EW asked if the Resident was short of breath? No answer noted.	
66.	January 16, 2012	EW receives written warning regarding not meeting the required needs of residents in a timely manner, and not following policy and procedure after a fall.	LTCI00016842
67.	January 16, 2012	In CIR #2636-000006-12 related to incident between EW and resident [CH] on January 12, 2012, Crombez notes: *Resident came to my office January 16, 2012 with B. Wettlaufer, RN and said that she came to apologize as RN did not hit her. B. Wettlaufer thanked her and recognized that this was a difficult thing for [CH] to do.*	LTCI00000522 LTCI00059485
68.	January 24, 2012	In CIR #2636-000006-12 related to incident between EW and resident [CH] on January 12, 2012, Crombez notes that resident [CH] called the MHLTC on January 23, 2012 to report that she had been slapped. Crombez notes: *June Osbourn called and spoke with J. Lowe, Assistant Director of Nursing Jan. 24, 2012.* The MHLTC's Inquiry/Intake Report of this conversation provides as follows: *January 24, 2012 I did call the home and spoke to Janet ADOC to see if the home was aware of this since an investigation and reporting needed to occur. Apparently the complainant was aware of this alleged abuse and did an investigation. There is no CI in the system pertaining to this.*	LTCI00000522 LTCI00059485 LTCI00059320
69.	January 30, 2012	Caressant Care files CIR #2636-000006-12 related to incident between EW and resident [CH] on January 12, 2012.	LTCI00000522 LTCI00059485
70.	February 8, 2012	Caressant Care files a Critical Incident Report [CIR #2636-000008-12] regarding an incident of February 8, 2012 wherein resident [CH] stated that she was sleeping in her bed and [EW] came in and hit her on her left frontal shoulder to wake her up to do her blood sugar. Crombez notes: *Resident reported to the Administrator that she was hit this*	LTCI00000389 LTCI00059487

	DATE	EVENT	SOURCE DOC ID
		morning. *B. Van Quaethem and H. Crombez met with [CH]. [CH] was asked for details of the incident.* *B. Van Quaethem reported the incident to Head Office.* *B. Van Quaethem called sister and POA and left a message asking her to call the home.* *Police were called and notified of the incident.* CIR indicates that police were called and interviewed [CH} and that she consented to having Van Quaethem and Crombez in the room with her. Crombez notes: *[CH] told the Police Officer that she was advised by her lawyer to keep her distance and not speak to the RN. Police Officer advised that B. Wettlaufer, RN, not give care to [CH] and to try to keep them separated for the time being.*	
71.	February 8, 2012	Crombez amends CIR #2636-000008-12 to indicate: *[CH] states that she is fine and not injured.* *Upper body examined by H. Crombez, RN. No areas of redness or bruising noted around left shoulder. Is wearing a sling since surgery performed on right shoulder. Indentations and redness caused by sling noted. Scar is healing.*	LTCI00000389 LTCI00059487
72.	February 14, 2012	Investigative meeting with EW regarding incidents re not making sure a resident has taken meds (resident SA). EW acknowledges that it would be serious if someone else had taken it and had an allergic reaction. Also discussed that EW had not given resident DW his mineral oil treatment. EW states that she thought that she had done it. Acknowledges that she did not chart that she had done it.	LTCI00016816
73.	February 22, 2012	EW giving counselling re an inappropriate conversation with a resident – telling the resident that she would no longer stand for being bullied.	LTCI00016840
74.	February 24, 2012	Caressant Care amends CIR #2636-000006-12 related to incident between EW and resident [CH] on January 12, 2012 to add the following: *Police were called and investigated on February 8, 2012 the incident with [CH] reporting that she was hit by the R.N. The police officer informed [CH] if she was lying that she could be charged. [CH] said*	LTCI00000522 LTCI00059485

	DATE	EVENT	SOURCE DOC ID
		she understood this. *February 16, 2012 [CH] was rude to Bethe Wettlaufer, R.N. [CH] later apologized for her behaviour to Bethe, R.N.* *February 24, 2012 A family meeting was held with POA & sister, niece, B. Wettlaufer, R.N., H. Crombez, DON & B. Van Quaethem, Adm. to discuss recent behaviour. [CH] and Bethe apologized to each other. Goals were set for [CH] with her input. [CH] was happy and relaxed after the meeting.* *After family members left and B. Wettlaufer left [CH] came to the office and asked if the Ministry could be called and asked not to come in. In questioning as to why, [CH] said the police lady said if I lied I would go to jail. [CH] was reassured that we recognized that she was angry and she wanted to get the R.N. in trouble. It was explained to [CH] that the incident was over and she would not be going to jail. It was explained to [CH] that she should tell the truth if the Ministry comes in to investigate.*	
75.	March 4, 2012	Email from M. Bhat to Crombez re various issues with EW, re narcotic counts, telling M. Bhat in front of residents that she is the boss etc. M. Bhat Indicates that finds it hard to do job with this kind of treatment. Handwritten note on email states "Manju emailed & did not want action taken"	LTCI00016841
76.	April 20, 2012	Investigative meeting with EW re April 19, 2012 incident – new admission, nothing initiated. States that she told another staff member to do to a head to toe assessment. EW explains "do you understand that this is my 7th shift in a row? I can and will do better. Yesterday I did the best I could" and that it is unfair, that she is the only one in the building.	LTCI00016837 LTCI00016838
77.	April 20, 2012	EW given verbal warning for not completing required admission work for a new resident on April 19, 2012.	LTCI00016835 LTCI00016836
78.	May 28, 2012	Handwritten note received re EW's interaction with a resident.	LTCI00016833
79.	May 28, 2012	Caressant Care receives handwritten note regarding issues with EW: • *Beth taking hour breaks again*	LTCI00016833

	DATE	EVENT	SOURCE DOC ID
		• *Telling staff when they report that a resident wants something for pain "I'll just wait & see if they ring again"* • *They say they just do their work and don't get her unless needed as doesn't really do anything anyways. (Donna Kirkpatrick, Nathan Brown)* • *2 staff have come to me re her boasting how much money she makes – tells them makes over $40/hr. This only causes resentment. They see as boastful and resent that she doesn't appear to work very hard for it (Barb Bennie & Dawn Pike)* • *"I bring in food to these girls – they only complain because I'm gay – Beth to Dawn?* • *There are a bunch of supps not given. They say she doesn't ask for help. I need help as does Lois with some, not all but most so how she does it I don't know. They never see her give them?*	
80.	June 2, 2012	Investigative meeting with EW regarding some issues such as EW not responding when a resident rings re pain – she has said that she waits "to see if they ring again". EW acknowledges that she does this with 1 resident. Also noted: • that staff have concerns that they report to her and she does nothing. • EW discusses how much money she makes and staff are resentful • Discussing sexual orientation with staff • Not being seen giving suppositories • Incident re arguing with a resident, covering up her name tag and the resident's response to that	LTCI00016827
81.	August 13, 2012	Doctor's note indicating EW to commence two-week leave	LTCI00016830
82.	August 28, 2012	Caressant Care files a Critical Incident Report [CIR # 2626-000027-12] identifying that Jennifer Hague, RN and Laura Long, RPN had just completed a narcotic count and it was discovered that a box of 5 Fentanyl Patches were missing and a single Fentanyl Patch missing. Van Quaethem notes:	LTCI00000433 LTCI00059506

	DATE	EVENT	SOURCE DOC ID
		All med carts searched for missing patches by Registered Staff, Administrator, Director of Nursing and Assistant Director of Nursing. No missing patches found. CIR indicates that police have been called and an investigation is taking place.	
83.	Undated (assume related to August 31, 2012 discipline)	Meeting with EW re not responding to a concern regarding a resident/charting re resident EL. Reference to "OCD" and "bi-polar" and "changing meds". EW told that her assessment skills were not up to par and her documentation skills are not up to par. Also advised that there were issues with her interaction with staff and "your talking to staff regarding narcotic bin".	LTCI00016826
84.	August 31, 2012	Written notice prepared regarding not assessing a resident (EL) as required when it was reported that the resident was apparently not herself. Notes that "If continued poor performance related to health issues continue, consideration may be given to report to the College of Nurses for "fitness to practice for review". EW asked to follow-up with the health issues that she discussed with them. Handwritten note on form states "explained to Bethe that she brought her health issues to us & we are obligated to ensure the safety of the residents".	LTCI00016823
85.	September 3, 2012	Disciplinary meeting with EW regarding the interview the previous week related to resident not being herself (EL). Receiving a written warning (assume it is notice dated August 31, 2012). Handwritten note provides "not doing that now (reporting to College) your health is our concern". EW notes that she has accessed a module on the CNO website and that she is working through that on her computer.	LTCI00016824
86.	September 4, 2012	Investigation meeting with EW re – not taking fridge temps and initialing the narcotic count but not doing it with the oncoming shift.	LTCI00016822
87.	September 4, 2012	CIR # 2626-000027-12 regarding missing narcotics discovered on August 28, 2012 amended to add:	LTCI00000433 LTCI00059506

	DATE	EVENT	SOURCE DOC ID
		Staff involved interviewed by the police officer, Administrator and Director of Nursing. No one admitted to taking the medication and they seemed sincere during their interview. The Police Officer felt there was not enough evidence against any single person so no charges could be laid. Police Officer said he would file a report and that if this should happen again to look for a pattern regarding staff working.	
88.	September 4, 2012	EW given a written warning regarding not counting narcotics as per protocol on Monday, September 3, 2012 & not taking med refrigerator temperature on Friday, August 31, 2012 and vaccine frig on August 27 & 29, 2012 as per requirements of Public Health.	LTCI00016821
89.	January 18, 2013	Meeting with EW re her attendance.	LTCI00016819
90.	January 18, 2013	EW given letter regarding her attendance – 11 shifts missed between January and December 2012.	LTCI00016818
91.	February 21, 2013	EW given written warning regarding not administering a medication to a resident following proper procedure and not administering mineral oil treatment to ears of another resident as required.	LTCI00016815
92.	March 14, 2013	Brenda Van Quaethem sends Wanda Sanginesi, VP Human Resources ("Sanginesi") EW's handwritten note regarding allegations made in a Human Rights Complaint by a co-worker.	LTCI00072022
93.	March 15, 2013	Caressant Care files a Critical Incident Report [CIR #2636-00006-13] regarding a controlled substance missing/unaccounted for on March 14, 2103. Reported that during a narcotic count by 2 RNs at shift change between evening and night shift it was noted that 1 capsule of Kadian SR 10mg was missing. The earlier narcotic count between the day and the evening shift was correct. Crombez notes: *It is possible that resident may have received a double dose as B. Wettlaufer, RN, reported that bin was searched and capsule could not be found.* *B. Wettlafter, RN notified the manager on call at 00:36, which was myself, H. Crombez. RN stated that there was a delay in reporting as they searched the lower drawer/bin for the capsule but could not find it. H. Crombez asked that Police Department be notified and investigate which was done. Cst. Randy Rudy came to the nursing home and interviewed both B. Wettlaufer and L. Durbidge, Incident #WP130002571.*	LTCI00000643 LTCI00058984

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		Resident was assessed at 00:50 by b. Wettlaufer, RN due to possibility she may have received an extra dose of Kadian. [M] was easily roused, was alert and conversant. Temperature 36.1, pulse 70, respirations 18, blood pressure 116/72. *Resident monitored throughout the night by L. Durbidge, RN. [M] slept her normal sleep pattern, roused to verbal stimuli when checked. [M] was appropriate during toileting rounds and up in her chair conversing this morning.* *[M] is her usual self today. Vital signs stable as reported by N. Lim, RN.*	
94.	March 15, 2013	Email from Helen Crombez to Sanginesi regarding the missing narcotic requesting advice as to whether they can give EW a 1 day suspension.	LTCI00072026
95.	March 19, 2013	Investigation meeting with EW regarding missing narcotic on her shift. EW thinks she gave the medication and didn't sign off. Admits she did three things wrong: • Not signing MAR • Not signing NARC • Giving earlier	LTCI00016814
96.	March 19, 2013	EW given a 1 day suspension regarding a narcotic not accounted for at shift count.	LTCI00016813
97.	March 28, 2013	CIR #2636-00006-13 amended to add the following: *Memo to all registered staff that starting immediately they are to initial the bubble of each medication they pop out of medication card. This step is in addition to their regular charting, recording and counting of narcotics an controlled substances. Incident is being investigated and staff are being interviewed.* *Incident was investigated. B. Wettlaufer felt that she may have given the medication earlier as resident complained of a severe headache at suppertime. She feels she may have given it again at bedtime. She made medication errors in giving medication earlier than allowed and not charting at the time of administration. She received a one-day suspension as we do progressive discipline.*	LTCI00000643 LTCI00058984
98.	April 1, 2013	Handwritten note from Wendy MacKnott, PSW, re EW. EW talked about one resident (DW) being ignorant to another resident (DS). EW stated that DW was making fun of DS's laugh and she asked him to stop, that it was ignorant what he was doing and that she asked him if he needed a psychiatric assessment done. Wendy	LTCI00016810 LTCI00016811

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		MacKnott indicates that this is an inappropriate way to talk to residents. Typed note received from Laura Long, RPN, regarding EW saying to resident DW "Do you need a Haldol injection? Do you need a psychiatric evaluation?" Note also outlines additional concerns.	
99.	April 1, 2013	Caressant Care files a Critical Incident Report [CIR #2636-000007-13] regarding an incident involving EW and a resident [DW] on April 1, 2013. Crombez reports: *Resident came to my office this morning to say he did not want Bethe Wettlaufer giving him medication again as he did not trust her to give him his correct medication. He said if she comes near me again he would kick her and punch her in the teeth. Resident said he "would kill her", "kick the shit out of her", "kick her until her bowels are on the floor", "I'll kill her and go to the nut house. I'll go to jail".* *Bethe Wettlaufer charted the following:* *"[DW] came out of his room at 06:45 and sat near resident room 2 bed 4. Whenever that resident laughed, [DW] would voice a fake laugh and then say "look at me, I'm a laughing fool too".* *Intervention: [DW] was informed by the writer that his actions were rude and bullying and he was asked to stop. [DW] was also reminded by the writer that resident room 2 bed 4 had agreed that if [DW] told her her laughing bothered him and asked her to move, that she would move.* *Time and Frequency: 1 staff x 5 minutes x 3.* *Evaluation: Ineffective. [DW] became angry and threatened writer that he would kick her stomach through her spine and smash her teeth in with his fist".* Crombez notes that the Police were called to speak to the resident and reported that the resident is calm and that the resident had assured him there would be no further incident.	LTCI00000639 LTCI00058989
100.	April 2, 2013	Caressant Care amends CIR #2636-000007-13 to identify the actions taken since the incident. Urine tests were done on the resident and indicated a urine infection. Crombez further notes: *B. Wettlaufer advised with a voice message last evening April 1/13 to not approach resident alone at any time. She is to have a PSW*	LTCI00000639 LTCI00058989

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		with her at all times when entering his room or dealing 1:1 with resident. *Resident accepted his blood sugar tested this morning from Bethe and she had a PSW go into resident's room with her.*	
101.	April 9, 2013	Medication Form 449 prepared by Jacqueline Morris re resident JM – medication for Monday April 8, 2013 found in strip pack in medication cart. Indicated in eMAR that EW had given the medication at 10:30 and 20:00.	LTCI00016798
102.	April 12, 2013	Investigation meeting with EW regarding medication error (JM). EW explanation – "I believe I made them (errors) just don't know how". EW advised that she is receiving a 5-day suspension effective immediately.	LTCI00016808
103.	April 12, 2013	EW given a 5-day suspension for incident that occurred April 8, 2013 – Resident medication was indicated as given in eMAR and was not given.	LTCI00016797 LTCI00016804
104.	April 16, 2013	Caressant Care files a Critical Incident Report [CIR #2636-000011-13] identifying that the pharmacy consultant had been in that day to destroy meds and had discovered an individual narcotic card of 31 tablets of Hydromorphone 1mg was missing. Tablets had been put in the medication destruction box by Lois Durbridge, RN and Jennifer Hague, RN on March 21, 2013. The Police were notified. Crombez notes: *Investigation taking place.* *Narcotic Disposal Box inspected by B. VanQuaethem and H. Crombez April 16/13 and found to have a gap where possibly a medication card could be removed by sticking your hand in or using tongs. We showed C. Pink this and she has put in a request for equipment service to this box or a replacement for this box. Request is marked as "urgent".*	LTCI00000623 LTCI00059007
105.	April 17, 2013	CIR #2636-000011-13 notes that on April 17, 2013 the Police were in to investigate. Crombez notes: *Constable McLeod took a list of names of registered staff, RN and RPN, that work here and also a list of staff who worked night shift alone on this side of the building.*	LTCI00000623 LTCI00059007
106.	April 23, 2013	EW files grievance ONA#201303298 regarding her 5-day suspension. Van Quaethem emails Cheryl MacDonald asking how this is handled.	LTCI00072544 LTCI00072545

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107.	May 8, 2013	Email from Helen Crombez to Brenda Van Quaethem regarding EW's having been in a car accident.	LTCI00072026
108.	May 21, 2013	EW submits her application for a current job posting as afternoon RN on Level A1.	LTCI00072026
109.	June 7, 2013	Handwritten note by Brenda Black, PSW, that the previous week she witnessed EW do something inappropriate. Alleges that between 7:30 and 8:00 a.m. when she was pushing a resident into the dining room EW said "Oh, wait she loves it when I do this". Then EW turned so her backside was facing the resident and proceeded to shake her butt in the resident's face. EW called the resident's name several times so she had her full attention.	LTCI00016796
110.	July 13 - 14, 2013	EW admitted to having committed the 1st Degree Murder of Helen Young on July 13 – 14, 2013. [*For details, see Volume 5(x) - Chronology related to Helen Young*]	LTCI00057683
111.	July 30, 2013	Letter from Jayne A. Homes, Labour Relations Officer, ONA, to Sanginesi indicating that EW has requested that the Union withdraw Grievance #201303298.	LTCI00072546
112.	September 19, 2013	Doctor's note re absence September 16, 2013 – September 20, 2013	LTCI00016923
113.	November 7, 2013	Doctor's note re absence November 7, 2013 – November 8, 2013	LTCI00057100
114.	November 11, 2013	Caressant Care receives a handwritten note from Dianne Fleming, PSW, dated November 8, 2013. Note alleges: • *EW is a bully* • *Will interrupt us to tell us something she wants us to do* • *In dining room she tells us when we can start serving, what we should be doing* • *Tells us to toilet people during dinner* • *Told me to wear a hairnet because then I become part of the kitchen help* • *Spoke loud to me (later apologized)* • *Oct. 6 – she shhssed them – said she was on the phone and they were loud – told her not to sh me again, I was not a child, she could ask me to lower my voice – she stood up,*	LTCI00016793

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		told me I was being insubordinate, she was my supervisor and I had to obey her • *Accused me of not wanting to toilet person* • *Knows 3 people that won't work over here because of me and that she was going to report me – I said go ahead* • *EW said "how do you feel working here when there are residents younger than you?"* • *Has said "When are you going to retire"* • *Feels she singles me out* • *Said wing is so much better with her there* • *Controller* • *PSWs not comfortable when she works* • *Both Mary and Vanessa said she is a bully and out of control* *There is more that I would be happy to discuss in person*	
115.	November 25, 2013	Investigation meeting with EW regarding a complaint from a family member that they gave a urine sample to EW and that it was not tested. When asked why the sample was not tested, EW is noted to have replied: • Busy • No sign of UTI • Came from a PSW • Doctor's won't do anything • No paper with it & then forgot • Found it Thursday & then destroyed it • I apologized at least twice	LTCI00016790
116.	November 25, 2013	Letter to EW counselling that she is not working to best of ability. Incidents referred to: • Resident's family complained that they gave EW a urine sample for a loved one and that was put in the refrigerator and later discarded as stale. • Family upset and reported to management. • Responsibility to ensure as RN that sample processed	LTCI00016789

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		properly. • Work performance not adequate – not doing assessments, processing and following up on doctor's orders or other work as required of the Registered Staff. Letter states "We do not want to proceed to further discipline. We want to give you every opportunity to improve. We know you are capable".	
117.	December 14, 2013	Reported by Krawczyk, RN, that she was approached by a family member of resident RC who told her that EW was "not a good nurse at all". Family member reports that EW puts both RC's eye drops in at the same time, that she told EW that she should wait at least 5 minutes until administering the second drop and that EW responded "I know"	LTCI00016783
118.	December 16, 2013	Meeting with family member regarding eye drops for resident RC. Family member observed EW putting both medications in, one right after the other. States that she asked EW "Are you aware they are not going to work – 5 min apart at least" and EW responded "I know". Family member thought that was a strange answer.	LTCI00016783
119.	December 19, 2013	Investigation meeting held with EW over allegation that she gave two medications (eye drops) to a resident (RC) at the same time. Noted that EW admitted she gave both at once and that it was an error on her part. Noted that these are serious issues and that Caressant Care cannot have any more mistakes. Attendance also addressed. Notes provide "If we sent this to h.o. the outcome wouldn't be good".	LTCI00016780 LTCI00016776
120.	December 19, 2013	*Performance review for EW. Summary:* • *performance this year has been below what is expected. I do feel you have the capability and potential to do better. This is what we need and want for you. Beth get 2014 off to a great start*	LTCI00016785

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121.	December 19, 2013	EW is given a letter outlining that she is not working to the best of her ability. Items referenced are: • Resident's family (RC) complained that EW administered 2 types of eye drops at the same time. • During the investigation meeting EW admitted to doing this and stated that she knew it was wrong. • Attendance not acceptable. • EW assigned student aides' duties that were not within their job description. EW advised that Caressant Care cannot continue to have a good working relationship if these issues continue. Hopes for improvement in the New Year and states that EW is a valuable member of the nursing team.	LTCI00016775
122.	December 23, 2013	Email from Helen Crombez to Brenda Van Quaethem indicating that she had met RC's wife and told her that they had spoken to EW.	LTCI00072026
123.	January 20, 2014	Caressant Care receives a written statement B. Pinsonneault, PSW, that he was working the evening shift on January 15, 2014 with EW when she told him and another person that they were not allowed to sit behind the desk – also told him that he was not a part of the health care team and was not valued. EW told him that she was his supervisor. B. Pinsonnault also reports that EW has said that the floor had gotten better with her and that she had whipped all staff so they listen to her.	LTCI00016773
124.	January 21, 2014	Caressant Care files a Critical Incident Report [CIR #2636-000003-14 in relation to an incident on January 20, 2014. The CIR refers to Abuse/Neglect, Resident to Resident. CIR indicates that at 15:25 Ms. Pickering wandered into another resident's room and was assisted out 2 times in 5 minutes. Crombez notes: *When RN [EW] attempted to explain to asked her to stay out of resident's room, she denied being in it. RN attempted to explain that she was forgetful and needed to trust staff, resident grabbed RN's hand, squeezed it and yelling angrily "I don't forget".* The CIR further also references additional aggressive incidents between staff and Ms. Pickering and between Ms. Pickering and	LTCI00017034 LTCI00042806

	DATE	EVENT	SOURCE DOC ID
		another resident. In respect of the resident to resident issue, Crombez notes: *At 18:45 Student Aide observed resident approach resident Room 120 who was sitting in her doorway facing the hall. Residents were speaking loudly to each other, arguing. Then resident struck resident in Room 120 in the face, chest and arms at least 7 times.*	
125.	January 22, 2014	Caressant Care receives handwritten notes dated January 21, 2014 regarding concerns about EW. Note writer indicates: • Not sure if she follows direction • Treatment for one resident involves flushing catheter and flushing/irrigating wound • Heard from resident that EW does not always irrigate her catheter • Heard from PSW EW doesn't irrigate the wound • Another resident indicates that EW does not put cream on her face at bedtime • PSWs have complained about EW Attaches notes from PSW staff: • EW told PSWs they are not part of the team • Busy making jokes that aren't funny • Asking residents if they had a "dump" rather than asking if their bowels had moved • Resident rang asking for a man to have sex – EW asked Shanna (PSW?) to go tell resident it would be $200 • EW syringed a resident and 20 minutes later the resident rang – her bed was wet. When mentioned to EW, she smiled. Person queries "What if it was a resident who didn't ring?" • EW has not been irrigating a resident's wound	LTCI00016752
126.	January 22, 2014	EW prepares Progress Note for resident VA at 23:50, stating that resident's: • blood sugar at 21:30 was 3.2. She was given 100 ccs orange juice and a slice of toast. At 22:55, her blood sugar was 3.4.	LTCI00016768

	DATE	EVENT	SOURCE DOC ID
		She was given 120 ccs of orange juice with 15ml of sugar and a vanilla pudding. Her blood sugar at 23:40 was 5.6. Night staff will continue to monitor	
127.	January 22, 2014	Handwritten note by, Rosalynd Sim, the Assistant Director of Nursing that, with respect to resident VA, EW had done an incorrect treatment of hypoglycemic episode, and had incomplete charting, untimely charting, no communication to physician/dietician and no communication to night staff.	LTCI00016770 LTCI00016771
128.	Undated (assume January 2014)	Handwritten notes that appear to document a discussion with EW regarding resident VA's hypoglycemic episode. EW claims that it was an extremely busy night and that she had not done a referral because the resident had been vomiting and that was the reason that resident's blood sugars were low. EW indicates that she will make referrals from then on.	LTCI00016772
129.	January 23, 2014	Van Quaethem writes to Sanginesi, advising that an investigative meeting was held with EW regarding why medication was given to Maureen Pickering [victim] at the wrong time (early). [This is related to the incident on January 20, 2014] Van Quaethem indicates that EW did not believe that it was a medication error but rather was an "evidence based nursing decision" as the resident was starting to escalate her behaviours and EW felt that it would be good to de-escalate the situation. EW claims that the Caressant Care policy, Nursing Practice Medication Administration #4 and the CON's standards of practice (medication pg 5) support her decision. EW claims that she tried other interventions but acknowledges that she did not chart them. EW denies having told Maureen Pickering "you are sick, you have Alzheimer's, you are confused, so you do not know what you are talking about, you cannot remember, you need to trust the staff". EW states that she told Ms. Pickering that Ms. Pickering forgets and that Ms. Pickering responded that she didn't forget. EW was also asked about other incidents, one regarding whether she obtained a urine sample from Ms. Pickering when she was asked to and one regarding a resident (VA) who was hypoglycemic and for which EW didn't follow policy as to interventions to follow when blood sugar level is under 4. It appears that EW claims that	LTCI00016740 LTCI00016742 LTCI00016746

	DATE	EVENT	SOURCE DOC ID
		she was not aware of policy.	
130.	January 28, 2014	Van Quaethem writes to Sanginesi attaching a letter and discipline form that she wishes to give EW and asks Sanginesi for advice.	LTCI00072039
131.	January 29, 2014	Disciplinary meeting held January 29, 2014. Notes from the meeting state, in part: Bethe my attention was to help resident no malice was intended. She was trying to prevent an incident from happening even though one happened any ways. Resident had been hitting staff and punched one staff member. Bethe feels she made the right choice and stands by her choice. She feels targeted by management. That they would never have noticed the incident unless she had told them. She was honest about giving out the medication early when she reported the behaviour incident to them. Nurse make judgment calls and she made a judgment call. Bethe does not believe it is a med error. Helen then read the letter of discipline to Bethe and there is a 5 day suspension. Need to take incident seriously and reflect on what happened. Bethe stated she is taking this seriously as this is her job and she has pride in it. Bethe will be appealing this. Helen you have every right to. Bethe this is unfair. Helen told her the reasoning and as manager of nursing department takes my guidance and reflects on your actions. Bethe will certainly do this and is already doing this….. Not meant to hurt you Bethe and you are taking it personally. Will chart better next time. Bethe feels this is wrong. EW is given a letter indicating that she is not working to the standards required for Caressant Care. Incident involves Maureen Pickering and is described as follows: *A resident was given medication outside of the allowable time frame, this same resident was spoken to in an inappropriate manner that resulted in upsetting the resident and you failed to document the interventions that you said you tried for this resident. All of these issues are being brought to your attention. Please reflect on your actions.* EW receives a 5-day suspension and warning that continued poor work performance would lead to further discipline up to and including termination.	LTCI00016739 LTCI00072042

	DATE	EVENT	SOURCE DOC ID
132.	January 30, 2014	EW files grievance ONA#201401159 regarding her 5-day suspension.	LTCI00053014
133.	March 14, 2014	Further to the grievance filed regarding EW's 5 day suspension, Sanginesi sends EW's personnel file to Jill Allingham ("Allingham"), Labour Relations Officer, ONA.	LTCI00072053
134.	March 20, 2014	EW comes on shift at 3:00. RN Krawczyk reports (on March 24, 2014) that she told EW on March 20, 2014 that resident HD's insulin pen was empty and that more had been ordered and would be received that evening.	LTCI00016736 LTCI00016764
135.	March 21, 2014	Progress note by Jonathan Audet, RN, at 22:43 indicating that a resident (HD) was "flailing limbs uncontrollably in wheelchair at 1700 in dining room. Resident nearly slipping out of chair. Blood sugar checked and was 2.3. Writer fed resident yogurt with honey and crackers with peanut butter. Resident then brought to supper and ate moderate amount. Resident's blood sugar @2010h 16.4. Insulin at supper was held".	LTCI00016760
136.	March 22 – 24, 2014	EW admitted to having committed the 1st Degree Murder of Maureen Pickering on March 22 – 28, 2014. [For details, see Volume 5(xi) – Chronology related to Maureen Pickering]	LTCI00057683
137.	March 24, 2014	Progress Note entered by Krawczyk, RN, at 09:04 indicating that on March 24, 2016 she found Humalog insulin cartridge in a resident's (HD) pen rather than Humalog Mix 25. Notes that EW replaced the pen with the wrong insulin on Thursday pm. Describes having alerted EW to the fact that there was no more Humalog MIX 25 and that the insulin has been re-ordered and would be available that afternoon.	LTCI00016760
138.	March 24, 2014, revised March 26, 2014	Krawczyk, RN, prepares medication report #973 regarding insulin incident re resident HD.	LTCI00016758
139.	Undated	Krawczyk, RN, signs a written statement as to the sequence of events between March 20, 2014 and March 24, 2014. Krawczyk indicates that on March 20, 2014 she administered a specific type of insulin (Humalog Mix 25) to resident HD as ordered. The cartridge was then empty and when she went to the fridge to replace the cartridge there was no more insulin in the fridge. She	LTCI00016736 LTCI00016764

	DATE	EVENT	SOURCE DOC ID
		then re-ordered the insulin and let the Pharmacy know that it would be needed for the resident's evening dose. Krawczyk claims that she left an empty insulin pen (without the cartridge) in 3 pieces on top of the med cart to remind herself to tell EW about it and claims that she did so at shift change that afternoon. Notes that she showed EW the empty insulin pen and told her that the insulin would be coming down from the Pharmacy and that EW would have to replace it. AK claims that after they did the narcotic count, she mentioned again to EW about the insulin and pointed to the empty pen. Krawczyk was then off for three days and when she returned on August 24, 2014 she found Humalog insulin in the resident's pen rather than Humalog Mix 25 insulin (the milky insulin). She then found a new box of Humalog Mix 25 insulin which was not opened and which indicated that it was sent Thursday March 20/14. Krawczyk concludes that EW had replaced the pen with wrong insulin and that the resident (HD) was therefore receiving the wrong insulin for 3 days.	
140.	March 26, 2014	Investigative meeting with EW regarding insulin medication error re HD. It is noted that during the meeting: • EW acknowledges that she used insulin from one resident to give to another resident. • EW states that she doesn't not remember Krawczyk saying anything about an order. • EW indicates that she thought the insulin was the same. • EW asks whether she will lose her job, claiming that it was an honest mistake. EW put off work until March 31, 2014.	LTCI00016733 LTCI00016756
141.	March 26, 2014	Email from Van Quaethem to Sanginesi indicating EW is off until further notice and they will be meeting with Allingham on March 31, 2014 to give whatever decision Sanginesi makes.	LTCI00072088
142.	March 28, 2014	Email from Van Quaethem to Sanginesi indicating that they need the decision from Sanginesi as to whether they terminate EW or not.	LTCI00072091
143.	March 31, 2014	Sanginesi emails draft EW termination letter to Van Quaethem.	LTCI00072092
144.	March 31, 2014	Meeting with EW to terminate her employment. Termination letter read to EW. Letter indicates that EW gave the wrong medication	LTCI00016755 LTCI00016763

	DATE	EVENT	SOURCE DOC ID
		which resulted in resident, HD, being incorrectly medicated as well as over-medicated, and that the resident had experienced distress as a result of same. Letter identifies that EW has had extensive discipline for medication-related errors which includes numerous warnings and 1, 3 and two 5 day suspensions. As a result of the most recent incident, a termination is warranted.	
145.	March 31, 2014	Email from Sanginesi to James Lavelle ("Lavelle"), Carol Hepting ("Hepting") and Tim Dengate seeking approval to terminate EW. Approval is given.	LTCI00072096
146.	March 31, 2014	Email from Van Quaethem to Sanginesi indicating the meeting went well and they will be reporting the termination to the College of Nurses.	LTCI00072094
147.	March 31, 2014	EW files grievance ONA#201402812 regarding the termination of her employment. Allingham requests that, pursuant to Article 21.09 of the Collective Agreement, Caressant Care provide a reference letter detailing employment dates, length of service and experience.	LTCI00053013 LTCI00070533 LTCI00072098
148.	March 31, 2014	Caressant Care prepares Report Form for Facility Operators and Employers regarding EW's termination.	LTCI00016717
149.	April 9, 2014	Caressant Care issues EW's Record of Employment identifying that she was dismissed from her employment.	LTCI00016731
150.	April 14, 2014	Email from Allingham to Sanginesi requesting Step 2 for EW's grievance.	LTCI00072101
151.	April 17, 2014	Email from Van Quaethem to Sanginesi asking whether a grievance has been filed on behalf of EW. Sanginesi confirms that a grievance has been filed.	LTCI00072102
152.	April 17, 2014	Caressant Care submits its Report Form for Facility Operators and Employers dated March 31, 2014 to the CNO, reporting that it has terminated EW for a medication error that resulted in putting a resident at risk. Caressant Care identifies that it is filing the Report Form pursuant to Section 85.5 of the RHPA– termination for reasons of	LTCI00016716 LTCI00016717

	DATE	EVENT	SOURCE DOC ID
		professional misconduct, incompetence or incapacity. Report Form identifies incidents/discipline on: • March 20, 2014 – termination • January 28, 2014 – 5 day suspension • January 22, 2014 – counselling • December 19, 2013 – letter of warning • November 25, 2013 - letter re work performance not adequate • April 8, 2013 – 5 day suspension • March 14, 2013 – 1 day suspension • February 12, 2013 – written warning • September 3, 2012 – warning • August 29, 2012- written warning Caressant Care identifies that there are other reports from staff (related to attendance, professional behaviour) that did not lead to discipline but were considered at time of termination.	
153.	May 8, 2014	Email from Allingham to Sanginesi recapping discussion: Union's position: - one week for every year of service with the Caressant Care Woodstock - the possibility of a reference letter and "sealing the grievor's personnel file" - changing the "termination" to "a resignation for personal reasons".	LTCI00072105
154.	May 12, 2014	Email from Allingham to Sanginesi asking for a draft letter of reference for EW to review and asking whether Caressant Care would be prepared to classify the $2000 as damages to prevent tax deduction.	LTCI00072105
155.	May 22, 2014	Email from Sanginesi to Allingham attaching draft letter of reference for EW. Allingham indicates that blanks would have to be filled in for EW's employment date and EW will need to confirm	LTCI00072105

	DATE	EVENT	SOURCE DOC ID
		if she is OK with the way that Sanginesi has characterized her leaving. Confirms the $2000 can be paid as damages.	
156.	May 23, 2014	Email from Alllingham to Sanginesi indicating that EW has agreed to the terms of the settlement.	LTCI00072105
157.	June 2, 2014	Email from Allingham to Sanginesi asking whether Sanginesi has a standardized Minutes of Settlement.	LTCI00072105
158.	June 2, 2014	Email from Allingham to Sanginesi attaching draft Minutes of Settlement.	LTCI00072111
159.	June 2, 2014	Email from Sanginesi to Allingham returning Minutes of Settlement executed by Sanginesi.	LTCI00072115
160.	June 4, 2014	Email from Allingham to Sanginesi confirming that EW has signed the Minutes of Settlement.	LTCI00072115
161.	June 4, 2014	Minutes of Settlement between Caressant Care Nursing and Retirement Homes Limited (Woodstock) and ONA regarding EW's grievances over her 5-day suspension and her termination. Terms of the Minutes of Settlement include: • Voluntary resignation effective March 31, 2014. • File to reflect resignation rather than termination and to be sealed, except where required by law. • Lump-sum payment of $2000 to EW. • Letter of Employment in form attached. • Caressant Care will cooperate with CNO if information/documentation requested. • Grievances withdrawn.	LTCI00016707 LTCI00016711 LTCI00016712
162.	June 11, 2014	Caressant Care pays $2,000.00 settlement and provides EW with reference letter as agreed to in the Minutes of Settlement. Reference letter: • Confirms employment from June 27, 2007 to March 24, 2014. • Indicates that EW has been responsible for providing	LTCI00016709 LTCI00016710

	DATE	EVENT	SOURCE DOC ID
		nursing care and supervising the work of RPNs and PSWs. • Indicates that EW proved to be a good problem solver and had strong communication skills. • Indicates that EW was punctual and enjoyed sharing her knowledge with others. • Indicates that EW left Caressant Care to pursue other opportunities. • Wishes EW well and states that Caressant Care is pleased to provide her with the reference.	
163.	July 17, 2014	CNO writes to Caressant Care confirming its receipt of Caressant Care's Report Form for Facility Operators and Employees dated March 31, 2014. CNO notifies Caressant Care that the CNO is unable to inform it of the proceedings or the outcome of any investigation which may ensue and directs Caressant Care to retain all documentation for a period of up to 2 years.	LTCI00016715
164.	2007 – 2014	EW Employee Time Sheet identifying shifts worked.	LTCI00016924 LTCI00016926 LTCI00016928 LTCI00016930 LTCI00016932 LTCI00016934 LTCI00016935
165.	October 5, 2016	Caressant Care files a Critical Incident Report stating that on October 4, 2016 the police had visited and informed Crombez that EW had confessed to injecting residents with insulin to cause their death. Notes that the confession states that 7 residents died and 4 others were injected and lived	LTCI00001065
166.	October 12, 2016	Caressant Care checks "Find a Nurse" re EW's current status.	LTCI00016714
167.	October 14, 2016	Carol Hepting, Vice President, Operations, Caressant Care, writes to the CNO indicating that based on information that has recently come to its attention it wants to restate its position that EW is unfit to safely practice nursing. Caressant Care advises CNO that it has "Serious concerns regarding this nurse's ability to practice with an unrestricted license, which she continues to hold according to information on the College's	LTCI00016713

DATE	EVENT	SOURCE DOC ID
	Find a Nurse Webpage" and asks that the CNO give the matter its urgent attention.	

VOLUME 5(C): CARESSANT CARE

RELEVANT STANDARDS, GUIDELINES, POLICIES AND PROCEDURES

NO.	DOCUMENT	SOURCE DOC ID
A. Staffing and Administration		
1.	Staffing Plan/ Reassignment of Duties. Eff. Oct. 2015. Rev. Mar. 2017	LTCI00016517
2.	Staffing Plan/ Reassignment of Duties. Eff. Feb. 2011. Rev. Sep. 2015	LTCI00016523
3.	Staff Recruitment. Eff. Mar. 2003. Supersedes Oct. 1989. Rev. May 2017	LTCI00016507
B. Training and Education		
4.	Staff Orientation Program. Eff. Nov. 2002. Rev. Aug. 2017	LTCI00072183
5.	Review of Medication Rights May 2011	LTCI00072406
6.	Nursing Inservice – Glucometer Testing	LTCI00072423
7.	Diabetes Management – Insulin	LTCI00072426
8.	Diabetes Management – Insulin	LTCI00072440
9.	Medication Administration and Medication Errors	LTCI00072449
C. Medication Management		
10.	Medication Management System – Program Evaluation	LTCI00016416
11.	Medication – Acceptance of upon Admission. Eff. Feb. 2003. Policy No. NPM 3.1	LTCI00016429
12.	Medications – Release on Discharge. Eff. Feb. 2003. Policy No. NPM 3.27	LTCI00016466
13.	Medications – Transferred or Discharged Residents. Eff. May 2004. Policy No. NPM 3.28	LTCI00016467
D. Medical Directives		
14.	Medical Orders – Change of Directions. Eff. Feb. 2003. Policy No. NPM 3.23	LTCI00016458
15.	Physicians' Orders – Processing and Transcribing. Eff. Feb. 2003. Policy No. NPM 8	LTCI00016473
E. Purchasing and Handling of Drugs		
16.	Medication - Emergency Drug Box and Starter-Packs. Eff. Feb. 2003. Policy No. NPM 3.14	LTCI00016445
17.	Medications – Ordering from Pharmacy. Eff. Nov. 2002. Policy No. NPM 3.25	LTCI00016462
18.	Drugs Formulary. Eff. Feb. 2003. Policy No. NPM 3.11	LTCI00016440
19.	Drug Record Book. Eff. Dec. 2002. Policy No. NPM 3.13	LTCI00016443
20.	Drug Record Book	LTCI00016444

NO.	DOCUMENT	SOURCE DOC ID
F. Safe Storage of Drugs		
21.	Controlled Medications – Receiving and Storage of. Eff. Feb. 2003. Policy No. NPM 3.8	LTCI00016438
22.	Controlled Medications on LOA – Release of. Eff. Feb. 2003. Policy No. NPM 3.9	LTCI00016439
23.	Narcotic Drug Count. Eff. Feb. 2003. Policy No. NPM 3.33	LTCI00016472
24.	Drug Orders – Storage of Medications. Eff. Feb. 2003. Policy No. NPM 3.12	LTCI00016441
G. Administration of Drugs		
25.	Medical Pharmacies – Pharmacy Policy & Procedure Manual for LTC Homes. Section 3: The Medication System - Policy 3-6, The Medication Pass, January 2014	LTCI00016419
26.	Medical Pharmacies – Pharmacy Policy & Procedure Manual for LTC Homes Section 8: Documentation and Record-Keeping – Policy 8-4, PRN Administration & Documentation, January 2014	LTCI00016424
27.	Medical Pharmacies – Pharmacy Policy & Procedure Manual for LTC Homes Section 8: Documentation and Record-Keeping – Policy 8-1, Medication Administration Record (MAR), January 2014	LTCI00016421
28.	Medication Administration Audit	LTCI00016414
29.	Medication Administration – Eff. Nov. 2002. Policy No. NPM.3	LTCI00016427
30.	Medication System – Hours of Medication Administration. Eff. Feb. 2003. Policy No. NPM 3.19	LTCI00016450
31.	MAR - Medication Administration Record. Eff. Feb. 2003. Policy No. NPM 3.29	LTCI00016468
32.	MAR – Monthly Checking and Updating. Eff. Feb. 2003. Policy No. NPM 3.30	LTCI00016469
33.	Physician's Quarterly Review. Eff. Feb. 2003. Policy No. NPM 9	LTCI00016475
34.	Medications – Self Administration of. Eff. Feb. 2003. Policy No. NPM 3.18	LTCI00016449
35.	Master Signature Sheet. NPM.2. Eff. Feb. 2003	LTCI00016426
36.	Automatic Stop Orders. Eff. Feb. 2003. Policy No. NPM 3.7	LTCI00016436
37.	Individual Narcotic Medication Record. Eff. Feb. 2003. Policy No. NPM 3.20	LTCI00016452
38.	Narcotic Medication Record	LTCI00016453
39.	Medication – Insertion of a Subcutaneous Port for the Infusion of. Eff. Feb. 2003. Policy No. NPM 3.21	LTCI00016454
40.	Medication Systems. Eff. Dec. 2002. Policy No. NPM 24	LTCI00016460
41.	Medication – Stat. Orders. Eff. Feb. 2030 [2003?] Policy No. NPM 3.32	LTCI00016471
42.	Medications, Handling of – Crushing Medications. Eff. Feb. 2003 Policy No. NPM 3.17	LTCI00016448
43.	Anticoagulants – Administration of Oral. Eff. Feb 2003 Policy No. NPM 3.2	LTCI00016430
44.	Medication - Administration of Subcutaneous Anticoagulants (Heparin, Fragmin) Eff. Feb. 2003. Policy No. NPM 3.3	LTCI00016431
45.	Medication - Administration of Pneumovax. Eff. Feb. 2003. Policy No. NPM 3.4	LTCI00016433

NO.	DOCUMENT	SOURCE DOC ID
46.	How to Adminster Insulin – 2/17	LTCI00072505
H. Medication Incidents and Adverse Drug Reactions		
47.	Adverse Drug Reactions. Eff. Feb. 2003. Policy No. NPM 3.5.	LTCI00016434
48.	Medication Errors. Eff. Dec. 2002. Policy No. NPM No. 3.22	LTCI00016456
49.	Medication – Drug Allergies. Eff. Feb. 2003. Policy No. NPM 3.31	LTCI00016470
50.	Hypoglycemia – Jan. 2003	LTCI00072161
51.	Diabetes/Hyper/Hypoglycemia – Eff. July 2010, Reviewed May 2015	LTCI00072163
52.	Diabetes/Hyper/Hypoglycemia – Eff. July 2010, Reviewed July 2016	LTCI00072166
53.	Diabetes/Hyper/Hypoglycemia – Eff. July 2010, Reviewed April 2018	LTCI00072169
I. Drug Destruction and Disposal		
54.	Medication – Handling of, Following Death. Eff. Feb. 2003. Policy No. NPM 3.16	LTCI00016447
55.	Medications – Disposal and Destruction of. Eff. Feb. 2003. Policy No. NPM 3.26	LTCI00016464
56.	Handling of Medication – Drug Destruction and Disposal – 2/17	LTCI00072498
57.	Surplus Medications List	LTCI00016465
J. Dementia Care/Responsive Behaviours		
58.	Corporate Policy re: Resident Behaviour Mgmt. Eff. Sept. 2014. Rev. July 2016.	LTCI00016410
59.	Corporate Policy re: Responsive Behaviour Mgmt. Eff. Sept. 2014. Rev. Sept. 2014	LTCI00016412
K. Abuse and Neglect		
60.	Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff. Eff. Feb. 2017. Supersedes Aug. 2016. Rev. Feb. 2017	LTCI00016477
61.	Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff. Eff. Aug. 2014. Supersedes Mar. 2014. Rev. Aug. 2014	LTCI00016488
62.	Licensee Reporting of Emotional Abuse. Flowchart. Gov't of Ontario. May 2012.	LTCI00016538
63.	Licensee Reporting of Financial Abuse. Flowchart. Gov't of Ontario. May 2012.	LTCI00016540
64.	Licensee Reporting of Neglect. Flowchart. Gov't of Ontario. May 2012.	LTCI00016542
65.	Licensee Reporting of Verbal Abuse. Flowchart. Gov't of Ontario. May 2012.	LTCI00016544
66.	Licensee Reporting of Sexual Abuse. Flowchart. Gov't of Ontario. May 2012.	LTCI00016546
67.	Licensee Reporting of Physical Abuse. Flowchart. Gov't of Ontario. May 2012.	LTCI00016548
L. Concerns, Complaints		
68.	Response to Complaints. Eff. May 2017. Supersedes Feb. 2014. Rev. May 2017	LTCI00016566
69.	Whistle-Blowing Protection and Staff Reporting. Eff. June 2011. Supersedes Feb. 2003. Rev. May 2017.	LTCI00017054

NO.	DOCUMENT	SOURCE DOC ID
M. Critical Incident Reporting		
70.	Critical Incident Reporting. Eff. Sep. 2013. Supersedes Sep 2012. Rev. May 2017	LTCI00016531
N. End of Life Care, Pronouncement and Process on Death of a Resident		
71.	**Death of a Resident – Registered Staff Role**	**LTCI00072195**
O. Quality and Risk Management		
72.	Program Reporting. Eff. Apr. 2014. Supersedes Apr. 2007. Rev. Apr. 2014.	LTCI00016346
73.	Program Evaluation. Eff. Apr. 2014. Supersedes Apr. 2007. Rev. Apr. 2014.	LTCI00016347
74.	Medication Management System Program Evaluation	LTCI00016348
75.	Responsive Behavioural Program Evaluation	LTCI00016351
76.	Orientation and Training Program Evaluation	LTCI00016357
77.	Abuse Prevention Program Evaluation	LTCI00016363
78.	Safety/Risk Management Program Evaluation	LTCI00016366
79.	Medical Services Program Evaluation	LTCI00016382
80.	Quality Improvement Program Program Evaluation	LTCI00016384
P. Human Resources		
81.	Human Rights and Anti-Harassment Policy. Eff. Sept. 2016. Supersedes May 2014. Rev. Sept. 2017.	LTCI00017040
82.	Progressive Discipline. Eff. Jun. 2010. Rev. Apr. 2016.	LTCI00017050
83.	Dismissal – Eff. Feb. 2003	LTCI00072172
84.	Terminations. Eff. Mar. 2003. Supersedes Jan. 1995. Rev. May 2017.	LTCI00017053

VOLUME 5(i): CLOTILDE ADRIANO CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Ms. Clotilde Adriano was Elizabeth (Bethe) Wettlaufer's ("EW") first victim at Caressant Care. EW admitted to having given Ms. Adriano extra doses of insulin during the time period June, 2007 to December, 2007.

Ms. Adriano was born in Portugal on October 25, 1920. She moved to Canada and became a Canadian citizen. Ms. Adriano resided in the Woodstock area. She was married and had two children. Ms. Adriano was predeceased by her husband.

The chronology below sets out Ms. Adriano's history while at Caressant Care. Ms. Adriano had a number of ailments including diabetes controlled with injected insulin. The evidence indicates that Ms. Adriano had a history of hypoglycemic episodes prior to EW commencing her employment with Caressant Care.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	May 26, 2005	Ms. Adriano moved to Caressant Care Retirement Home where she was under the care of Dr. Brioux.	LTCI00012099
2.	February 22, 2007	Ms. Adriano applies for long-term care and selects Caressant Care. Her application is accepted by Caressant Care on February 26, 2007.	LTCI00011901 LTCI00011902
3.	March 5, 2007	Ms. Adriano is admitted to Caressant Care. In respect of her diabetes, it was noted that if Ms. Adriano was hypoglycemic, staff were to give 125 ml apple or orange juice and then check her BS in 15 min. If Ms. Adriano's BS was less than 4 and meal/snack over an hour away, staff were to give her cheese and crackers or ½ sandwich or 125 ml milk. Document behaviour, actions. Ms. Adriano's Insulin medication was Novolin 30/70, 45 units in the a.m. and 40 units in the p.m.	LTCI00011841 LTCI00011847 LTCI00011569 LTCI00011990
4.	March 2007	During Ms. Adriano's stay at Caressant Care, blood sugar readings were to be taken 4 times daily. For approximately three weeks after she entered Caressant Care they were taken twice a day. For ease of reference, the location of each month's blood sugar readings is included in this chronology	LTCI00012132 LTCI00012133 LTCI00011521 LTCI00011569

	DATE	EVENT	SOURCE DOC ID
		and referred to as "BS readings". Medication Administration Records ("MAR") for insulin have also been included in this chronology for ease of reference. They indicate the type of insulin administered, the timing of same and by whom.	
5.	March, 2007	Ms. Adriano experiences multiple hypoglycemic episodes. Her insulin is changed to 40 units in the a.m. and 20 units in the p.m. It was changed again to 30 units in the a.m. and 20 units in the p.m.	LTCI00011522 LTCI00011569 LTCI00011994 LTCI00011995
6.	April 23, 2007	Progress note entered by Shelly Clark, RN, at 23:07 that they are giving Ms. Adriano extra snacks to prevent an insulin reaction through the night. It was noted that her BS is often still low in the a.m. or Ms. Adriano has had an insulin reaction through the night. Note left for Dr. Reddick to review.	LTCI00011342
7.	April 25, 2007	Noted hypoglycemic episodes at night. Ms. Adriano's insulin is changed to 25 units in the a.m. and 15 units in the p.m.	LTCI00011590 LTCI00011997
8.	April, 2007	MAR – Insulin and BS readings	LTCI00012133 LTCI00011590
9.	May 3, 2007	Progress note entered by Laura Huck, RPN, at 22:50 that Ms. Adriano's BS was 3.5, orange juice and ½ meat sandwich given.	LTCI00011342
10.	May 25, 2007	Internal Resident Incident Report form completed – forgot to give insulin to Ms. Adriano at 16:30 – Novolin 30/70 15 units. Night nurse notified and advised not to give insulin at this point. 21:00 hrs BS was 11.4. Ms. Adriano seemed to be okay	LTCI00011830
11.	May 26, 2007	Progress note entered by Lois Durbridge, RN, at 02:44 that RN reported at 23:00 that 16:30 insulin appeared not to have been given as the needle assembly appeared intact. BS @ 20:00 was 11.3 so RPN instructed not to give it.	LTCI00011342
12.	May, 2007	MAR – Insulin and BS readings	LTCI00012135 LTCI00011600
13.	June 5, 2007	Nursing Quarterly Summary prepared where it is noted that Ms. Adriano has been stable since an insulin adjustment had been made the previous month.	LTCI00011342
14.	June 13, 2007	Progress Note entered by Shelly Clark, RN, at 22:51 that Ms. Adriano's BS was 3.9. Noted that after a full sandwich, 180ml of orange juice and milk,	LTCI00011342

	DATE	EVENT	SOURCE DOC ID
		BS at 22:30 was still 3.9. Ms. Adriano is given Resource and corn syrup.	
15.	June 14, 2007	Progress Note entered by Alicia Sauve, Dietary Nutritional Manager, at 20:46 indicating that Ms. Adriano is at high risk due to uncontrolled Diabetes, has episodes of low blood sugar despite evening snacks. Referral to RD completed.	LTCI00011342
16.	June 20, 2007	Progress Note entered by Karen Reading, Dietician, at 21:13 regarding Nutrition Referral. Noted that Ms. Adriano was experiencing hypoglycemic reactions during the night despite extra HS snack being given. Noted that low bedtime and evening blood sugars most likely result of excessive amount of insulin, inappropriate time of insulin peak or insufficient dinner meal.	LTCI00011342
17.	June 20, 2007	Progress Note entered by Jennifer Cake, RN, at 21:58, that Ms. Adriano's BS was only 5 @21:00 and therefore orange juice and snack given. BS after snack was 7.2.	LTCI00011342
18.	June 27, 2007	EW's commences her employment at Caressant Care.	LTCI00057092 LTCI00057098
19.	Unknown	EW admits that she recalled working a night shift when she deliberately attended Ms. Adriano's rooms and injected her with an additional dose of insulin. She admits that she gave Ms. Adriano the additional insulin on more than one occasion, the first being prior to the death of James Silcox (August 12, 2007).	LTCI00057683
20.	June, 2007	MAR – Insulin and BS readings	LTCI00012135 LTCI00011610
21.	July, 2007	MAR – insulin and BS readings (though dated June)	LTCI00011616 LTCI00012138
22.	July 5, 2007	Progress Note entered by Jennifer Cake, RN, at 22:36 that Ms. Adriano's BS was 5.6 at 20:00 so juice and Resource provided.	LTCI00011342
23.	July 15, 2007	Progress Note entered by Jennifer Cake, RN, at 22:25 that Ms. Adriano was out with her family for supper and returned at 17:15. Blood sugar was only 3.4 at HS. Snack given.	LTCI00011342
24.	July 17, 2007	Progress Note entered by Laura Huck, RN, at 13:40 that Ms. Adriano's BS at 11:30 was 2.6. Orange juice was given and her BS at 13:00 was 7.5.	LTCI00011342

	DATE	EVENT	SOURCE DOC ID
25.	July 23, 2007	Progress Note entered by Suzanne Kungl, RN, that Ms. Adriano's BS was 2.6 on evenings. RN had given Resource and her BS increased to 4.4 by 23:00. Ms. Adriano was given more Resource and her BS at 24:00 was 6.3 BS in morning within normal range.	LTCI00011342
26.	July 30, 2007	Progress Note entered by Karen Reading, Dietician, at 11:25, indicating that Ms. Adriano is still experiencing hypoglycemic incidents which tend to occur in the evening despite getting milk at PM snack and a whole sandwich at HS. Identifies that for hypoglycemic episodes administer 15 grams of quick acting glucose such as 125 ml of apple or orange juice (Resource not best choice). Repeat in 15 minutes if blood glucose level remains less than 4 mmol/L	LTCI00011342
27.	August 6, 2007	First Progress Note entered by EW at 00:34 indicating that Ms. Adriano was refusing her HS snack and that her BS that night was 3.6. Notes that Ms. Adriano was given snack and staff stayed with her until she had taken it all. BS at 22:50 was 5.6.	LTCI00011342
28.	August 23, 2007	Progress Note entered by Lois Durbridge, RN, at 23:16 that Ms. Adriano's BS was 3.6.	LTCI00011342
29.	August 26, 2007	Progress Note entered by EW at 22:32 that Ms. Adriano's BS was 5.3. Indicates that Resource was given at 17:10 as supper was served to Ms. Adriano late and she was slumped at table with her eyes closed.	LTCI00011342
30.	August 27, 2007	Progress Note entered by Suzanne Kungl, RN, at 07:48 that Ms. Adriano was pale, clammy, perspiring and difficult to rouse at 00:30. Her BS was 2.4 and Ms. Adriano was having difficulty swallowing due to drowsiness so corn syrup given. BS 3.2 after 20 min. Notes that Ms. Adriano was more alert, less clamming and perspiring was reduced but remained very pale and "not feeling well". After another 30 cc of corn syrup and orange juice as Ms. Adriano was unable to eat well, BS up to only 3.6. Sandwich, juice given with good results and BS at 06:00 was 9.6. Stable	LTCI00011342
31.	August 30, 2007	Progress Note entered by Karen Reading, Dietician, at 14:17 that hypoglycemic episodes continue in the evening, most likely related to refusing HS nourishment. Receives 124ml of milk at p.m. and a whole sandwich at HS. Notes that if Ms. Adriano refuses whole sandwich at HS encourage her to eat half and then give 125 ml of milk. Will monitor blood	LTCI00011342

	DATE	EVENT	SOURCE DOC ID
		sugars.	
32.	August, 2007	MAR – Insulin and BS readings	LTCI00011630 LTCI00012139
33.	June 1, 2007 – August 31, 2007	Physician's Medication Review	LTCI00011999
34.	September 3, 2007	Progress Note entered by EW that Ms. Adriano's BS at 16:30 was 4.9 and that Ms. Adriano was given orange juice. BS at HS 9.0.	LTCI00011342
35.	September 7, 2007	Physician's Orders from WGH – Novolin 30/70, 11 units in the a.m. and 5 units in the p.m.	LTCI00011817 LTCI00011939
36.	September 20, 2007	Progress Note entered by Karen Reading, Dietician, at 07:21 that hypoglycemic episodes tend to occur at 16:30 and around HS. Notes that intake varies but Ms. Adriano is usually eating poorly. Low BS at 16:30 most likely related to inadequate lunch and p.m. snack. If lunch intake is less than 50% provide a yogurt. Will send ½ sandwich for p.m. snack in addition to 125ml of milk. Notes that if this does not help, insulin dose may need to be lowered. Will monitor.	LTCI00011342
37.	September 28, 2007	Progress Note entered by EW at 13:48 re Nursing Quarterly Summary that Ms. Adriano has been stable this last quarter.	LTCI00011530
38.	September 30, 2007	Noted that Ms. Adriano's BS was down at 21:00 hrs.	LTCI00011522
39.	September, 2007	MAR – Insulin and BS readings	LTCI00011640 LTCI00012139
40.	October 2007	MAR – Insulin and BS readings	LTCI00012120 LTCI00011502
41.	October 2, 2007	Progress Note entered by Shelly Clark, RN, at 15:57 that she reviewed Ms. Adriano's BS with Dr. Reddick over the phone as they have been low in the morning and he decreased Ms. Adriano's insulin.	LTCI00011342
42.	October 2, 2007	Ms. Adriano's diabetes medication is changed from Novolin 30/70 25 units in morning and 15 units in the evening to 22 units in a.m. and 11 units in p.m.	LTCI00011502

	DATE	EVENT	SOURCE DOC ID
43.	October 5, 2007	Progress Note entered by Lois Durbidge, RN, at 03:54, Quarterly Nursing Summary, indicating that Ms. Adriano had been stable this quarter up until the last week when her blood sugars were trending low and insulin adjustments were made.	LTCI00011530
44.	October 6, 2007	Internal Resident Incident Report completed regarding a medication error – Ms. Adriano's BS kept bottoming out overnight (1.9 – 2.2). Noted that when the RN called Dr. Yu about orders for treatment, he was told that a nurse had called Dr. Yu that evening about an insulin overdose. Dr. Yu orders Ms. Adriano's BS to be taken every q1h. Ms. Adriano was given Glucagon 1mg, corn syrup, juice with sugar.	LTCI00012113
45.	October 7, 2007	Progress Note entered by Bradley Layne, RN, at 04:56 that Ms. Adriano was found at 23:25 by PSWs as diaphoretic, lethargic. BS was 1.9, 10 cc corn syrup, 7 tsp sugar and 450cc of apple juice given. BS increased to 3.8. At 03:30 BS 2.2, Glucagon given, Ms. Adriano roused and she was given more apple juice. Noted that Ms. Adriano's BS remained unstable, continually dropping. Dr. Yu called. Noted that the doctor indicated "A nurse from CC had called earlier in the evening to inform him of an insulin overdose, the resident was receiving 30/70 insulin and got a dose of almost 30 units". RN Layne told to monitor BS and continue to give juice and carbohydrates. RN Layne notes that he checked for incident reports and found none completed. Not informed of any overdoses at shift change.	LTCI00011342
46.	October 7, 2007	PSW notes that Ms. Adriano was found laying with her head at her foot board and her legs on the floor. When staff went to reposition her, her eyes rolled back and she was very weak, cold and clammy. Notes that they got the nurse right away to check her BS and they were told it was very low. Ms. Adriano was given juice with sugar and a sandwich and checked every 15 minutes.	LTCI00011522
47.	October 7, 2007	Progress Note entered by Miriam Wright, RN, at 16:33 that at 10:30 staff reported that Ms. Adriano was very diaphoretic, BS 1.9. after snack BS up to 5.3 but by 11:30 down to 3.3. BS 3.7 after good lunch. Noted that Ms. Adriano's daughter wanted her mother checked and doctor called. Doctor indicated that an infection usually makes BS go up, and agreed to send Ms. Adriano to hospital. Ms. Adriano is transferred to hospital. Transfer record identifies "unable to maintain normal blood sugar level". Identifies levels going up and then	LTCI00011342 LTCI00012115

	DATE	EVENT	SOURCE DOC ID
		down.	
48.	October 7, 2007	Progress Note entered by Miriam Wright, RN, at 17:58 that Ms. Adriano's daughter called and indicated that she was being admitted and that she was on IV, getting glucose, yet her BS was still only around 5.	LTCI00011342 LTCI00011929 LTCI00012118 LTCI00012119 LTCI00012121
49.	October 15, 2007	Ms. Adriano returned from hospital. Noted that she appears pale and frail.	LTCI00011342
50.	October 16, 2007	Ms. Adriano's diabetes medication is changed from Novolin 30/70 22 units in a.m. and 11 units in p.m. to 10 units in a.m. and 4 units in p.m.	LTCI00011502 LTCI00012003
51.	October 30, 2007	Progress Note entered by Karen Reading, Dietician, at 21:05 that Ms. Adriano continues to experience hypoglycemic episodes despite extra snacks provided and decrease in insulin dose. Food and fluid flow sheets indicate that Ms. Adriano is eating special snacks being provided to her, however lunch and supper intake are sometimes only ½ to ¼. Noted that when meals are less than 50% eaten to offer/encourage Ms. Adriano to eat yogurt.	LTCI00011342
52.	November 5, 2007	Internal Resident Incident Report completed – Ms. Adriano was found lying on her left side/stomach on the floor with her head against the dresser. When the RN arrived, Ms. Adriano was attempting to stand up by herself. Said she hit her head and was uncomfortable and in pain. Assessed and then to bed. BS – 11.4	LTCI00011342 LTCI00011831 LTCI00011881
53.	November 9, 2007	Progress Note entered by EW at 22:08 that Ms. Adriano was difficult to rouse at 21:00 and lethargic once roused. Had taken 19:00 snack. BS 9.9.	LTCI00011342
54.	November 12, 2007	Internal Resident Incident Report completed – Ms. Adriano was found sitting upright on the floor. She had been attempting to get up herself.	LTCI00011342 LTCI00011833
55.	November 28, 2007	Progress Note entered by Karen Reading, Dietician, at 20:38 noted that Ms. Adriano's BS have been fairly stable that month with a few exceptions. She receives diabetic snacks at p.m. and HS to prevent low blood sugars during the night. Current nutrition care plan remains appropriate.	LTCI00011342
56.	November, 2007	MAR – Insulin and BS readings	LTCI00011650 LTCI00011835 LTCI00011957

	DATE	EVENT	SOURCE DOC ID
57.	December 17, 2017	Progress Note entered by Karen Reading, Dietician, at 18:44 that quarterly assessment finds risk downgraded to moderate as blood sugars are stabilized and hypoglycemic episodes have decreased.	LTCI00011342
58.	December 27, 2007	Progress Note entered by Shelly Clark, RN, at 21:59 that BS at 22.2, previous evening 20.4. Sugars are highest at HS now.	LTCI00011342
59.	December, 2007	MAR – Insulin and BS readings	LTCI00011660 LTCI00011835 LTCI00011957
60.	January, 2008	MAR – Insulin and BS readings	LTCI00011670 LTCI00011228
61.	January 18, 2008	Internal Resident Incident Report completed – Ms. Adriano received 1 M-Esion @0700 instead of 2, today and yesterday. January 17, 2008 received 1 @ 0700 and 2 at 1200 – Ms. Adriano is much more alert this am, talking etc. Doctor to be called to decrease med to 1 tab TID.	LTCI00011818
62.	January 30, 2008	Progress Note entered by Karen Reading, Dietician, at 18:11 that Blood sugars have been running high at HS. Will decrease p.m. nourishment to ½ whole wheat sandwich and HS nourishment to ½ whole wheat sandwich and 125 ml milk.	LTCI00011342
63.	February 23, 2008	Progress Note entered by Karen Reading, Dietician, at 21:48 that Ms. Adriano's blood sugars were running high so Dr. Reddick increased Novolin 30/70 to 12 units in a.m. and 4 units in p.m.	LTCI00011342
64.	December 1, 2007 – February 29, 2008	Physician's Medication Review	LTCI00012009
65.	February, 2008	MAR – Insulin and BS readings	LTCI00011672 LTCI00011835 LTCI00011957
66.	March 26 - 27, 2008	Internal Resident Incident Report completed - M-Esion signed on MAR and narcotic record for blister 25 and 26 but they were not given	LTCI00011820 LTCI00011823 LTCI00011824
67.	March 31, 2008	Progress Note entered by Karen Reading, Dietician, at 13:27, noting receiving ferrous gluconate and increased dosage of Novolin both at a.m. and p.m.	LTCI00011342

	DATE	EVENT	SOURCE DOC ID
68.	March, 2008	MAR – insulin and BS readings Insulin changed on March 13, 2008 from 12 units in a.m. and 4 units in p.m. to 14 units in a.m. and 4 units in p.m. Changed again on March 27, 2008 to 14 units in the a.m. and 7 units in the p.m.	LTCI00011690 LTCI00011835 LTCI00011957
69.	April 8, 2008	Internal Resident Incident Report and Progress Note completed – Ms. Adriano was found sitting on the floor in front of her bed. She had tried to get up unassisted to the bathroom	LTCI00011342 LTCI00011986
70.	April, 2008	MAR – Insulin and BS readings	LTCI00011700 LTCI00011835 LTCI00011957
71.	May 29, 2008	Internal Resident Incident Report and Progress Note completed – Ms. Adriano's roommate alerted staff that Ms. Adriano had fallen. She was found lying on her right side on the floor with her head against the furniture. She had been attempting to get to the bathroom	LTCI00011342 LTCI00011988
72.	May 31, 2008	Progress Note entered by Karen Reading, Dietician, at 20:20 indicating that weight loss and glycemic control is the goal.	LTCI00011342
73.	March 1, 2008 – May 31, 2008	Physician's Medication Review	LTCI00012012
74.	May, 2008	MAR – Insulin and BS readings	LTCI00011702
75.	June 3, 2008	Internal Resident Incident Report completed regarding medication error – Nitro patches left on June 3/08, not removed at hs.	LTCI00011826
76.	June 3, 2008	Internal Resident Incident Report completed regarding missing narcotic from 2000 card – discovered by J. Emmerson and EW	LTCI00011828
77.	June 16, 2008	Progress Note entered by Jennifer Cake, RN, at 21:26, Nursing Quarterly Summary indicating that Ms. Adriano's diabetes was adequately controlled with insulin.	LTCI00011342
78.	June, 2008	MAR – Insulin and BS readings	LTCI00011720 LTCI00012138

	DATE	EVENT	SOURCE DOC ID
79.	July 17, 2008	Ms. Adriano is transferred to WGH for assessment. Noted that large abdominal mass discovered enlarged. Ms. Adriano is returned to Caressant Care to be made comfortable.	LTCI00012116 LTCI00012117
80.	July 17, 2008	Ms. Adriano returns to Caressant Care. She is palliative.	LTCI00012015 LTCI00011342
81.	July 19, 2008, July 21, 2008 and July 22, 2008	Progress notes entered by EW regarding discussions with family members over morphine dosage.	LTCI00011342
82.	July 24, 2008	Ms. Adriano's insulin is changed to 10 units in the a.m. and 5 units in the p.m.	LTCI00012015
83.	July 30, 2008	Ms. Adriano passes away at Caressant Care. Medical Certificate of Death completed by Dr. Jonny Tam lists cause of death as CAD.	LTCI00011394
84.	July 30, 2008	Dr. Tam signs Resident Death Form, indicating cause of death is CAD, hypertension and breast cancer.	LTCI00011395
85.	July 30, 2008	Lois Durbidge, RN, signs Institutional Patient Death Record Version 3. None of the questions are answered "Yes", therefore no requirement to contact the local coroner immediately. Death recorded on Death Registry	LTCI00011396 LTCI00071972
86.	July, 2008	MAR – Insulin and BS readings	LTCI00011840 LTCI00011844

VOLUME 5(ii): ALBINA DEMEDEIROS CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Ms. Albina deMedeiros was Elizabeth (Bethe) Wettlaufer's ("EW") second victim at Caressant Care. EW admitted to having given Ms. deMedeiros extra doses of insulin during the time period June, 2007 to December, 2007.

Ms. deMedeiros was born in Portugal on February 25, 1919. She moved to Canada to join her brothers and family and became a Canadian Citizen. Ms. deMedeiros and her husband grew tobacco in the Woodstock area. Ms. deMedeiros and Ms. Albino were sisters-in-law.

The chronology below sets out Ms. deMedeiros' history while at Caressant Care. Ms. deMedeiros had a number of ailments including diabetes controlled with injected insulin. The evidence indicates that Ms. deMedeiros had a history of hypoglycemic episodes prior to EW commencing her employment with Caressant Care.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	October 14, 2006	Ms. deMedeiros is admitted to Woodstock General Hospital ("WGH"). That month an application is made for her to enter long-term care.	LTCI00011292
2.	December 4, 2006	Ms. deMedeiros is admitted to Caressant Care from WGH. Her diabetes medication is Toronto Insulin, 14 units before breakfast, lunch and supper and NPH insulin 28 units qhs	LTCI00010557 LTCI00011100
3.	December, 2006	During Ms. deMedeiros' stay at Caressant Care, blood sugar ("BS") readings were taken. For ease of reference, the location of each month's readings (where identifiable) are included in this chronology and referred to as "BS readings". Medication Administration Records ("MAR") for insulin have also been included in this chronology for ease of reference. They indicate the type of insulin administered, the timing of same and by whom.	LTCI00010557

	DATE	EVENT	SOURCE DOC ID
4.	January 7, 2007	Internal Resident Incident Report completed – Ms. deMedeiros got up on her own and slipped on the floor.	LTCI00011092
5.	January 8, 2007	BS are fluctuating between 2.4 and 9. Ms. deMedeiros experiences a fall.	LTCI00010457
6.	January 10, 2007	Strange behaviour noted. Ms. deMedeiros is unsteady on her feet and aggressive, complains of being hungry. After given a snack, BS 4.7.	LTCI00010457
7.	January 27, 2007	BS are at 1.9 - Orange juice given and at HS BS was 9.9.	LTCI00010457
8.	January, 2007	MAR – Insulin and BS readings (unable to locate)	LTCI00010562
9.	February 21, 2007	Ms. deMedeiros experiences a fall. Noted that she was shaky, giggling. BS 2.1, Orange Juice and corn syrup given. Internal Resident Incident Report completed.	LTCI00010457 LTCI00011092
10.	February 28, 2007	Ms. deMedeiros indicated she didn't feel right, found sitting on the side of the bed. Blood sugar 1.8. Orange juice and corn syrup given.	LTCI00010457
11.	February, 2007	MAR – insulin and BS readings Insulin doses changed in February to Toronto Insulin 14 units breakfast and supper, 12 units lunch and Novolin NPH 27 units qhs.	LTCI00010563 LTCI00011222
12.	March 5, 2007	Ms. deMedeiros' sister-in-law, Ms. Adriano, enters Caressant Care.	LTCI00057683
13.	March 30, 2007	Plan of Care amended to add goal of maintaining glucose levels within normal range of 3.3 – 8.3 and decrease risks associated with hypo/hyperglycemia	LTCI00010862
14.	March, 2007	MAR – insulin and BS readings (unable to locate) Insulin dose changed in March to Toronto 16 units at breakfast, 14 units at lunch and supper, Novolin NPH 24 units @ hs	LTCI00010571 LTCI00011107
15.	April 4, 2007	Ms. deMedeiros was found moaning, not answering questions, sweating. Her BS is 1.9. Corn syrup and resource, rechecked and is at 2.00. Given more resource and rechecked – 2.4. Continues to moan, doesn't open eyes. BS rechecked, now 4.8. Opens eyes and	LTCI00010457

	DATE	EVENT	SOURCE DOC ID
		responds.	
16.	April 5, 2007	BS continue to rise. Progress Note entered by Laura Huck, RPN at 22:34 indicating that Ms. deMedeiros' BS were 15.7 and she had complained of feeling unwell before supper.	LTCI00010457 LTCI00010416
17.	April 8, 2007	Progress Note entered by Shelly Clark, RN, at 00:11 that BS is 7.0 and Resource was given.	LTCI00010416
18.	April 11, 2007	Progress Note entered by Shelly Clark, RN, at 00:37 that Ms. deMedeiros was found at 23:30 moaning, diaphoretic and stated that she is sick. BS 1.8, Corn syrup given with juice. Rechecked 10 mins later and was still 1.8. given 4 oz corn syrup in juice. Remains alert. BS at 01:18 3.2. Given more Resource with corn syrup.	LTCI00010416
19.	April 12, 2007	Progress Note entered by Miriam Wright, RN, that the Doctor was informed of the low BS. Decreased insulin by 2 units ac supper	LTCI00010416
20.	April 19, 2007	Progress Note entered by Lois Durbidge, RN, at 23:12 that BS at HS was 6.8 and insulin held.	LTCI00010416
21.	April 23, 2007	Progress Note by Shelly Clark, RN, at 22:05 that BS was 10.6. Ms. deMedeiros is getting a whole sandwich and a glass of juice each night, sometimes a glass of resource depending on BS to prevent insulin reaction through the night. Note left with Dr. Reddick to review her blood sugars.	LTCI00010416
22.	April 25, 2007	Progress Note entered by Shelly Clark, RN, at 21:40 that BS that day were 3.6, 2.8 and 3.9 at 16:30. 16:30 dose of insulin held. Dr. Reddick in and decreased insulin.	LTCI00010416
23.	April 30, 2007	Progress Note entered by Alicia Sauve, Nutritional Manager – high risk due to uncontrolled Diabetes, RD referral completed.	LTCI00010416 LTCI00010775
24.	April, 2007	MAR – insulin and BS Readings (unable to locate) A number of changes are made – as of the end of March insulin is Novolin Toronto 15 units before breakfast, 14 units before lunch, 8	LTCI00010577 LTCI00011107

	DATE	EVENT	SOURCE DOC ID
		units before supper and Novalin NPH 20 units at bedtime.	
25.	May 2, 2007	Progress Note entered by Lois Durbidge, RN, at 22:57 that BS at HS are 8.6. Snack of sandwich and OJ given.	LTCI00010416
26.	May 3, 2007	Progress Note entered by Karen Reading, Dietician, at 22:02 indicating nutritional referral for hypoglycemic episodes during evening. Reviewed chart and noted that Dr. Reddick had since reduced bedtime insulin from 27 units of NPH to 20 units (April 25, 2007). Ms. deMedeiros receives a whole sandwich at HS and OJ. Continue to provide the whole sandwich at HS and if HS glucometer is less than 7 mmol/L provide 125 ml of milk. Discontinue use of OJ at HS and only provide to treat hypoglycemia. Milk provides a slower release of glucose into the bloodstream and will help prevent rebound hyperglycemia. This combined with the reduction in NPH at HS may help.	LTCI00010416
27.	March 1, 2007 – May 31, 2007	Physician's Medication Review	LTCI00011105
28.	May, 2007	MAR – insulin and BS readings	LTCI00010583 LTCI00011222
29.	June 17, 2007	Progress Note entered by Jennifer Cake, RN, at 13:31 that BS was 4.4 at 11:30 a.m. and therefore insulin withheld and applesauce given.	LTCI00010416
30.	June 27, 2007	EW commences her employment at Caressant Care.	LTCI00057092 LTCI00057098
31.	June, 2007	MAR – insulin and BS readings	LTCI00010588 LTCI00011222
32.	June, 2007 – December 2007	EW admits to having given Ms. deMedeiros a non-medically prescribed dose of 30 to 40 units of long lasting insulin. EW admits to having overdosed Ms. deMedeiros on more than one occasion, the first being prior to the death of Mr. Silcox (August 12, 2007). EW estimates that another occasion was in October, 2007.	LTCI00057683
33.	July 4, 2007	Progress Note entered by Lois Durbidge, RN, at 15:54, Quarterly Nursing Summary, that Ms. deMedeiros diabetes was adequately controlled with insulin, and at present diabetes is stable, though	LTCI00010416

	DATE	EVENT	SOURCE DOC ID
		there has been some adjustment the past quarter	
34.	July 5, 2007	Progress Note entered by Jennifer Cake, RN, at 21:25 that BS was 6.1 and therefore insulin withheld and given glass of juice.	LTCI00010416
35.	July 11, 2007	Progress note entered by Lois Durbidge, RN, at 02:02 that BS 5.6, mild and ½ meat sandwich given.	LTCI00010416
36.	July 23, 2007	Progress note entered by Jennifer Cake, RN, at 20:57 that Ms. deMedeiros was given Resource because BS was 6.9 at 20:00.	LTCI00010416
37.	July, 2007	MAR – insulin and BS readings	LTCI00010593 LTCI00011222
38.	August, 2007	MAR – insulin and BS readings	LTCI00010598 LTCI00011222
39.	June 1, 2007 – August 31, 2007	Physician's Medication Review	LTCI00011109
40.	September 12, 2007	Ms. deMedeiros' Plan of Care is updated.	LTCI00010862
41.	September 28, 2007	Ms. deMedeiros' Plan of Care is updated.	LTCI00010871
42.	September, 2007	MAR– insulin and BS readings	LTCI00010603 LTCI00011222
43.	October 4, 2007	Progress Note entered by Shelly Clark, RN, at 22:38, Nursing Quarterly Summary, diabetes adequately controlled with insulin and has been stable this last quarter.	LTCI00010416
44.	October 4, 2007	Ms. deMedeiros' Plan of Care is updated.	LTCI00010880
45.	October 7, 2007	Progress Note by Shelly Clark, RN, at 22:31 that that it was reported by RPN that Ms. deMedeiros had a fall at 16:30, complained of dizziness. Incident Form completed.	LTCI00010416 LTCI00011094
46.	October 9, 2007	Progress Note by Miriam Wright, RN, at 18:13 that Ms. deMedeiros was feeling dizzy and fatigued after breakfast. BS at 09:50 was 16.5.	LTCI00010416

	DATE	EVENT	SOURCE DOC ID
47.	October 14, 2007	Ms. deMedeiros' Plan of Care updated to note anxiety related to her blood sugars and health, will refuse to go out with family as she is afraid she will "die" while away from home.	LTCI00010895
48.	October, 2007	MAR – Insulin and BS readings	LTCI00010609 LTCI00011222
49.	September 1, 2007 – November 30, 2007	Physician's Medication Review.	LTCI00011111
50.	November 9, 2007	Progress Note entered by Karen Reading, Dietician, at 19:29 regarding a nutrition referral. Notes that blood sugars have been running high before lunch and also occasionally at HS. Dr. Reddick increased Toronto insulin dose at breakfast by 1 unit to 16 units. This change along with discontinuing extra bread at meals may help glycemic control. Upgraded to high risk	LTCI00010416
51.	November 12, 2007	EW's first Progress Note re Ms. deMedeiros.	LTCI00010416
52.	November, 2007	MAR – Insulin and BS readings (readings are changed from daily to 3 times a week) Insulin dose changed November 2, 2007 to Novolin Toronto 17 units at breakfast, 14 units at lunch, 8 units at supper. Novolin NPH remains at 20 units at bedtime	LTCI00010615 LTCI00011228 LTCI00011045
53.	December 3, 2007	Ms. deMedeiros develops a gangrenous change involving her left heal, probably due to combination of peripheral vascular disease and diabetes mellitus.	LTCI00011251 LTCI00011252 LTCI00011253 LTCI00011254
54.	December 15, 2007	Progress Note entered by Miriam Wright, RN, at 07:29 that Dr. Reddick had been in the previous evening and had changed Ms. deMedeiros insulin and signed a 3-month review.	LTCI00010416
55.	December, 2007	MAR – Insulin and BS readings Novolin Toronto changed to 18 units at breakfast, 16 units at lunch, 8 units at supper, Novolin NPH changed to 22 units at bedtime.	LTCI00010616 LTCI00011115 LTCI00011045
56.	January 3, 2008	Progress Note entered by Jennifer Cake, RN, at 15:53. Quarterly Nursing Summary notes, among other things, that Ms. deMedeiros has anxiety related to diabetes. Intervention is "1 staff to spend 5 – 10 mins each episode calming and reassuring resident that she is	LTCI00010416

	DATE	EVENT	SOURCE DOC ID
		going to be okay. Happens when family would like to take her out with them".	
57.	January 16, 2008	Progress note entered by Helen Crombez, Director of Nursing, at 10:28, that she met with family to review condition of left heal (diabetic ulcer). Notes that Ms. deMedeiros has been told by her family that she needs to lie down on her side for 1 hour a.m. and p.m. notes that "Family states she's always scared she will be forgotten, has always been scared of everything for no reason".	LTCI00010416
58.	January 23, 2008	Progress Note by Shelly Clark, RN, at 22:42 that Dr. Reddick had been in, had reviewed blood sugars.	LTCI00010416
59.	January, 2008	MAR – Insulin (says 2007) and BS readings.	LTCI00010626 LTCI00011045
60.	February, 2008	MAR – Insulin and BS readings	LTCI00010627 LTCI00011045
61.	December 1, 2007 – February 28, 2007	Physician's Medication Review	LTCI00011115
62.	January 3, 2008	Ms. deMedeiros' Plan of Care is updated.	LTCI00010902
63.	March, 2008	MAR – Insulin and BS readings Insulin dose changed to Novolin Toronto, 19 units at breakfast, 16 units at lunch, 8 units at supper, Novolin NPH 23 units @ HS.	LTCI00010633 LTCI00011124 LTCI00011045
64.	April 5, 2008	Ms. deMedeiros' Plan of Care is updated.	LTCI00010909
65.	April 5, 2008	Progress Note entered by Lois Durbidge, RN, at 13.18, Nursing Quarterly Summary, that Ms. deMedeiros continues to be anxious related to her diabetes, intervention is 1 staff to spend 5 – 10 mins each episode calming and reassuring her that she is going to be okay. Happens when family would like to take her out with them.	LTCI00010416
66.	April, 2008	MAR – Insulin (April 18 – May 18) and BS readings	LTCI00010644 LTCI00011045 LTCI00011231
67.	May, 2008	MAR – Insulin and BS readings.	LTCI00010646 LTCI00011231

	DATE	EVENT	SOURCE DOC ID
68.	March 1, 2008 – May 31, 2008	Physician's Medication Review.	LTCI00011124
69.	June 4, 2008	Progress Note entered by Shelly Clark, RN, at 18:56, BS ac supper was 3.9. Staff said she had a cookie and drink for staff. Given a glass of orange juice, rechecked and was 6.2. BS at 20:40 was 5.8, at 22:45 was 7.5.	LTCI00010416
70.	June 4, 2008	Incident Form completed – Medication error – Ms. deMedeiros' tensor bandages were left on overnight on both legs and ankles – were to be removed at 20:00 and replaced at 10:00 – June 3 and 4, 2008.	LTCI00011098
71.	June 20, 2008	Progress Note by Tara Mahoney, RPN, that 1700 insulin was withheld because BS was only 3.8.	LTCI00010416
72.	June, 2008	MAR – Insulin and BS readings	LTCI00010657 LTCI00011231
73.	July 3, 2008	Progress Note by Lois Durbidge, RN, at 15:31, Nursing Quarterly Summary noting same anxiousness relating to diabetes.	LTCI00010416
74.	July 3, 2008	Ms. deMedeiros' Plan of Care is updated.	LTCI00010917 LTCI00010923
75.	July 12, 2008	Progress Note by Karen Reading, Dietician, at 20:07, Dietary Quarterly Summary, notes poorly controlled diabetes and that Ms. deMedeiros may be experiencing symptoms of diabetic gastropathy (decreased appetite, early satiety, abdominal pain and bloating, blood glucose fluctuations. Will implement Small Portion interventions as small frequent meals are recommended.	LTCI00010416
76.	July 30, 2008	Ms. Adriano, Ms. deMedeiros' sister-in-law, passes away.	LTCI00010416
77.	July, 2008	MAR – Insulin and BS readings	LTCI00010665 LTCI00011231
78.	August 5, 2008	Progress Note entered by EW at 07:23 "While writer was taking Albina's blood sugar this am, Albina stated 'most nurses nice. Nurse yesterday morning too fast, too rough".	LTCI00010416
79.	August, 2008	MAR – Insulin and BS readings	LTCI00010671 LTCI00011231

	DATE	EVENT	SOURCE DOC ID
80.	June 1, 2008 – August 31, 2008	Physician's Medication Review	LTCI00011129
81.	September, 2008	MAR – Insulin and BS readings	LTCI00010676 LTCI00011231
82.	October 3, 2008	Progress Note entered by Jennifer Emmerson, RN, at 15:45, Nursing Quarterly Summary, that diabetes adequately controlled with insulin, has been stable this last quarter.	LTCI00010416
83.	October 3, 2008	Ms. deMedeiros' Plan of Care is updated.	LTCI00010926
84.	October 5, 008	Ms. deMedeiros' Plan of Care is updated.	LTCI00010935
85.	October, 2008	MAR – Insulin and BS readings	LTCI00010682 LTCI00011231
86.	November 7, 2008	Ms. deMedeiros' Plan of Care is updated.	LTCI00010886
87.	November, 2008	MAR – Insulin and BS readings	LTCI00010686 LTCI00011231
88.	December, 2008	MAR – Insulin and BS readings	LTCI00010687 LTCI00011231
89.	January 2, 2009	Progress Note entered by Karen Routledge, RN, at 20:14, Nursing Quarterly Summary, that diabetes adequately controlled with insulin, has been stable this last quarter.	LTCI00010416
90.	January 3, 2009	Ms. deMedeiros' Plan of Care is updated.	LTCI00010962
91.	January 30, 2009	Progress Note entered by Karen Reading, Dietician, at 13:39, Dietary Quarterly Summary, that Ms. deMedeiros had been downgraded to moderate risk as per protocol. Diabetes is well controlled with diet and insulin.	LTCI00010416
92.	January, 2009	MAR – insulin and BS readings	LTCI00010697 LTCI00011231
93.	February 20, 2009	Progress Note entered by Karen Reading, Dietician, re Nutrition Referral, discontinue sending peanut butter sandwich for p.m. nourishment as glycemic control is improved (no low blood sugars in evening) and weight is still an issue.	LTCI00010416

	DATE	EVENT	SOURCE DOC ID
94.	February, 2009	MAR – Insulin and BS readings	LTCI00010702 LTCI00011231
95.	December 1, 2008 – February 28, 2009	Physician's Medication Review	LTCI00011134
96.	March 3, 2009	Progress Note entered by Margaret Darling, RPN, Nursing Quarterly Summary, that diabetes has been stable this last quarter.	LTCI00010416
97.	March 3, 2009	Ms. deMedeiros' Plan of Care is updated. Handwritten notes on Plan of Care dated March 3, 2009 re Ms. deMedeiros' anxiety related to her blood sugars and health - "happens daily 3x" and "15 min".	LTCI00010971
98.	March 4, 2009	Progress Note entered by Shelly Clark that Dr. Reddick was in, reviewed Ms. deMedeiros sugars, hs dose of insulin changed from NPH to Lantus.	LTCI00010416
99.	March 4, 2009	Progress Note entered by Margaret Darling, RPN, at 22:55 that insulin held at 17:00, as BS 4.1.	LTCI00010416
100.	March 25, 2009	Progress Note entered by Shelly Clark, RN, at 16:14 that Dr. Reddick was in, lantus insulin 22 units qhs.	LTCI00010416
101.	March, 2009	MAR – Insulin (March 18 – April 17) and BS readings Novolin insulin changed to Lantus Insulin 23 units qhs and then to 22 units qhs.	LTCI00010713 LTCI00011231
102.	April 15, 2009	Progress Note entered by Karen Reading, Dietician, at 19:52, Nutrition Referral, notes discontinued half PB sandwich previous month as blood sugars are improved, monitor and notify RD if Ms. deMedeiros has low morning blood sugars.	LTCI00010416
103.	April, 2009	MAR – Insulin (March 18 – April 17) and BS readings	LTCI00010713 LTCI00011231
104.	May 28, 2009	Progress Note by EW at 02:32 that Dr. Reddick was in and increased Lantus insulin.	LTCI00010416
105.	May, 2009	BS readings (to May 13, 2009)	LTCI00011231
106.	March 1, 2009 – May 31, 2009	Physician's Medication Review	LTCI00011136

	DATE	EVENT	SOURCE DOC ID
107.	June 4, 2009	Progress Note entered by Lois Durbidge, RN, at 15:29, Nursing Quarterly Summary, indicates that diabetes has been stable this last quarter and BS done Mon/Wed/Fri.	LTCI00010416
108.	June 4, 2009	Ms. deMedeiros' Plan of Care is updated.	LTCI00010979
109.	June 8, 2009	Medication Review Report	LTCI00011141
110.	June, 2009	MAR – Insulin	LTCI00010718
111.	August 12, 2009	Progress Note entered by Lois Durbidge, RN, at 02:15 that blood glucose monitoring order was corrected in computer	LTCI00010416
112.	September 9, 2009	Ms. deMedeiros' Plan of Care is updated.	LTCI00010953
113.	September 23, 2009	Progress Note entered by EW at 20:49 that Ms. deMedeiros threw the lunch meat from her sandwich across the hall. EW asked Ms. deMedeiros why she did so and Ms. deMedeiros responded "you put in garbage". EW asks Ms. deMedeiros not to do that again.	LTCI00010416
114.	September 24, 2009	Quarterly Medication Review	LTCI00011143
115.	October 7, 2009	Progress note by Janette Langford, RPN, at 17:54 that supper insulin withheld BS 3.5.	LTCI00010416
116.	October 7, 2009	Progress Notes start to reflect Novolin units given at breakfast (20 units), lunch (16 units) and supper (8 units).	LTCI00010416
117.	October 14 or 19, 2009	Medication Review re BG high at lunch	LTCI00010729
118.	November 29, 2009	Quarterly Medication Review	LTCI00011146
119.	September 1, 2009 – November 30, 2009	Physician's Medication Review	LTCI00011132
120.	December 5, 2009	Progress Note entered by EW at 16:04, Annual Nursing Review indicates no significant changes over past year. In terms of Ineffective Coping, notes:	LTCI00010416

	DATE	EVENT	SOURCE DOC ID
		Albina has anxiety requiring 15 minutes of interventions every 24 hours. Albina acts sad and depressed requiring 20 minutes of interventions every 24 hours. Abina is resistive to care requiring 6 minutes of interventions every 24 hours. Albina hoards food and dishes, requiring 5 minutes of interventions every 24 hours. In total as per her care plan, Albina requires 46 minutes of ongoing interventions to effectively manage her behaviours. These behaviours are predictable, have been ongoing since admission and are not expected to decrease.	
121.	December 5, 2009	Ms. deMedeiros' Plan of Care is updated.	LTCI00010944
122.	December 15, 2009	Updated Plan of Care – does not refer to anxiety related to blood sugars – now references Psychosocial well being – potential negative feelings regarding self and social relationships characterized by conflict with room mate	LTCI00010988
123.	December 15, 2009	Annual Assessment	LTCI00011012
124.	January, 2010	MAR – insulin Insulin dose changed Novolin Toronto from 20 units at breakfast, 16 units at lunch and 8 units at supper to 22 units at breakfast, 16 units at lunch and 8 units at supper.	LTCI00010724 LTCI00011146
125.	February 20, 2010	Progress Note entered by Brenda Pearce, RN, at 10:56 that Ms. deMedeiros has been lethargic, complains of right flank area pain, ate very little and slightly elevated temperature	LTCI00010416
126.	February 21, 2010	Progress Note entered by EW at 16:28 that Ms. deMedeiros was transferred to WGH Emergency. EW notes at 22:22 that she spoke with Emergency Room RN and was told that Ms. deMedeiros had severe congestive heart failure.	LTCI00010416
127.	February 25, 2010	Ms. deMedeiros passes away at WGH.	LTCI00010416

	DATE	EVENT	SOURCE DOC ID
128.	Undated	4 months of BS readings with no date	LTCI00011218

VOLUME 5(iii): JAMES SILCOX
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Mr. James Silcox was Elizabeth (Bethe) Wettlaufer's ("EW") first murder victim at Caressant Care. EW admitted to giving Mr. Silcox extra doses of insulin leading to his death in August, 2007.

Mr. Silcox was born on February 17, 1923. He was a World War II veteran. Mr. Silcox settled for most of his life in Woodstock. He worked for more than 30 years at Standard Tube in Woodstock. He was married and he and his wife Agnes, had six children.

The chronology below sets out Mr. Silcox's history while at Caressant Care. Mr. Silcox had a number of ailments including diabetes controlled with injected insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	March 5, 2007	Mr. Silcox is admitted to Woodstock General Hospital ("WGH") as he was not managing at home.	LTCI00004792
2.	April 14, 2007	An Application for Long-term care is prepared identifying that Mr. Silcox needs 24 hour care for all of the activities of daily living. He is thereafter assessed for long-term care.	LTCI00004787
3.	May, 2007	Mr. Silcox suffers a fall in hospital, and on May 4, 2007 a CT scan of his pelvis identifies undisplaced fractures on his right side.	
4.	May 8, 2007	Mr. Silcox's Application for Long-term Care is sent to Caressant Care.	LTCI00004898
5.	May 9, 2007	Caressant Care accepts Mr. Silcox's application.	LTCI00004899
6.	June 27, 2007	EW commences her employment at Caressant Care.	LTCI00057092 LTCI00057098

	DATE	EVENT	SOURCE DOC ID
7.	July 17, 2007	WGH indicates that the only appropriate further measures for Mr. Silcox would appear to be long-term care.	
8.	July 25, 2007	Mr. Silcox is admitted to Caressant Care. He suffers from a number of conditions, including Alzheimer's disease and diabetes. His diabetes is controlled with insulin injection Novolin – 25 units at breakfast and 13 units at supper. Mr. Silcox's Plan of Care notes issues with inappropriate behaviour – interventions are outlined. Various Assessments are completed on Mr. Silcox's admission.	LTCI00004970 LTCI00004717 LTCI00004746 LTCI00004860
9.	July 25, 2007	Progress Note entered by Miriam Wight, RN, at 20:08 re arrival of Mr. Silcox at Caressant Care. Notes as follows: *Resident has a diagnosis of Diabetes (insulin dependent) Hypertension – Alzheimer's, and Diverticulosis.* *He has been in the hospital for 4 and a half months as he has had a stroke, affecting his rt side, and he is prone to fallsx (sic). He had one in the hospital and broke his pelvis.* *He gets confused at times. Forgets where he is and that he cannot walk. Family wish him in geri-chair with either seatbelt or tray.* *Pleasant but restless, and does not really appear aware of where he is. Asks frequently for wife. Family very supportive*.	LTCI00004711
10.	July 25, 2007	Progress Note entered by Laura Huck, RPN, at 21:42 that when trying to do a head to toe assessment on Mr. Silcox, he asked her to get in bed with him, touched her arm and was speaking inappropriately. She notes that she spoke kindly to Mr. Silcox and left the room.	LTCI00004711
11.	July, 2007	During Mr. Silcox' stay at Caressant Care, blood sugar ("BS") readings were taken. For ease of reference, the location of each month's readings (where identifiable) are included in this chronology and referred to as "BS readings". Medication Administration Records ("MAR") for insulin have also been included in this chronology for ease of reference. They indicate the type of insulin administered, the timing of same and by whom.	LTCI00004852 LTCI00004739
12.	July 26, 2007	Progress Note entered by Linda Kirby, RPN, at 15:26 that Mr. Silcox seemed to be adjusting okay except that he unbuckled himself in his	LTCI00004711 LTCI00004823

	DATE	EVENT	SOURCE DOC ID
		w/c and tried to get up and slid to the floor instead. No injuries noted and good range of motion in all joints. Internal Resident Incident Report filed.	
13.	July 27, 2007	Progress Note entered by Shelly Clark, RN, at 05:22 that Mr. Silcox was intermittently calling out for Agnes and needed extra care the last two nights for "wandering hands".	LTCI00004711
14.	July 27, 2007	Progress Note entered by Shelly Clark, RN, at 06:28 that Mr. Silcox was up early that morning in his chair as he was hollering and disturbing his roommate.	LTCI00004711
15.	July 27, 2007	Progress Note entered by Jennifer Cake, RN, at 13:58 that Mr. Silcox was confused, stating many times he wanted to go home.	LTCI00004711
16.	July 27, 2007	Progress Note entered by Miriam Wight, RN, at 19:18 that Mr. Silcox was able to undo the seatbelt on his wheelchair and attempted to walk – would have fallen except staff caught him and lowered him to the floor, very restless.	LTCI00004711
17.	July 28, 2007	Progress Note entered by Miriam Wight, RN, at 15:57 that Mr. Silcox was restless asking to go home; trying to get out of chair.	LTCI00004711
18.	July 28. 2007	Progress Note entered by Jennifer Cake RN, at 21:49 that Mr. Silcox appeared to have a better day.	LTCI00004711
19.	July 28, 2007	Progress Note entered by Jennifer Cake, RN, at 21:50 that there were no complaints from fall on July 26, 2007.	LTCI00004711
20.	July 28, 2007	Progress Note entered by EW at 22:44 regarding inappropriate behaviour.	LTCI00004711
21.	July 29, 2007	Progress Note entered by Shelly Clark, RN, at 07:09 that Mr. Silcox slept well until the early morning when he called out for Agnes.	LTCI00004711
22.	July 29, 2007	Progress Note by Miriam Wight, RN, at 17:09 regarding inappropriate behaviour. Notes that it occurs with most cares and at times a male staff is sent in to assist with care when available.	LTCI00004711
23.	July 29, 2007	Progress Note by Linda Kirby, RN, at 23:00 that Mr. Silcox was found on floor at end of his bed at 1940. No injuries noted except that he stated his rt hip was a little sore. Given reg Tylenol for rt hip soreness at hs ROM good in all joints. Plan: Monitor and encourage/remind him to stay in bed and pull his call bell if he needs something.	LTCI00004711 LTCI00004760 LTCI00004762

	DATE	EVENT	SOURCE DOC ID
		Internal Resident Incident Report completed	
24.	July 29, 2007	Progress Note entered by Linda Kirby, RPN, at 23:05 that Mr. Silcox was continuing to adjust to Caressant Care but displays inappropriate touching of staff and other residents at times.	LTCI00004711
25.	July 30, 2007	Progress Note entered by Suzanne Kungl, RPN, at 07:16 that Mr. Silcox was calling out loudly 1.5 h at beginning of shift. Calm, cooperative when spoken to and settled for a few minutes each time, but disoriented and asking for Agnes. Staff reoriented resident consistently and he settled for remainder of night.	LTCI00004711
26.	July 30, 2007	Progress Note entered by Laura Huck, RPN, at 21:56 that Mr. Silcox appeared to be adjusting better to the environment and routine. Not calling out that shift.	LTCI00004711
27.	July 31, 2007	Progress Note entered by Shelly Clark, RN, at 04:59 that Mr. Silcox was hollering out at the start of the shift for Agness, settled around 0:200.	LTCI00004711
28.	July 31, 2007	Progress Note entered by Lois Durbidge, RN, at 14:36 that Mr. Silcox appeared settled that shift.	LTCI00004711
29.	July 31, 2007	Physiotherapy Assessment – Notes that he ambulated with a walker with one person if done in the a.m. but too tired and week in the p.m.	LTCI00004878
30.	July 31, 2007	Progress Note entered by EW at 22:37 that Mr. Silcox's family was in to visit and that he was very confused.	LTCI00004711
31.	August 1, 2007	Progress Note entered by Shelly Clark, RN, at 05:21 that Mr. Silcox slept well, called out a few times at start of shift but then settled and slept well. No complaints or evidence of injury re fall July 30.	LTCI00004711
32.	August 1, 2007	Progress Note entered by Shelly Clark, RN, at 05:31 that evening staff reported that Mr. Silcox was not standing well.	LTCI00004711
33.	August 1, 2007	Progress Note entered by Miriam Wight, RN, at 17:53 that Mr. Silcox's daughter was in and stated that he was not weight bearing she was told. Physio confirmed that Mr. Silcox did not weight bear the previous afternoon, physio thought he was tired. Had not appeared to be in pain but Physio tried to walk him again and complained of discomfort and did not wt bear well. Daughter wishes him to have X-ray. Agreed that he be sent to hospital for same. Mr. Silcox admitted to hospital with a fractured right hip	LTCI00004711 LTCI00004759

	DATE	EVENT	SOURCE DOC ID
34.	August 2, 2007	Caressant Care files an Unusual Occurrence Report re fall of July 29, 2007 after Mr. Silcox is transferred to WGH.	LTCI00004815 LTCI00004825
35.	August 4, 2007	Mr. Silcox undergoes surgery in WGH. No complications.	LTCI00004711
36.	August 10, 2007	Mr. Silcox returns to Caressant Care.	LTCI00004711 LTCI00004755
37.	August 10, 2007	Progress Note entered by Laura Huck, RPN, at 21:31 that Mr. Silcox's BS is 8.6 and he was resting well.	LTCI00004711
38.	August 10, 2007	Progress Note entered by Laura Huck at 21:37 that Mr. Silcox's BS at 16:30 was 1.8 and he was given orange juice with sugar, ate everything at dinner and BS at HS was 8.6. Diabetic Monitoring Sheet identifies Mr. Silcox's BS as 1.8 upon return from hospital. Progress Note at 21:31 indicates that his BS is 8.6 and he was resting well	LTCI00004711
39.	August 11, 2007	Mr. Silcox's Plan of Care is updated.	LTCI00004847
40.	August 11, 2007	Progress Note entered by Suzanne Kungl, RN, at 07:40 that Mr. Silcox had slept well all night. No issues with BS in morning. But further noted that he continues to touch staff inappropriately.	LTCI00004711
41.	August 11, 2007	Progress Note entered by Miriam Wight, RPN, at 15:58 that Mr. Silcox had been restless most of the day but was asking for scissors to "get out of this place".	LTCI00004711
42.	August 11, 2007	EW begins a double shift. She admits entering the medical storage room at approximately 21:30 and locates a spare insulin needle. She prepares a dose of 50 units of short acting insulin which was kept in the medical storage fridge. EW admits that at approximately 22:30, she entered Mr. Silcox's room and injects him with the insulin, hoping he would die. After she injected him, he called out "I'm sorry" and "I love you".	LTCI00057683
43.	August 12, 2007	Mr. Silcox was found cold and blue around 0:400.	LTCI00004743
44.	August 12, 2007	Progress Note entered by EW at 07:55 that Mr. Silcox was found vital signs absent at 03:55.	LTCI00004711
45.	August 12, 2007	*Progress Note entered by EW at 07:58:*	LTCI00004711

	DATE	EVENT	SOURCE DOC ID
		Resident's daughter was called at 4am by this RN and informed that her father had been found vital signs absent. Daughter arrived at 5am and spoke to this RN and viewed her resident's body. Resident's wife came at 5:30 am and spoke with this RN and viewed resident's body.	
46.	August 12, 2007	Institutional Patient Death Record and Resident Death Form completed by EW and faxed to the Office of the Chief Coroner. EW checks of that this is an "Accidental Death" and "sudden and unexpected" requiring the local coroner to be called directly and immediately. Death recorded on Death Registry	LTCI00004726 LTCI00004727 LTCI00004728 LTCI00071970
47.	August 12, 2007	Dr. George completes the Medical Certificate of Death identifying that Mr. Silcox's immediate cause of death was "Complications of Fractured Right Hip" and that an autopsy was not being done. Also fills out portion of Resident Death Form.	LTCI00004725 LTCI00004711 LTCI00004727
48.	August, 2007	MAR – Insulin and BS readings	LTCI00004749 LTCI00004739

VOLUME 5(iv): MAURICE GRANAT CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Mr. Maurice Granat was Elizabeth (Bethe) Wettlaufer's ("EW") second murder victim at Caressant Care. EW admitted to giving Mr. Granat insulin, though he was not a diabetic, leading to his death in December, 2007.

Mr. Granat was born on February 7, 1923 in Saskatchewan. He lived the majority of his life in the Town of Tillsonburg. He was a tinsmith by trade and ran a small shop in Tillsonburg. He was married and had a step-daughter. Mr. Granat's wife predeceased him.

The chronology below sets out Mr. Granat's history while at Caressant Care. Mr. Granat had a number of ailments but did not have diabetes and did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	June 21, 2006	Mr. Granat is admitted to Tillsonburg District Memorial Hospital after a fall and assessed with general weakness and debility.	
2.	August - October 2006	Mr. Granat is assessed for and applies to long-term care.	LTCI00005321
3.	October 26, 2006	Mr. Granat is accepted at Caressant Care. On October 31, 2006 he is accepted for an interim bed at Caressant Care.	LTCI00005300 LTCI00005322
4.	December 4, 2006	Mr. Granat was admitted into Caressant Care from Tillsonburg District Memorial Hospital. He was not diabetic and had no medical need for synthetic insulin. He did have advanced cancer and a number of other ailments. Initial Plan of Care and other assessments are completed.	LTCI00005234 LTCI00005337
5.	February 1, 2007	Mr. Granat's Plan of Care is updated.	LTCI00005215
6.	May 15, 2007	Mr. Granat's Plan of Care is updated.	LTCI00005218
7.	June 25, 2007	EW commences her employment at Caressant Care.	LTCI00057092

	DATE	EVENT	SOURCE DOC ID
			LTCI00057098
8.	June, 2007	Mr. Granat's Plan of Care is updated to include the potential for inappropriate sexual behaviour.	LTCI00005012
9.	September 27, 2007	Progress Note entered by Barbara Baker, RN, at 23:04 that Mr. Granat appeared more pale and lethargic, becoming weaker and sleeping frequently during the day.	LTCI00004994
10.	September 30, 2007	Progress Note entered by Agatha Krawczyk, RN, at 13:05 that Mr. Granat's general condition is deteriorating.	LTCI00004994
11.	October 4, 2007	Mr. Granat's Plan of Care is updated.	LTCI00005072
12.	October 27, 2007	Progress Note entered by Karen Reading, Dietician, at 20:02 re weight warning – Mr. Granat's weight had decreased. She notes that he is refusing Resource and eating very little – most likely related to deteriorating condition and pain from bone metastasis.	LTCI00004994
13.	November 19, 2007	Progress Note entered by Agatha Krawczyk, RN, at 14:47 that Mr. Granat's general condition was deteriorating and he was becoming weaker.	LTCI00004994
14.	November 22, 2007	Mr. Granat experienced a fall – found lying on the floor beside his bed. It is noted that Mr. Granat said that he was transferring himself from bed to w/c and lost his balance.	LTCI00004994 LTCI00005094
15.	November 22, 2007	Progress Note entered by Karen Reading, Dietician, at 19:23 that she asked Mr. Granat if there was anything they could get him to eat or drink and he replied no, that he was just not hungry. Mr. Granat refuses supplements and assistance while eating. He insists he isn't in any pain.	LTCI00004994
16.	November 30, 2007	Mr. Granat transfers from an Interim Bed to basic accommodation. CCAC file closed.	LTCI00005099
17.	November 30, 2007	Progress note entered by Barbara Baker, RN, at 14:52 that Mr. Granat is pale, weak and lethargic, quiet and withdrawn. He was complaining of pain to shoulders and legs.	LTCI00004994
18.	November 30, 2007	Progress Note entered by Barbara Baker, RN, at 15:23 that she had spoken to Mr. Granat about his wishes and he decided to sign as	LTCI00004994

	DATE	EVENT	SOURCE DOC ID
		Code 2, that he would stay at Caressant Care re life threatening illness rather than be transferred to hospital. Noted that Mr. Granat seemed pleased that he would get to stay there rather than going to hospital.	
19.	December 4, 2007	Progress Note entered by Agatha Krawczyk, RN, at 14:52 that Mr. Granat's condition remains frail and he is becoming very weak.	LTCI00004994
20.	December 9, 2007	Progress Note entered by Shelly Clark, RN, that Mr. Granat's condition is frail.	LTCI00004994
21.	December 13, 2007	Progress Note entered by Shelly Clark, RN, at 06:55 re End of Life Care Note – Mr. Granat slept comfortably, periods of apnea noted and colour is poor.	LTCI00004994
22.	December 12, 2007	Mr. Granat is moved to Room 15 for closer observation.	LTCI00004994
23.	December 20, 2007	Progress Note entered by Jennifer Cake, RN, at 21:38 that Mr. Granat remains frail and isn't eating but he is taking some fluids and medications. No complaints of pain.	LTCI00004994
24.	December 21, 2007	Progress Note entered by Shelly Clark, RN, at 07:05 that Mr. Granat slept comfortably all night.	LTCI00004994
25.	December 21, 2007	Progress Note entered by Miriam Wight at 16:07 that Mr. Granat did not wish to get up.	LTCI00004994
26.	December 22, 2007	Progress Note entered by Shelly Clark, RN, at 07:14 that Mr. Granat had slept comfortably all night.	LTCI00004994
27.	December 22, 2007	Progress Note by Frances Crown, RN, at 13:50 that Mr. Granat refused to get up that day, was lethargic and very pale. Noted that he was complaining of a fair amount of pain and that the PSWs had been unable to find a pain patch on him so a new one was applied.	LTCI00004994
28.	December 22, 2007	Progress Note entered by Linda Kirby, RPN, at 23:03 that Mr. Granat stayed in bed all evening. It was noted that he was scratching.	LTCI00004994
29.	December 22, 2007	EW is working the night shift, from 11:00 to 07:00.	LTCI00057683

	DATE	EVENT	SOURCE DOC ID
30.	December 23, 2007	EW admits that she attends the medical storage room and retrieves an insulin pen from the allocated drawer and insulin from the medical refrigerator. EW admits that she enters Mr. Granat's room and tells him that she needs to give him a vitamin shot. She injects between 40 and 60 units of short acting insulin into Mr. Granat, knowing that he is not diabetic.	LTCI00057683
31.	December 23, 2007	Progress Note entered by EW at 02:05 that Mr. Granat was scratching his chest and arms and had opened a 3 cm long scratch on his left arm. Noted that cream was applied to increase comfort and decrease scratching.	LTCI00004994
32.	December 23, 2007	Progress Note entered by EW at 04:01 that Mr. Granat was found at 03:30 by PSWs as very confused and attempted to climb out of bed. She notes that he settled back to bed but they could not attach the call bell to his clothing as he would not keep his clothing on.	LTCI00004994
33.	December 23, 2007	Progress Note entered by EW at 07:08 that at 05:00 Mr. Granat was found diaphoretic and struggling to breathe. She notes that his family is at his bedside and that he appears comfortable.	LTCI00004994
34.	December 23, 2007	Progress note by Frances Crown, RN, at 10:39 that Mr. Granat was unresponsive and comfortable even when repositioned. Condition remains very guarded.	LTCI00004994
35.	December 23, 2007	Progress Note entered by Frances Crown, RN, at 11:45 that Mr. Granat's respirations had ceased and he had been pronounced dead by Dr. Yu.	LTCI00004994
36.	December 23, 2007	Mr. Granat passed away in Caressant Care. The Medical Certificate of Death is completed by Dr. Yu and identifies "Old age debility" as the immediate cause of death, with metastatic prostate cancer as a significant contributing factor. Frances Crown, RN, completes Institutional Patient Death Record and Resident Death Form. Death recorded on Death Registry	LTCI00005030 LTCI00005031 LTCI00005032 LTCI00005098 LTCI00071971

VOLUME 5(v): WAYNE HEDGES CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to attempting to murder Mr. Wayne Hedges in the Fall of 2008.

Mr. Hedges was born on April 23, 1951. At the age of 3 he was adopted by Bruce and Helen Hedges. He left home at the age of 17 and entered Caressant Care at the age of 48. Prior to and while living at Caressant Care, Mr. Hedges worked at ARC Industries.

Among other conditions at the time he entered Caressant Care, Mr. Hedges had diabetes, schizophrenia, a seizure disorder and mental disabilities. His diabetes was normally treated with insulin injections.

The chronology below sets out Mr. Hedges' history while at Caressant Care.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	April 17, 1998	Mr. Hedges enters Versa Care Windsor Place in Windsor. The reason is related to hypoglycemia.	
2.	April 26, 1999	Mr. Hedges applies for admission to Caressant Care to be closer to family. Various assessments are completed over the next few months.	
3.	July 15, 1999	Mr. Hedges' application is accepted by Caressant Care.	LTCI00007917
4.	January 22, 2000	Mr. Hedges enters Caressant Care from Versa Care, Windsor. Mr. Hedges was at high risk for falls during his stay at Caressant Care. Due to the high incidence of recorded falls, they have not been individualized in this Overview Statement unless it results in a transfer to hospital or is in close proximity to the date upon which EW has admitted to administering an overdose of insulin.	LTCI00008210 LTCI00007947
5.	January 22, 2002	Medication error. Mr. Hedges' dose of NPH insulin is not changed on divider card med cart though the order was changed from 6 units to 4 units January 14, 2000. An Internal Resident Incident Report is completed.	LTCI00008000

	DATE	EVENT	SOURCE DOC ID
6.	March 13, 2003	Mr. Hedges is diagnosed with a right femur fracture after a fall at Caressant Care on March 12, 2003. He is admitted to WGH and returns to Caressant Care on April 1, 2003. An Internal Resident Incident Report is completed.	LTCI00007344 LTCI00007345 LTCI00007678
7.	March 8, 2004	Medication error. Mr. Hedges was given 54 units of Novolin 30/40 by mistake. An Internal Resident Incident Report is completed.	LTCI00008051
8.	July 16, 2005	Medication error. Mr. Hedges' breakfast insulin was not given. An Internal Resident Incident Report is completed.	LTCI00008051
9.	July, 2005	EW was not hired until June, 2007. Mr. Hedges' Medical Administration Records for Insulin ("MAR – Insulin") have been noted in this chronology for a two-year period prior to EW being hired for ease of reference. They indicate the type of insulin administered, the timing of same and by whom. During Mr. Hedges' stay at Caressant Care, blood sugar ("BS") readings were taken. For ease of reference, the location of each month's readings (where identifiable) are included in this chronology and referred to as "BS readings". As of July, 2005, Mr. Hedges' was receiving: • Novolin NPH – 30 units before breakfast, 8 units before supper • Novolin Toronto – 10 units before breakfast, 4 units before supper	LTCI00010030 LTCI00010031
10.	August, 2005	MAR – Insulin and BS readings.	LTCI00010034 LTCI00008692
11.	September 2005	MAR – Insulin and BS readings	LTCI00010039 LTCI00008692
12.	July 1, 2005 – September 30, 2005	Physician's Medication Review Progress Notes and Physician's Orders showing high BS readings	LTCI00008437 LTCI00008440
13.	October, 2005	MAR – Insulin and BS readings	LTCI00010046 LTCI00008692

	DATE	EVENT	SOURCE DOC ID
14.	November, 2005	MAR – Insulin and BS readings	LTCI00010050 LTCI00008692
15.	October, 2005 – December 2005	Physician's Medication Review Progress Notes and Physician's Orders showing high bs readings	LTCI00008442 LTCI00008445 LTCI00008452
16.	December, 2005	MAR – Insulin	LTCI00010051
17.	January, 2006 – March, 2006	Physician's Medication Review. Physician's Orders are now: • Novolin NPH – 30 units before breakfast, 8 units before supper • Novolin Toronto – 10 units before breakfast, 4 units before supper (may give 5 if bs greater than 25) Progress Notes and Physician's Orders showing high BS readings	LTCI00008446 LTCI00008452
18.	January, 2006	MAR – Insulin and BS readings	LTCI00010058 LTCI00008692
19.	February 2006	MAR – Insulin and BS readings	LTCI00010062 LTCI00008692
20.	March, 2006	MAR – Insulin and BS readings	LTCI00010066 LTCI00008692
21.	April, 2006	MAR – Insulin and BS readings	LTCI00010067 LTCI00008692
22.	May, 2006	MAR – Insulin and BS readings	LTCI00010074 LTCI00008692
23.	June 13, 2006	Mr. Hedges is diagnosed with a left hip fracture after a fall at Caressant Care. He is transferred to WGH and then to LHSC for surgery. He returned to Caressant Care on July 4, 2006. Unusual Occurrence Report completed June 15, 2006.	LTCI00007347 LTCI00008084
24.	June, 2006	MAR – Insulin	LTCI00010078 LTCI00010079
25.	April, 2006 – June, 2006	Physician's Medication Review	LTCI00008449 LTCI00008452

	DATE	EVENT	SOURCE DOC ID
26.	July 4, 2006	Physician's Orders on return from WGH	LTCI00008445
27.	July 18, 2006	Mr. Hedges is transferred to WGH for assessment re distended abdomen etc. and returned on July 21, 2006.	LTCI00007416 LTCI00008470
28.	June 22, 2006 – July 2006	MAR – Insulin (July 1 – 22) and BS readings	LTCI00010079 LTCI00008714
29.	July 19, 2006 – August 18, 2006	MAR – Insulin and BS readings	LTCI00010088 LTCI00008714
30.	September, 2006	MAR – Insulin	LTCI00010097
31.	July, 2006 – September, 2006	Physician's Medication Review	LTCI00008466
32.	October, 2006	MAR – Insulin and BS readings	LTCI00010102 LTCI00008692
33.	November, 2006	MAR – Insulin and BS readings	LTCI00010103 LTCI00008714
34.	December 21, 2006	An RPN self-reported having forgotten to give Mr. Hedges his 08:00 medication – phenobarbital. An Internal Resident Incident Report is completed.	LTCI00008000
35.	December, 2006	MAR – Insulin and BS readings	LTCI00010113 LTCI00008714
36.	October, 2006 – December, 2006	Physician's Medication Review	LTCI00008476
37.	2001 – 2006	Plans of Care are updated for Mr. Hedges. They refer to fluctuating blood sugars, behaviours, risk of falls etc.	LTCI00008210 LTCI00008215 LTCI00008223 LTCI00008231 LTCI00008247 LTCI00008251 LTCI00008256 LTCI00008279
38.	January, 2007	MAR – Insulin and BS readings	LTCI00010117 LTCI00008714
39.	February, 2007	MAR – Insulin and BS readings	LTCI00010118 LTCI00008714

	DATE	EVENT	SOURCE DOC ID
40.	March, 2007	MAR – Insulin and BS readings	LTCI00010127 LTCI00008722
41.	January, 2007 – March, 2007	Physician's Medication Review	LTCI00008480
42.	April, 2007	MAR – Insulin	LTCI00010132
43.	May 1, 2007 – May 31, 2007	MAR – Insulin	LTCI00009814
44.	June 27, 2007	EW commences her employment at Caressant Care.	LTCI00057092 LTCI00057098
45.	June 20, 2007	Progress Note entered by Karen Reading, Dietician, at 19:53 re weight warning. Noted that Mr. Hedges' blood sugars have been running high in the evening after supper meal. Recommended to decrease dinner carbohydrate content. AM, PM and HS nourishment to remain the same to prevent hypoglycemia during the night.	LTCI00007803
46.	June, 2007	MAR – Insulin and BS readings	LTCI00009809 LTCI00008723
47.	April, 2007 – June 2007	Physician's Medication Review	LTCI00008486
48.	July 10, 2007	Progress Note entered by Karen Reading, Dietician, at 20:05 noting that Mr. Hedges' BS had been running high during evening and through the night – adjusted intake.	LTCI00007803
49.	July, 2007	MAR – Insulin and BS readings	LTCI00009804 LTCI00008723
50.	August, 2007	MAR – Insulin and BS readings	LTCI00009799 LTCI00008692
51.	September 21, 2007	Mr. Hedges' Plan of Care is updated.	LTCI00008266
52.	September 23, 2007	Progress Note entered by Suzanne Kungl, RPN at 06:46 that Mr. Hedges' BS that morning was 3.6.	LTCI00007803
53.	September 29, 2007	Progress Note entered by Karen Reading, Dietician, at 21:38, that Mr. Hedges' BS are improved in the evening but noted one recent low BS in a.m. on September 23, 2007.	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
54.	September 30, 2007	Progress Note entered by EW at 22:30 that Mr. Hedges was yelling that he was itchy. Notes that she applied cream to his back and reminded him that people were sleeping and he should not be yelling. Notes that he yelled 5 different times and he was reminded to be quieter 5 x 2 minutes each. Notes that he quieted down.	LTCI00007803
55.	September, 2007	MAR – Insulin and BS readings	LTCI00009794 LTCI00008692
56.	July 2007 – September, 2007	Physician's Medication Review	LTCI00008460
57.	October 8, 2007	Progress Note entered by Karen Reading, Dietician, at 13:39 noting that Mr. Hedges' hypoglycemic episodes have improved.	LTCI00007803
58.	October 15, 2007	Mr. Hedges' Plan of Care is updated.	LTCI00008272
59.	October 16, 2007	Progress Note entered by Shelly Clark, RN, at 07:17 that Mr. Hedges' BS was 3.0. Given orange juice and rechecked – 4.7.	LTCI00007803
60.	October 16, 2007	Progress Note entered by Barbara Baker, RN, at 07:30 that Mr. Hedges' BS was 7.1.	LTCI00007803
61.	October 20, 2007	Progress Note entered by Margaret Darling, RN, at 22:34 that Mr. Hedges' BS at 16:30 was 21.8, at 20:15 it was 33.3 and at 22:15 it was 25.8.	LTCI00007803
62.	October 28, 2007	Quarterly Team Conference Review	LTCI00007581
63.	October, 2007	MAR – Insulin and BS readings	LTCI00009789 LTCI00008692
64.	November 5, 2007	Mr. Hedges' Plan of Care is updated.	LTCI00008301
65.	November 25, 2007	Progress Note by Karen Routledge, RN, at 12:35 that Mr. Hedges had increased lethargy and confusion. His BS is 25.4.	LTCI00007803
66.	November, 2007	MAR – Insulin and BS readings	LTCI00009785 LTCI00008692
67.	December 4, 2007	Progress Note by EW at 22:56 that at 19:45 Mr. Hedges was extremely confused, yelling "2, 2, 2" and trying to get on the elevator. His BS high. She notes that 5u Toronto insulin is given and	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
		his BS at 22:30 was 30.5.	
68.	December 4, 2007	Progress Notes entered by Shelly Clark at 23:52 and 23:54 that Mr. Hedges was loud and confused. Noted on unit planner to notify Dr. Reddick as Mr. Hedges is not himself and his sugars are out of control.	LTCI00007803
69.	December 5, 2007	Mr. Hedges is transferred to Woodstock General Hospital for assessment. His BS at the time of transfer was 27.5. Mr. Hedges is noted as loud and confused the previous evening.	LTCI00007803 LTCI00007449 LTCI00007450
70.	December 5, 2007	Tests done at WGH. Random Glucose – 20.2.	LTCI00007316
71.	December, 2007	Physician's Orders and Progress Notes – blood sugars elevated, increased confusion, lethargy, vomiting after eating – transfer to WGH.	LTCI00008498
72.	December 11, 2007	Progress Note by Miriam Wright, RN, at 16:54 that she spoke to hospital staff and was advised that Mr. Hedges was not doing well. His BS were elevated and his insulin was being changed.	LTCI00007803
73.	December 13, 2007	Progress Note by Miriam Wight, RN, at 16:22 that she spoke to hospital staff and Mr. Hedges' BS are somewhat better.	LTCI00007803
74.	December 17, 2007	Mr. Hedges returns from WGH. Insulin Order changed.	LTCI00007803
75.	December 18, 2007	Progress Note by Karen Routledge, RN, at 09:17 that a message was left for Dr. Reddick re PRN order for Toronto insulin if BS greater than 25.	LTCI00007803
76.	December 18, 2007	Progress Note entered by Lois Durbidge, RN, at 16:25 that Dr. Reddick does not want PRN insulin at this time.	LTCI00007803
77.	December 18, 2007	Progress Note entered by EW at 22:31 that Mr. Hedges was lethargic all shift and was difficult to arouse for his pills.	LTCI00007803
78.	December 27, 2007	Progress Note entered by Karen Reading, Dietician at 20:31 that Mr. Hedges' BS have been better since returning from hospital but still run on the high side.	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
79.	December 30, 2007	Progress Note entered by Lois Durbidge, RN, at 07:20 that Mr. Hedges' BS at 07:00 was 2.9.	LTCI00007803
80.	October, 2007 – December, 2007	Physician's Medication Review	LTCI00008490 LTCI00008493
81.	December 17, 2007	Physician's Orders – Insulin changed. • Novolin NPH – 30 units before breakfast, 10 units at bedtime • Novolin Toronto – 10 units before breakfast, 6 units with lunch, 8 units at supper	LTCI00008494 LTCI00007569
82.	December, 2007	MAR – Insulin and BS readings	LTCI00009776 LTCI00008692
83.	January 8, 2008	Progress Note entered by Shelly Clark, RN, at 07:19 that at 05:45 they were unable to wake Mr. Hedges. BS 1.1. Unable to swallow corn syrup and was given glucagon. Sugar at 05:50 was 2.2 but Mr. Hedges was unresponsive. At 06:10 he was yelling, flailing in bed, BS was 4.9. At 06:20 BS 5.8, eyes open and answers questions. By 06:40 BS was 9.5 and was resting in bed but responds as per usual self. Notes that BS was 12.5 last evening.	LTCI00007803
84.	January 15, 2008	Progress Note entered by Shelly Clark, RN, at 07:25 that BS at 06:00 only 2.8. Given Resource. Rechecked in 20 min and was only 3.3.	LTCI00007803
85.	January 16, 2008	Progress Note entered by Shelly Clark, RN, at 07:57 – evening staff held snack as sugar was 24. In the past his sugar has gone from 31 at hs to 2 in the morning.	LTCI00007803
86.	January 19, 2008	Progress Note entered by Karen Reading, Dietician, at 14:25 that for HS nourishment will request that Mr. Hedges receive 1 whole puree sandwich and 125 milk. For hypoglycemic episodes: administer 15 grams of quick acting glucose such as 125ml apple or OJ, 80 ml cranberry, grape juice, 125 ml ginger ale or 1 Tbsp sugar. Repeat treatment in 15 minutes if blood glucose remains less that 4 mmol/L. if next snack is more than 1 hour away, follow treatment with a sustaining snack that combines carbohydrate and protein such as ½ sandwich or 125 milk. When given Resource and protein powder to treat hypoglycemia the protein slows the absorption of the glucose need to treat the low blood sugar level. Too much glucose administered (overfeeding) results in hyperglycemia and possibly rebound hypoglycemia.	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
87.	January 28, 2008	Progress Note entered by Shelly Clark, RN, at 15:44, Nursing Quarterly Summary, that Mr. Hedges blood sugars continue to be uncontrolled as they have been since he was admitted.	LTCI00007803
88.	January 28, 2008	Mr. Hedges' Plan of Care is updated.	LTCI00008292
89.	January 23, 2008	Progress Note entered by Karen Routledge, RN, at 09:14 that Mr. Hedges' BS have dropped below 4 in the a.m. x 4 since January 6 and message left for Dr. Reddick to review.	LTCI00007803
90.	January 30, 2008	Doctor's Progress Notes – noted that Mr. Hedges is having the occasional hypoglycemic episodes in the a.m. He has received Glucagon one time – decrease night NPH.	LTCI00008505
91.	January 31, 2008	Progress Note entered by Shelly Clark, RN, at 00:41 that Dr. Reddick had been in and conducted a quarterly med review, NPH insulin decreased.	
92.	January, 2008	MAR – Insulin [misdated 2007] and BS readings.	LTCI00009771 LTCI00008692
93.	February 4, 2008	Progress Note entered by Barbara Baker, RN, at 22:58 that insulin held at 16:30 as BS 6.4. BS 10.5 at HS.	LTCI00007803
94.	February 15, 2008	Progress Note entered by Shelly Clark, RN at 07:32, noted that Mr. Hedges' BS at 01:00 was 11.4. BS at 06:30 4.8. Resource protein powder given as pureed snack not available.	LTCI00007803
95.	February 20, 2008	Doctor's Progress Notes – sugars better	LTCI00008505
96.	February 23, 2008	Progress Note entered by Karen Reading, Dietician, at 20:30 that she will put in a reminder to dietary to ensure Mr. Hedges receives puree diabetic snacks at pm and HS as per care plan so that Resource and Protein powder are not used to treat low BSs as Mr. Hedges does not have an order for those supplements.	LTCI00007803
97.	February, 2008	MAR – Insulin and BS readings	LTCI00009766 LTCI00008723
98.	March 4, 2008	Progress Note entered by Margaret Darling, RPN at 13.59 that Mr. Hedges' BS at 11:00 was 5.4 and at 13:30 was 5.1.	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
99.	March 18, 2008	Mr. Hedges became angry at another resident and pushed her and she fell on the floor. An Internal Resident Incident Report is completed.	LTCI00008101
100.	March 24, 2008	Progress Note by Lois Durbidge, RN, at 03:43 that Mr. Hedges' HS insulin given at 00:30 as discussion with 1500-2300 hr shift RN (EW) – stated it had not been given. An Internal Resident Incident Report is completed.	LTCI00007803 LTCI00008107
101.	March 24, 2008	Medication Error is reported regarding Mr. Hedges. Lois Durbidge, RN, states that she was notified by Res 3 – 11 that she [sp] had not received HS insulin. 1500 – 2300 RN [EW] telephoned at home and confirmed that Wayne Hedge's insulin had not been given Mr. Hedges' blood sugar was [greater than] 26.	LTCI00016908
102.	March 30, 2008	Progress Note by Karen Reading, Dietician, at 17:54 that Mr. Hedges' BS continue to run high throughout the day.	LTCI00007803
103.	March 30, 2008	Progress Note entered by Jennifer Hague, RN, at 23:23 that BS at 16:30 was 6.3 which was low for Mr. Hedges. Orange juice given. BS checked at 18:00 and it was 4.8. Pureed sandwich and a glass of milk given, BS at 18:45 was 4.9. Sweetened drinks and yogurt given. BS at 20:00 was 12.3 and at 22:00 was 12.6.	LTCI00007803
104.	March 1, 2008 – March 31, 2008	MAR – Insulin and BS readings	LTCI00009761 LTCI00008723
105.	January, 2008 – March, 2008	Physician's Medication Review – Insulin changed: • Novolin NPH – 30 units before breakfast, 8 units before bedtime • Novolin Toronto – 10 units before breakfast, 6 units before lunch and 8 units before supper	LTCI00008499
106.	April 4, 2008	Progress note by Shelly Clark, RN, at 07:15. Mr. Hedges' BS at 06:15 was 3.7. Given juice and milk and BS at 07:00 was 5.3.	LTCI00007803
107.	April 7, 2008	There is a discussion with EW about medication error re Mr. Hedges (March 24, 2008) – noted that to remedy this EW will take med cards for insulin & put on top of med cart.	LTCI00016908

	DATE	EVENT	SOURCE DOC ID
108.	April 8, 2008	Doctor's Progress Note – Sugars low in a.m. – 8 – 12 at other times – decrease insulin.	LTCI00008505
109.	April 8, 2008	Progress Note entered by Karen Routledge, RN, at 14:36 that Dr. Reddick was in, quarterly review done and NPH insulin decreased in a.m.	LTCI00007803
110.	April 16, 2008	Progress Note entered by Lois Durbidge, RN at 07:06 that Mr. Hedges' BS at 05:45 was 2.7. Fruit Resource with corn syrup. At 06:45 BS was 7.5.	LTCI00007803
111.	April 16, 2008	Doctor's Progress note – occasional low blood sugar – a.m. 2 – 3. Decrease NPH.	LTCI00008505
112.	April 16, 2008	Progress Note entered by Shelly Clark, RN, at 22:32 that Dr. Reddick was in and insulin dose changed.	LTCI00007803
113.	April 20, 2008	Doctor's Progress note to verify insulin dose.	LTCI00008505
114.	April 20, 2008	Progress Note by Karen Reading, Dietician, at 20:16 that Mr. Hedges continues to have many episodes of low BS, usually early in am and after supper as a result of emesis. Dr. Reddick decreased a.m. and p.m. insulin dose.	LTCI00007803
115.	April 26, 2008	Progress Note by EW at 06:52 that Mr. Hedges' BS at 06:20 was 3.7. Given Orange Juice with sugar and a bowl of yogurt and at 06:45 BS was 4.5.	LTCI00007803
116.	April 28, 2008	Mr. Hedges Plan of Care is updated.	LTCI00008281 LTCI00008290
117.	April 28, 2008	Progress Note by Jennifer Cake, RN, at 15:35, Nursing Quarterly Summary, indicating that Mr. Hedges' BS continue to be uncontrolled.	LTCI00007803
118.	April, 2008	MAR – Insulin and BS readings	LTCI00009756 LTCI00008723
119.	April 18 – May 18, 2008	MAR – Insulin and BS readings	LTCI00009752 LTCI00008731

	DATE	EVENT	SOURCE DOC ID
120.	May 20, 2008	Progress Note entered by Margaret Darling, RPN, at 22:38 that Mr. Hedges' BS 3.9 at 16:30, Orange Juice given, Insulin held. BS 11.9 at 21:00.	LTCI00007803
121.	May 21, 2008	Progress note entered by Margaret Darling, RPN, at 22:18 that Mr. Hedges' BS was 6.4 at 16:00. His insulin was held. 2 emesis after supper. BS 5.4 at 20:00 insulin held, snack given.	LTCI00007803
122.	May 27, 2008	Progress Note entered by Karen Reading, Dietician, at 20:09, that Mr. Hedges is at high risk, continues to vomit after meals and this affects his blood sugars. Will try providing a small teaspoon to slow eating down as Mr. Hedges does still occasionally feed himself. Do not allow to wear tight fitting pants/belts during meals. Try drinks between meals not during meals.	LTCI00007803
123.	June 6, 2008	Progress Note entered by Jennifer Cake, RPN, at 06:06 that Mr. Hedges' BS at 05:30 was 3.6. Orange Juice was provided.	LTCI00007803
124.	June 9, 2008	Progress Note entered by EW at 07:02 that Mr. Hedges' BS at 06:30 was 3.3. Given Orange Juice and Sugar.	LTCI00007803
125.	June 15, 2008	Medication error. Mr. Hedges' 08:00 phenobarbital was not given. Internal Resident Incident Report completed.	LTCI00008111
126.	June 18, 2008	Progress Note entered by Lois Durbidge, RN, at 07:40 that Mr. Hedges' BS was 3.3 at 06:30. Orange Juice and corn syrup given. BS 11.8.	LTCI00007803
127.	June 19, 2008	Progress Note entered by Lois Durbidge, RN, at 07:42 that Mr. Hedges' BS was 2.8 that morning.	LTCI00007803
128.	June, 2008	MAR – Insulin and BS readings	LTCI00009746 LTCI00008736
129.	April, 2008 – June, 2008	Physician's Medication Review – Insulin changed: • Novolin NPH – 28 units before breakfast, 8 units before bedtime • Novolin Toronto – 10 units before breakfast, 6 units before lunch and 8 units before supper	LTCI00008502
130.	July 22, 2008	Mr. Hedges' Plan of Care is updated. New categories created by EW	LTCI00008309

	DATE	EVENT	SOURCE DOC ID
		include: • Demands attention related to yelling "ow" for no apparent reason • Aggression, verbal r/t becoming upset when receiving care • Resists care related to not wanting to get up in am	
131.	July 22, 2008	Progress Note entered by EW at 16:18, Nursing Quarterly Summary. notes that Mr. Hedges' diabetes is at times uncontrolled and this is an ongoing issue. Notes that Mr. Hedges yells at staff when receiving care. He also randomly yells "ow" for no apparent reason. Mr. Hedges is at risk for falls as he will often become impatient and attempt to transfer himself rather than waiting for staff.	LTCI00007803
132.	July 26, 2008	Mr. Hedges is reported to be aggressive with another resident. An Internal Resident Incident Report is completed.	LTCI00007803 LTCI00008121
133.	July, 2008	MAR – Insulin and BS readings (partial)	LTCI00009741 LTCI00008736
134.	August, 2008	MAR – Insulin and BS readings	LTCI00009736 LTCI00008734
135.	September 12, 2008	Medication error. Mr. Hedges' HS phenobarbital had been signed as given but was not given. An Internal Resident Incident Report is completed.	LTCI00008109
136.	September, 2008	MAR – Insulin and BS readings	LTCI00009731 LTCI00008737
137.	July, 2008 – September, 2008	Physician's Medication Review – Insulin changed: • Novolin NPH – 26 units before breakfast, 8 units before bedtime • Novolin Toronto – 10 units before breakfast, 6 units before lunch and 8 units before supper	LTCI00008525
138.	October, 2008	EW admits to having intentionally overdosed Mr. Hedges with a large dose of insulin in October, 2008.	LTCI00057683
139.	October 4, 2008	Mr. Hedges experiences a fall. An Internal Resident Incident Report is completed.	LTCI00008123

	DATE	EVENT	SOURCE DOC ID
140.	October 10, 2008	Mr. Hedges experiences a fall. An Internal Resident Incident Report is completed.	LTCI00008133
141.	October 15, 2008	Progress Note entered by Shelly Clark, RN, at 12:09 indicating that Mr. Hedges BS were elevated, he was not eating and was very nauseated. Consulted with Dr. Reddick regarding transferring Mr. Hedges to WGH.	LTCI00007803
142.	October 15, 2008	Doctor's Progress Notes – send to WGH for assessment.	LTCI00008505
143.	October 15, 2008	Mr. Hedges is transferred to WGH for assessment. Found to have broken ribs. Returned to Caressant Care that same day.	LTCI00007356 LTCI00007357 LTCI00007451 LTCI00007453 LTCI00007583
144.	October 17, 2008	Mr. Hedges is again transferred to WGH for assessment regarding abdominal pain. Admitted to hospital.	LTCI00007803 LTCI00007457
145.	October 20, 2008	Progress Note entered by EW at 15:06 that she had spoken to someone at the WGH nurses' station and had been told that Mr. Hedges had vomiting that day, that his blood sugars were erratic but that otherwise he appeared to be fine.	LTCI00007803
146.	October 24, 2008	Mr. Hedges returns from WGH. Discharge medications include: • NPH insulin – 26 units before breakfast, 8 units at bedtime • Toronto Insulin – 10 units before breakfast, 6 units before lunch • Sliding scale	LTCI00008513 LTCI00008521
147.	October 27, 2008	Mr. Hedges experiences a fall. An Internal Resident Incident Report is completed.	LTCI00008131
148.	October 27, 2008	Progress Note entered by EW at 05:38 that Mr. Hedges had been awake and persistently yelling at 01:00. Notes that Mr. Hedges settled at 04:00.	LTCI00007803
149.	October 27, 2008	Progress Note entered by Tara Mahoney, RPN, at 18:07 that Mr. Hedges was very lethargic, non-responsive to verbal stimuli and responded poorly to painful stimuli. BS was 2.4. At 16:40 he was	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
		given glucagon, blood sugar at 16:50 was 3.3 and at 17:00 it was 4.0. Notes that at 18:00 Mr. Hedges was sitting in bed yelling, was awake and very verbal, yelling "ow" and wanting to get up. BS was 6.8. Staff to continue to monitor for signs of hypoglycemia.	
150.	October 28, 2008	Progress Note entered by EW at 01:37 that Mr. Hedges' BS at midnight was 13.6. Notes that his respirations were noisy at 26 with periods of apnea. States "Rechecked Wayne at 1030, resps 30, Pulse 114, Bp96/55, pulse ox 84, temp 38, Wayne awake and quietly saying "help" at this time. Will continue to monitor".	LTCI00007803
151.	October 28, 2008	Progress Note entered by EW at 08:03 as follows: *At 02:30 Wayne's 02 sat was 80% and his temp was 38.2. Chest clear on auscultation with good air entry to all fields. Started on 02 2 litres via mask.* *At 04:00 Wayne's 02 sat was 92%. Bp 100/65 pulse 93, resps 26, temp 37.3. Given 2 Tylenol extra strength* *At 06:35, Wayne's Blood sugar was 1.4 and he was nonresponsive to voice and touch. He was given Glucagon at 06:45. Blood sugar at 07:05 was 3.4. Wayne was responsive to voice and touch. Given 250 c.c.s. Orange juice with 2 tbsps sugar and 250 ml of chocolate pudding, Blood sugar at 07:30 was 6.5.*	LTCI00007803
152.	October 28, 2008	Progress Note entered by Margaret Darling, RPN, at 22:50 indicating that Mr. Hedges' BS was 5.7 at 16:00. At 18:10 his BS was 3.4 and he was given pudding and orange juice. BS at 20:30 was 5.3 so insulin was withheld and yogurt given. BS at 22:00 was 6.6	LTCI00007803
153.	October 29, 2008	Progress Note entered by EW at 05:37 that Mr. Hedges appeared to rest comfortably all night, no current concerns.	LTCI00007803
154.	October 29, 2008	Progress Note entered by Margaret Darling, RPN, at 23:39 that Mr. Hedges' BS at 16:00 was 3.8, given orange juice and sugar, and his BS was 9.2 at 20:00. Hs insulin was withheld.	LTCI00007803
155.	October 30, 2008	Progress Note entered by Jennifer Emmerson, RN, at 16:08, Nursing Quarterly Summary, indicating that Mr. Hedges BS continues to be poorly managed and he has had two episodes requiring a glucagon intervention which was effective with no need for hospitalization.	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
156.	October 30, 2008	Mr. Hedges' Plan of Care is updated	LTCI00008319
157.	October, 2008	MAR – Insulin and BS readings	LTCI00009730 LTCI00008734
158.	November 10, 2008	Progress Note entered by EW at 04:54 that Mr. Hedges was yelling "ow ow" repeatedly. Continued to yell every half hour so moved to bed 15 so roommates could sleep.	LTCI00007803
159.	November 10, 2008	Mr. Hedges' Plan of Care is updated.	LTCI00008330
160.	November 13, 2008	Progress note by Shelly Clark, RN, at 19:18 that Dr. Reddick was advised of Mr. Hedges' increased agitation and yelling, sleeping poorly at times. Dr. Reddick did not wish to make any changes at present.	LTCI00007803
161.	November 14, 2008	Progress Note entered by Linda Kirby, RPN, that at 4.3 Mr. Hedges' BS was only 4.3. BS at HS was only 6.7 so insulin withheld.	LTCI00007803
162.	November, 2008	MAR – insulin and BS readings	LTCI00009719 LTCI00008737
163.	December 6, 2008	Progress Note entered by Tara Mahoney, RPN, at 21:35 that Mr. Hedges BS at HS was only 6.8, insulin withheld.	LTCI00007803
164.	December 13, 2008	Progress Note entered by Aundrea Gick, RPN, that BS 4.3 at 21:00 so insulin held, pudding given.	LTCI00007803
165.	December 14, 2008	Progress Note entered by EW at 18:35 that dietary refused to supply plate without meat. EW had to personally request twice that Mr. Hedges receive a plate with no meat. Dietary complied and Mr. Hedges ate all of his supper.	LTCI00007803
166.	December 16, 2008	Doctor's Progress Notes – sugars okay recently	LTCI00008531
167.	December 18, 2008	Progress Note entered by Linda Kirby, RPN at 23:32 that at 20:00 Mr. Hedges' BS was 3.4 so insulin was held. Given snack and at 21:30 BS was 5.7. Insulin was held.	LTCI00007803
168.	October, 2008 – December, 2008	Physician's Medication Review – Insulin changed: • Novolin NPH – 26 units before breakfast, 8 units before	LTCI00008528 LTCI00008531

	DATE	EVENT	SOURCE DOC ID
		bedtime • Novolin Toronto – 10 units before breakfast, 6 units before lunch	
169.	December, 2008	MAR – insulin and BS readings	LTCI00009712 LTCI00008737
170.	January 21, 2009	Progress Note entered by Shelly Clark, RN, at 09:12 that Mr. Hedges was not himself that morning. Not able to swallow meds or food or fluids. BS 18.8 before breakfast.	LTCI00007803
171.	January 21, 2009	Progress Note entered by Lois Durbidge, RN, at 23:58 that staff have voiced concerns regarding Mr. Hedges' affect, how he stares with a vacant expression on his face, mouth open and drooling, how flaccid his extremities are. Occasionally turns head towards name being called but does not make eye contact. Said yes when asked if he had pain but could not say where. Taking fluids well when offered, no difficulty swallowing.	LTCI00007803
172.	January 22, 2009	Progress Note entered by Shelly Clark, RN, at 14:41 indicating that she spoke with Dr. Reddick regarding Mr. Hedges' condition. Dr. Reddick agrees Mr. Hedges likely had a stroke as at high risk. Reviewed sugars. Sugars 16.6 ac breakfast and insulin given, 8.3 ac lunch so insulin held. Mr. Hedges is not taking meds well and can't swallow at present.	LTCI00007803
173.	January 22, 2009	Progress Note entered by Jennifer Emmerson, RN, at 15:47 Nursing Quarterly Summary indicating that Mr. Hedges had deteriorated significantly in the last two days, that he was no longer eating or drinking adequately, has lost the ability to swallow and is only slightly responsive.	LTCI00007803
174.	January 24, 2009	Mr. Hedges passed away at Caressant Care. Progress Note entered by Jennifer Hague, RN, at 01:30 that she called the Coroner's Answering Service as this was a threshold case as well as the third death within 24 hours.	LTCI00007803
175.	January 24, 2009	Progress Note entered by Jennifer Hague, RN, at 01:56 that she received a call from the coroner on call stating that she would not be able to be in to pronounce death until the morning at the earliest. She will require Mr. Hedges' chart and the death registered. Coroner requested that Ms. Hague call the physician on call and have them pronounce his death instead. Dr. Miettinen informed and will be in	LTCI00007803

	DATE	EVENT	SOURCE DOC ID
		in the morning.	
176.	January 24, 2009	Medical Certificate of Death completed by Dr. Miettenen. It Indicates an immediate cause of death as CVA with diabetes mellitus as an atecedant cause. Resident Death Form completed by Dr. Miettinen Institutional Patient Death Record completed by Jennifer Hague. Death recorded on Death Registry	LTCI00007608 LTCI00007609 LTCI00007610 LTCI00071973
177.	January, 2009	MAR – insulin and BS readings	LTCI00009702 LTCI00008737
178.	January, 2009 – March, 2009	Physician's Medication Review	LTCI00008534
179.	Various	BS readings – older readings - some with no year	LTCI00008669 LTCI00008677 LTCI00008684 LTCI00008685 LTCI00008687 LTCI00008688

VOLUME 5(vi): MICHAEL PRIDDLE

CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to attempting to murder Mr. Michael Priddle in 2008 or 2009.

Mr. Priddle was born on June 1, 1949 in London, Ontario. He grew up in Ingersoll and was married to Margaret in 1971. They had one son. Mr. Priddle's occupations included meat manager and butcher.

Mr. Priddle was diagnosed with Huntington's Disease which eventually incapacitated him to the point that he needed 24-hour care.

The chronology below sets out Mr. Priddle's history while at Caressant Care. Mr. Priddle had a number of ailments but did not have diabetes and therefore did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	July 19, 2006	Mr. Priddle applies for long-term care.	LTCI00006738
2.	July 24, 2006	Caressant Care accepts Mr. Priddle's application.	LTCI00006739
3.	October 20, 2006	Mr. Priddle enters Caressant Care from Parkwood Hospital where he was admitted in March, 2003. Mr. Priddle was not a diabetic and had no medical need for synthetic insulin. By the time that he entered Caressant Care, Mr. Priddle was only able to eat thickened juices, puddings etc. He was totally dependent on staff to feed him, provide him with personal care, dress him. He was at high risk of falls, both while in bed and while in his Broda chair. He had difficulty choking. He liked to sit and watch television. Mr. Priddle had multiple falls during his stay at Caressant Care, particularly when in bed as he would be found on the mat beside his bed frequently. Due to the high incidence of recorded falls, they have not been individualized in this Overview Statement unless they resulted in a transfer to hospital.	
4.	June 27, 2007	EW commences her employment at Caressant Care	LTCI00057092 LTCI00057098

	DATE	EVENT	SOURCE DOC ID
5.	August 13, 2007	Medication error. Mr. Priddle's 20:00 dose of Haldol 0.5 mg was left over in cycle card. Internal Resident Incident Report completed.	LTCI00006457
6.	August 24, 2007	Mr. Priddle's Plan of Care is updated.	LTCI00006029
7.	October 14, 2007	Mr. Priddle's Plan of Care is updated.	LTCI00006036
8.	November 24, 2007	Progress Note entered by Lois Durbridge, RN, at 15:36, Nursing Quarterly Summary, indicates that Mr. Priddle had been stable that quarter. Mr. Priddle's' Plan of Care is updated.	LTCI00006793 LTCI00006045
9.	February 24, 2008	Progress Note entered by Shelly Clark, RN, at 22:48, Nursing Quarterly Summary, indicates that Mr. Priddle had been stable that last quarter. Mr. Priddle's Plan of Care is updated.	LTCI00006793 LTCI00006058
10.	March 3, 2008	Medication error – lunch dose left over in cycle pack. Internal Resident Incident Form Completed.	LTCI00006468
11.	May 24, 2008	Progress Note entered by Jennifer Hague, RN, at 15:40, Nursing Quarterly Summary, at 15:40 that Mr. Priddle had been stable that past quarter Mr. Priddle's Plan of Care is updated.	LTCI00006793 LTCI00006066
12.	July 23, 2008	Progress Note entered by Lois Durbidge, RN, at 22:52 indicating that Mr. Priddle had a prolonged coughing spell at the end of supper, his colour was dusky, extremities cool, he was diaphoretic and his respirations were wheezy and congested. Notes that his colour and respirations eventually returned to normal.	LTCI00006793
13.	August 20, 2008	Mr. Priddle's Plan of Care is updated.	LTCI00006050
14.	August 22, 2008	Progress Note entered by EW at 14:10, Nursing Quarterly Summary, indicating that Mr. Priddle had experienced weight loss that past quarter. Mr. Priddel's Plan of Care is updated.	LTCI00006793 LTCI00006074

	DATE	EVENT	SOURCE DOC ID
15.	August 25, 2008	Progress Note entered by Shelly Clark, RN, at 16:15, Nursing Quarterly Summary, almost identical to EW's in content.	LTCI00006793
16.	September 11, 2008	Mr. Priddle's Plan of Care is updated.	LTCI00006082
17.	November 8, 2008	Mr. Priddle's Plan of Care is updated.	LTCI00006091
18.	November 20, 2008	Progress Note entered by EW at 22:35, Nursing Quarterly Summary, indicating that Mr. Priddle has been stable this last quarter. Mr. Priddle's Plan of Care is updated.	LTCI00006793 LTCI00006099
19.	2009	EW claims that one night in 2009 she gave Mr. Priddle a large amount of insulin and believed it was 90 units in total.	LTCI00057683
20.	January 24, 2009	Progress note entered by EW at 22:50, Nursing Quarterly Summary, that Mr. Priddle had been stable this last quarter. Mr. Priddle's Plan of Care is updated.	LTCI00006793 LTCI00006108
21.	April 17, 2009	Progress note entered by Jennifer Hague, RN, at 15:35, Nursing Quarterly Summary, indicating that Mr. Priddle had been stable this last quarter.	LTCI00006793
22.	July 21, 2009	Progress note entered by Lois Durbidge, RN at 15:49, Nursing Quarterly Summary, indicating that Mr. Priddle had been stable this last quarter. Mr. Priddle's Plan of Care is updated.	LTCI00006793 LTCI00006233
23.	October 20, 2009	Progress Note entered by Lois Durbidge, RN at 15:34, Nursing Quarterly Summary, indicating that Mr. Priddle had been stable this last quarter. Mr. Priddle's Plan of Care is updated.	LTCI00006793 LTCI00006242
24.	January 22, 2010	Mr. Priddle's Plan of Care is updated.	LTCI00006148
25.	April 29, 2010	Mr. Priddle's Plan of Care is updated.	LTCI00006165
26.	July 20, 2010	Mr. Priddle's Plan of Care is updated.	LTCI00006183

	DATE	EVENT	SOURCE DOC ID
27.	October 20, 2010	Annual Assessment – Mr. Priddle is noted to no longer be able to communicate and does not always respond to what is being said to him. He may sometimes respond to direct questions – i.e. he may open his mouth for pills. Mr. Priddle's Plan of Care is updated.	LTCI00006121 LTCI00006125 LTCI00006127
28.	January 18, 2011	Mr. Priddle's Plan of Care is updated.	LTCI00006198
29.	April 18, 2011	Mr. Priddle's Plan of Care is updated.	LTCI00006215
30.	November 29, 2012	Progress note entered by Barbara Bennie, RPN, at 15:30 indicating that Dr. Reddick had been in and deemed Mr. Priddle palliative. Mr. Priddle is moved to Room 15.	LTCI00006793
31.	December 2, 2012	Mr. Priddle passed away. Institutional Patient Death Record completed by Barbara Bennie, RPN. Medical Certificate of Death completed by Dr. Tam, identifying Huntington's Disease as Mr. Priddle's cause of death. Resident Death Form completed by Dr. Tam. Death recorded on Death Registry	LTCI00006793 LTCI00005343 LTCI00005344 LTCI00005346 LTCI00071976
32.	December 3, 2012	Cumulative Plan of Care closed.	LTCI00006901

VOLUME 5(vii): GLADYS MILLARD
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to the 1st Degree Murder of Ms. Gladys Millard in October, 2011.

Ms. Millard was born on October 11, 1924 in New Glasgow, Nova Scotia. She married Henry and settled in the town of Woodstock. They had two children. Ms. Millard was a seamstress. She was predeceased by her husband.

The chronology below sets out Ms. Millard's history while at Caressant Care. Ms. Millard had a number of ailments but did not have diabetes and therefore did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	August 14, 2006	Ms. Millard applies for long-term care.	
2.	August 29, 2006	Ms. Millard is accepted at Caressant Care.	LTCI00013129
3.	September 11, 2006	Ms. Millard is admitted to Caressant Care from Caressant Care Retirement Home. Ms. Millard had Alzheimer's disease and other conditions but was not diabetic.	
4.	September 14, 2006	Caressant Care files an Unusual Occurrence Report with the MHLTC when a private citizen calls and states that Ms. Millard was found walking outside. Private citizen returned Ms. Millard to the Caressant Care.	LTCI00013255
5.	June 27, 2007	EW commences her employment with Caressant Care.	LTCI00057092 LTCI00057098
6.	July 12, 2007	Progress Note entered by Shelly Clark, RN, at 00:05, Nursing Quarterly Summary. Describes Ms. Millard's condition that quarter as having been stable. Notes various interventions required for behaviours such as resisting care.	LTCI00012142
7.	September 20, 2007	Ms. Millard's Plan of Care is updated.	LTCI00012863

	DATE	EVENT	SOURCE DOC ID
8.	October 6, 2007	EW completes an Internal Resident Incident Report identifying that Ms. Millard had overheard that a resident had just hit his wife and she walked up to the resident, said "you don't do that or you get one of these" and punched the resident in the nose.	LTCI00013267
9.	October 11, 2007	Progress Note entered by Shelly Clark, RN, at 16:03, Nursing Quarterly Summary. Describes Ms. Millard's condition that quarter as having been stable. Notes various interventions required for behaviours such as anger, aggression, agitation, restlessness and resisting care.	LTCI00012142
10.	October 11 and 14, 2007	Ms. Millard's Plan of Care is updated.	LTCI00012847 LTCI00012855
11.	January 11, 2008	Progress Note entered by Margaret Darling, RPN, at 15:20, Nursing Quarterly Summary notes that Ms. Millard has been stable this quarter. Notes various interventions for ineffective coping, anger, aggression, agitation, restlessness and resisting care.	LTCI00012142
12.	January 11, 2008	Ms. Millard's Plan of Care is updated.	LTCI00012874
13.	February 25, 2008	Medication error. Ms. Millard's Risperdal was signed for and not given. An Internal Resident Incident Report is completed.	LTCI00013299
14.	April 11, 2008	Progress Note entered by Aundrea Gick, RPN, at 15:57, Nursing Quarterly Summary notes that Ms. Millard has been stable this quarter. Notes various interventions for ineffective coping, anger, aggression, agitation, restlessness and resisting care.	LTCI00012142 LTCI00013011
15.	July 11, 2008	Progress Note entered by Jennifer Emmerson, RN, at 15:59, Nursing Quarterly Summary notes that Ms. Millard had the following changes last quarter – hypertension medications were changed due to low blood pressure. Notes various interventions for ineffective coping, anger, aggression, agitation, restlessness and resisting care.	LTCI00012142
16.	August 20, 2008	Ms. Millard's Plan of Care is updated.	LTCI00012807
17.	October 12, 2008	Ms. Millard's Plan of Care is updated.	LTCI00012798
18.	October 15, 2008	Progress Note entered by Karen Routledge, RN, at 13:59, Nursing Quarterly Summary notes that Ms. Millard has physically and mentally deteriorated this last quarter, requiring a mechanical lift	LTCI00012142

	DATE	EVENT	SOURCE DOC ID
		and wheelchair bound with seatbelt restraint. Blood pressure became increasingly low and both BP med discontinued. Notes various interventions for ineffective coping, aggression, agitation, restlessness and resisting care.	
19.	November 10, 2008	Ms. Millard's Plan of Care is updated.	LTCI00012789
20.	January 9, 2009	Progress Note entered by Karen Routledge, RN, at 10:56, Nursing Quarterly Summary notes that Ms. Millard has been stable this past quarter. Notes various interventions for ineffective coping, anger, aggression, agitation and resisting care. Further notes that all behaviours require 178 minutes of interventions daily and are effective. Behaviours are continuous, ongoing and expected to increase as disease progresses.	LTCI00012142
21.	March 16, 2009	Progress Note entered by Shelly Clark, RN, at 11:36, Nursing Quarterly Summary notes that Ms. Millard has continued to deteriorate that quarter. Notes various interventions for ineffective coping, anger, aggression, agitation, sleeplessness and resisting care. Further notes that all behaviours require 193 min/24 hrs of interventions as per care plan to manage behaviours. Behaviours are continuous/ongoing since admission, are predictable and only expected to increase as Alzheimer's progresses.	LTCI00012142
22.	June 8, 2009	Progress Note entered by Elizabeth Gunter, RN, at 11:40, Nursing Quarterly Summary notes that Ms. Millard has become less aggressive in the past few weeks due to the progression of her disease process. Notes various interventions for ineffective coping, anger, aggression, sleeplessness and resisting care. Further notes that all behaviours require 193 min/24 hrs of interventions as per care plan to manage behaviours. Behaviours are continuous/ongoing since admission, are predictable and only expected to increase as Alzheimer's progresses.	LTCI00012142
23.	June 30, 2009	Ms. Millard's Plan of Care is updated.	LTCI00012880
24.	October 1, 2009	Ms. Millard's Plan of Care is updated.	LTCI00012778
25.	December 13, 2008	Ms. Millard's Plan of Care is updated.	LTCI00012772

	DATE	EVENT	SOURCE DOC ID
26.	December 14, 2009	Progress Note entered by Kathleen Toon, RN, at 22:57, Nursing Quarterly Summary notes that Ms. Millard has been stable this quarter. Notes various interventions for ineffective coping, aggression, agitation, sleeplessness and resisting care. Ms. Millard requires 193 min/24 hrs of interventions as per care plan to manage behaviours. Behaviours are continuous/ongoing since admission, are predictable and only expected to increase as Alzheimer's progresses.	LTCI00012142
27.	January 2, 2010	Ms. Millard's Plan of Care is updated.	LTCI00012763
28.	March 30, 2010	Ms. Millard's Plan of Care is updated.	LTCI00012747
29.	June 23, 2010	Ms. Millard's Plan of Care is updated.	LTCI00012735
30.	September 8, 2010	Progress Note entered by Katherine Rusz, RCC, at 16:00 indicating that an Annual Family/Team Conference was held. Notes that all interventions remain current and ongoing with the exception that Ms. Millard is no longer resistive to care.	LTCI00012142
31.	September 27, 2010	Ms. Millard's Plan of Care is updated.	LTCI00012924
32.	December 13, 2010	Ms. Millard's Plan of Care is updated.	LTCI00012937
33.	March 10, 2011	Ms. Millard's Plan of Care is updated.	LTCI00012722
34.	June 6, 2011	Ms. Millard's Plan of Care is updated.	LTCI00012896
35.	June 26, 2011	Progress Note entered by EW at 06:40 that Ms. Millard was calling out loudly at 01:15 and was given 2 Tylenol for possible pain. Noted that she rested quietly for the rest of the shift.	LTCI00012142
36.	July 20, 2011	Progress Note entered by Jennifer Hague, RN, at 15:34 indicating that Dr. Reddick was in to assess a lump in Ms. Millard's breast. Noted that it is likely a cancerous tumor. Dr. Reddick does not feel a biopsy is necessary at this time and feels that it is not something that will cause her pain. Notes that the family does not wish treatment but wishes to keep Ms. Millard comfortable.	LTCI00012142

	DATE	EVENT	SOURCE DOC ID
37.	September 1, 2011	Ms. Millard's Plan of Care is updated.	LTCI00012910 LTCI00012921
38.	September 12, 2011	Progress Note entered by Richang (Patty) Xia, RN, at 16:25 that Annual Family/Team Conference held.	LTCI00012142
39.	October 13, 2011	EW is working the night shift from 19:00 to 07:00. EW admits that at approximately 5:00 a.m. on October 14, 2011 she attended the medical room and obtained long and short acting insulin from the medical refrigerator. She injected Ms. Millard, though the amounts are not clear.	LTCI00057683
40.	October 14, 2011	Progress Note in Original Physician's Order by RNs that Ms. Millard had decreased responsiveness, tremors, frothing at the mouth. Dr. Reddick orders morphine.	LTCI00003479
41.	October 14, 2011	Progress Note entered by EW at 07:23. States that acetaminophen given as Ms. Millard has been awake all night, was crying out and had a very tense look on her face. EW notes that Ms. Millard fell asleep and is currently sleeping. "Staff instructed to leave her in bed asleep". EW instructs the RPN to hold Ms. Millard's a.m. medications until she Ms. Millard is awake.	LTCI00012142
42.	October 14, 2011	EW helps to move Ms. Millard into Room 15.	LTCI00057683
43.	October 14, 2011	Progress Note entered by Linda Guetter, RPN at 09:45 that just before breakfast Ms. Millard was found to be diaphoretic, cold and clammy, foaming, drooling at the mouth. Pulse was 124 and Resp 24. Body and extremities were twitching.	LTCI00012142
44.	October 14, 2011	Progress Note entered by Robyn Laycock, RPN, at 16:05 that she had been called into Room 15 at 15:40 and asked to check Ms. Millard. All respirations ceased and Dr. Reddick notified at 16:00.	LTCI00012142
45.	October 14, 2011	Ms. Millard passed away at Caressant Care. Medical Certificate of Death completed by Dr. Reddick identifying "Alzheimer's Disease" as the cause of death with hypertension and CVH as significant conditions contributing to the death. Institutional Patient Death Record completed by Janette Langford, RPN. Resident Death Form completed by Dr. Reddick	LTCI00036699

	DATE	EVENT	SOURCE DOC ID
46.	October 14, 2011	Cumulative Plan of Care closed. Death recorded on Death Registry	LTCI00012185 LTCI00071974

VOLUME 5(viii): HELEN MATHESON CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to the 1st Degree Murder of Ms. Helen Matheson in October, 2011.

Ms. Matheson was born on June 4, 1916. She settled in the Village of Innerkip. She married and they had two children. Ms. Matheson was a teacher. Her husband predeceased her.

The chronology below sets out Ms. Matheson's history while at Caressant Care. Ms. Matheson had a number of ailments but did not have diabetes and therefore did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	June 27, 2007	EW commences her employment with Caressant Care.	LTCI00057092 LTCI00057098
2.	January 14, 2010	Ms. Matheson applies for long-term care.	LTCI00013720
3.	January 20, 2010	Ms. Matheson is admitted to Caressant Care from WGH. She suffered from dementia and other conditions but was not diabetic.	LTCI00013330
4.	May 11, 2010	Ms. Matheson's Plan of Care is updated.	LTCI00013567 LTCI00013579
5.	August 9, 2010	Ms. Matheson's Plan of Care is updated.	LTCI00013541
6.	November 8, 2010	Ms. Matheson's Plan of Care is updated.	LTCI00013530 LTCI00013535
7.	January 21, 2011	Progress Note entered by Sandra Erb, Dietician, at 12:09 that Annual Assessment is completed – Ms. Matheson's appetite is good at means and snacks.	LTCI00013330

	DATE	EVENT	SOURCE DOC ID
8.	January 31, 2011	Ms. Matheson's Plan of Care is updated.	LTCI00013518
9.	April 16, 2011	Progress Note entered by Jennifer Hague, RN, that Dr. Vu had been in and at bedside and is sure that Ms. Matheson has uterine cancer and has spoken to Ms. Matheson's son. Chosen comfort measures when needed.	LTCI00013330
10.	April 19, 2011	Progress Note entered by Sandra Erb, Nutritional Manager, at 10:22 that Quarterly Assessment complete and that Ms. Matheson's appetite is good at both meals and snacks.	LTCI00013330
11.	May 4, 2011	Ms. Matheson's Plan of Care is updated.	LTCI00013504
12.	July 19, 2011	Progress Note entered by Ian Tan, Nutritional Manager, at 12:02 that Quarterly Assessment is completed, Ms. Matheson's appetite is good at both meals and snacks.	LTCI00013330
13.	July 27, 2011	Ms. Matheson's Plan of Care is updated.	LTCI00013553
14.	August 29, 2011	Progress Note entered by Alicia Sauve, Dietician, at 09:32 that Ms. Matheson had poor food and fluid intake, noted to encourage her food intake, while respecting right to refuse.	LTCI00013330
15.	September 6, 2011	Progress Note entered by EW at 22:55 that Ms. Matheson was curled up in her bed while her roommate was yelling at her. Noted that perhaps Ms. Matheson could benefit from moving to room 24-2.	LTCI00013330
16.	September 9, 2011	Progress Note entered by Wendy Sziklai, RCC, at 12:40 that Ms. Matheson had moved to room 24-2 due to issues with her current roommate.	LTCI00013330
17.	September 13, 2011	Ms. Matheson experiences a fall. Internal Resident Incident Report is completed – signed by EW. Safety Plan – Post Fall Investigation is completed – signed by EW.	LTCI00013630
18.	September 13, 2011	Physiotherapy Reassessment/Quarterly Report completed indicating that Ms. Matheson demonstrates range of motion within normal limits for all extremities. Her strength has decreased overall. She is at risk for falls.	LTCI00013694

	DATE	EVENT	SOURCE DOC ID
19.	September 22, 2011	Progress Note entered by Lois Durbidge, RN, at 22:31 that Ms. Matheson's intake continues to be poor, refused medications, demeanour sad and resigned "What is there to be happy about?"	LTCI00013330
20.	October 6, 2011	Progress Note entered by EW at 22:06, 22:08 and 22:35. Has completed a head to toe assessment. Notes that Ms. Matheson ate only a few bites of supper, appeared listless and refused medications.	LTCI00013330 LTCI00013419
21.	October 12, 2011	Progress Note entered by Hoda Soltani, Dietician, at 15:59, Quarterly assessment triggered – Ms. Matheson is deemed at high risk due to low intake, significant weight loss and hypertension.	LTCI00013330
22.	October 14, 2011	Progress Note entered by EW at 05:23 that Ms. Matheson appeared very fatigued and feeble.	LTCI00013330
23.	October 17, 2011	Progress Note entered by Hoda Soltani, Dietician, at 10:14 that Ms. Matheson had lost 5% of her body weight in the last month. Recently put on Resource.	LTCI00013330
24.	October 18, 2011	Progress Note entered by EW at 06:57 that Ms. Matheson appeared very pale and listless.	LTCI00013330
25.	October 19, 2011	Progress Note entered by EW at 04:56 that Ms. Matheson had lost 14kg since July 3rd. Dietician is aware of weight loss. Ms. Matheson rarely eats more than 7 units of food daily.	LTCI00013330
26.	October 19, 2011	Progress Note entered by EW at 05:09 that Ms. Matheson had refused to drink overnight.	LTCI00013330
27.	October 23, 2011	Progress Note entered by Suzanne Kungl, RN, at 09:57 that she discussed palliative measures with staff and charge nurse regarding holding meds, wearing a hospital gown for comfort etc.	LTCI00013330
28.	October 25, 2011	EW is working the afternoon shift from 15:00 to 11:00.	LTCI00057683
29.	October 25, 2011	Progress Note entered by EW at 23:25 that Ms. Matheson that night at hs appeared very alert. EW notes: *She informed writer that she would like a piece of blueberry pie 'with the crust on'. She and writer had a 5 minute conversation about pies and how to make them. A staff member went on their*	LTCI00013330

	DATE	EVENT	SOURCE DOC ID
		break and got blueberry pie for Helen. She ate 4 bites with ice cream then smiled and said 'That's enough dear, but the crust is lovely	
30.	October 25, 2011	EW admits having attended the medical supply room, obtained a spare insulin needle and insulin and having injected Ms. Matheson with approximately 50 to 60 units of short acting insulin.	LTCI00057683
31.	October 26, 2011	EW is working the afternoon shift from 15:00 to 11:00.	LTCI00057683
32.	October 26, 2011	Progress Note entered by EW at 20:15 that Ms. Matheson appears pale and listless and responds to voice occasionally. Ms. Matheson was moved to Room 15.	LTCI00013330
33.	October 26, 2011	Progress Note entered by EW at 22:20 that Ms. Matheson was having periods of apnea.	LTCI00013330
34.	October 26, 2011	Progress Note entered by EW at 22:28 that Ms. Matheson was flinching and appeared uncomfortable so 10 mg of morphine was given. Noted that Ms. Matheson then appeared to be resting comfortably.	LTCI00013330 LTCI00013426
35.	October 27, 2011	At 01:00 Jon Matheson, Ms. Matheson's son, notified staff that his mother had stopped breathing while he was with her. Resident Death Form signed by Dr. Andersen-kay identifying apparent cause of death "natural causes - ? undiagnosed cancer" Medical Certificate of Death is completed by Dr. Andersen-kay noting immediate cause of death: • Natural causes – cancer NYD • Weight loss – failure to thrive • Old age debility Other significant conditions: • Dementia • Vasculopathy Institutional Patient Death Record is completed by Lois Durbidge, RN	LTCI00013330 LTCI00013412 LTCI00013413 LTCI00013414 LTCI00071975

	DATE	EVENT	SOURCE DOC ID
		Death recorded on Death Registry	
36.	October 27, 2011	Cumulative Plan of Care closed	LTCI00013362

VOLUME 5(ix): MARY ZURAWINSKI
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to the 1st Degree Murder of Ms. Mary Zurawinski in November, 2011.

Ms. Zurawinski was born on April 7, 1915. She spent much of her youth in Sudbury. She worked as a waitress. Ms. Zurawinski was married twice, to Eugene and Eddie, and had four sons. Three sons and her husband predeceased her.

The chronology below sets out Ms. Zurawinski's history while at Caressant Care. Ms. Zurawinski had a number of ailments but did not have diabetes and therefore did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	June 27, 2007	EW commences her employment at Caressant Care.	LTCI00057092 LTCI00057098
2.	August, 2007	Ms. Zurawinski is hospitalized at Woodstock General Hospital ("WGH"). She develops a compression fracture of her lower thoracic spine. She transfers to Caressant Care Retirement Home.	
3.	June 24, 2010	Ms. Zurawinski applies for long-term care. Her application is accepted by Caressant Care on June 24, 2010.	LTCI00015187 LTCI00015188 LTCI00015189
4.	December 17, 2010	CCAC provides updated information to Caressant Care re Ms. Zurawinski.	LTCI00015215
5.	May 5, 2011	Ms. Zurawinski 's updated application for transfer to long-term care at Caressant Care is accepted.	LTCI00015168
6.	May 6, 2011	Ms. Zurawinski enters Caressant Care from Caressant Care Retirement Home. Ms. Zurawinski had a number of conditions including dementia but not diabetes.	LTCI00014943 LTCI00015038 LTCI00015227
7.	May 9, 2011	Physiotherapy Initial Assessment. Ms. Zurawinski reports feeling	LTCI00015163

	DATE	EVENT	SOURCE DOC ID
		good, no complaints.	
8.	May 11, 2011	Progress Note entered by EW at 22:11 that Ms. Zurawinski was at pub night and enjoyed it.	LTCI00014943
9.	May 12, 2011	Progress Note entered by EW at 18:35 that Ms. Zurawinski continued to adjust well.	LTCI00014943
10.	May 30, 2011	Ms. Zurawinski's Plan of Care is updated.	LTCI00015069
11.	July 29, 2011	Physiotherapy Quarterly Assessment is completed. Ms. Zurawinski was feeling good, no complaints.	LTCI00015159
12.	August 18, 2011	Ms. Zurawinski's Plan of Care is updated.	LTCI00015052
13.	October 12, 2011	Progress Note entered by Jennifer Hague, RN, at 11:22 that at 10:15 Ms. Zurawinski was heard to be falling. Found supine with her walker on its side behind her. Unresponsive for several minutes. Transferred to WGH. Internal Resident Incident Report is completed. Ms. Zurawinski was unresponsive to verbal and physical stimuli and could not be roused for 3 – 4 minutes. Assessed for physical injuries – BS checked – 6.6. Safety Plan – Post Fall Investigation is completed.	LTCI00014943 LTCI00015096 LTCI00015098 LTCI00015131 LTCI00015140
14.	October 12, 2011	Progress note entered by Lois Durbidge, RN, at 21:02 that Ms. Zurawinski returned from WGH, admission cancelled after consult with Dr. Miettinen. Noted that Ms. Zurawinski guards her right rib cage when changes position, coughs, attempts to stand – "states pain is very sharp 'all of a sudden'? bruised/fractured? ribs from fall this morning?" Right rib cage very tender on palpitation.	LTCI00014943 LTCI00015142
15.	October 13, 2011	Physiotherapist Report after hospital visit. Ms. Zurawinski states that she has pain with breathing/coughing in right ribs.	LTCI00015155
16.	October 13, 2011	Progress Note entered by Lois Durbidge, RN, at 21:16 that at 16:00 Ms. Zurawinski came to the desk asking for something for pain, holding right lower rib cage. Tylenol #3 given for sharp stabbing pain on movement. Ms. Zurawinski complains of right lower	LTCI00014943

	DATE	EVENT	SOURCE DOC ID
		ribcage pain, especially when she coughs.	
17.	October 14, 2011	Progress Note entered by Jane Jennings, RN (EC), Nurse Practitioner at 12:27 that Registered staff are concerned re a general decline in Ms. Zurawinski. Ms. Zurawinski was in palliative room – had fall October 12, 2011. Hospital records reveal no fractures on CX$ or rib cage. Staff to determine if UTI, to notify Dr. Miettinen with further concerns.	LTCI00014943
18.	October 14, 2011	Progress Note entered by Richang (Patty) Xia, RN, at 22:02 that Ms. Zurawinski was more alert, responsive and pleasant during dinner time.	LTCI00014943
19.	October 15, 2011	Progress Note entered by EW at 03:41 that Ms. Zurawinski had no further complaints of pain, appears to be sleeping comfortably.	LTCI00014943
20.	October 15, 2011	Ms. Zurawinski is found on the floor beside her bed. Stated she hit her head but couldn't find any bumps or bruises on her head. Complained of pain in her left side around her chest area which she had since her last fall. Internal Resident Incident Form is completed. Safety Plan – Post Fall Investigation is completed. Notes that Ms. Zurawinski is getting weaker and weaker.	LTCI00014943 LTCI00015101 LTCI00015103
21.	October 17, 2011	Physiotherapist Report identifying that Ms. Zurawinski is not herself, more lethargic and complains of dizziness. Ms. Zurawinski reports to Physiotherapist that she has pain with breathing/coughing on her right ribs and states she is not feeling well, is dizzy.	LTCI00015151
22.	October 18, 2011	Progress Note entered by Richang (Patty) Xia, RN, at 20:40 that Ms. Zurawinski was getting more and more confused, refused her dinner and stated she didn't like it, still weak and pale.	LTCI00014943
23.	October 20, 2011	Ms. Zurawinski was found on the floor, stated she did hit her head. Complains of feeling unwell and wished to stay in bed. Internal Resident Incident Report is completed. Safety Plan – Post Fall Investigation is completed. Ms. Zurawinski was not diabetic, so blood sugars were taken. Noted that Dr. Miettinen refuses to sign Internal Resident Incident Report	LTCI00014943 LTCI00015091 LTCI00015093

	DATE	EVENT	SOURCE DOC ID
24.	October 21, 2011	Progress Note entered by Jane Jennings, RN (EC) Nurse Practitioner that Ms. Zurawinski had lethargy, falls, likely due to UTI diagnosed that day. Ms. Zurawinski reports to Physiotherapist that she has pain with breathing/coughing on her right ribs and states she is not feeling well, is dizzy. Noted that she is not herself, more lethargic and complains of dizziness.	LTCI00014943 LTCI00015126 LTCI00015127 LTCI00015144 LTCI00015147
25.	October 24, 2011	Ms. Zurawinski is reported to have fallen out of bed at 01:00. Internal Resident Incident Report is completed. Safety Plan – Post Fall Investigation is completed.	LTCI00014943 LTCI00015106 LTCI00015108 LTCI00015146
26.	November 4, 2011	Progress Note entered by EW at 17:53 that Ms. Zurawinski was no longer wearing her teeth and was having difficulty swallowing regular texture food. Referral sent to trial minced texture for 7 days.	LTCI00014943
27.	November 5, 2011	Progress Note entered by Jennifer Hague, RN, at 10:46 that Ms. Zurawinski appeared more frail that morning. Colour is pale. She complains of pain upon movement but is comfortable when resting in bed.	LTCI00014943
28.	November 6, 2011	EW is working the afternoon shift from 15:00 to 11:00. She admits that at approximately 16:30 she obtained an insulin pen and insulin from the medication room, both long and short acting insulin. EW admits that she administered 50 units of short acting insulin and 30 units of long acting insulin into Ms. Zurawinski.	LTCI00057683
29.	November 6, 2011	Progress Note entered by EW at 17:22 that she was able to get through to Ms. Zurawinski's son's phone and left message for him to call regarding her condition.	LTCI00014943
30.	November 6, 2011	Progress Note entered by EW at 17:23 as follows: *Mary was sitting at the dining room table at 16:55 and was very pale. She started breathing in soft gasps, 30 per minute. She asked staff to put her back to bed 'so I can die there'.* *She was taken to the palliative room and put to bed. She then asked for someone to pray with her. PSW O.R. said "Hail Mary"*	LTCI00014943

	DATE	EVENT	SOURCE DOC ID
		with her and Mary visibly relaxed. Son has been called.	
31.	November 6, 2011	Progress Note entered by EW at 18:13 that Ms. Zurawinski's son had called and she had informed him "her pulse and respirations are rapid and erratic and that she has been moved into the palliative care room".	LTCI00014943
32.	November 6, 2011	Progress Note entered by EW at 19:14 and 19:15 re medication administrations notes that Ms. Zurawinski is "palliative".	LTCI00014943
33.	November 6, 2011	Progress Note entered by EW at 21:45 that Ms. Zurawinski's son and friend had come to see Ms. Zurawinski.	LTCI00014943
34.	November 7, 2011	Progress Note entered by Suzanne Kungl, RN, at 02:36 that Ms. Zurawinski was checked every 15 min by staff and her. Ms. Zurawinski appeared comfortable and asleep. At 02:15 Ms. Zurawinski was found with no vital signs present.	LTCI00014943
35.	November 7, 2011	Ms. Zurawinski passed away at Caressant Care. Institutional Patient Death Record is completed by Suzanne Kungl, RN. Medical Certicate of Death is completed by Dr. Kocsis identifying Ms. Zurawinski's cause of death as CVA, with COPD and dementia as contributing factors. Resident Death Form signed by Dr. Kocsis with the apparent cause of death as CVA. Death recorded on Death Registry	LTCI00014943 LTCI00014995 LTCI00015002 LTCI00015003 LTCI00071975
36.	November 7, 2011	Cumulative Plan of Care is closed	LTCI00014963
37.	January 17, 2012	EW phones Ms. Zurawinski's son regarding her belongings.	LTCI00014943

VOLUME 5(x): HELEN YOUNG

CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to the 1st Degree Murder of Ms. Helen Young in July, 2013.

Ms. Young was born on June 29, 1923 in Edinburgh, Scotland. She served in the Air Force in World War II in several locations and met her husband Peter. They had no children. Ms. Young and her husband moved to Canada in 1948, settling in the Woodstock area in 1971. Her husband predeceased her.

The chronology below sets out Ms. Young's history while at Caressant Care. Ms. Young had a number of ailments but did not have diabetes and therefore did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	June 27, 2007	EW commences her employment at Caressant Care.	LTCI00057092 LTCI00057098
2.	October 26, 2009	Ms. Young is admitted to Woodstock General Hospital ("WGH") after being found on the floor at home.	LTCI00014753
3.	November 20, 2009	Ms. Young applies for long-term care while in WGH.	
4.	December 16, 2009	Ms. Young entered Caressant Care from Bonnie Brae Nursing Home in Tavistock. Ms. Young had a number of medical issues including dementia but not diabetes.	LTCI00013753
5.	December 30, 2009	Ms. Young's Plan of Care is updated. (missing one page)	LTCI00014580
6.	December 31, 2009	Progress Note entered by Margaret Darling, RN, at 08:59 that Ms. Young was slapped in the face after shouting at a resident to get out of her room.	LTCI00013753
7.	January 30, 2010	Progress Note entered by EW at 21:33 indicating that Ms. Young's niece had concerns regarding Ms. Young's care. Among other things, Ms. Young had complained to her niece that a staff had handled her roughly and made her shoulder sore. EW states that Ms. Young was vague about when it happened and what staff it may have been. Ms.	LTCI00013753

	DATE	EVENT	SOURCE DOC ID
		Young stated that "someone pulled her arm when helping her dress". EW purports to have spoken with several staff and each one stated that Ms. Young will not allow staff to help her dress or undress Note that progress note for January 24 identifies that staff assisted Ms. Young with removing clothing though Ms. Young was resistive and wanted to call police.	
8.	January 30, 2010	EW signs a "Palliative Performance Scale & Care Plan Review" regarding Ms. Young.	LTCI00014721
9.	April 5, 2010	Ms. Young's Plan of Care is updated.	LTCI00014566
10.	June 29, 2010	Ms. Young's Plan of Care is updated.	LTCI00014549
11.	September 9, 2010	Progress Note entered by EW at 21:00 that Ms. Young became angry when EW asked her to take her pills in front of her.	LTCI00013753
12.	September 29, 2010	Ms. Young's Plan of Care is updated.	LTCI00014648
13.	December 16, 2010	Progress Note entered by EW at 04:47 that Ms. Young had rated her pain as "horrible and shocking" but analgesic had good effect.	LTCI00013753
14.	December 16, 2010	Suggestions from pharmacist made because Ms. Young was refusing meds, especially her hydromorph contin and was having resultant pain issues.	LTCI00014303
15.	December 24, 2010	Progress Note entered by EW at 21:50 that Ms. Young had asked for her pills to be left with her and she would take them later. When told they would have to be taken out of her room she started yelling but then took them. Then observed to have spit them into a Kleenex. EW notes that the pills were wasted, including the morphine. Notes that a similar incident had occurred December 22, 2010.	LTCI00013753
16.	December 28, 2010	Annual Family/Team Conference [attended by EW] – noted that there were no significant changes in Ms. Young's condition – continues to refuse activities, refuses aid etc.	LTCI00013753
17.	January 22, 2011	Medication error re Ms. Young. Ms. Young missed her 07:30 hydromorph. Incident Resident Incident Report completed.	LTCI00014925

	DATE	EVENT	SOURCE DOC ID
18.	February 1, 2011	Progress Note entered by Lois Durbidge, RN, at 22:50 that Ms. Young had reported that she was being abused during HS care. Noted that Ms. Young claimed that she had been pushed and pulled around and into the bathroom and that her right arm had been pulled and was sore. Ms. Durbidge assured Ms. Young that her comments would be recorded. Ms. Young also requests a change to a single room.	LTCI00013753
19.	February 23, 2011	Ms. Young's Plan of Care is updated.	LTCI00014583
20.	May 18, 2011	Ms. Young's Plan of Care is updated.	LTCI00014604
21.	June 20, 2011	Physiotherapy Progress Note entered by Julie Dunphy, Physiotherapist, at 12:09 indicating that Ms. Young had yelled for help and she was in a lot of pain. Noted that it was a possible right shoulder dislocation and she should be x-rayed, doctor should be notified. Dr. Reddick was notified. Ordered portable x-ray of Ms. Young's right shoulder. Requisition made out and faxed.	LTCI00013753 LTCI00014507 LTCI00014515
22.	June 24, 2011	Progress Note entered by Tiffany Dubreuil, RN, at 13:29 that she called the imaging company and was told that they did not receive the original Requisition. The Requisition was sent again. Called again by Richang (Patty) Xia, RN, and was told to call back on Monday (June 27, 2011) to check the schedule	LTCI00013753
23.	June 27, 2011	Progress Note entered by Agatha Krawczyk, RN, at 15:19 that Ms. Young's right shoulder was x-rayed. No fracture was present. Query noted as to whether there is clinical evidence of septic arthritis.	LTCI00013753 LTCI00014938
24.	August 1, 2011	Ms. Young experiences a fall. Assessed by EW who took her initial vitals but then stated that Ms. Young refused to have any other head injury routine assessments done stating "leave me alone with that business for the night, I'm fine".	LTCI00013753
25.	August 18, 2011	Ms. Young's Plan of Care is updated.	LTCI00014626
26.	August 29, 2011	Progress Note entered by Kathleen Toon, RN, at 23:02 that Ms. Young refused to go to the hospital although she was complaining of pain – femoral hernia appears to have increased in size.	LTCI00013753

	DATE	EVENT	SOURCE DOC ID
27.	December 15, 2011	Ms. Young's Plan of Care is updated.	LTCI00014667
28.	December 16, 2011	Annual Family/Team Conference – noted that Ms. Young declines most interventions from health care team and she has been aggressive lately. Progress Note entered by Kathleen Toon, RN, at 23:40 noting that Ms. Young told a PSW to wash her face and when PSW went to do so, Ms. Young bit her thumb and held on for at least 5 sec before the PSW was able to push her away and release her thumb.	LTCI00013753
29.	February 3, 2012	Ms. Young experiences a fall. Assessed by EW. She is expressing pain and confused. Progress Note by EW at 06:37 indicates that Ms. Young shrieked with pain when she touched her hip so range of motion was not assessed. Dr. Reddick called and Ms. Young was transported to WGH. Ms. Young returns from WGH. No fracture shown in x-rays. RPN notes "Requested EW attention towards the fall and resident transferred to the hospital via ambulance". Internal Resident Incident Report is completed.	LTCI00013753 LTCI00014892
30.	February 6, 2012	Caressant Care submits Critical Incident Report [CIR #2636-000007-12] indicating that on February 3, 2012 Ms. Young was found on her left side on the floor. Ms. Young was sent to WGH for assessment and returned that same day	LTCI00017007
31.	April 4, 2012	Progress Note entered by EW at 19:59 that Ms. Young refused her hydromorph capsule in spite of reapproach.	LTCI00013753
32.	April 26, 2012	Progress Note entered by EW at 22:21 that Ms. Young refused her morphine, stating that she was in no pain and didn't need it. EW notes that the medication was "wasted" and at 22:00 Ms. Young rang and asked for her pain medication as she is in terrible pain. EW states she gave Dilaudid.	LTCI00013753
33.	June 1, 2012	Ms. Young is moved to a room across from the nurses' station as she is at high risk for falls and is high needs. [Note – only those falls which were assessed by EW, or which resulted in a transfer to Hospital are noted in this Chronology).	LTCI00013753
34.	July 1, 2012	Ms. Young experiences two falls. One in her room and one at the	LTCI00013753

	DATE	EVENT	SOURCE DOC ID
		nurse's station. Ms. Young is transferred to WGH. Received sutures. Noted to be difficult to work with at the hospital. Returned on July 2, 2012.	
35.	July 6, 2012	Caressant Care submits Critical Incident Report [CIR #2636-000023-12] indicating that Ms. Young was found on the floor in front of the nurse's station. She had been leaning forward and seconds later fell to the floor.	LTCI00059502
36.	August 3, 2012	Progress Note entered by EW at 07:04 that Ms. Young's clothing was soaked with urine after supper and when a PSW went to remove her clothes and wash her, Ms. Young started screaming "help, murder", over and over.	LTCI00013753
37.	October 12, 2012	Progress Note entered by Nicole Lim, RN, at 21:40 that Ms. Young was calling out for help continuously, that other residents have expressed discomfort as she constantly yells for help and sometimes goes into their room during the night.	LTCI00013753
38.	October 15, 2012	Progress Note entered by Agatha Krawczyk, RN, at 13:29 indicating that Ms. Young had been calling out for help repeatedly, refusing help from staff.	LTCI00013753
39.	December 1, 2012	Progress Note entered by Jacqueline Morris at 04:28 that Ms. Young spent most of the night ambulating around the hallway in her wheelchair, refusing to go to bed. Progress Note entered by Jacqueline Morris, RN, at 06:18 that Ms. Young was shouting that she was being murdered and abused. She was intentionally trying to fall from the toilet.	LTCI00013753
40.	December 9, 2012	Progress Note entered by Nicole Lim, RN, indicating that Ms. Young had been continuously yelling "Help me" "Help me".	LTCI00013753
41.	December 13, 2012	Progress note entered by Jubin Raju, RPN, that Ms. Young had been in a disturbed mood that shift. Always calling out "help me, help me".	LTCI00013753
42.	December 18, 2012	Annual Family/Team Conference – Ms. Young does not spend much time in her room. Refuses meals and medications.	LTCI00013753

	DATE	EVENT	SOURCE DOC ID
43.	December 30, 2012	Progress note entered by Nicole Lim, RN, indicating that Ms. Young was refusing to have her vitals taken and was yelling out for help continuously.	LTCI00013753
44.	January 4, 2013	Ms. Young experiences a fall. Sent to WGH to assess laceration to temple as it won't stop bleeding. Ms. Young returns from WGH.	LTCI00013753 LTCI00014871 LTCI00014873
45.	January 9, 2013	Progress note entered by Jacqueline Morris, Rn, at 22:45 that Ms. Young was spitting onto the floor and stating that she wanted to die, refusing to take medications.	LTCI00013753
46.	January 16, 2013	Quarterly Physiotherapy Re-assessment - Ms. Young is able to propel her wheelchair with her feet, has good balance while sitting. She is aggressive at times and cooperates for physio depending on her mood.	LTCI00013753
47.	February 8, 2013	Progress note entered by Ifeyinwa Anazodo, RPN, at 08:40 that Ms. Young was up all night shouting/talking to an imaginary figure.	LTCI00013753
48.	February 16, 2013	Progress note entered by Nicole Lim, RN, at 11:06 that Ms. Young was very resistive that shift, kicking and pulling Ms. Lim's hair.	LTCI00013753
49.	February 28, 2013	Progress note entered by Nicole Lim, RN, at 23:41 that Ms. Young yelled non-stop that shift.	LTCI00013753
50.	May 23, 2013	Progress Note entered by Rouanne Manser, Nursing, temp license, that Ms. Young was calling out loudly between 02:00 and 03:00, yelling she wanted to go "out to the road" and "wanted to die".	LTCI00013753
51.	May 24, 2013	Progress Note entered by Nicole Lim, RN, at 13:47 that Ms. Young was resistive and aggressive during the 10:00 treatment, scratched the nurse's arm and tried to kick her.	LTCI00013753
52.	June 17, 2013	Nutrition Referral indicates that Ms. Young's appetite continues to be fair to poor at meals and snacks.	LTCI00013753
53.	July 11, 2013	Physiotherapy reassessment indicates that Ms. Young is sore but has good balance in sitting, able to propel her wheelchair with her feet, is aggressive at times and co-operates with physio depending on her mood.	LTCI00013753

	DATE	EVENT	SOURCE DOC ID
54.	July 13, 2013	EW is working the afternoon shift from 15:00 to 11:00. EW admits that prior to dinner she prepared two insulin injections, attended Ms. Young's room and injected her with one shot of 60 units of short-acting insulin. EW admits that after dinner she injected Ms. Young with an additional 60 units of long acting insulin.	LTCI00057683
55.	July 13, 2013	Progress Note entered by EW at 19:27 as follows: *Helen was diaphoretic after supper and was slurring her words. Her skin is moist and shows no tenting. Her mucous membranes appear moist. Her vitals are temp 35.8, pulse 55, resps 14, BP 105/50, 02 sat 96%. She was placed in the tv room for cooling purposes but adamantly refused to stay here. She is a code 2. Will continue to monitor.*	LTCI00013753
56.	July 13, 2013	Progress Note entered by EW at 22:14 that she gave Ms. Young morphine at 22:00.	LTCI00013753
57.	July 13, 2013	Progress Note entered by EW at 22:16 that Ms. Young appeared to swallow pills, then spit out later.	LTCI00013753
58.	July 14, 2013	Progress Note entered by EW at 00:06: *At 20:30 Helen was attempting to slide out of her wheelchair. When staff attempted to reposition her she struggled and kicked and tried to scratch them. She was assisted into bed. When staff attempted to undress her, she again attempted to scratch, hit and kick them. she was moaning at the time.* *She sustained 4 skin tears. Refer to note under wounds.* *Writer gave Helen her hs pain pill and sedation and thought she swallowed them.* *At 21:40, K.D. PSW summoned writer to Helen's room. Helen's face was red, her arms and legs were bent inward, her eyes were bulging and she was moaning loudly. When writer asked if she was in pain, she nodded. Writer noted that Helen had spit out her meds. On call Dr. Dr. Brio, was called and ordered morphine subcue. The first dose was given at 22:00.*	LTCI00013753
59.	July 14, 2013	Progress Note entered by EW at 00:17 that Ms. Young had appeared	LTCI00013753

	DATE	EVENT	SOURCE DOC ID
		calm and relaxed at 23:00. Respirations were 6 per minute and she was having periods of apnea lasting up to 45 seconds. Ms. Young's niece was called and advised of events of the evening and Ms. Young's current condition.	
60.	July 14, 2013	Progress Note entered by EW at 00:19 that Ms. Young had skin tears that were sustained when she was attempting to get out of her wheelchair and struggling with staff. Indicates that skin tears were cleaned and dressing applied.	LTCI00013753
61.	July 14, 2013	Ms. Young passed away at Caressant Care at 08:40. The Medical Certificate of Death is completed by Dr. Michelle Anderson-kay identifying old age debility as the immediate cause of death and atrial fibulation as a significant contributing factor. Dr. Anderson-kay completed the Resident's Death Form. Agatha Krawczyk, RN, completes the Institutional Patient's Death Record. Death recorded on Death Registry	LTCI00013753 LTCI00034764 LTCI00071977
62.	July 15, 2013	Cumulative Plan of Care closed. [Note – document split]	LTCI00013919 LTCI00014023

VOLUME 5(xi): MAUREEN PICKERING CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Elizabeth (Bethe) Wettlaufer ("EW") admitted to the 1st Degree Murder of Ms. Maureen Pickering in March, 2014.

Ms. Pickering was born on June 9, 1935 in Montreal Quebec. She went to McGill University for economics. She married Hugh in 1962. Ms. Pickering worked at Bell Canada and was a homemaker. Her husband was diagnosed with Parkinson's disease and she took care of him. They had no children. Her husband predeceased her.

The chronology below sets out Ms. Pickering's history while at Caressant Care. Ms. Pickering had a number of ailments but did not have diabetes and therefore did not have any need for insulin.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	June 27, 2007	EW commences her employment at Caressant Care.	LTCI00057092 LTCI00057098
2.	August, 2013	Ms. Pickering is found wandering and is hospitalized. She is referred to the CCAC and an application is made for long-term care. Caressant Care accepts the application on September 4, 2013	LTCI00015573
3.	September 9, 2013	Ms. Pickering entered Caressant Care from Tillsonburg Hospital where she had been since August 21, 2013. Ms. Pickering had a number of medical issues including dementia and Alzheimer's disease but not diabetes.	LTCI00015439 LTCI00015496
4.	September 9, 2013 - September 10, 2013	Progress Notes entered that Ms. Pickering is in good spirts, socializing with residents and cooperative with care. Noted that she is adjusting well and likes to socialize.	LTCI00015236
5.	September 14, 2013	Ms. Pickering is transferred to Woodstock General Hospital ("WGH") after having been found on the floor in the hallway outside of her own room. Emergency notes state "I understand she was pushed".	LTCI00015236 LTCI00015592
6.	September 15, 2013	Ms. Pickering returns from WGH but is sent back the same day	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		and then again returned that same day.	LTCI00015592
7.	September 16, 2013	Caressant Care files a Critical Incident Report [CIR #2636-000030-13] regarding an incident on September 14, 2013 indicating that Ms. Pickering was walking down the hallway and it is believed that she entered another resident's room. They are unsure as to whether they pushed or shoved. Both residents were found on the floor and the other resident was mad that Ms. Pickering had entered her room. Ms. Pickering had a small pool of blood under her head. Notes that Ms. Pickering was transferred to WGH, where a CT scan was negative and she received 1 stitch.	LTCI00055904
8.	October 10, 2013	Progress Note entered by Laura Long, RPN, at 14:35 that another resident entered Ms. Pickering's room when she was sleeping and began slapping her in the face, then slapped the PSW as she came to intervene.	LTCI00015236
9.	December 9, 2013	Progress Note entered by EW at 23:22 that Ms. Pickering was extremely restless before and after supper. After supper student aide took Ms. Pickering to get clothing cart from retirement side, after which she did settle. EW identifies that this will be tried every afternoon shift that week.	LTCI00015236
10.	December 19, 2013	Progress Note entered by EW at 22:17 that Ms. Pickering was unusually belligerent with staff that shift.	LTCI00015236
11.	December 21, 2013	Progress Notes entered by Anita Breton, RN at 11:02 and 11:32 that Ms. Pickering had complained of feeling dizzy and slid to the floor and sat. She felt unwell and her pulse was lower than normal. BS taken – as she was extremely shaky – 5.7.	LTCI00015236
12.	December 21, 2013	Progress Note entered by Anita Breton, RN, at 13:15 that Ms. Pickering complained of feeling frightened and keeps shaking.	LTCI00015236
13.	December 26, 2013	Progress Note entered by EW at 20:25 that Ms. Pickering was walking down the hall, leaned against the wall and started to slide to the floor. She was awake and alert.	LTCI00015236
14.	December 30, 2013	Progress Note entered by EW at 20:09 that another resident had rang the bell at 19:40 indicating that Ms. Pickering had entered	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		her room, slapped her, pulled her hair and scratched her. Noted that Ms. Pickering approached EW at 19:45 and said "She screamed at me so I slapped her to shut her up"	
15.	January 3, 2014	Progress Note entered by Rouanne Manser, BSO RPN, at 17:38 regarding Ms. Pickering's recent behaviours: *Writer received referral regarding increase in wandering which led to an altercation. Upon review of chart and recent urine results this wandering into rooms appears to be bathroom seeking related. Writer had extensive discussion with B.W. RN regarding resident's behaviours.* *Resident is noted by staff to sit in chairs down at the end of Level 1. When resident requires the bathroom she simply finds the closest one which leads to her appearing in S.S. room. Staff requesting resident be moved closer to nursing station for closer monitoring and clearer redirection. Use of signage and increased convenience to bathroom, bedroom, dining room and activity area will hopefully reduce the wandering and agitation as well as reducing the potential for altercations when resident becomes lost.*	LTCI00015236
16.	January 3, 2014	Progress Note entered by EW at 22:48 that Ms. Pickering approached the med cart at 20:00 and was touching it. When asked not to she slapped EW's arm.	LTCI00015236
17.	January 13, 2014	Progress Note entered by Rouanne Manser, BSO RPN, at 16:52 that Ms. Pickering was exhibiting extremely agitated behaviour several times a day to several times an hour, cursing, verbal aggression, constant unwarranted requests for attention, hitting, pushing, trying to get into different places etc. She was being treated for a UTI. BSO Assessment indicated a suggestion of depression. Suggested Dr. Reddick consider an anti-depressant or referral to Geriatric BSO mobile team for further assessment.	LTCI00015236 LTCI00015504 LTCI00015505 LTCI00015506 LTCI00015508
18.	January 17, 2014	Progress Note entered by EW at 16:26 that at 16:10 Ms. Pickering was hanging onto the med cart, blocking EW from accessing the lower drawer. When EW touched her right hand and asked her to let go of the med cart, Ms. Pickering scratched her hand.	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
19.	January 17, 2014	Progress Note entered by EW at 16:30 that a resident had reported that Ms. Pickering entered her room, grabbed her hands and shook her. Left when she was yelled at.	LTCI00015236
20.	January 18, 2014	Progress Note entered by Agatha Krawczyk, RN, at 13:46 that Ms. Pickering had entered another resident's room and scratched the resident.	LTCI00015236
21.	January 18, 2014	Progress Note entered by Jonathan Audet, RN, at 21:43 that Ms. Pickering had entered another resident's room and when he arrived she had grabbed the resident's television remote and raised it as if threatening to swing.	LTCI00015236
22.	January 20, 2014	Progress Note entered by EW at 15:25 that Ms. Pickering had wandered into another room and was assisted out twice in 5 minutes. EW attempted to explain to Ms. Pickering that she was forgetful and needed to trust staff when Ms. Pickering grabbed and squeezed her right hand and yelled angrily "I don't forget".	LTCI00015236
23.	January 20, 2014	Progress Note entered by EW at 18:25 that Ms. Pickering was verbally aggressive with staff and "as a nursing measure she was given her 20:00 Risperidone at this time even though it was 40 minutes early. The assessment made by EW was that "receiving the medication early would be of the most benefit to Maureen".	LTCI00015236
24.	January 20, 2014	Progress Note entered by EW at 19:04 that a PSW reported that Ms. Pickering had punched her in the back as she walked past the nursing desk.	LTCI00015236
25.	January 20, 2014	Progress Note entered by EW at 19:06 that at 18:45 a nursing student had seen Ms. Pickering strike another resident in the face, chest and arms at least 7 times.	LTCI00015236
26.	January 20, 2014	Progress Note entered by EW at 20:32 that as she was on the phone to Ms. Pickering's POA, Ms. Pickering came by and when she heard her name, attempted to hit the phone and hang up the phone.	LTCI00015236
27.	January 20, 2014	Progress Note entered by EW at 20:53 stating that Ms. Pickering was given Haldol as she was attempting to hit staff, hitting hallway computers, calling staff liars and stating that she felt	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		nervous and very angry.	
28.	January 21, 2014	Ms. Pickering's medications are changed.	LTCI00015236
29.	January 21, 2014	Progress Note entered by EW at 22:34 that Ms. Pickering was being sarcastic to staff and making comments to other residents such was "Stop crying or I'll make you cry more" and "You're just a stupid man. You need to be in bed".	LTCI00015236
30.	January 21, 2014	Progress Note entered by EW at 22:45 that Haldol was given to Ms. Pickering for increasing agitation and verbal aggression. Notes that Ms. Pickering agreed she needed something to help her calm down and asked for something that would "work fast".	LTCI00015236
31.	January 21, 2014	Caressant Care files a Critical Incident Report [CIR #2636-000003-14] in relation to incident on January 20, 2014 involving EW and Ms. Pickering. CIR indicates that at 15:25 Ms. Pickering wandered into another resident's room and was assisted out 2 times in 5 minutes. When EW asked her to stay out of the room, Ms. Pickering denied being in it. EW attempted to explain to Ms. Pickering that she was forgetful and needed to trust staff, when Ms. Pickering grabbed EW's hand, squeezed it and yelled angrily "I don't forget". CIR also references additional aggressive incidents with staff and resident.	LTCI00000792
32.	January 22, 2014	Progress Note entered by Ifeyinwa Anazodo, RPN, at 05:00 that Ms. Pickering had displayed no aggressive or wandering behaviour that shift. Notes that she sat by the nurses' station at the beginning, became sleepy, went to bed and was still in bed.	LTCI00015236
33.	January 22, 2014	Progress Note entered by Agatha Krawczyk at 14:45 that Ms. Pickering was calm and cooperative most of the shift. At 13:00 she was reported kicking another resident's bathroom door and saying "this is my room, this is my room".	LTCI00015236
34.	January 22, 2014	Progress Note entered by EW at 15:20 that Ms. Pickering was starting to become agitated and every time she heard a staff member she would say "Liars. You are all lying".	LTCI00015236
35.	January 23, 2014	Brenda Van Quaethem, Administrator, writes to Sanginesi, advising that an investigative meeting was held with EW regarding why medication was given to Ms. Pickering at the	LTCI00016740 LTCI00016742 LTCI00016746

	DATE	EVENT	SOURCE DOC ID
		wrong time (early). [Relates to January 20, 2014 incident] Van Quaethem indicates that EW did not believe that it was a medication error but rather was an "evidence based nursing decision" as the resident was starting to escalate her behaviours and EW felt that it would be good to de-escalate the situation. EW claims that the Caressant Care policy, Nursing Practice Medication Administration #4 and the CON's standards of practice (medication pg 5) support her decision. EW claims that she tried other interventions but acknowledges that she did not chart them. EW denies having told Maureen Pickering "you are sick, you have Alzheimer's, you are confused, so you do not know what you are talking about, you cannot remember, you need to trust the staff". EW states that she told Ms. Pickering that Ms. Pickering forgets and that Ms. Pickering responded that she didn't forget. EW was also asked about other incidents, one regarding whether she obtained a urine sample from Ms. Pickering when she was asked to and one regarding a resident (VA) who was hypoglycemic and for which EW didn't follow policy as to interventions to follow when blood sugar level is under 4. It appears that EW claims that she was not aware of policy.	
36.	January 23, 2014	Progress Note entered by Sandra Fluttert, R.C.C. at 17:23 that she was standing talking to EW when Ms. Pickering came up to EW, grabbed at her breast and name tag, stating that she knew she was marked and what she was all about. Noted that Ms. Pickering was quire agitated. EW wondered whether Ms. Pickering had seen her tattoo and that was what she was commenting on.	LTCI00015236
37.	January 23, 2014	Progress Note entered by EW at 18:07 that Ms. Pickering had been agitated since after supper, calling staff liars, attempting to walk into other residents' rooms. EW notes that she showed Ms. Pickering the stuffed black dog in her bedroom and attempted to hand it to her when Ms. Pickering said "I don't want anything from you" and struck EW on her right arm.	LTCI00015236
38.	January 23, 2014	Progress note entered by EW at 22:50 that Ms. Pickering had calmed considerably. Had gone to an activity. No further verbal	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		aggression or physical aggression that shift.	
39.	January 25, 2014	Progress note entered by EW at 22:21 that Ms. Pickering was very calm that evening, though complained of nervousness three times.	LTCI00015236
40.	January 26, 2014	Progress note entered by Jonathan Audet, RN, at 13:45 that Ms. Pickering had become agitated at the end of breakfast and had thrown juice onto a PSW.	LTCI00015236
41.	January 26, 2014	Progress Note entered by EW at 15:52 that Ms. Pickering was at the desk with a piece of graph paper and a pen making and discussing schedules to which staff had input. Was calm and engaged. EW suggests that this has been an engaging and apparently satisfying activity for Ms. Pickering and that she could make use of a "schedule book", pens, pen case and brief case.	LTCI00015236
42.	January 28, 2014	EW is given a letter indicating that she is not working to the standards required for Caressant Care. Incident involves Ms. Pickering and is described as follows: *A resident was given medication outside of the allowable time frame, this same resident was spoken to in an inappropriate manner that resulted in upsetting the resident and you failed to document the interventions that you said you tried for this resident. All of these issues are being brought to your attention. Please reflect on your actions.* EW receives a 5-day suspension and warning that continued poor work performance would lead to further discipline up to and including termination.	LTCI00016739
43.	January 30, 2014	Progress Note entered by Jubin Raju, RN, at 18:00 regarding Ms. Pickering's behaviours: *Client has been wandering in the hall ways, J.H. BSO assist had been conversing with client and observing client's behaviours, accompanying client. On talk with client, client stated she is getting much thoughts which makes her anxious and not helping her to settle. On description of thoughts, client stated someone behind her to shoot her. While trying to adapt client with the fact of realisation, client added that she may also shoot if needed.*	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		Client appears to have delusions of persecution. Client stated nothing goes on right.	
44.	February 1, 2014	Progress Note entered by Jia Shang, RN, 21:21 that Ms. Pickering was soaked head to toe in sweat at 18:45 but was extremely cold to touch. BS 6.0. Ms. Pickering was complaining of being light-headed.	LTCI00015236
45.	February 2, 2014	Progress Note entered by Agatha Krawczyk at 13:42 that Ms. Pickering had been found lying on the floor at 13:30 in the hall and looked like she was sleeping in bed.	LTCI00015236
46.	February 4, 2014	Progress Note entered by Helen Crombez, DON, at 11:30 that Ms. Pickering had gone into another resident's room and hit her in the face that morning. Suggested to try a wheelchair with a seatbelt to see if she would be able to settle herself down if more confined. They described it to Ms. Pickering as if it were a seatbelt in a car and it would keep her safe. Ms. Pickering agreed to try it and was restful and said she was comfortable.	LTCI00015236
47.	February 4, 2014	Progress Note entered by Britiny Holder, RPN, at 22:28 that Ms. Pickering was extremely agitated in the chair. When she was removed from the chair she began wandering and kicking the walls, punching the fire extinguisher box.	LTCI00015236
48.	February 5, 2014	Progress Note entered by Rouanne Manser, BSO RPN, at 19:42 that when Ms. Pickering was wandering and agitated she should be monitored 1:1 supervision. Note left in day planner to alert staff. Ms. Manser also faxed Dr. Reddick indicating that Ms. Pickering was of great concern behaviourally – constant wandering, increased concentration, numerous physical altercations with other residents and staff. Attached suggestions from Dr. Amanullah re medications	LTCI00015236 LTCI00015516 LTCI00015517
49.	February 6, 2014	Ms. Pickering's medications are changed.	LTCI00015236
50.	February 6, 2014	Progress Note entered by EW at 18:19 that Ms. Pickering had been agitated since 15:00, states she feels nervous.	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
51.	February 6, 2014	Progress Note entered by EW that she gave Ms. Pickering her first dose of a new order, Dilaudid 25 mg and she was very sleepy and asked to go to bed.	LTCI00015236
52.	February 8, 2014	Progress Note entered by EW at 22:45 that Ms. Pickering was agitated and exit seeking before and after supper.	LTCI00015236
53.	February 8, 2014	Progress Note entered by EW at 23:02 that she gave Ms. Pickering Seroquel at 19:25 due to agitation, exit seeking and wandering into other's rooms. Started to show effects of calming around 21:00.	LTCI00015236
54.	February 9, 2014	Progress Note entered by EW that Ms. Pickering was agitated and exit seeking. At 17:25 she struck a PSW on the arm when the PSW tried to redirect her to the dining room to eat. Noted that 1:1 staffing has been effective and Ms. Pickering has settled and appears content as long as someone is with her.	LTCI00015236
55.	February 9, 2014	Progress Note entered by EW at 22:26 that Ms. Pickering had remained calm but refused to stay in bed. Staff have kept her with them as they perform their tasks.	LTCI00015236
56.	February 10, 2014	Progress Note entered by Ifeyinwa Anazodo, RPN, at 07:33 that Ms. Pickering was pacing up and down the hallway, following her around. Ms. Pickering wanted a wheelchair that was big enough for the RPN to sit with her. Ms. Pickering was taken to her room more than 15 times but would not stay more than 2 minutes.	LTCI00015236
57.	February 11, 2014	Progress Note entered by Agatha Krawczyk, RN, at 13:18 that Ms. Pickering was restless, wandering halls, entering other residents' rooms, etc. In the dining room at the table Ms. Pickering hit another resident in the face with the bib and said "you shut up". After lunch at 13:00 Ms. Pickering was in another room and was hitting the resident with a plastic water bottle.	LTCI00015236
58.	February 11, 2014	Progress Note entered by Sandra Fluttert, R.C.C. at 16:57 that she had spoken to Dr. Reddick and staff were to give Ms. Pickering all the PRNs that she can have on a continuous basis.	LTCI00015236
59.	February 11, 2014	Progress Note entered by Sandra Fluttert, R.C.C. at 17:06 that she had spoken with the senior's outreach team and they had suggested that if Ms. Pickering continued to have aggression	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		issues that she needed to be sent to the hospital for assessment.	
60.	February 12, 2014	Progress Note entered by Sandra Fluttert, R.C.C. at 11:42 that senior outreach team felt that Ms. Pickering's actions warranted an admission to psych for them to adjust meds and watch her behaviours.	LTCI00015236
61.	February 12, 2014	Progress Note entered by Jia Shang, RN, at 22:07 that Ms. Pickering was getting increasingly nervous throughout the shift, stating her stomach is turning, everything inside feels tight. She was exit seeking, trying to open doors and wanting to go home.	LTCI00015236
62.	February 12, 2014	Ms. Pickering was to go to WGH for an evaluation but no beds were available.	LTCI00015236
63.	February 13, 2014	Progress Note entered by EW at 19:31 that she received Ms. Pickering agitated and pacing, exit seeking. All attempts to distract Ms. Pickering or channel her energy were ineffective. She continued to pace and demand to go home.	LTCI00015236
64.	February 13, 2014	Progress Note entered by EW at 19:35 that Ms. Pickering was pacing after supper, then agreed to lay down. staff stayed with her while she settled. Effective. Ms. Pickering had been resting in bed for half an hour, door was closed and door alarm turned on.	LTCI00015236
65.	February 14, 2014	Progress Note entered by EW at 15:42 that she received Ms. Pickering agitated and pacing. Told Ms. Pickering she would be going to the hospital for help with her "nervous Nelly". Ms. Pickering was originally receptive to this and then became agitated. Paced into the dining room and threw over a table, then appeared visibly relaxed.	LTCI00015236
66.	February 14, 2014	Ms. Pickering was transferred to WGH for psychiatric evaluation.	LTCI00015236
67.	March 3, 2014	Progress Note entered by Rouanne Manser, BSO RPN regarding discussion with RN at WGH. Ms. Pickering still experiencing occasional outbursts. Stresses that Ms. Pickering needs to be monitored for S & S of agitation which will need to be addressed early.	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
68.	March 5, 2014	Ms. Pickering returns to Caressant Care from WGH for a three day leave of absence.	LTCI00015236 LTCI00015615 LTCI00015616 LTCI00069418
69.	March 5, 2014	Progress Note entered by Jubin Raju, RN, at 22:24 describing Ms. Pickering's behaviours: *Client wandering all around the hallways of nurses station. Client occasionally gets agitated. Client was placed in bed in different times. Came out of bed many times. Not getting settled. Client was given drinks and snacks in between. Client is walking behind all staff. Client has several thoughts going on in her mind. Client need 1:1 attention. Her agitation may make other resident's at risk of physical injury, and there is history stating that. Client is exit seeking too. One time client was screaming like "I want to go home". Client at room 108 was also calling out throughout the shift. Client got agitated with this noice. Staff ofeten times needed to reorientated and redirect the resident. Client looks tired but not settling in bed. Client went for concert and staff at activity reported that she was doing fine at concert time. She was calm and quiet for concert.* Evaluation "Client needs attention and seek for attention all the times"	LTCI00015236
70.	March 7, 2014	Ms. Pickering was transferred to WGH to be re-evaluated because of her aggression.	LTCI00015236
71.	March 17, 2014	Patient Transfer Record from WGH indicates that Ms. Pickering ambulates independently.	LTCI00015612
72.	March 17, 2014	Readmission Medication Orders are completed by three nurses, including EW.	LTCI00015433 LTCI00015443 LTCI00015444
73.	March 17, 2014	Progress Note entered by EW at 22:55 that Ms. Pickering was sitting across from the desk and appeared relaxed. EW notes that Ms. Pickering "appears to be attention seeking" and frequently calls out "I'm cold", "I'm hot" "I'm scared".	LTCI00015236
74.	March 18, 2014	Progress Note entered by Rouanne Manser, BSN RPN regarding Ms. Pickering's behaviour. Ms. Manswer noted that Ms. Pickering continues to demand constant attention. Notes that PSWs and all staff are encouraged to offer her Montessori	LTCI00015236

	DATE	EVENT	SOURCE DOC ID
		opportunities as often as possible to keep her busy and directed.	
75.	March 22, 2014	Progress note entered by Megan Furtney, RN, at 14:02 that Ms. Pickering had stated she felt nervous and had shaky hands.	LTCI00015236
76.	March 22, 2014	Progress note entered by Megan Furtney, RN, at 14:17 that Ms. Pickering had been very agitated that afternoon .	LTCI00015236
77.	March 22, 2014	Progress note entered by EW at 15:32 that she had received Ms. Pickering in a highly agitated state. Ms. Pickering has been pacing in and out of her room and back and forth in front of the nurses' station. Also went into room 108 and yelled at resident and has been stating she will go home and is complaining of feeling nervous and scared.	LTCI00015236
78.	March 22, 2014	EW admits that at approximately 20:00 she attended the unit's medical storage room and located an insulin pen and insulin. She prepared two needles for Ms. Pickering. EW admits that she gave Ms. Pickering the two injections approximately 2 ½ hours apart. First 80 units of long-acting insulin and second 60 units of short-acting insulin. EW also admits that she gave Ms. Pickering a sedative before giving her the first injection. She states that she misrepresented it as a vitamin injection.	LTCI00057683
79.	March 22, 2014	Progress note entered by EW at 23:27 that Ms. Pickering had started to settle down at 14:30 and had stopped complaining of feeling nervous. Noted that she got up at 19:00 and assisted staff by folding towels but resettled at 19:30 and was asleep every time she was checked on. EW records "Maureen has called out 'help help' twice since 22:00 but both times she was asleep".	LTCI00015236
80.	March 23, 2014	Progress note entered by Karen Routledge, RN, at 10:59 that at 08:00 Ms. Pickering was responding to questions but drowsy and did not want to come for breakfast. Noted that Ms. Pickering was checked on every 30 mins and at 10:50 was found unresponsive, diaphoretic, cold and clammy with deep snoring sounding respirations and mucous. Ambulance called and Ms. Pickering was transferred to WGH for assessment.	LTCI00015236 LTCI00015594

	DATE	EVENT	SOURCE DOC ID
81.	March 23, 2014	Emergency Record indicates that glucose was given. Diagnosis – severe hypoglycemia. CT is completed.	LTCI00015613 LTCI00015623 LTCI00001670
82.	March 23, 2014	Progress Note by EW at 17:11 that a call was received from Dr. Urbantke at WGH that Ms. Pickering continues to be unresponsive and tests show the possibility of a "mid brain" stroke. She is to return to Caressant Care in a palliative state.	LTCI00015236
83.	March 23, 2014	Ms. Pickering returns to Caressant Care. Emergency Department references "comfort measures only".	LTCI00015236 LTCI00015446 LTCI00015596
84.	March 23, 2014	Progress Note entered by EW at 22:46 that Ms. Pickering continues to respond to voice and touch by moaning and moving her eyes. EW notes "She appears comfortable".	LTCI00015236
85.	March 23, 2014	Progress Note entered by EW at 17:21 that Dr. Urbantke mentioned that Ms. Pickering's blood sugar was low when she arrived at the hospital so if Ms. Pickering passes "it might be a good idea to call the coroner on this one".	LTCI00015236
86.	March 28, 2014	Progress Note entered by Karen Routledge, RN, at 09:23 that Ms. Pickering had been found with no aspirations or pulse. Notes that as per the recommendation of the Woodstock Hospital Emergency physician, Dr. Urbantke, the coroner on call, Dr. George, was contacted. Dr. George did not feel that this was a coroner's case	LTCI00015236
87.	March 28, 2014	Ms. Pickering passed away at Caressant Care. Medical Certificate of Death is completed by Dr. Reddick. Immediate cause of death identified as CVA (one week) and Alzheimer's and hypertension as significant conditions contributing to her death Resident's Death Form is completed by Dr. Reddick, Karen Routledge and another RN. Online Institutional Death Record is completed by Karen Routledge. Dr. George was the Coroner notified. Mrs. Pickering's death is not recorded on the Death Registry.	LTCI00015236 LTCI00015386 LTCI00015387 LTCI00015388 LTCI00015389 LTCI00071978
88.	March 28, 2014	Cumulative Plan of Care closed.	LTCI00015295

VOLUME 6: MEADOW PARK
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Meadow Park London Long Term Care is a long-term care home located in London, Ontario ("Meadow Park") licensed to Jarlette Health Services. Elizabeth (Bethe) Wettlaufer ("EW") was hired by Meadow Park in April 2014 as a Registered Nurse. She resigned on September 25, 2014, indicating that she had an illness that required long term treatment. The chronology below outlines EW's work history at Meadow Park.

EW has admitted to the 1st Degree Murder of Arpad Horvath, a resident of Meadow Park, in August, 2014.

Mr. Horvath was born on November 14, 1938, in Hungary. He went to Engineering School and served in the armed forces. Mr. Horvath was a POW for a period of time before he managed to escape in 1956 and went to Austria with his sister. Mr. Horvath married and they had two children. Mr. Horvath became a tool and die maker and eventually opened his own business in London, Ontario.

Among other conditions at the time that he entered Meadow Park, Mr. Horvath had diabetes. His diabetes was not being treated with insulin. It was being treated daily with Metformin (an oral hypoglycemic medication) while at Meadow Park.

The chronology sets out Mr. Horvath's history at Meadow Park up to and including his transfer to London Health Sciences Centre (Victoria Hospital), London on August 24, 2014. Mr. Horvath passed away in Victoria Hospital on August 31, 2014.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	April 13, 2013	An application is submitted to the CCAC for determination of Mr. Horvath's eligibility for admission to a long-term care home. At the time, Mr. Horvath was in Victoria Hospital.	LTCI00020656
2.	April 26, 2013	Mr. Horvath is discharged from Victoria Hospital but readmitted that same day.	
3.	May 24, 2013	A behavioural assessment is completed by South West Community Care Access Centre. It is noted that Mr. Horvath is easily agitated and is	

	DATE	EVENT	SOURCE DOC ID
		focused on wanting to get back to work. He is exit seeking.	
4.	June 11, 2013	SWCCAC refers Mr. Horvath to Meadow Park.	LTCI00033195
5.	June 27, 2013	Meadow Park accepts referral to its Secure Unit.	LTCI00020648
6.	August 26, 2013	Dr. Dulay completes a MHLTC Health Assessment for Mr. Horvath, which is transmitted to Meadow Park on August 27, 2013. Dr. Dulay notes that Mr. Horvath is medically stable though he has shown a decline while in hospital due to deconditioning (refusing physiotherapy). Dr. Dulay notes that Mr. Horvath can be resistive to positioning/movement but has had no aggression recently and is co-operative with other aspects of care.	
7.	August 28, 2013	SWCCAC confirms a placement for Mr. Horvath at Meadow Park. It notes that the doctor has advised that Mr. Horvath is reported to be medically stable and ready for discharge from the hospital. It is noted that he has had a slow decline in health related to vascular dementia.	LTCI00020131L TCI00020611
8.	August 29, 2013	Mr. Horvath is discharged from Victoria Hospital to Meadow Park. At the time of his admittance to Meadow Park, Mr. Horvath had been diagnosed with, among other things, vascular dementia and Diabetes Mellitus Type 2. It was noted that upon his discharge from Victoria Hospital his diabetes was under fair control. Mr. Horvath was receiving Metformin 1,000 mg oral 2 times a day for his diabetes. The documents indicate that, on multiple occasions, Mr. Horvath displayed aggressive behaviour and at times refused his medications. Given the high incidence of such behaviours, they have not been individualized in this Chronology until August, 2014, the month that he was murdered.	LTCI00020234 LTCI00020153 LTCI00020194 LTCI00020197
9.	November 19, 2013	Medication Regimen Review by Tanya Adams, Consultant Pharmacist identifies that Mr. Horvath's "diabetes appears to be stable".	LTCI00033170
10.	November 21, 2013	The physician visits with Mr. Horvath and notes that he has been more lethargic in last 2 days.	LTCI00020199

	DATE	EVENT	SOURCE DOC ID
11.	November 25, 2013	Mr. Horvath is transferred to Victoria Hospital for assessment, admitted November 26, 2013. Chest x-ray showed lower left lobe pneumonia.	LTCI00020179 LTCI00020269
12.	November 29, 2013	Upon discharge from Victoria Hospital, Mr. Horvath's diabetes' medication is changed from Insulin aspart (NovoRapid) injection as directed by subcutaneous sliding scale [which he was receiving in Victoria Hospital] to MetFormin 1000mg oral 2 times a day.	LTCI00020177 LTCI00020265
13.	December 29, 2013	A Risk Occurrence Report Form is completed by C. Pizzarro, indicating that a resident was given another resident's insulin. It is noted that Dr. Payne is notified and inquired as to what happened. The response is that insulin "is not labelled at all". Noted that all Insulin was then properly labelled.	LTCI00017727
14.	February 20, 2014	Medication Regimen Review by Tanya Adams, Consultant Pharmacist identifies that Mr. Horvath's diabetes appears to be stable. She notes: *Arpad's diabetes appears to be stable with a HbA1c of 0.075. Since he also has CKD, could his dose of metformin be decreased to 500mg bid? All other dosages are appropriate for renal function.*	LTCI00033169
15.	February 27, 2014	Physician orders Glucose Strips STR "Test Blood Sugars 3 times a week at alternate times".	LTCI00020169 LTCI00020837
16.	March, 2014	Mr. Horvath's Blood Sugar summary for March, 2014 is noted in his Medication Administration Record, as well as in a Weights and Vitals Summary printed on October 24, 2016.	LTCI00017883L TCI00020325
17.	April 13, 2014	EW applies for Employment at Meadow Park. EW acknowledges that she was dismissed from Caressant Care. EW provides the following references: • Karen Routledge • Jenn Hague • Sandra Fluttert • David Petkau	LTCI00017511 LTCI00017513 LTCI00017521
18.	April 14, 2014	EW is interviewed for employment by Heather Nicholas, Director of Care ("Nicholas"). Form indicates that EW is accepted for employment starting April 15, 2014.	LTCI00017511
19.	Undated	Handwritten notes are taken for what appears to be EW's interview. The Notes identify that at Caressant Care "Put wrong insulin mistake got	LTCI00017519

	DATE	EVENT	SOURCE DOC ID
		noticed".	
20.	Undated	Employee File Checklist completed for EW – noted still needs vulnerable sector police reference check.	LTCI00017515 LTCI00017530
21.	April 21, 2014	Reference check completed by Nicholas. She contacts David Petkau of Christian Horizons. Noted that Mr. Petkau indicates that he would rehire EW, that EW was very positive and very dedicated.	LTCI00017516
22.	April 21, 2014	Reference check completed done by Nicholas. She contacts Sandra Fluttert, an RN at Caressant Care. Noted that Ms. Fluttert indicates that EW is a good worker, very good with residents, slow at some tasks. Identifies circumstances around EW leaving Caressant Care as "Personality conflict both sides with manager, other involved in med error not just her".	LTCI00017516
23.	April 21, 2014	Reference check completed by Nicholas. She contacts Jennifer Hague RN at Caressant Care. Noted that Ms. Hague indicates that EW was good with residents, very conscientious. Identifies circumstances around EW leaving as "Med error, I wasn't in on it. Multiple people were involved couple med errors".	LTCI00017516
24.	April 21, 2014	CNO "Find a Nurse" search completed re EW – identifies that she is entitled to practice with no restrictions.	LTCI00017528
25.	April 22, 2014	Physician changes orders for Mr. Horvath regarding his Risperidone.	LTCI00020169
26.	April 22, 2014	Police record check on EW completed. It does not identify any criminal record based on name and date of birth. Clearance is for employment with vulnerable sector.	LTCI00017523
27.	April 22, 2014	Orientation day one for EW at Meadow Park. Signs off, among other things, having received a copy of Resident's Bill of Rights and Confidentiality Agreement. EW also signs the Staff Acknowledgment of Meadow Park's Zero Tolerance Policy for Resident Abuse and Neglect.	LTCI00017564 LTCI00017532 LTCI00017534 LTCI00017535
28.	April 22, 2014	EW signs "Medication Chapter Test Yourself".	LTCI00017562
29.	April 23, 2014	Orientation day two for EW at Meadow Park. Among other things, she takes a Workplace Violence and Harassment Worker test and receives orientation on Dementia Care, including Responsive Behaviours.	LTCI00017549 LTCI00017546 LTCI00017550 LTCI00017555 LTCI00017548

	DATE	EVENT	SOURCE DOC ID
30.	April 24, 2014	Physician changes Mr. Horvath's Risperidone.	LTCI00020169
31.	April 24, 2014	A Risk Occurrence Report Form is completed in relation to a missing narcotic during drug destruction. Tanya Adams, Consultant Pharmacist, and an RN identified a missing card of hydromorphone 2 mg x 11 tabs. The "narcotic count sheet was present and signed x2 but no [illegible]." The RPN was called.	LTCI00017732
32.	February 1, 2014 – April 30, 2014	A Three Month Medication Review for Mr. Horvath is completed.	LTCI00020171
33.	May 14, 2014	Staff member adds to form "Reported Concerns to Physician" identifying that Mr. Horvath's sugars are consistently high at lunch.	LTCI00020157
34.	May 22, 2014	Medication Regimen Review by Tanya Adams, Consultant Pharmacist indicates that Mr. Horvath's blood glucose readings have been higher with some readings running in the 20's and also as high as 30.2. Ms. Adams identifies that Risperidone may be contributing to elevated glucose readings and asks whether increasing Mr. Horvath's dose of mirtazapine or increasing the dosing frequency of trazodone could be considered in place of Risperidone.	LTCI00033171
35.	May 26, 2014	Staff member adds to form "Reported Concerns to Physician"; identifying that Mr. Horvath's sugars are consistently high at lunch.	LTCI00020157
36.	May 27, 2014	Physician notes to increase Mr. Horvath's Metformin to 1000 mg BID.	LTCI00020164
37.	May 29, 2014	Physician stops Risperidone.	LTCI00020164
38.	June 11, 2014	EW provides Meadow Park with a reference Letter from Caressant Care signed by Wanda Sanginesi, VP Human Resources. It identifies that EW left "to pursue other opportunities" and that Caressant Care is "pleased to provide her with this reference".	LTCI00017569
39.	June 11, 2014	Staff member adds to form "Reported Concerns to Physician" identifying that Mr. Horvath struck a PSW with a closed fist in the arm during care.	LTCI00020157
40.	June 13, 2014 – June 17, 2014	A Pieces Assessment is completed for Mr. Horvath by Jennifer Stewart-Paff BSO Manager, RPN. It indicates, among other things, that Mr. Horvath is at risk for harming staff due to his unpredictable nature. He is stated to be at times resistive and aggressive and other times he is not.	LTCI00020380

	DATE	EVENT	SOURCE DOC ID
		The care approach that best serve his need are identified as "Resident would likely be better suited with a care approach by staff where tasks/activities were explained to him prior to beginning to ensure resident is not startled and resident is prepared for the task". The information is to be shared with behaviour management team that meets monthly and to be shared through the care plan and kardex for PSWs. Tasks to be updated on the POC as needed.	
41.	June 20, 2014	EW types a note indicating that she mediated a conversation between two PSW's that day.	LTCI00017574
42.	June 2014	An assessment of Mr. Horvath indicates that he is exhibiting the following behaviours: • Hitting (including self) – Once or twice a day • Kicking – Once or twice a week • Grabbing on to people – never • Hurt self or others – less than once a week • Making physical sexual advances – less than once a week • General restlessness – less than once a week • Making verbal sexual advances – less than once a week • Cursing or verbal aggression: once or twice a week • Negativism – less than once a week	LTCI00020527
43.	June, 2014	Mr. Horvath's Blood Sugar summary for June, 2014 is noted in his Medication Administration Record as well as in a Weights and Vitals Summary printed on October 24, 2016.	LTCI00020854L TCI00020325
44.	July 18, 2014	A Nutritional Risk Assessment is completed for Mr. Horvath – indicates that he has uncontrolled Diabetes Mellitus, and that while his CBC has improved, his A1c has deteriorated, his BGs are elevated overall and he is maxed out on metformin – referred to MD.	LTCI00020378
45.	July 23, 2014	Staff member fills out form "Reported Concerns to Physician" identifying a concern that Mr. Horvath is "Physically aggressive, hitting staff, punching staff chest, cognitive declining".' Also noted on form "Dr. aware"	LTCI00020157
46.	July 24, 2014	A Risk Occurrence Report Form is completed in relation to a missing 1mg	LTCI00017786

	DATE	EVENT	SOURCE DOC ID
		of Ativan.	
47.	July 26, 2014	Meadow Park files a Critical Incident Report [CIR #2643-000011-14] regarding an incident on July 25, 2014 between Mr. Horvath and a staff member. It is noted that on July 25, 2014 Mr. Horvath was having many behavioural issues that were discussed at a nursing huddle. When two PSWs entered his room to provide care, Mr. Horvath hit one staff member in the arm, who then slapped Mr. Horvath on the right arm. It is reported that Mr. Horvath then proceeded to spit at the staff member who spit back at him. The Charge Nurse was notified and the staff member sent home pending investigation. The police were also contacted.	LTCI00019476
48.	July 26, 2014	Staff member adds to form "Reported Concerns to Physician" identifying a concern that the staff member spoke with the doctor regarding Mr. Horvath's behaviour and that the doctor was to see Mr. Horvath on Tuesday.	LTCI00020157
49.	July, 2014	Mr. Horvath's Blood Sugar summary for July, 2014 is noted in his Medication Administration Record as well as in a Weights and Vitals Summary printed on October 24, 2016.	LTCI00020869L TCI00020325
50.	May, 2014 – July, 2014	A Three Month Medication Review is completed for Mr. Horvath.	LTCI00020166
51.	August 2, 2014	Progress Note entered by Gabrielle Gogas, RN, at 08:30 indicates that Mr. Horvath was aggressive and combative that morning.	LTCI00020697
52.	August 4, 2014	Progress Note entered by Marija Ivanoski, RPN, at 14:04 indicates that Mr. Horvath became aggressive that morning as a result of his razor being too dull and pulling on his hair.	LTCI00020697
53.			
54.	August 5, 2014	Progress Note entered by Cassidy Pizarro, RPN, at 13:44 indicates that Mr. Horvath was resistive to care.	LTCI00020697
55.	August 5, 2014	Progress Note entered by EW at 22:33 indicates that Mr. Horvath was accepting of care with no aggression.	LTCI00020697
56.	August 6, 2014	Progress Note entered by Marija Ivanoski, RPN, at 13:48 indicates that Mr. Horvath was resistive to care, swinging fists.	LTCI00020697
57.	August 6,	Progress Note entered by EW indicates that Mr. Horvath attempted to	LTCI00020697

	DATE	EVENT	SOURCE DOC ID
	2014	strike staff during care.	
58.	August 8, 2014	EW is notified that her attendance is on the threshold parameters of Meadow Park's Attendance Awareness Program of more than 2 days in one month or 3 months with one occurrence in each month. EW is encouraged to take the required steps to maintain regular attendance for scheduled work.	LTCI00017577
59.	August 9, 2014	Progress Note entered by Gabrielle Gogas, RN, at 06:12 indicates that Mr. Horvath was aggressive towards a PSW.	LTCI00020697
60.	August 9, 2014	Progress Note entered by EW indicates no aggressive behaviours by Mr. Horvath that shift.	LTCI00020697
61.	August 10, 2014	Progress Note entered by John Anderson, RPN, at 14:13 indicates that Mr. Horvath was aggressive, kicking, punching and biting at PSW.	LTCI00020697
62.	August 10, 2014	Progress Note entered by John Anderson, RPN, at 14:15 indicates Mr. Horvath became aggressive, kicking, hitting and biting. Mr. Anderson notes that Mr. Horvath has been known to refuse medications frequently and that a discussion with the doctor has taken place and Mr. Horvath is to have a geriatric consult.	LTCI00020697
63.	August 10, 2014	Progress Note entered by EW at 17:25 indicates that Mr. Horvath swung his fists and kicked his feet at PSWs and remained aggressive when reapproached.	LTCI00020697
64.	August 10, 2014	Progress Note entered by EW at 17:27 indicates that when she went to give Mr. Horvath his pills at 16:45 she found that the draw string from his pants was wrapped around the bedrail three times and tied in a tight knot. Mr. Horvath was unable to turn on his left side. She states that she checked Mr. Horvath for injuries and noted none. Progress Notes indicate that she notified the manager on call re this unusual occurrence.	LTCI00020697
65.	August 11, 2014	Progress Note entered by Jennifer Stewart-Paff, BSO Manager, RPN at 12:49 indicates that PSWs reported that Mr. Horvath was aggressive. Staff to monitor and document behaviours.	LTCI00020697
66.	August 11, 2014	Progress Note entered by Jennifer Stewart-Paff, VSO Manager, RPN, at 13:09 indicates that PSW reported that Mr. Horvath grabbed her hand and attempted to twist her fingers.	LTCI00020697

	DATE	EVENT	SOURCE DOC ID
67.	August 12, 2014	Progress Note entered by Felina Cabrera, RN, at 02:43 indicates that Mr. Horvath swung his arm and attempted to hit a PSW.	LTCI00020697
68.	August 12, 2014	A Pain Assessment is completed which indicates that Mr. Horvath has exhibited resistiveness to care, restlessness, fluctuation in mental functioning, aggressiveness/physical or verbally abusive. The conclusion is that Mr. Horvath's behaviours do not appear to be related to pain at that time.	LTCI00020370
69.	August 12, 2014	Meadow Park amends CIR # 2643-000011-14 indicating that the employee was terminated on August 5, 2014 and that Education is planned to continue to ensure compliance with the Home's policy and Ministry standards.	LTCI00019476
70.	August 13, 2014	Progress Note entered by EW at 21:56 indicates that there was no behaviour that shift and that PSW staff note that Mr. Horvath's behaviour is less aggressive if one staff does his care.	LTCI00020697
71.	August 14, 2014	Progress Note entered by Cassidy Pizarro, RPN, at 13:03 indicates that Mr. Horvath hit out and started shaking the lift.	LTCI00020697
72.	August 14, 2014	The physician sees Mr. Horvath. It is noted: *Behaviours have been difficult for staff – usually around personal care and contact.* *When he came he was on a regular BID risperidone which was slowly withdrawn in May.* *Will restart small dose In AM of risperidone 0.25 mg*	LTCI00020199
73.	August 14, 2014	Progress Note entered by Nicole Bailie, RPN, at 21:49 indicates that Mr. Horvath was aggressive during care, attempted to hit and kick a HCA and was verbally abusive.	LTCI00020697
74.	August 15, 2014	Progress Note entered by Felina Cabrera, RN, at 06:02 indicates that Mr. Horvath's care was done by 2 PSWs due to his being resistive, verbally abusive and attempting to hit them despite explanation and encouragement.	LTCI00020697
75.	August 15, 2014	Progress Note entered by EW at 22:41 that there was no aggressive behaviour during her shift.	LTCI00020697

	DATE	EVENT	SOURCE DOC ID
76.	August 16, 2014	Progress Note entered by Ameena Mujeebur rahaman, RN, at 13:47 indicates that Mr. Horvath refused his lunch pills, tried to smack her and then hit a PSW when she tried to feed him.	LTCI00020697
77.	August 17, 2014	Progress Note entered by Linda Smith, RN, at 11:44 indicates that Mr. Horvath had kicked another resident in the dining room. In addition, when a PSW went to lift up his leg to put it on his wheelchair, Mr. Horvath started swearing and told the PSW to "get the fuck out of my face".	LTCI00020697
78.	August 17, 2014	Progress Note entered by Nicole Bailie, RPN at 12:55 indicates that a HCA reported that Mr. Horvath was agitated in the dining room at lunch, throwing cutlery and kicking and hitting staff.	LTCI00020697
79.	August 17, 2014	Progress Note entered by Nicole Bailie, RPN at 13:13 indicates that a HCA reported that when doing care on Mr. Horvath, Mr. Horvath became agitated in the middle of care and kicked the HCA in the head. HCA filled out a risk report.	LTCI00020697
80.	August 17, 2014	Staff member adds to form "Reported Concerns to Physician" identifying a concern that Mr. Horvath has "Increased aggression, throwing cutlery, hitting and kicking staff. Possible PRN?" Also noted that "MD informed 0 n/o a new trial see pce for details	LTCI00020157
81.	August 18, 2014	Progress Note entered by Nicole Bailie, RPN, at 09:45 indicates that Mr. Horvath refused his medication twice that morning.	LTCI00020697
82.	August 19, 2014	Medication Regimen Review by Tanya Adams, Consultant Pharmacist. She notes *Art's blood glucose readings have been higher with some readings running in the 20's. His most recent HbAIC was 0.107. Sitagliptin 50mg once daily could be considered, based on his CrCI.* *Art continues to have aggressive behaviours toward staff and sometimes fellow residents. Risperidone 0.25mg am was recently restarted. If behaviours do not improve with this dose and with non-pharmacological interventions, an increase to risperidone 0.25 mg bid could be considered.*	LTCI00033168
83.	August 19, 2014	Progress Note entered by Cassidy Pizarro, RPN at 10:18 indicates that during a.m. care Mr. Horvath punched, kicked and grabbed D.B.F. wrist and twisted it, banging the bed rails and exhibiting other aggressive behaviours.	LTCI00020697

	DATE	EVENT	SOURCE DOC ID
84.	August 19, 2014	Progress Note entered by Vanna Sreyna Sok, RN at 14:30 indicates that a review and discussion was held with the BSO team to try to find solutions and interventions to help manage Mr. Horvath's recent aggression. It is noted that he is often refusing his medications, including his psychotropic medications that may help to improve and reduce behavioural outbursts. A trial strategy is to be put in place.	LTCI00020697
85.	August 19, 2014	Progress Note entered by Cassidy Pizarro, RPN at 14:36 indicates that BSO staff have started an ABC chart that has been placed on the PSW clipboard.	LTCI00020697
86.	August 19, 2014	Progress Note entered by EW at 22:11 indicates that Mr. Horvath was calm and cooperative with his care. She notes that the PSWs had indicated that Mr. Horvath is calmer if just one staff does all of the talking.	LTCI00020697
87.	August 20, 2014	Progress Note entered by MaryAnn Flynn, RN, at 06:05 indicates that Mr. Horvath tried to strike out at her that morning. Calm again when she left him alone.	LTCI00020697
88.	August 20, 2014	Progress Note entered by EW at 22:26 that Mr. Horvath struck out at PSWs during his care.	LTCI00020697
89.	August 21, 2014	Physician signs off on Three Month Review of medication for Mr. Horvath.	LTCI00020161
90.	August 21, 2014	Progress Note entered by Cassidy Pizarro, RPN at 13:13 indicates that Mr. Horvath starting hitting and kicking the staff that morning and punched D.B.F. in the right breast``.	LTCI00020697
91.	August 21, 2014	Progress Note entered by Cassidy Pizarro, RPN at 13:15 indicates that Mr. Horvath refused to be put back to bed after lunch and refused to have any care.	LTCI00020697
92.	August 21, 2014	EW's Progress Note at 22:04 indicates that Mr. Horvath hit and kicked staff during his care, in spite of re-approach.	LTCI00020697
93.	August 23, 2014	EW's Progress Note at 22:53 indicates that "Resident was yelling, spitting and swinging his fists when approached for his care at 19:30. He was reapproached at 20:00 and was swearing and kicking. He was reapproached at 20:50 and was calm. His care was done and resident was put to bed".	LTCI00020697

	DATE	EVENT	SOURCE DOC ID
94.	August 23, 2014	EW admits that at approximately 20:00 she attended Mr. Horvath's room and injected him with 80 units of short-acting insulin and 60 units of long-acting insulin.	LTCI00057683
95.	August 24, 2014	Felina Cabrera's Progress note at 06:21 indicates that a PSW found Mr. Horvath unresponsive. Upon assessment, he had no response to any sternal rub and was cold, diaphoretic and clammy. Vitals taken. Blood sugar noted to be 3.1 and glucagon given.	LTCI00020697
96.	August 24, 2014	Mr. Horvath is transferred to Victoria Hospital.	LTCI00020697
97.	August 24, 2014	Progress note by EW at 15:38 that she has called the hospital for an update on Mr. Horvath's condition. Notes that she spoke with an RN and was told that he had been admitted to the critical care unit with his admitting diagnosis as "decreased level of consciousness". She notes that Mr. Horvath was responding minimally to pain but otherwise he was non-responsive.	LTCI00020697
98.	August 25, 2014	Staff member adds to form "Reported Concerns to Physician" regarding Mr. Horvath, stating "1. Pls obtain an order for transfer to hospital (Sent on Aug 24/14) and 2. Pls obtain an order for Glucagon".	LTCI00020157
99.	August 25, 2014	The physician makes the following Order: T/O Dr. Payne/Vanna Sok (RN) Send to hospital for assessment. Glucagon 1mg/vial x 1 dose Stat on Aug 24/14	LTCI00020160
100.	August 25, 2014	Progress note by EW at 15:39 that she has spoken with an RN at the hospital who indicated that Mr. Horvath tested positive for MRSA. He is in the critical care unit and occasionally opens his eyes to stimuli but remains minimally responsive otherwise.	LTCI00020697
101.	August 27, 2014	Progress note by EW at 23:11 that she has spoken with an RN at the hospital who indicated that Mr. Horvath was unresponsive to voice and touch and had had 4 seizures that day. EW notes that an MRI was conducted which showed a massive brain bleed.	LTCI00020697
102.	August 31, 2014	Mr. Horvath dies in Victoria Hospital. EW notes his death in a Progress Note.	LTCI00020697L TCI00020126

	DATE	EVENT	SOURCE DOC ID
103.	August 31, 2014	Progress note by EW at 18:40 that she has spoken with Mr. Horvath's daughter-in-law who called to inform Meadow Park that Mr. Horvath had passed away that day. EW notes that condolences were passed on to the family.	LTCI00020697
104.	August 2014	Mr. Horvath's Blood Sugar summary for August is noted in his Medication Administration Record and also in a Weights and Vitals Summary printed on October 24, 2016 as follows: August 23, 2014 - 16:54 - 5.8 August 18, 2014 - 08:12 - 10.9 August 11, 2014 - 08:07 - 12.8 August 9, 2014 - 20:02 - 9.2 August 6, 2014 - 11:16 - 17.6 August 4, 2014 - 07:55 - 9.6 August 2, 2014 - 17:13 - 15.1	LTCI00020878L TCI00020325
105.	September 1, 2014	Death Checklist completed for Mr. Horvath.	LTCI00020121
106.	Undated	EW makes a handwritten request for a change in her upcoming stat day.	LTCI00017573
107.	September 2, 2014	Nicholas emails "Christina" stating that EW had advised that she had hand-delivered her request for a suggested change in her stat day to Christina on August 25, 2014. Nicholas indicates that she has advised EW that in the future she is to use the proper forms and obtain approval from Nicholas. Nicolas has approved the requested change in stat day.	LTCI00033247
108.	September 2, 2014	Cumulative Plan of Care closed.	LTCI00033126
109.	July 13, 2014 – September 7, 2014	Time Schedules for RNs and Casual RNs identifying EW shifts.	LTCI00033072 LTCI00033073 LTCI00033083 LTCI00033084
110.	September 16, 2014	Note from RN Felina Cabrera to EW, copy provided to Nicholas, outlining issues and things she has observed, including: 1*) Please do not make it a habit of not counting meds before you leave. It*	LTCI00017584 LTCI00017585

	DATE	EVENT	SOURCE DOC ID
		is not safe and proper putting your signature, trusting me and let me do the counting alone. I was just waiting for you to finish charting so I did Lambton first and waited for you to call me and count meds with you but you were already gone by the time I came back to Kent. This is not the first time or second time that this has happened. *2) Please tidy your mess at the nurse's station and med room before you leave. It is not fair for me to clean up after you. I have to always throw overflowing garbage after your shift, sometimes even contaminated dressings are left in the garbage bin on the side of the treatment cart.* *3) Tonight, I was left with eight charts, not only needing second checks but some have to be completely processed.*	
111.	September 25, 2014	EW signs an "Offence Declaration" declaring that she has no convictions under the Criminal Code.	LTCI00017522
112.	September 25, 2014	EW resigns from Meadow Park indicating that she has an illness which will require long term treatment. EW states "I will be unable to work during this treatment and also unable to work as an RN following treatment". EW indicates that her resignation will be effective October 15, 2014.	LTCI00017578
113.	September 26, 2014	EW's last day of work at Meadow Park. An Employee Termination Checklist indicates that her final pay is for October 4, 2014.	LTCI00017580 LTCI00017581
114.	October 1, 2014	EW's physician signs a note that she is off work until further notice.	LTCI00017579
115.	October 2, 2014	Meadow Park files a Critical Incident Report [CIR #2643-000013-14] regarding missing narcotic medication – Hydromorphone 1mg card was ordered for resident on September 26, 2014. Shipping Reports, Delivery Driver report and Drug record book confirm that medication ordered September 26, 2014 and delivered September 26, 2014. Driver's log book confirmed that RPN S.B. received 3 white bags of narcotics and 1 brown bag of regular medication. All medications delivered, received, signed and accounted for but the Hydromorphone. Police contacted. An investigation is completed by Meadow Park into the incident. An investigation is completed by the London Police Service into the incident.	LTCI00017595 LTCI00072011 LTCI00072547
116.	October 7, 2014	An RN notes that when a driver from Classic Care Pharmacy was delivering medication the previous evening he asked "how is she?" to which the RN	LTCI00017576

	DATE	EVENT	SOURCE DOC ID
		stated "what, I don't know what you're talking about". Writer goes on to describe incident as follows: *He said "she overdosed, that's what I heard". I had no idea what he meant. He said "you know, last week..I've been in this business a long time and it's nothing new for an RN who is an addict to steal narcotics from a nursing home. It happens all the time." I said that I didn't know anything about that. He acted like I should know what he meant saying "oh, come on".*	
117.	Undated	Typed written notes, not dated, not signed, regarding "Dottie" asking how "Beth" was because "the Classic Care Driver asked when delivering meds last evening how the nurse was that had overdosed. Noted that "staff had assumed it was Beth as her absence???". Writer notes a number of steps taken that night in regard to this report: *I expressed to Dottie (RN) that Beth was fine but stated that I was not confirming anything about any over dose, and asked that there be no further conversation about any questions. And I left the building (needed to think how I was going to handle).* *When I arrived home I called Tanya as I was concerned about why the driver would have known about this nor had the right to discuss with our staff. I had to attend an appointment around the time having discussion with Tanya, as did she so we decided to reconvene our discussion later this evening.* *I received a call from the facility at approximately 1920, Dottie stating that Rudy from Classic Care had called and requested to speak with me. She gave me his phone number.* *I then also spoke with Arlene and asked that she share with me the comments that had been made by the driver from classic care the night before. She stated that when he came in there conversation lead to him asking about how the nurse was that overdosed. When Arlene responded that she didn't know what he was talking about, he replied by saying something like "I have been in this industry a long time and it is not unheard that an RN take narcotics". I asked Arlene to write down the discussion on paper, place in a sealed envelope and place under my door. I also requested that the conversation not be shared with anyone else.* *I then called Rudy back around 2015 and had discussion. Rudy felt that the conversation that Horse (CC driver) had was out of concern for the nurse and meant no harm. I expressed my concerns*	LTCI00017575

	DATE	EVENT	SOURCE DOC ID
		that staff were not aware of the issue with the overdose as it was personal and confidential to the staff member despite its relevance to the case of missing narcotics. He stated that Peter, Griese and Jennifer Brown had also been contacted thru the evening. Rudy stated he had spoke to Horse as well and they would be discussing this concern internally tomorrow as well. *I then called Jenn Brown to explain the reason for the initial call so she was aware of the chain of events transpiring. She was reassured that James Abraham was aware of the occurrence and investigation. She was also reassured that the CIS had been completed by Heather and Melanie on Thursday evening (day of findings) and police involvement. She was also informed that the investigating officer had phone my cell late day today requesting that I return his call tomorrow to touch base as to the progression and status of the investigation.* *I then called Heather and informed of the series of events this evening. Heather had stated on the phone that Dottie had spoke to earlier about the missing card but did not at that time mention that she was aware of the nurse overdosing comments from the delivery employee.* Writer notes that her comments can be copied and pasted into a report if it is required by head office.	
118.	October 17, 2014	Meadow Park amends CIR #2643-000013-14 indicating that the police are still investigating and the medication had not yet been found.	LTCI00017595
119.	August, 2014 – October, 2014	A Three Month Medication Review is completed for Mr. Horvath.	LTCI00020161
120.	November 6, 2014	Email from Jennifer Brown, RN, Care Services Coordinator, Jarlette Health Services to Nicholas stating that she needed more detail about the missing narcotic that they had in October as she needed to report about it.	LTCI00017598
121.	November 6, 2014	Email from Nicholas to Jennifer Brown indicating that she had completed a CIS report about the missing narcotic and that the MHLTC had been in that week as a follow-up to the CIS report and were impressed with how they had handled the situation. Nicholas reports that there were no findings and that they "had done everything right".	LTCI00017598

	DATE	EVENT	SOURCE DOC ID
122.	November 6, 2014	Jennifer Brown writes to Nicholas that she does not need a long explanation, just what was missing, was it found and if there was any finding regarding the staff member that was involved.	LTCI00017598
123.	November 7, 2014	Nicholas writes to Jennifer Brown regarding the missing narcotic. She states: *Hi Jennifer it was Hydro morphine ½ tabs 0.5 mg 15 tablets in one card. It was discovered missing when an RPN was reordering the medication for a resident in Kent Wing.* *The pharmacist called back and said they had already processed the order and it was delivered on a Friday evening September 26 2014. October 02 2014 is when we discovered the medication missing. Investigation was started right away an audit was completed by Tanya our pharmacist on October 02 2014. The missing medication was tracked from processing of the medication from the Pharmacy to deliver to the home on September 26 2014.* *A physical check was done even checking other med carts to see if it was accidentally placed in the wrong med cart. The medication was never found. We checked who received and signed for the medication. We investigated where the medications were taken.* *The medication in question was delivered by an RN to the nursing station on Kent wing to the RN on Kent that was working the evening shift.* *The medication was never entered in as being received by the RN who is now in question.* *I called the police and started an investigation. Rob, Melanie, Tanya and myself met with the police who are still investigating the case no arrest have been made.* *The RN in question interestingly had come to me on September 30, 2014 to me that she had a terrible weekend and had been in hospital with an overdose and that she had a alcohol and drug addiction. I did convey that to the police.* *The RN had resigned from here and her planned last day of work was October 15, 2014 but she was never back in the home working since the evening in question.* *CIS report was completed right away and was submitted.* *The Ministry was in this past week and we had no findings.*	LTCI00017626

	DATE	EVENT	SOURCE DOC ID
		No other medication has been missed since that event. The RN was a recently new hire just completed 3 months employment with us but she had worked in Long term care for 10 years at a facility in Woodstock. *I hope this helps. Have a great weekend.* Someone has added in handwriting "Elizabeth" and "Elizabeth – handed in resignation September 25, 2016 – last shift worked was Sept. 26, 2016"	
124.	November 12, 2014	Summary of Incomplete Tasks by EW – includes failing to sign off on Code of Conduct – outstanding since July 4, 2014	LTCI00017563
125.	February 6, 2015	Meadow Park is advised by the Employment Insurance Commission that it has approved the reason for separation of EW. Letter states "We consider that they voluntarily left their employment with just cause because they had no reasonable alternative in the circumstances"	LTCI00017583
126.	October 5, 2016	Meadow Park files a Critical Incident Report [CIR #2643-000027-16] indicating that two police officers had attended the home and advised that they were currently investigating a Registered Staff member for abuse of a resident.	LTCI00017588
127.	October 7, 2016	Meadow Park Amends CIR #2643-000027-16 to indicate that the police will advise family members.	LTCI00017588
128.	December 5, 2016	Meadow Park receives a letter from the College of Nurses of Ontario identifying that an investigation has commenced pursuant to Section 75(a) of the Health Professions Procedural Code of the *Nursing Act, 1991.*	LTCI00033058 LTCI00033059

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RELEVANT STANDARDS, GUIDELINES, POLICIES AND PROCEDURES

NO.	DOCUMENT	SOURCE DOC ID
A. Rights of Residents		
1.	Resident Information Package	LTCI00023670
2.	Admission of Residents – Information for Residents Policy. Eff. 09/16/13. Version 1	LTCI00023696
3.	Residents Bill of Rights. Eff. 07/21/15. Version 1	LTCI00024128
4.	Philosophy of Health and Wellness. Eff. 10/16/13	LTCI00024022
B. Staffing and Administration		
5.	Nursing and Personal Support Services – Staffing Plan. Eff. 2015/05/01	LTCI00018537
6.	General Management - On-Call. Eff. 09/16/13.	LTCI00024007
7.	Hiring the Jarlette Way	LTCI00072015
8.	Criminal Record Check Policy (Vulnerable Sector Screening) Eff. 10/01/04. Rev. Oct. 2012	LTCI00017551
9.	Monitoring of Residents. Eff. 09/16/13	LTCI00022162
10.	Daily Walk-thru Nursing Manager Template	LTCI00022187
C. Training and Education		
11.	Silverfox Policy and Procedures (PowerPoint). Undated.	LTCI00022378
12.	Silverfox Policy and Procedures (PowerPoint.) Undated.	LTCI00022505
13.	Silverfox Medication Management System Assessment. Undated	LTCI00022496
14.	Silverfox Pharmacy Training Agenda. Undated.	LTCI00022494
15.	Silver Fox Pharmacy Training Agenda and Presentation (2017)	LTCI00072017
16.	Classic Care Pharmacy – Managing Behaviours in Long Term Care, March 19, 2014.	LTCI00022821
17.	Relias Learning – Depression (2016)	LTCI00022794
18.	Relias Learning – Abuse and Neglect. (2016)	LTCI00022476
19.	Relias Learning – Abuse and Neglect. (2016)	LTCI00022632
20.	Relias Learning – Workplace Violence (2016)	LTCI00022658
21.	Relias Learning – Communication in Dementia	LTCI00022616

NO.	DOCUMENT	SOURCE DOC ID
22.	Relias – Jarlette Health Services - Abuse Prevention Quiz. Sept. 11/17	LTCI00022472
23.	Promoting Awareness – Healthy Work Environments – Module 5 (PowerPoint – Government of Canada). Undated.	LTCI00022770
24.	Promoting Awareness – Understanding Elder Abuse – Module 1 (PowerPoint – Government of Canada) (undated.)	LTCI00022672
25.	January 2014 Specific Educational Plan	LTCI00022807
26.	Managing Concerns and Complaints – Whose job is it anyway?	LTCI00022809
27.	February 2014 Requirements for Education	LTCI00022817
28.	Mandatory Education Requirements for March 2014 – Abuse Prevention Focus	LTCI00022819
29.	December Mandatory Education 2014 – Mental Health and Wellness	LTCI00022852
30.	February 2015 Requirements for Education	LTCI00022628
31.	Mandatory Education Requirements for March 2015 – Relias Transition – Abuse Prevention Focus	LTCI00022630
32.	Mandatory Education Plan for April 2015	LTCI00022644
33.	Preventing and Addressing Abuse of Older Adults: Long-Term Care Videos Discussion Guide (Registered Nurses' Association of Ontario, April 2015)	LTCI00022338
34.	Annual Education June 2015	LTCI00022669
35.	2015 July Mandatory Education	LTCI00022702
36.	Promoting Awareness – Recognizing Elder Abuse – Module 2 (PowerPoint – Government of Canada) (undated)	LTCI00022704
37.	Mandatory Education for August 2015	LTCI00022722
38.	Promoting Awareness – Learning the Law – Module 3 (PowerPoint – Government of Canada) Undated.	LTCI00022724
39.	Promoting Awareness – Intervention and Strategies – Module 4 (PowerPoint – Government of Canada) (undated)	LTCI00022745
40.	September 2015 – Mandatory Education Pain Management, End of Life Care, WHIMIS	LTCI00022743
41.	Mandatory Education Plan for November 2015	LTCI00022768
42.	December Mandatory Education 2015 – Mental Health and Wellness	LTCI00022792
43.	January 2016 Specific Educational Plan	LTCI00022468
44.	Mandatory Education Requirements for March 2016: Abuse Prevention Focus	LTCI00022470
45.	April 2016 ED Plan Workplace Violence and Responsive Behaviour Management	LTCI00022608
46.	Jarlette Health Services Education Days – June 2016	LTCI00022610
47.	December Mandatory Education 2016 – Mental Health and Wellness	LTCI00022614
48.	January 2017 Educational Plan	LTCI00022334
49.	February 2017 Requirements for Education (January 25, 2017)	LTCI00022332

NO.	DOCUMENT	SOURCE DOC ID
50.	Mandatory Education Requirements for March 2017: Abuse Prevention Focus	LTCI00022336
51.	April 2017 Workplace Violence and Responsive Behaviour Management (March 27, 2017)	LTCI00022375
52.	Shifting Focus: a guide to understanding dementia behaviour. Undated.	LTCI00022646
53.	Responsive Behaviours in LTC. Aggression in the Elderly. Brochure with handwritten notes.	LTCI00018223
54.	Practice Standard: Decisions About Procedures and Authority. College of Nurses of Ontario.	LTCI00023862
D. Nursing and Medical Services		
55.	Medical – Medical Director. Eff. 09/16/13.	LTCI00024005
56.	Medical – Attending Physician. Eff. 09/16/13	LTCI00024000
57.	Medical – Emergency Physician Coverage. Eff. 09/16/13.	LTCI00024003
E. Medication Management		
58.	Medication Management System Competency Assessment, August 2014.	LTCI00022847
59.	Medication Management – Education. Eff. 08/01/12. Rev. Oct. 7/13.	LTCI00018341
60.	Medication Management – Medication Administration Record – Checking Of. Eff. 05/01/07. Rev. Oct 7/13	LTCI00018415
61.	Medication Management – Medication Administration Record – Checking Of - eMAR. Eff. 05/01/13. Rev. Oct 7/13	LTCI00018417
62.	Medication Management – Three Month Medication Review. Eff. 05/01/07. Rev. Oct 7/13	LTCI00018470
63.	Medication Management – Three Month Medication Review. Eff. 05/01/07. Rev. Jul 24/14. Version 2	LTCI00018466
64.	Medication Management –Do Not Use Abbreviations. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018330
65.	Medication Management - Proactive Risk Assessment. Eff. 05/01/07. Rev. Oct 7/13.	LTCI00018456
66.	Medication Management – Medication Reconciliation. Eff. 05/01/07. Rev. Jul 20/17	LTCI00018426
F. Medical Directives		
67.	Medication Management – Medical Directives. Eff. 05/01/07. Rev. Oct 7/13.	LTCI00018404
68.	Medication Management – Physician Orders – Transcription (Routine and Stat Orders). Eff. 05/01/07. Rev. Jul 20/17	LTCI00018443
69.	Medication Management – Physician Orders – Written, Verbal, & Telephone. Eff. 06/01/09. Rev. Oct 7/13	LTCI00018446
G. Pharmacy Service Provider		
70.	Medication Management – Evaluation of Pharmacy Services. Eff. 07/01/07. Rev. Oct. 7/13.	LTCI00018356
71.	Medication Management – Organized Pharmacy Services. Eff. 05/01/07. Rev. Nov 7/14	LTCI00018434
72.	Medication Management – Refusal to Process or Fill an Order. Eff. Jan 8/12. Rev. Oct 7/13	LTCI00018458

NO.	DOCUMENT	SOURCE DOC ID
73.	Medication Management – Reordering of Medication. Eff. Jan 8/12. Rev. Oct 7/13	LTCI00018460
74.	Medication Management – Medication Shortages. Eff. 02/01/09. Rev. Oct 7/13	LTCI00018429
H. Purchasing and Handling of Drugs		
75.	Medication Management – Labelling of Drug Containers. Eff. 07/01/07. Rev. Oct. 7/13.	LTCI00018402
76.	Management – Medication Brought Into Home. Eff. 05/01/07 Rev. Oct 7/13	LTCI00018418
77.	Medication Management – Emergency Drug Box. Eff. 07/01/07. Rev. Oct. 7/13.	LTCI00018354
78.	Medication Management – Government Stock. Eff. 07/01/07. Rev. Oct 7/13.	LTCI00018361
79.	Medication Management – Ordering and Receiving Medications. Eff. 05/01/07. Rev. Jul 20/17	LTCI00018432
80.	Medication Management – Medication Recall. 05/01/07 Rev. Oct 7/13	LTCI00018424
I. Safe Storage of Drugs		
81.	Medication Management – Drug Storage. Eff. 07/01/07 Rev. Oct. 7/13.	LTCI00018337
82.	Medication Management – Narcotics and Controlled Substances. Eff. 05/01/07. Rev. Oct 7/13	LTCI00018430
J. Administration of Drugs		
83.	Classic Care Pharmacy – Policy and Procedure Manual – Multi-Dose System. Revised March 2009. Reviewed 2010, 2011, 2012.	LTCI00023400
84.	Classic Care Pharmacy – Policy and Procedure Manual – Multi-Dose System. Revised November 2014, Reviewed November 2015	LTCI00023132
85.	Silverfox Policy and Procedure Manual. June 2016.	LTCI00022926
86.	Silverfox Policy and Procedure Manual. Last revision: October 2017.	LTCI00022854
87.	Medication Management – Administration of Medications. Eff. 10/21/13. Rev. July 20/17. Version 3.	LTCI00018282
88.	Medication Management – Administration of Medications. Eff. 10 /21/13. Rev. July 24/15. Version 2.	LTCI00018285
89.	Medication Management – Administration of Medications. Eff. 10/21/13.	LTCI00018288
90.	Medication Management – Administration of Medications – Self Medication. Eff. 07/01/07. Rev. Jul. 20/17. Version 3	LTCI00018291
91.	Medication Management – Administration of Medications – Self Medication. Eff. 07/01/07. Rev. Jul. 24/15. Version 2	LTCI00018293
92.	Medication Management – Administration of Medications – Self Medication. Eff. 07/01/07. Rev. Oct.7/13. Version 1	LTCI00018295
93.	Medication Management – Administration of Medications – Intravenous Medications. Eff. 05/01/07. Rev. Jul. 24/15. Version 2.	LTCI00018304
94.	Medication Management – Administration of Medications – Intravenous Medications. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018310
95.	Medication Management – Diabetic Care. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018325

NO.	DOCUMENT	SOURCE DOC ID
96.	Medication Management – Diabetic Care – Blood Glucose Monitoring. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018328
97.	Medication Management – Diabetic Protocol – Blood Glucose Monitoring. Eff. 09/16/13. Version 1.	LTCI00023807
98.	Emergency Care – Hypoglycemia, 09/16/13. Version 1.	LTCI00023850
99.	Medication Management – Electronic Medication Administration Record (eMAR). Eff. 07/01/07. Rev. Jul 24/15. Version 2.	LTCI00018343
100.	Medication Management – Electronic Medication Administration Record (eMAR). Eff. 07/01/07. Rev. Oct. 7/13.	LTCI00018349
101.	Medication Management – Electronic Medication Administration Record (eMAR) – Contingency Plan for eMAR Interruption. Eff. 08/01/12. Rev. Oct. 7/13.	LTCI00018352
102.	Medication Management – Medication Administration Record. Eff. 07/01/07. Rev. Jul 24/15 Version 2	LTCI00018411
103.	Medication Management – Medication Administration Record. Eff. 07/01/07. Rev. Oct 7/13	LTCI00018413
104.	Medication Management – Infusion Pumps. Eff. 02/01/10. Rev. Jul 30/14.	LTCI00018389
105.	Medication Management – Safe Practice Environment. Eff. 06/01/09. Rev. Oct 7/13	LTCI00018464
106.	Medication Management – Safe Practice Environment. Eff. 06/01/09. Rev. Jan 7/16. Version 2	LTCI00018462
107.	Medication Management – Treatment Administration Record. Eff. 05/01/07. Rev. Jul 24/15. Version 2	LTCI00018468
108.	Medication Management –Administration of Medications – Topical - Unregulated Care Providers. Eff. 11/07/14. Rev. Aug 24/15. Version 2.	LTCI00018298
109.	Medication Management –Administration of Medications – Topical Unregulated Care Providers. Eff. 11/07/14.	LTCI00018300
110.	Medication Management – Administration of Medications – High Alert – Determining. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018302
111.	Medication Management – Peripherally Inserted Central Catheters (PICC) – Medication Administration. Eff. 10/11/14. Version 1	LTCI00018440
112.	Medication Management –Administration of Medications – PRN Medications. Eff. 07/01/07. Rev. July 20/17 Version 3	LTCI00018314
113.	Medication Management –Administration of Medications – PRN Medications. Eff. 07/01/07. Rev. July 24/15 Version 2	LTCI00018316
114.	Medication Management –Administration of Medications – PRN Medications. Eff. 07/01/07. Rev. Oct. 7/13	LTCI00018318
115.	Medication Management – High Risk Medications - Opioid Analgesics. Eff. 08/01/12. Rev. Oct 7/13.	LTCI00018363
116.	Medication Management – High Risk Medications – Antithrombotics. Eff. 02/01/10. Rev. Oct 7/13.	LTCI00018366
117.	Medication Management – High Risk Medications – Concentrated Electrolytes. Eff. 02/01/10. Rev. Oct 7/13.	LTCI00018369
118.	Medication Management – High Risk Medications – Concentrated Medications. Eff. 02/01/10. Rev. Oct 7/13.	LTCI00018370
119.	Medication Management – High Risk Medications – Cytotoxic Medications. Eff. 02/01/10. Rev. Feb 25/14	LTCI00018377

NO.	DOCUMENT	SOURCE DOC ID
120.	Medication Management – High Risk Medications – Cytotoxic Medications. Eff. 02/01/10. Rev. Jul 24/14.	LTCI00018372
121.	Medication Management – High Risk Medications – Fentanyl Patch. Eff. 02/01/10. Rev. Oct 7/13.	LTCI00018382
K. Medication Incidents and Adverse Drug Reactions		
122.	Medication Management – Adverse Reactions to Drugs. Eff. 07/01/07. Rev. Oct. 7/13.	LTCI00018320
123.	Medication Management – Allergies. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018323
124.	Medication Management – Drug Interaction Surveillance. Eff. 05/01/07. Rev. Oct. 7/13.	LTCI00018335
125.	Medication Management – Medication Incident. Eff. 05/01/07. Rev. Jul 20/17. Version 2.	LTCI00018420
126.	Medication Management – Medication Errors. Eff. 05/01/07. Rev. Oct 7/13. Version 1	LTCI00018422
L. Drug Destruction and Disposal		
127.	Medication Management – Drug Disposal and Wasting of Medications. Eff. 07/01/07. Rev. Jul. 20/17.	LTCI00018332
M. Dementia Care/Responsive Behaviours		
128.	Responsive Behaviour Meeting – Meeting Minutes. Chart.	LTCI00019150
129.	Responsive Behaviour – Program. Eff 09/t 16/13. Version 1.	LTCI00019156
130.	Responsive Behaviour Meeting – Terms of Reference	LTCI00019151
N. Abuse and Neglect		
131.	Abuse – Education and Training. Eff. 09/16/13. Version 1	LTCI00023607
132.	Abuse – Prevention. Eff. 09/16/13. Version 1	LTCI00023611
133.	Abuse – Evaluation. Eff. 09/16/13. Version 1	LTCI00023609
134.	Abuse - Eff. 09/16/13. Revised Mar. 26/15 Version 1	LTCI00021951
135.	Abuse – Zero Tolerance Policy for Resident Abuse and Neglect. Eff. 09/16/13. Revised June 2/17 Version 2	LTCI00023632
136.	Abuse – Zero Tolerance Policy for Abuse and Neglect. Staff Acknowledgment. Eff. 09/16/13. Rev. March 23/15. Version 1	LTCI00021710
137.	Abuse – Zero Tolerance Policy for Resident Abuse and Neglect – Staff Acknowledgement. Eff. May 2007. Rev. Jan. 13	LTCI00017535
138.	Flow Chart - Licensee Reporting of Physical Abuse (O. Reg 79/10). May 2012.	LTCI00023622
139.	Flow Chart - Licensee Reporting of Emotional Abuse (O. Reg 79/10). May 2012.	LTCI00023620
140.	Flow Chart - Licensee Reporting of Sexual Abuse (O. Reg 79/10). May 2012.	LTCI00023624
141.	Flow Chart - Licensee Reporting of Verbal Abuse (O. Reg 79/10). May 2012.	LTCI00023626
142.	Flow Chart - Licensee Reporting of Financial Abuse (O. Reg 79/10). May 2012.	LTCI00023628

NO.	DOCUMENT	SOURCE DOC ID
143.	Flow Chart - Licensee Reporting of Neglect (O. Reg 79/10). May 2012.	LTCI00023630
O. Concerns, Complaints		
144.	Concern/Complaint Form	LTCI00019045
145.	Concern-Complaint Follow-Up Log	LTCI00021541
146.	Reporting and Complaints – Concerns and Complaints Management. Eff. 04/01/14. Rev. Sept 18/17. Version 4	LTCI00019086
147.	Reporting and Complaints – Concerns and Complaints Management. Eff. 04/01/14. Rev. June 12/15. Version 3	LTCI00019089
148.	Reporting and Complaints – Concerns and Complaints Management. Eff. 04/01/14. Rev. Nov. 6/14. Version 2	LTCI00019091
149.	Ontario Government. How to Report a Concern or Complaint about a Long-Term Care home.	LTCI00019078
150.	Reporting and Complaints – Concerns and Complaint Process. Eff. 09/16/13. Rev. May 10/17. Version 7	LTCI00019047
151.	Reporting and Complaints – Concerns and Complaint Process. Eff. 09/16/13. Rev. Feb. 4/16. Version 6	LTCI00019050
152.	Reporting and Complaints – Concerns and Complaint Process. Eff. 09/16/13. Rev. Oct. 13/15. Version 5	LTCI00019053
153.	Reporting and Complaints – Concerns and Complaint Process. Eff. 09/16/13. Rev. Oct. 13/15 Version 4	LTCI00019056
154.	Reporting and Complaints – Concerns and Complaint Process. Eff. 09/16/13 Rev. June 1/15. Version 3	LTCI00019059
155.	Reporting and Complaints – Concerns and Complaint Process. Eff. 09//13. Rev. Feb. 24/15. Version 2	LTCI00019062
156.	Reporting and Complaints – Concerns and Complaint Process.	LTCI00019065
157.	Reporting and Complaints – Whistle-Blowing Protection. Eff. 09/16/13. Rev. June 2/17. Version 3	LTCI00019082
158.	Reporting and Complaints – Whistle-Blowing Protection. Eff. 09/16/13. Version 1	LTCI00019084
159.	Disclosure Policy. Eff. 10/25/13. Version 1.	LTCI00023912
160.	Administration Investigation Check-Off List	LTCI00019548
161.	Sentinel Events. Eff. 02/25/14.	LTCI00024123
162.	Ethics – Ethical Decision Making. Eff. Date 09/16/13. Version 1.	LTCI00023916
163.	Ethics – Ethics Code. Eff. Date 09/16/13. Version 1	LTCI00023926
164.	Ethics Framework. Eff. 09/16/13.	LTCI00023933
165.	Ethics – Ethics Committee - Home. Eff. 09/16/13.	LTCI00023927
166.	Ethics – Ethics Committee - Corporate. Eff. 09/16/13. Version 1.	LTCI00023930
P. Critical Incident Reporting		
167.	Reporting and Complaints – Critical Incident Reporting. Eff. 03/14/17. Rev. May 15/17. Version 3	LTCI00019068

NO.	DOCUMENT	SOURCE DOC ID
168.	Reporting and Complaints – Critical Incident Reporting. Eff. 07/21/14. Version 1	LTCI00019073
Q. End of Life Care, Pronouncement and Process on Death of a Resident		
169.	Medication Management – Death of Resident. Eff. 07/01/07. Rev. Oct. 7/13.	LTCI00018324
170.	End of Life Care – Statement of Purpose. Eff. 09/16/13. Version 1.	LTCI00023887
171.	End of Life Care – Pronouncement of Death by RN or RPN. Eff. 09/16/13. Rev. Sept. 28/17. Version 2.	LTCI00023886
172.	End of Life Care – Pronouncement of Death by RN or RPN. Eff. 09/16/13. Version 1	LTCI00023888
R. Quality and Risk Management		
173.	Operations Visits to Homes. Eff. 09/16/13. Rev. Sept. 16/16. Version #4	LTCI00024010
174.	Operations Visits to Homes. Eff. 09/16/13. Rev. July 9/15. Version #3.	LTCI00024013
175.	Operations Visits to Homes. Eff. 09/16/13. Rev. July 9/15. Version #2.	LTCI00024016
176.	Operations Visits to Homes. Eff. 09/16/13.	LTCI00024019
177.	Site Visit Report – Care Service Coordinators	LTCI00033312
178.	General Management – Satisfaction Survey. Eff. Aug. 4/14. Version 1	LTCI00024125
179.	General Management – Risk Management – Program and Plan. Eff. Date 10/16/13.	LTCI00024102
180.	General Management – Risk Management – Program and Plan Reporting and Analysis. Eff. 10/16/13. Rev. Sept. 6/16.	LTCI00024104
181.	Jarlette Health Services – RISK Occurrence Report Form.	LTCI00024106
182.	RISK Management Meeting (Home Name). Chart.	LTCI00024108
183.	General Management – Quality Council. Eff. 09/16/13.	LTCI00024064
184.	General Management – Quality Council Standing Agenda Items. Eff. 09/16/13. Version 1	LTCI00024067
185.	General Management – Risk Management – Program and Plan – Abaqis. Eff. 10/16/13. Rev. Oct. 17/13.	LTCI00024117
186.	General Management – Risk Management – Terms of Reference and Standing Agenda. Eff. 10/16/13.	LTCI00024121
187.	General Management – Risk Management – Terms of Reference and Standing Agenda. Eff. 10/16/13. Rev. Sept.6/16. Version 2.	LTCI00024119
188.	Quality Improvement Plan (QIP) – Narrative for Health Care Organizations in Ontario Mar. 21/17	LTCI00020048
S. Human Resources		
189.	Harassment Policy (April 2001, Revised July 2006)	LTCI00017555
190.	Workplace Violence and Harassment Prevention Program. Eff. 01/01/08. Rev. June 1/10	LTCI00022303
191.	Code of Conduct. Eff. 04/01/01. Rev. June 27/16	LTCI00021959
192.	The Positive Discipline Overview. Eff. 04/01/01. Rev. July 7/15.	LTCI00033283

NO.	DOCUMENT	SOURCE DOC ID
193.	When Positive Discipline Fails. Eff. 04/01/01. Rev. July 1/06	LTCI00033284
194.	Correcting Performance Problems & Performance Counselling. Eff. 04/01/01. Rev. July 1/06	LTCI00033285
195.	Oral Reminder. Eff. 04/01/01. Rev. Sept. 1/12	LTCI00033286
196.	Written Warning. Eff. 04/01/01. Rev. March 1/11	LTCI00033288
197.	Decision Making Leave – Suspension. Eff. 04/01/01. Rev. July 1/06	LTCI00033290
198.	Termination - Dismissal of Employment. Eff. 04/01/01. Rev. Feb. 7/13	LTCI00033292
199.	Loss of Seniority (Termination) – Non-Union Employee. Eff. 04/01/01. Rev. July 1/06	LTCI00033294
200.	Performance Tracking System. Eff. 04/01/01. Rev. March 1/11	LTCI00033296
201.	Positive Discipline Approach	LTCI00033298

VOLUME 7: LIFEGUARD HOMECARE INC. CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Lifeguard Homecare Inc. ("Lifeguard") is a private, unlicensed agency that offers registered staffing support to various facilities, including long-term care homes, as well as private residents. Lifeguard employed Elizabeth (Bethe) Wettlaufer (EW) between January, 2015 and September, 2016. During that time period, EW was assigned to shifts as both a Registered Nurse and a Personal Support Worker at various long-term care homes and retirement residences, including Telfer Place.

EW admitted to unlawfully injecting Sandra Towler, a resident of Telfer Place, with insulin in September, 2015 with the intention of ending Ms. Towler's life. The chronology below outlines EW's employment with Lifeguard and the issues which arose during the course of that employment. Separate chronologies have been prepared for each of the long-term care homes and/or retirement residences to which she was assigned during the course of her employment with Lifeguard.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	Unknown but presumably January 2015	The specific date of EW's application to Lifeguard is unknown. Given that she commenced her shifts in January, 2015 that is the time frame that has been presumed. EW provides her resume. She completes "Employee Information Sheets" and "Lifeguard Homecare Availability." EW states she is available for day, afternoon, night, and overnight shifts. Her preferred shifts are Saturdays and Sundays (day, afternoon, night, and overnight.) She is looking for 40 hours/week but will accept more.	LTCI00017387 LTCI00017410 LTCI00017418
2.	Undated but presumably January 2015	EW provides Lifeguard with a reference list which includes: • Sandra Fluttert, RN (EW identifies her as a former supervisor) • Jennifer Hague, RN (EW identifies her as a former co-worker) • Karen Routledge, RN (EW identifies her as a former care co-worker)	LTCI00017373

	DATE	EVENT	SOURCE DOC ID
		• David Petkau (EW identifies him as a former supervisor) Handwritten notes suggest Sandra Fluttert is contacted. Notes appear to indicate that Ms. Fluttert stated that EW was: • *RN at Woodstock* • *Very caring* • *One on one best type of nursing* • *Good team player* • *Residents still ask about her* • *Good critical thinking skills* • *Could deal well with behavioural* • *Left due to personality conflicts but good nurse* Handwritten note also states "Carole Hepting"	
3.	January 28, 2015	A faxed copy of a Woodstock Police Service's RCMP records check for EW, dated April 22, 2014, appears to have been provided to Lifeguard. The document provides that "A search of the National Criminal Records Repository maintained by the RCMP did not identify any records for a person with the name and the date of birth of the applicant", nor was a record of a sexual offence for which a pardon has been granted identified. Clearance is for employment with the vulnerable sector.	LTCI00017374
4.	January 28, 2015	Lifeguard searches for EW on the College of Nurses of Ontario's ("CNO") website, "Find a Nurse" section	LTCI00072509
5.	January 28, 2015	EW signs "Lifeguard Homecare Professional Code of Conduct Policy Guidelines" identifying, among other things that employees will: • Treat our clients with dignity and kindness • Never abuse them, either emotionally or physically or financially • Always provide the best total client care within the limits of my professional ability utilizing compassion, empathy and competence • Strive to keep the client safe and as comfortable as possible at all times • Conduct myself in a professional manner at all times, and follow	LTCI00017416

	DATE	EVENT	SOURCE DOC ID
		"best practices" • The use of alcohol or illegal substances prior/during a shift is strictly prohibited	
6.	January 28, 2015	EW signs Lifeguard "Grounds for Immediate Termination" sheet and initials beside each of the following: • Client Abandonment; • Neglecting to Follow Client Care plan; • Fraud/theft of any kind; • Manipulation of client for self interest in any way through communications, or actions, or solicitation of clients business; • Breaching client confidentiality; • Entering into a conflict of interest of any kind; • Failure to follow Health & Safety Protocol; • Failure to follow Communication Protocol; • Abuse, verbal and/or physical abuse to either the clients or employees; and • The use of illegal substance that impedes our judgment resulting in putting clients at risk.	LTCI00017386
7.	January 29, 2015	A handwritten note on a questionnaire for references (which states that the form should be emailed back to Lifeguard when complete) states: "David Petkau NO Concerns."	LTCI00017377
8.	January 29, 2015	According to EW's Record of Employment, this is EW's first day of work with Lifeguard.	LTCI00017433
9.	January 29, 2015	EW and Lifeguard sign a Non-Disclosure/Non-Solicitation Agreement. EW acknowledges having received the Employee Handbook, which includes: • Procedures for Home Visits • Professional Code of Conduct Guidelines • Health and Safety Policy • Employee Responsibility Safety Sheet • In Home Client Services Job Description	LTCI00017413
10.	October 26, 2015	Meeting between EW and Ms. Heidi Wilmot-Smith ("Wilmot-Smith), President of Lifeguard, regarding EW's failure to attend a shift at Telfer	LTCI00017399 LTCI00017400

	DATE	EVENT	SOURCE DOC ID
		Place. EW emails an apology to Wilmot-Smith regarding the missed shift and states that it was because she did not record the shift when it was assigned and that she did not check her schedule in StaffPoint. She states that when she was alerted that she had missed her shift, she was out-of-town. EW promises to be more diligent about checking her shifts. Wilmot-Smith emails Sherri Toleff, Director of Care at Telfer Place ("Toleff") and copies Ms. Louise Allard ("Allard") and Taryn Smith (RN supervisor), both employees of Lifeguard. Wilmot-Smith attaches EW's apology.	
11.	October 28, 2015	EW receives a letter dated October 26, 2016 from Wilmot-Smith confirming their meeting regarding EW's failure to attend work for the shift at Telfer Place scheduled from 14:00 to 22:00 on October 24, 2015. Wilmot-Smith notes that EW's failure to attend "resulted in the resident population being put at risk and the regular day nurse doing 'a double shift.'" Wilmot-Smith acknowledges that EW is "flexible and hard-working" but notes that it is her responsibility to know her schedule. Wilmot-Smith believes that going forward, EW "will take the necessary steps to attend all shifts you have accepted and are assigned to you ensuring that any errors will be reported to us immediately."	LTCI00017397 LTCI00017398
12.	November 13, 2015	Allard emails Wilmot-Smith, stating that "Bonnie" from Delrose had called to report two medication errors by EW on November 2 and 7, 2015. Both involved EW applying a full patch of nitroglycerin to two residents when the prescription only called for ½ patch. Allard reports that she spoke to EW about the medication errors when she called in and states "she seems to have been aware of this." Allard notes that she spoke with Bonnie to advise her that she had spoken to EW.	LTCI00017395
13.	January 4, 2016	Ms. Taryn Smith emails Allard, stating the following: *I spoke with Beth at length in regards to sick time. She acknowledges that it was inappropriate to call in late for scheduled shifts. I did investigate further and Beth stated to me that she has started to drink again and that she is seeking help and going to AA meetings etc. I advised Beth to keep the lines of communication open so that can assist her to the best of our ability. I'm not sure how you want to proceed with this information. She did give her availability for January.*	LTCI00017401
14.	March 31,	EW emails Allard to say that she made a medication error at Telfer Place.	LTCI00017402

	DATE	EVENT	SOURCE DOC ID
	2016	She states that she missed giving a scheduled narcotic and that she filled out the appropriate in-home report.	
15.	April 12, 2016	Wilmot-Smith emails EW to remind her to discuss only non-controversial topics at Telfer and at any other institution. She states "I understand sometimes you need to let off steam, and what may be said in jest, can come back to be used against you at a later time, when it becomes a tool for them to use for their own agenda. Please do not make yourself vulnerable". Wilmot-Smith also notes that the CNO requires EW to have Registered Nurses Association of Ontario ("RNAO") coverage at all times and requests that EW provide her membership number to Allard.	LTCI00017403
16.	April 15, 2016	EW emails Wilmot-Smith, stating that she allowed her RNAO to lapse and that she rejoined the previous Friday. Wilmot-Smith asks EW to let Allard know when it arrives.	LTCI00017389
17.	April 20, 2016	Michelle Cornelissen, Director of Care at Telfer Place ("Cornelissen"), reports various issues with EW to Wilmot-Smith via email. Cornelissen states that Telfer Place is not comfortable having EW in their home. The complaints are summarized as follows: • A PSW who worked with EW overnight on April 19th reported a workplace injury to EW by a resident. EW did not file an incident report. The resident's chart did not have these identified behaviours. The PSW told EW that she was concerned for the safety of the resident and other residents "due to demonstrated behaviours". • The PSW asked EW to check on the resident frequently. EW did not. • EW did not notify incoming staff of the issues "experienced throughout the night." • The physician brought up concerns related to EW and stated that he did not feel confident in her abilities "to assess our residents and carry out basic nursing duties. The physician also mentioned that he felt she lacked accountability as a nurse and to the Residents of the home". Cornelissen also notes that it had previously been brought to Wilmot-Smith's attention that EW had made vulgar and inappropriate comments to Telfer Place staff.	LTCI00017404
18.	April 20, 2016	Wilmot-Smith emails Allard "Bethe can no longer work at Telfer Place. Please ensure she is not sent there and coordinate a meeting between her	LTCI00017437

	DATE	EVENT	SOURCE DOC ID
		and Taryn.	
19.	April 25, 2016	Lindsay Astley, Associate Director of Care/Restorative Care Coordinator at Telfer Place, emails Lifeguard for an "RN today", 2pm-10pm. She notes the following: "At this time we will not be able to bring Bethe back so it will have to be someone else."	LTCI00017430
20.	April 25, 2016	EW sends Allard her RNAO number. Allard provides same to Wilmot-Smith	LTCI00017375
21.	April 27, 2016	Lifeguard searches for EW on the College of Nurses of Ontario's ("CNO") website, "Find a Nurse" section. EW is listed as entitled to practice with no restrictions. She has been registered with the CNO since June 8, 1995 and as a Registered Nurse with the CNO since August 11, 1995.	LTCI00017360
22.	May 4, 2016 – May 16, 2016	Wilmot-Smith emails Cornelissen, stating that she and Wilmot-Smith have met with EW. Wilmot-Smith asks if Cornelissen is free to meet the following week. On May 10, 2016 Cornelissen writes "Sorry what are we meeting to discuss?" Wilmot-Smith responds on May 11, 2016 stating "I thought it would be helpful to meet over your concerns with Bethe, and the outcome of meetings [. . .]" On May 16, 2016 Cornelissen agrees to look at her calendar and get back to Wilmot-Smith. In the interim, she asks why Wilmot-Smith "charged 54.5 hours for Beth and am just confused as to why as after reviewing my schedule and OT requests there were none made."	LTCI00017406
23.	May 4, 2016	EW completes a Lifeguard Incident Report regarding an incident at Brierwood Gardens. EW states that she was in the nursing office and attempted to sit on a wheeled office chair when it rolled away from her. She fell backwards and landed on her buttocks, right elbow, and right hand. She struck a filing cabinet with her back on the right side of the bed and the back of her head on the right side. She notes that she sustained a cut to her back. Samatha Steeves, RPN at Brierwood, and Shelly, RAI Coordinator at Brierwood, assisted EW to her feet. A Band-Aid was applied to her cut. The Executive Director of Brierwood Gardens was notified and removed the chair.	LTCI00017393
24.	July 22, 2016	Screenshots of text messages between EW and an unknown person (presumably Lifeguard) asking if she can do a PSW shift the next day, EW responds that she is unavailable until August 1, 2016 as she is doing full time orientation at her new job.	LTCI00017422

	DATE	EVENT	SOURCE DOC ID
25.	July 26, 2016	EW emails Lifeguard, thanking them for their patience while she was training fulltime. EW states she is available August 2, 3, 6, and 7.	LTCI00017442
26.	August 2, 2016	Allard emails "Lifeguard Scheduler" and copies Wilmot-Smith and Natalie Hrivnak the following: *I spoke with Heidi and she said that although Amanda from Dover Cliffe said if our RN staff have worked at Telfer or Brierwood they do not need orientation at Dover Cliffe;* *Heidi wants our RN to have at least one hour of orientation to the building of Dover Cliffe for Health and safety reasons.* *I believe Bethe is trying to waive this.* *Can you please confirm that you have read and understood and will put Bethe into at least one hour of orientation?*	LTCI00017427
27.	August 3, 2016	Screenshots of text messages between EW and an unknown person (presumably Lifeguard) setting her orientation at Dover Cliffs for Friday, August 6, 18:00 – 24:00.	LTCI00017422
28.	August 4 - 7, 2016	Screenshots of text messages between EW and an unknown person (presumably Lifeguard). EW turns down an offer of shifts on August 6 and 7th as she already has shifts at Dover Cliffs.	LTCI00017422
29.	August 8, 2016	Screenshots of text message from EW: "Mix up at Dover Cliffs. I was told Friday that there was no lab work scheduled today. The lab lady arrives and I didn't have anything ready for her. So the 2 day nurses and I had to scramble to get things ready. So if you get a complaint that I didn't have the lab requisitions ready, that's . . ."	LTCI00017422
30.	August 12, 2016	Lifeguard emails a list of CNO Registration Numbers, including that of EW, to Danielle Simington at Anson Place Care Centre	LTCI00017428
31.	August 17, 2016	Last Day EW worked at Lifeguard	LTCI00017433
32.	August 20, 2016	Last day at Lifeguard for which EW paid (pay period ending date).	LTCI00017433
33.	August 21, 2016	Screenshots of text message from EW: "Just found out my other job has to switch me to afternoons this week. I will be unavailable to work with Yvonne Tuesday and Wednesday."	LTCI00017422
34.	August 25, 2016	Screenshots of text messages between EW and an unknown person (presumably Lifeguard) – EW turns down shifts at Park Lane for Friday and	LTCI00017422

	DATE	EVENT	SOURCE DOC ID
		Saturday.	
35.	August 26, 2016	Wilmot-Smith asks Cornelissen if she has time to meet with Taryn Smith on September 2, 2016. Ms. Cornelissen responds on August 29, 2016 noting that she is not there on Fridays.	LTCI00017409
36.	September 7, 2016	EW emails Wilmot-Smith and resigns from Lifeguard. The text of her email reads as follows: *Please accept this letter as my resignation from Lifeguard Homecare, effective immediately. I am thankful for the opportunities I have had with your company. I am no longer able to work as a registered nurse. Sincerely Bethe Wettlaufer.* Handwritten Notes state "Start – Jan 2015 Last Shift – Aug. 7"	LTCI00017432
37.	October 6, 2016	Lifeguard schedules employees to shifts on October 7, 2016 and October 10, 2016 at Telfer Place. Handwritten notes identify that these shifts were canceled by "Lyndsey" at Telfer on October 7, 2016.	LTCI00017390 LTCI00017392
38.	October 7, 2016	Handwritten notes identify that "Lyndsey from Telfer called said cancel shift for today 4 to 11 as our contract is outdated". Another handwritten note identifies "Wendy Gilmore, Senior Vice President Revera" and "vulnerable".	LTCI00017440
39.	October 8, 2016	Lifeguard searches for EW on the CNO website, "Find a Nurse" section. EW is listed as being entitled to practice with no restrictions.	LTCI00017420 LTCI00017421
40.	October 11, 2016	Lifeguard issues EW her ROE identifying her first day of work as January 29, 2015 and her last day for which paid as August 17, 2016.	LTCI00017433
41.	January, 2015 – August 2016	Lifeguard shift assignments for EW	LTCI00017358 LTCI00017477 LTCI00017506
42.	November 10, 2016	Lifeguard faxes EW's RN # to Anson Place	LTCI00017475

VOLUME 7(C): LIFEGUARD

RELEVANT STANDARDS, GUIDELINES, POLICIES AND PROCEDURES

NO.	DOCUMENT	SOURCE DOC ID
A. Abuse and Neglect		
1.	Abuse Policy (Undated)	LTCI00069421

VOLUME 7(i): TELFER PLACE
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Telfer Place is a long-term care home located in Paris, Ontario ("Telfer Place"), licensed to Revera Long Term Care Inc. ("Revera"), Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to Telfer Place at various times between February, 2015 and April, 2016. The chronology below outline's EW's work history at Telfer Place, including Telfer Place's report to Lifeguard in April, 2016 that it would no longer be comfortable in utilizing EW as a Registered Nurse.

EW admitted to unlawfully injecting Sandra Towler, a resident of Telfer Place, with insulin in September, 2015 with the intention of ending Ms. Towler's life.

Ms. Towler was born on April 6, 1939. She resided in Brant County and raised two children. Ms. Towler entered Telfer Place with a number of ailments, including diabetes. Ms. Towler's diabetes was controlled by oral medication, not insulin. The chronology provides details as to Ms. Towler's hypoglycemic episode in September 2015.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	February 12, 2014	Ms. Towler enters Telfer Place.	LTCI00024852
2.	February 15, 2015	Elizabeth (Bethe) Wettlaufer ("EW") is assigned her first shift at Telfer Place (evenings).	LTCI00026297
3.	February 15, 2015	EW signs off Agency Staff Orientation Checklist for Registered Staff at Telfer place. Some policies are initialed by EW and the DOC, some are not.	LTCI00024849
4.	February 2015	During the month of February, EW works the following shifts: • February 15, 2015 • February 16, 2015 • February 19, 2015	LTCI00026297
5.	April 14, 2015	Telfer Place and Lifeguard enter into a Service Contract and Agreement for Payment. Lifeguard to provide the services of	LTCI00072549

	DATE	EVENT	SOURCE DOC ID
		professional health care staff, including Registered Nurses and Registered Practical Nurses, and when requested, PSWs etc. All staff provided by Lifeguard are to be in "Good Standing with the College of Nurses where applicable, and have a valid registration certificate. Additionally, the company will submit, upon request, Proof of WSIB and liability insurance coverage". The April 2015 Service Contract is signed by Dian Shannon, Executive Director, of Telfer Place.	
6.	April 24, 2015	EW works an evening shift.	LTCI00026298
7.	May 2015	During the month of May, EW works the following shifts: • May 1, 2015 • May 6, 2015 • May 7, 2015 • May 9, 2015 • May 10, 2015 • May 15, 2015 • May 16, 2015 • May 17, 2015 • May 27, 2015	LTCI00026298
8.	June, 2015	During the month of June, EW works the following shifts: • June 16, 2015 • June 17, 2015 • June 24, 2015 • June 29, 2015	LTCI00026298
9.	July 24, 2015	Telfer Place and Lifeguard enter into a Service Contract and Agreement to Pay. Lifeguard to provide the services of professional health care staff, including Registered Nurses and Registered Practical Nurses, and when requested, P.S.W.'s etc. All staff provided by Lifeguard are to be in "Good Standing with the College of Nurses where applicable, and have a valid registration certificate. Additionally, the company will submit, upon request, Proof of WSIB and liability insurance coverage". The July 2015 Service Contract is signed by Kim Brennan, Assistant	LTCI00024136

	DATE	EVENT	SOURCE DOC ID
		Director of Telfer Place. Telfer Place's copy of the contract is not signed by Lifeguard.	
10.	July 2015	During the month of July, EW works the following shifts: • July 4, 2015 • July 5, 2015 • July 9, 2015 • July 11, 2015 • July 12, 2015 • July 17, 2015 • July 18, 2015 • July 20, 2015 • July 24, 2015 • July 25, 2015 • July 26, 2015 • July 28, 2015 • July 29, 2015 • July 30, 2015 • July 31, 2015	LTCI00026298
11.	August 14, 2015	Telfer Place and Lifeguard entered into another Service Contract and Agreement to Pay (the "August 2015 Service Contract). The August 2015 Service Contract is signed by Dian Shannon, Executive Director of Telfer Place. Telfer Place's copy of the contract is not signed by Lifeguard.	LTCI00024134
12.	August, 2015	During the month of August, EW works the following shifts: • August 1, 2015 • August 2, 2015 • August 6, 2015 • August 7, 2015 • August 9, 2015 • August 10, 2015	LTCI00026298

	DATE	EVENT	SOURCE DOC ID
		• August 11, 2015 • August 12, 2015 • August 13, 2015 • August 21, 2015 • August 25, 2015 • August 26, 2015 • August 28, 2015 • August 29, 2015 • August 30, 2015	
13.	September 6, 2015	EW works the evening shift at Telfer Place. Progress Note entered by EW at 22:24 that Ms. Towler "refused to have a bath this afternoon. Will attempt tomorrow".	LTCI00024852
14.	September 6, 2015	EW admits that sometime around September 6, 2015 she injected Ms. Towler with approximately 80 units of long-acting insulin and 60 units of short-acting insulin.	LTCI00057683
15.	September 7, 2015	At 01:20, Dianne Beauregard, RN ("Beauregard") records that Ms. Towler is unresponsive to staff. Ms. Towler is pale in colour. Her skin is cold, clammy, and diaphoretic. She is unresponsive to verbal and painful stimuli. Her blood sugar ("BS") measures 2.2. At 01:30, 911 is called. When the paramedics arrive at 01:40, they administer IV dextrose in her right arm. After 20 minutes, Ms. Towler is responsive. She converses with staff. Her speech is clear and she denies pain. She takes two cookies and a glass of apple juice with no difficulty. There is no indication of pain or discomfort. At 02:20, her BS is recorded as 6.7. Ms. Towler is not transferred to the hospital because she is "her normal self." Staff would continue to monitor her. At 05:48, Ms. Towler easily rouses when spoken to. She converses well and her speech is clear. The on-call physician is called and findings are discussed with him. Dr. Vlaar orders a stop on Diamicron and to follow-up with her family physician in two days. A check of Ms. Towler's BS is ordered to be done hourly. The "oncoming shift will be notified of above."	LTCI00024852

	DATE	EVENT	SOURCE DOC ID
		Ms. Towler's BS fluctuates between 3.4 (at 07:07) and 7.7 (at 11:00). At 10:49, the monitoring changes from every hour to every two hours.	
16.	September 7, 2015	EW works the evening shift. Her duties include monitoring Ms. Towler's BS. EW records Ms. Towler's BS on her Medication Administration Record ("MAR"), although she mistakenly records it under "pulse", on the record, at various times. EW records Ms. Towler's BS as follows: • 14:00 – 5.2 • 15:00 – 9 • 16:00 – (checkmark only) • 17:00 – 9 • 18:00 – (checkmark only) • 19:00 – 9. She also records it as 5.5 • 20:00 – 5.5 At 22:32, EW makes the following Progress Note: *Blood glucose test q 2h as ordered. All values were above 5. Sandy ate only half her supper. She drank 500ml of chocolate milk and ate a piece of pie.* At 22:20, Dianne Beauregard, RN, records Ms. Towler's BS as 3.4.EW works the evening shift. Her duties include monitoring Ms. Towler's BS.	LTCI00024852 LTCI00024804
17.	September 8, 2015	Progress note entered by Dianne Beauregard, RN, at 00:17 as follows: *Sandy was sleepy but able to rouse. 250ml of apple juice given with a packet of sugar . . . Sandy's blood sugars have been difficult to stabilize today even with all the added glucose. Plan – Sandy transferred to BGH at 22:40 for further assessment due to low blood sugars, and difficulty to stabilize . . .* At 00:21, Dr. Raja is notified to request a PRN order for Glucogon injection kit as needed for hypoglycemic episodes. He stated that he would not order at this time but to try giving orange juice as needed. Diamacron is still to be held and he is to be updated in two days. At 03:45, Ms. Towler returns to Telfer Place. She is, "alert and conversing. Report from BGH indicates if persistent low blood glucose of less than 5.0 change Janumet to Metformin 500mg 2 tabs BiD."	LTCI00024852 LTCI00024804

	DATE	EVENT	SOURCE DOC ID
		On Ms. Towler's MAR, her BS are recorded as follows: • 13:00 – 8.1 • 15:00 – 6.3 • 17:00 – 7.3 • 19:00 – 9.4 • 21:00 – 8.4 • 22:30 – 5.7	
18.	September 9, 2015	Ms. Towler's BS continue to be monitored every two hours. Progress note entered by Dianne Beauregard, RN, at 05:39 that Ms. Towler rouses easily when spoken to and is alert and talkative at each check.	LTCI00024852 LTCI00024804
19.	September 10, 2015	Dr. Raja is updated that Ms. Towler's BS have been stable, but during nights it is lower and interventions with OJ and choc milk have been given to stabilize. Dr. Raja provides new medication orders for Ms. Towler.	LTCI00024852 LTCI00024804
20.	September 11, 2015	Sandra Towler's BS continue to be monitored. At 10:05 Dr. Raja is updated: *blood sugars have remained at 5.0 or above. MD advised to continue to hold Diammicron and Janument. Blood sugar checks q4d x 24 hrs, then QID. If hypoglycemic again, notify on-call. otherwise, update on-call in 2 days re: sugars. Faxed order to pharmacy.*	LTCI00024852
21.	September 12, 2015	EW enters a Progress note at 14:21 indicating that Sandra Towler's Blood sugar is "stable at 7.6". At 11:30 EW records Sandra Towler's BS as 8 on the MAR.	LTCI00024852 LTCI00024804
22.	September 16, 2015	Progress note entered by Jasmin Estesta, RN, at 15:08 that the doctor had been in to assess Ms. Towler's needs and new Orders had been received.	LTCI00024852 LTCI00025852
23.	September, 2015	During the month of September, EW works the following shifts: • September 2, 2015 (22:00 – 06:00) • September 3, 2015 (22:00 – 06:00) • September 5, 2015 (10:00 – 22:00) • September 6, 2015 (14:00 – 22:00) • September 7, 2015 (14:00 – 22:00)	LTCI00026298 LTCI00026311

	DATE	EVENT	SOURCE DOC ID
		• September 12, 2015 (06:00 – 14:00) • September 21, 2015 (06:00 – 14:00)	
24.	October, 2015	During the month of October, 2015, EW works the following shifts: • October 1, 2015 • October 13, 2015 • October 15, 2015 • October 17, 2015 • October 18, 2015 • October 19, 2015	LTCI00026311
25.	December, 2015	During the month of December, EW works the following shifts: • December 5, 2015 • December 6, 2015 • December 11, 2015 • December 21, 2015 • December 22, 2015 • December 24, 2015 • December 25, 2015 • December 28, 2015	LTCI00026311
26.	December 2015	Quality Improvement Action Plan prepared for December 2015 notes issues/actions with high use of agency nurses, heavy workload etc.	LTCI00072530
27.	January 6, 2016	Tracy Raney, RN ("Raney"), emails Toleff to advise that "Despite signs on the door, Beth continues to leave the med room door and chart room door wide open and walks away, far away down the hall. Noted on the last night shift that she followed me. Thought you should no". Toleff acknowledges receipt and that she will followup.	LTCI00072536
28.	January 10, 2016	Raney emails Toleff and Lindsay Astley (Associate Director of Care) with concerns about EW. Raney writes EW "does not always relay important information" to doctors and registered staff. Information regarding a nail issue	LTCI00024212

	DATE	EVENT	SOURCE DOC ID
		with a resident was not charted, written in the report book, or passed on, with the result that it was not assessed for three days until an inquiry about it was phoned in. Raney also writes that EW suspected a resident had apnea. She called the family to report it but did not call the doctor, with the result that the doctor changed the resident's status to palliative and "initiated all the necessary drug changes in regards to palliation status."	
29.	January 15, 2016	Staffing Contract Agreement entered into between Dawn of Angels Health and Telfer Place	LTCI00072550
30.	January, 2016	During the month of January, EW works the following shifts: • January 1, 2016 • January 2, 2016 • January 7, 2016 • January 8, 2016 • January 15, 2016 • January 16, 2016 • January 21, 2016 • January 22, 2016 • January 24, 2016 • January 25, 2016 • January 26, 2016 • January 29, 2016 • January 30, 2016 • January 31, 2016	LTCI00026311
31.	February 1, 2016	A Medication Incident Report is completed by Marlena Amaral, RPN, regarding medication errors that occurred on January 31, 2016. It is noted that, among other things, "Also: used Ativan 0.1mg – not signed for? Where was it taken from?" The Director of Care and Associate Director of Care are notified.	LTCI00024246
32.	February 7, 2016	Raney emails Astley that the previous night EW seemed to be "on a mission" to try to find out the name of the other Agency Telfer Place was using. Astley notes that she has passed on the information to the new Director of Care.	LTCI00072536
33.	February 26, 2016	EW works one shift during the month of February.	LTCI00026311

	DATE	EVENT	SOURCE DOC ID
34.	March 31, 2016	EW makes a medication error and completes a Medication Incident Report. She pre-signed for medication but it was not poured. She did not double-check before signing. "AM dose of Kadian 10mg signed for not given. AM dose of Kadian 20mg signed for not given." EW notes that the medication was "presigned for but not poured right after presigning & was missed. Nurse did not doublecheck before final signing." The Corrective Action is that the "Nurse will pour each medication immediately after presigning and double check med was given before final signing." On July 11, 2016, Michelle Cornelissen, Director of Care ("Cornelissen") completes a "Medication Incidents Home" report, regarding this incident.	LTCI00024249 LTCI00024247
35.	March, 2016	During the month of March, 2016, EW works the following shifts: • March 5, 2016 • March 7, 2016 • March 10, 2016 • March 11, 2016 • March 13, 2016 • March 14, 2016 • March 16, 2016 • March 17, 2016 • March 19, 2016 • March 20, 2016 • March 22, 2016 • March 26, 2016 • March 27, 2016 • March 31, 2016	LTCI00026311
36.	April 18, 2016	EW's last shift at Telfer Place.	LTCI00026311
37.	April 20, 2016	Michelle Cornelissen, Director of Care at Telfer Place ("Cornelissen"), reports various issues with EW to Wilmot-Smith via email. Cornelissen states that Telfer Place is not comfortable having EW in their home. The complaints are summarized as	LTCI00024211

	DATE	EVENT	SOURCE DOC ID
		follows: • A PSW who worked with EW overnight on April 19th reported a workplace injury to EW by a resident. EW did not file an incident report. The resident's chart did not have these identified behaviours. The PSW told EW that she was concerned for the safety of the resident and other residents "due to demonstrated behaviours". • The PSW asked EW to check on the resident frequently. EW did not. • EW did not notify incoming staff of the issues "experienced throughout the night." • The physician brought up concerns related to EW and stated that he did not feel confident in her abilities "to assess our residents and carry out basic nursing duties. The physician also mentioned that he felt she lacked accountability as a nurse and to the Residents of the home". Cornelissen also notes that it had previously been brought to Wilmot-Smith's attention that EW had made vulgar and inappropriate comments to Telfer Place staff.	
38.	April 25, 2016	Astley emails Lifeguard for an "RN today", 2pm-10pm. She notes the following: "At this time we will not be able to bring Bethe back so it will have to be someone else."	LTCI00017430
39.	April, 2016	During the month of April, EW worked the following shifts: • April 4, 2016 • April 8, 2016 • April 10, 2016 • April 11, 2016 • April 12, 2016 • April 13, 2016 • April 14, 2016 • April 17, 2016 • April 18, 2016	LTCI00026311
40.	May 4, 2016 – May 16, 2016	Wilmot-Smith emails Cornelissen, stating that she and Wilmot-Smith have met with EW. Wilmot-Smith asks if Cornelissen is free to meet the following week.	LTCI00024211 LTCI00017406

	DATE	EVENT	SOURCE DOC ID
		On May 10, 2016 Cornelissen writes "Sorry what are we meeting to discuss?" Wilmot-Smith responds on May 11, 2016 stating "I thought it would be helpful to meet over your concerns with Bethe, and the outcome of meetings [. . .]" On May 16, 2016 Cornelissen agrees to look at her calendar and get back to Wilmot-Smith. In the interim, she asks why Wilmot-Smith "charged 54.5 hours for Beth and am just confused as to why as after reviewing my schedule and OT requests there were none made."	
41.	May 26, 2016	Service Agreement entered into between Revera Long Term Care Inc. and A-Supreme Nursing and Homecare for various locations including Telfer Place.	LTCI00072548
42.	July 11, 2016	Medication Error Report prepared by Cornelissen re incident of March 31, 2016. Incident was discovered – March 31, 2016 – Medication was presigned for but not poured – nurse did not double-check before final signing.	LTCI00024247
43.	October 4, 2016	Police Officer Eastlake attends Telfer Place and speaks with Cheryl Muise ("Muise"), Regional Manager Clinical Services, Cornelissen, and Lindsay Astley, ADOC re EW. Police advise that EW checked herself into care and admitted killing eight long term care residents with high doses of short acting and long acting insulin. Police advise that EW attempted two other murders but they survived, one of which was Sandra Towler in the Winter of 2016. Sandra Towler chart review completed re Winter of 2016 showing no significant incidents.	LTCI00025584
44.	October 5, 2016	Telfer Place submits Critical Incident Report 2742-000013-16 in relation to EW's attempted murder of Ms. Towler. Officer Overbaugh and Officer Eastlake attend Telfer Place and speak to Cornelissen and Cheryl Muise, Regional Director Clinical Services. The police report that EW had stated "that she attempted to kill the resident Sandra Towler at Telfer Place by giving her 60 units of fast acting insulin and 80 units of long acting insulin but she survived sometime in the Winter of 2016."	LTCI00025584
45.	October 5, 2016	Revera on behalf of Telfer Place prepares Report Form for Facility Operators and Employers under Section 85.2 of the RHPA – Incapacity re EW.	LTCI00025687

	DATE	EVENT	SOURCE DOC ID
		Revera reports what police had advised when they attended Telfer Place on October 4, 2016	
46.	October 7, 2016	Constable Eastlake contacts Telfer Place and advises that EW had provided additional information that the nurse who had "corrected" what she had done was Dianne Beauregard RN. Telfer Place submits an Amended Critical Incident Report outlining the events of September 6 and 7, 2015.	LTCI00025584
47.	October 12, 2016	A Quality Improvement Form Adverse Event Retrospective Review is prepared. Among other things, Telfer Place cross-references EW's shIfts with resident deaths and determines no foul play has occurred. The Review also identifies the factors contributing to the event as: *Severe long term staffing shortage at Telfer has lead to significant agency use. Measures have been put in place to reduce agency use at Telfer.*	LTCI00025852
48.	November 28 - 29, 2016	Telfer Place conducts an internal investigation. Jim Eagleton, Administrator for Telfer Place, conducts interviews with the following staff: • Dianne Beauregard, RN • Michele Pender – PSW • Susan Brown – PSW • Sheila Jansen – PSW • Karen Fedor – PSW • Cody Best – PSW • Ginny Sims – PSW • Dianne Millward – PSW • Lauren Gallant – PSW • Lynn Jackson – PSW	LTCI00024138 LTCI00024140 LTCI00024142 LTCI00024144 LTCI00024145 LTCI00024147 LTCI00024149 LTCI00024151 LTCI00024153 LTCI00024155
49.	December 5, 2016	Letter from College of Nurses of Ontario to Telfer Place c/o Revera advising that Remy Pearson, Investigator, Professional Conduct Department, has been appointed to investigate EW's nursing practice pursuant to Section 75(a) of the *Health Professions Procedural Cod*e and the *Nursing Act, 1991*.	LTCI00025742

VOLUME 7(i)(C): TELFER PLACE

RELEVANT STANDARDS, GUIDELINES, POLICIES AND PROCEDURES

NO.	DOCUMENT	SOURCE DOC ID
A. Rights of Residents		
1.	LTC – Residents' Bill of Rights – Eff. Aug/16	LTCI00072539
B. Staffing and Administration		
2.	External Service Provider Agencies - Eff. Apr/11. Rev. Aug/12	LTCI00025535
3.	External Service Provider Agencies - Eff. Apr/11, Rev. Aug/16	LTCI00025542
4.	External Service Provider Agencies - Eff. Apr/11, Rev. Aug/16	LTCI00025543
5.	External Service Provider Agencies – Eff. April/11, Rev. Mar/18	LTCI00072552
6.	Staffing Plan (2014)	LTCI00025737
7.	Staffing Plan (2016)	LTCI00025770
8.	Staffing Plan (2017)	LTCI00025795
9.	Template Nursing Agency Agreement	LTCI00072531
C. Training and Education		
10.	Medication Incidents – Omissions (February 2015)	LTCI00024469
11.	Annual Education for Contracted Services	LTCI00025545
12.	Agency Staff Orientation Checklist – Reg. Staff	LTCI00025539
13.	Agency Onboarding (2012)	LTCI00072521
14.	Agency Orientation	LTCI00072513
15.	Orientation Checklist – Registered Staff – Rev. Nov/14	LTCI00073543
16.	General Orientation Checklist – All Departments – Long Term Care – April/16	LTCI00072542
17.	Part 2 – Role/Discipline Specific Onboarding Checklist – Agency Registered Staff – Aug/10, Rev. Dec/16	LTCI00072553
18.	Resident Non-Abuse, Toolkit for Conducting an Alleged Abuse Investigation (November 2010)	LTCI00025704
19.	Medication Administration Presentation (June 2013	LTCI00025574
20.	Self-Administration of Medication (June 2013)	LTCI00025587
21.	Mandatory Education Standards (August 2016)	LTCI00072532

NO.	DOCUMENT	SOURCE DOC ID
22.	FAQs – Medication Management (February 2017)	LTCI00025693
23.	Medication Management – LTC Competency Team (2017)	LTCI00024498
24.	Medication Management – LTC Competency Team (February 2017)	LTCI00024533
25.	Medication Management (undated)	LTCI00027486
26.	Treatment of Hypoglycemia	LTCI00072551
27.	Managing Responsive Behaviours (undated)	LTCI00025823
D. Medication Management		
28.	Medication/Treatment Standards – Medication – Eff. Sept/01, Rev. Aug/12 and Nov/15	LTCI00025600
29.	Medication – LTC Medication Management – Eff. Aug/16	LTCI00025681
30.	Medication – LTC Medication Management – Eff. Aug/16, Rev. Aug/17	LTCI00025701
31.	Medication – LTC Medication Risk Management – Eff. Aug/16	LTCI00025684
32.	Medication – LTC Medication Risk Management – Eff. Aug. 16, Rev. Aug/17	LTCI00025695
33.	Medication Risk Management – High Alert Medications – Eff. Mar/09, Rev. July/14	LTCI00072519
34.	LTC – High Alert Medications – Eff. Aug/16	LTCI00072540
35.	MediSystem Facts – High Alert Medications	LTCI00072517
36.	ISMP High-Alert Medications in Acute Care Settings	LTCI00072512
37.	ISMP High-Alert Medications in LTC (added 2017)	LTCI00072512
38.	Diabetes Management Eff. Mar/17	LTCI00072520
E. Purchasing and Handling of Drugs		
39.	Drug Record Book Procedure – Eff. April/02, Rev. Nov/15	LTCI00072523
40.	Ordering and Receiving Medications – Receiving the Classic Care Pharmacy Delivery Eff. April/02, Rev. July 2014	LTCI00072529
F. Safe Storage of Drugs		
41.	Safe Storage of Medications – Eff. April 2002, Rev. July 2014	LTCI00072526
G. Administration of Drugs		
42.	Medication/Treatment Standards – High Alert/High Risk Medications – Independent Double Check – Eff. Feb/12, Rev. May/13	LTCI00025603
43.	Medication/Treatment Standards – Medication Administration – Eff. Sept/10, Rev. Aug/12 and Jan/16)	LTCI00025597
44.	Medication – LTC Medication Administration – Eff. Aug/16, Rev. Aug/17	LTCI00025698
45.	Adminstering and Documenting Controlled Substances – Eff. April/02, Rev. July 2014	LTCI00072525
46.	Administering Routine Medications – Eff. April/02, Rev. July/14	LTCI00072524

NO.	DOCUMENT	SOURCE DOC ID
H. Medication Incidents and Adverse Drug Reactions		
47.	Medication/Treatment Standards – Medication Incidents – Eff. Sept/01, Rev. Nov/15	LTCI00025601
48.	Medication – LTC Medication Incidents – Eff. Aug/16	LTCI00025691
I. Drug Destruction and Disposal		
49.	Medication Disposal – Eff. April 2002, Rev. July/14	LTCI00072527
50.	Medication Disposal – Controlled Substances/LTCH's – Eff. April/02, Rev. July/14	LTCI00072528
J. Dementia Care/Responsive Behaviours		
51.	Interprofessional Clinical Programs – Dementia Care – Eff. May/11, Rev. Aug/12 and Feb/14	LTCI00025812
52.	Dementia Care – LTC Dementia Care Program – Eff. Aug/16	LTCI00025815
53.	Dementia Care – LTC Dementia Care – Assessment and Planning – Eff. Aug/16	LTCI00025817
54.	Dementia Care – LTC – Dementia Care Program – Eff. Aug/16	LTCI00025819
55.	Dementia Care – LTC – Dementia Care – Assessment and Care Planning – Eff. Aug/16, Rev. Aug/17	LTCI00025821
K. Abuse and Neglect		
56.	Risk Management – Resident Non-Abuse – Eff. Sept/01, Rev. Apr/11	LTCI00025726
57.	Resident Non-Abuse – Resident Non-Abuse Program – Eff. Aug/16	LTCI00025739
58.	Resident Non-Abuse – Resident Non-Abuse Program – Eff. Aug/16, Rev. Aug/17	LTCI00025747
59.	Types & Definitions of Abuse and Neglect (undated)	LTCI00025734
60.	Resident Non-Abuse – Investigation of Abuse or Neglect – Eff. Aug/16	LTCI00025737
L. Concerns, Complaints		
61.	Management of Concerns, Complaints, and Compliments – Eff. Aug/16, Rev. Oct/17	LTCI00072537
M. Critical Incident Reporting		
62.	Resident Non-Abuse - Mandatory Reporting of Resident Abuse and Neglect. Eff. Aug/16	LTCI00025744
63.	Resident Non-Abuse - Mandatory Reporting of Resident Abuse and Neglect. Eff. Aug/16, Rev. Oct/17	LTCI00025750
N. End of Life Care, Pronouncement and Process on Death of a Resident		
64.	Procedure Upon Death of a Resident – Eff. Aug/16	LTCI00072541
O. Quality and Risk Management		
65.	Quality Risk Improvement Team Terms of Reference – Eff. Apr/14	LTCI00024195
66.	Clinical Quality and Risk Committee Terms of Reference (May, 2015)	LTCI00024204

NO.	DOCUMENT	SOURCE DOC ID
67.	Risk/Quality Improvement Committees, Structure and Membership	LTCI00024307
68.	Quality Program – LTC Quality Program - Eff. Aug/16	LTCI00024302
69.	Quality Program – LTC Quality Program - Eff. Aug/16, Rev. Aug/17	LTCI00024353
70.	Quality Reporting Schedule (undated)	LTCI00026275
71.	Staff Orientation & Education – Annual Program Evaluation Part 2 (March 2016)	LTCI00024226
72.	Staff Orientation & Education Support Office Program Evaluation (March 2016)	LTCI00025789
73.	Responsive Behaviours Program Evaluation (2014)	LTCI00026290
74.	Responsive Behaviours Program Evaluation Part 2 (2016)	LTCI00024213
75.	Medication Management & Medical Services Program Evaluation (2014)	LTCI00026287
76.	Medication Management Support Office Program Evaluation (March 2016)	LTCI00024235
77.	Medical Services Support Office Program Evaluation Summary (March 2016)	LTCI00024219
78.	Medical Services Program Evaluation (April 2017)	LTCI00024351
79.	Resident Non Abuse Program Evaluation Part 2 (2016)	LTCI00024240
80.	Resident Non Abuse Support Office Program Evaluation (March 2016)	LTCI00024285
81.	Resident Abuse Program Evaluation (2014)	LTCI00026281
82.	Resident Abuse Program Evaluation (March 2017)	LTCI00024346
P. Human Resources		
83.	Hiring “A” Player’s Toolkit (undated)	LTCI00025398
84.	Hiring – Eff. Mar/17	LTCI00025528
85.	Recruitment – Eff. Mar/17	LTCI00025529
86.	Recruitment Procedure – Eff. Mar/17	LTCI00025533
87.	Reference Requests – Eff. Mar/13	LTCI00025412
88.	Background Checks – Eff. Mar/17	LTCI00025530
89.	Front Line Performance Appraisals – Eff. Mar/13	LTCI00025409
90.	Performance Management – Eff. Oct/11, Rev. Sept/13	LTCI00025415
91.	Part 2 – Role/Discipline Specific Onboarding Checklist – Aug/10, Rev. Dec/16	LTCI00025568
92.	Terminations – Eff. Oct/11	LTCI00025408
93.	Code of Conduct & Business Ethics (undated)	LTCI00027194

VOLUME 7(ii): ANSON PLACE

CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Anson Place Care Centre is a long-term care home located in Hagersville, Ontario ("Anson Place") licensed to Revera Long Term Care Inc. ("Revera"). Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to Anson Place at various times between April, 2015 and February, 2016.

The chronology below outlines EW's work history at Anson Place. One internal complaint is noted by EW regarding a RPN, after which EW is no longer assigned by Lifeguard to any shifts at Anson Place.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	November 11, 2014	Anson Place and Lifeguard enter into a Service Contract and Agreement for Payment. Lifeguard to provide the services of professional health care staff, including Registered Nurses and Registered Practical Nurses, and when requested, P.S.W.s etc. Service Contract is signed by Lisa Roth, Administrator for Anson Place and Heidi Wilmot-Smith ("Wilmot-Smith"), President of Lifeguard. All staff provided by Lifeguard are to be "in Good Standing with the College of Nurses where applicable, and have a valid registration certificate. Additionally the company will submit, upon request, Proof of WSIB and liability coverage".	LTCI00055928
2.	April 5, 2015	EW is assigned her first shift at Anson Place consisting of orientation (18:30 – 22:30) and then a night shift (22:30 – 06:30)	LTCI00055962
3.	April 15, 2015	EW works 18:30 to 22:30 (orientation)	LTCI00055962 LTCI00055930
4.	April 16, 2015	EW works 06:30 to 14:30	LTCI00055962 LTCI00055930
5.	April 17, 2015	EW works 06:30 to 17:30.	LTCI00055962 LTCI00055930

	DATE	EVENT	SOURCE DOC ID
6.	May 13, 2015	EW works 22:30 to 06:30	LTCI00055964 LTCI00055931
7.	September 24, 2015	EW works 07:00 to 15:00.	LTCI00055965 LTCI00055932
8.	February 2, 2016	EW works 14:30 – 22:30.	LTCI00055966 LTCI00055933
9.	February 15, 2016	EW works 22:30 to 06:30.	LTCI00055967 LTCI00055934
10.	February 24, 2016	EW works 14:30 – 22:30	LTCI00055968
11.	February 25, 2016	EW works 14:30 – 22:30 Noted by M. Klitzke, RN, Director of Nursing, that she received a call at 17:30 from EW, identified as the agency nurse in charge, reporting that during report an RPN (BV) was vulgar and disruptive. EW further reports that BV is also insisting that EW do treatment which should be done by the RPN on shift. Notes the following about EW: *Bethe does not often work in the home, she is not a whirlwind of activity, but we have had no indication from past experience that her performance is not adequate. Her documentation is complete, assessments are sound, and critical thinking skills intact. She had her conversation with B. behind closed doors in the med room indicating a professional thought process.* *I find it hard to believe that Bethe would have reason to purposely fabricate the incidents she is reporting, given the fact that B. has been known to be less than professional and reasonable on previous occasions.*	LTCI00055968 LTCI00055935
12.	August 12, 2016	Louise Allard of Lifeguard emails Danielle Simington of Anson Place to advise of the CNO Registration Numbers for Lifeguard staff, including EW.	LTCI00038422
13.	November 16, 2016	In an interview conducted by the Ministry of Health and Long-term Care regarding Inspection 2016_205129_0014, it is noted that Maryanne Klitzke, Director of Care, advised that Anson Place's nursing scheduling clerk was directed to contact Lifeguard after EW's shift on February 25, 2016 and advise that they did not want EW to return to the home after her last shift. The reasons given are noted as the argument that occurred on February 25, 2016, as well as:	LTCI00038479

DATE	EVENT	SOURCE DOC ID
	- S*he seemed abrupt when communicating with staff – seemed to command instead of provide directions to front line staff, she portrayed an impression of arrogance.* - *It was a feeling that her approach did not fit in the "team" and the way the team was use to interacting with one another*	

VOLUME 7 (iii): FOX RIDGE CARE COMMUNITY CHRONOLOGY AND SOURCE DOCUMENTS:

SUMMARY:

Fox Ridge Care Community ("Fox Ridge"), is a long-term care home located in Brantford, Ontario, licensed to 2063414 Ontario Limited as General Partner of 2063414 Investment Lp, owned indirectly through Leisureworld Senior Care LP, by Sienna Senior Living Inc.

Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to two shifts at Fox Ridge between May and June, 2015.

The chronology below outlines EW's work history at Fox Ridge. It identifies a medication incident on EW's first shift at Fox Ridge.

CHRONOLOGY

	DATE	EVENT	SOURCE DOC ID
1.	April 27, 2015	EW is assigned to an evening shift at Fox Ridge, working 14:00 – 23:00. Her first hour is for orientation. During her first shift at Fox Ridge, EW missed giving a resident (WS) his 20:00 codeine 15 mg. The incident was reported by an RPN and the Supervisor notifed. A Medication Incident Report was completed.	LTCI00069238 LTCI00069239 LTCI00069260
2.	June 22, 2015	EW works 15:00 to 23:00. Progress Note entered by EW at 22:23 identifies that as she was giving a resident (MM) her insulin, the resident hit the needle, resulting in a 3cm x 3cm scratch to the resident.	LTCI00069236 LTCI00069237 LTCI00069259

VOLUME 7(iv): PARK LANE
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Park Lane Terrace Long Term Care Centre is a long-term care home located in Paris, Ontario ("Park Lane"), licensed to Park Lane Terrace Limited. Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to Park Lane for four shifts between May and July, 2015.

The chronology below outlines EW's work history at Park Lane.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	May 11, 2015	EW, through her employment with Lifeguard Homecare Inc. ("Lifeguard") works an evening shift at Park Lane. A faxed copy of a Woodstock Police Service's RCMP records check for EW, dated April 22, 2014, appears to have been provided to Park Lane. The document provides that "A search of the National Criminal Records Repository maintained by the RCMP did not identify any records for a person with the name and the date of birth of the applicant" nor was a record of a sexual offence for which a pardon has been granted identified. Clearance is for employment with the vulnerable sector. EW works a total of four shifts at Park Lane, with the first shift stated to have taken place on May 11.	LTCI00048722 LTCI00048727
2.	May 12, 2015	EW works a 7.5-hour evening shift at Park Lane.	LTCI00048724
3.	June 19, 2015	EW works a 7.5-hour evening shift at Park Lane.	LTCI00048726
4.	July 12, 2015	Park Lane and Lifeguard Homecare ("Lifeguard") enter into a Service Contract and Agreement for Payment. Lifeguard is to provide the services of professional health care staff, including Registered Nurses and Registered Practical Nurses. All staff provided by Lifeguard are to be in "Good standing with the College	LTCI00048728 LTCI00048729

	DATE	EVENT	SOURCE DOC ID
		of Nurses where applicable and have a valid registration certificate". Additionally, Lifeguard is to submit, upon request, proof of WSIB and liability insurance coverage. The contract is signed by JoAnne Halloway of Park Lane. There is no signatory for Lifeguard.	
5.	July 24, 2015	EW works an 8.0-hour night shift at Park Lane.	LTCI00048725
6.	March 4, 2016	Park Lane Orientation Binder sign-in sheet is signed by EW. During an inspection by the Ministry of Health and Long-term Care in 2016, it is noted that neither Park Lane nor Lifeguard believe that EW worked at Park Lane on that date.	LTCI00042535L TCI00042581
7.	October, 2016	Park Lane is contacted by the OPP regarding EW. Park Lane conducted an internal investigation and as a result of that investigation concluded that there was no negative outcome caused by EW to residents of Park Lane.	LTCI00048723
8.	Undated	Summary of all interactions between Lifeguard, EW and Park Lane relating to EW's shifts at Park Lane. Noted that an internal investigation had taken place that indicated that there were no incidents/adverse events.	LTCI00048722

VOLUME 7 (v): HARDY TERRACE

CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Hardy Terrace Care Community ("Hardy Terrace") is a long-term care home located in Brantford, Ontario, licensed to Diversicare Canada Management Services Co. Inc. Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to four shifts at Hardy Terrace in May, 2015.

The chronology below outlines EW's work history at Hardy Terrace.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	September 16, 2014	Hardy Terrace and Lifeguard enter into a "Staffing Service Agreement", stipulated to establish the minimum standards required of any staffing angency before entering into an agreement with that agency. The Agreement stipulates that Lifeguard shall ensure that any worker who is represented as a registrant of any College is, in fact, currently registered and in good standing. Lifeguards is o provide a list of appropriate documentation confirming the registration etc. Among other things, Lifeguard is to ensure that appropriate background checks are complete, including "appropriate reference checks, a criminal records check, and a vulnerable persons screening". The Agreement also provides that workers are expected to "Respect the rights of residents, and act in such a way as to uphold their dignity, well being, security and safety, in an environment free of abuse and in which residents are treated with fairness, respect and courtesy, and their emotional and physical needs are met". The Agreement is signed by Heidi Wilmot-Smith, President of Lifeguard ("Wilmot-Smith") and the Regional Manager of Diversicare.	LTCI00069274
2.	December 11, 2014	Hardy Terrace and Lifeguard enter into a Service Contract and Agreement for Payment. Lifeguard is to provide the services of professional health care staff, including Registered Nurses and Registered Practical Nurses. All staff provided by Lifeguard are to be in "Good standing with the College of Nurses where applicable and have a valid registration	LTCI00069275 LTCI00069276

		certificate". Additionally, Lifeguard is to submit, upon request, proof of WSIB and liability insurance coverage. It is signed by Dennis Boschetto of Diversicare and Wilmot-Smith.	
3.	May 21, 2015	EW is assigned the following shifts at Hardy Terrace: • May 22, 2015 15:00 – 19:00 (orientation) • May 24, 2015, 15:00 to 23:00 • May 28, 2015, 15:00 to 23:00 • May 29, 2015, 15:00 to 23:00	LTCI00069270
4.	May 22, 2015	EW receives four hours of orientation from 16:00 to 20:00.	LTCI00069265 LTCI00069266 LTCI00069267
5.	May 24, 2015	EW is absent from her scheduled shift (sick).	LTCI00069266
6.	May 27, 2015	EW works 15:00 to 23:00.	LTCI00069265 LTCI00069266 LTCI00069268

VOLUME 7(vi): DELROSE RETIREMENT RESIDENCE CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Delrose Retirement Residence is located in Delhi, Ontario ("Delrose"). It is not a long-term care home. Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to Delrose for a number of shifts between September, 2015 and January 2016.

The chronology below outlines EW's work history at Delrose. There were two medication errors noted and eventually Delrose advised Lifeguard not to assign any more shifts to EW at Delrose because she was seen eating the residents' food.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	September 25, 2015	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
2.	November 1, 2015	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
3.	November 6, 2015	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
4.	November 13, 2015	According to documents produced by Lifeguard, Louise Allard of Lifeguard emails Ms. Heidi Wilmot-Smith, President of Lifeguard ("Wilmot-Smith"), stating that "Bonnie" from Delrose had called to report two medication errors by EW on November 2 and 7, 2015. Both involved EW applying a full patch of nitroglycerin to two residents when the prescription only called for ½ patch. Ms. Allard reports that she spoke to EW about the medication errors when she called in and states "she seems to have been aware of this." Ms. Allard notes that she spoke with Bonnie to advise her that she had spoken to EW.	LTCI00017395

	DATE	EVENT	SOURCE DOC ID
5.	November 13, 2015	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
6.	November 14, 2015	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
7.	December 26, 2015	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
8.	January 14, 2016	EW works a night shift at Delrose.	LTCI00054944 LTCI00054946
9.	February 1, 2016	Bonnie Guthrie, Administrator ("Guthrie"), emails Wilmot-Smith re EW as follows: *Hi Heidi, hope you are doing well and you had a good holiday.* *Sorry to have to bring this to your attention but I am not comfortable having Beth working in the building. I have been reviewing some video footage regarding an employee and came across Beth on Dec 26th night shift. On Dec. 27th at 1:53 am Beth takes the left over squares from supper out of the fridge to wrap them (one of the jobs). She opens the box and eats a square right over top of the other ones. She continues to then wrap the squares while eating more and then eats the leftovers out of the box before throwing it out. Stealing food is considered theft in this work place and it is not sanitary to eat over top of other food.* *We can discuss if you would like but that is pretty much the details.* Wilmot-Smith responds that they will not send EW back.	LTCI00054945
10.	October 26-27, 2016	Wilmot-Smith emails Guthrie outlining the dates that it believes EW worked at Delrose. [Delrose agrees with all but April 28, 2015, which Delrose refers to as April 8, 2015].	LTCI00054944 LTCI00054943
11.	October 27, 2016	Guthrie responds to Wilmot-Smith: *I have reviewed all the progress notes in the residents carts for the dates you sent me. There is nothing charted that would be of concern and there were no resident health issues in which a resident needed ambulance/hospital care.*	LTCI00054944

VOLUME 7(vii): BRIERWOOD GARDENS CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Brierwood Gardens is a long-term care home located in Brantford, Ontario, licensed to Revera Long Term Care Inc. ("Revera"). Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to Brierwood Gardens for a number of shifts in 2015 and 2016.

The chronology below outlines EW's work history at Brierwood Gardens.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	July 25, 2013	Brierwood Gardens and Lifeguard enter into a Service Contract and Agreement for Payment. Lifeguard is to provide the services of professional health care staff, including Registered Nurses and Registered Practical Nurses. All staff provided by Lifeguard are to be in "Good standing with the College of Nurses where applicable, and have a valid registration certificate. Additionally, Lifeguard is to submit, upon request, proof of WSIB and liability insurance coverage (WSIB and Insurance Coverage submitted). 2012 Charge Out Rate document identifies that all Lifeguard employees are bonded and insured and that references are provided on request. Catherine Donahue signs the contract on behalf of Brierwood Gardens. Lifeguard's signatory is illegible.	LTCI00054939 LTCI00054940 LTCI00054941 LTCI00054942
2.	May 30, 2015	Lifeguard invoice indicates that EW receives two hours of orientation and works	LTCI00069594
3.	June 1, 2015	Lifeguard invoice indicates that EW works an 8 hour shift.	LTCI00069595
4.	June 2, 2015	Lifeguard invoice indicates that EW works an 8 hour shift.	LTCI00069595
5.	June 17, 2015	Lifeguard invoice indicates that EW works a 7 hour shift.	LTCI00069596

6.	July 3, 2015	Lifeguard invoice indicates that EW works an 8 hour shift.	LTCI00069597
7.	July 4, 2015	Lifeguard invoice indicates that EW works an 8 hour shift.	LTCI00069597
8.	August 25, 2015	Lifeguard invoice indicates that EW works a 7.5 hour shift.	LTCI00069598
9.	August 29, 2015	Lifeguard invoice indicates that EW works a 7.5 hour shift.	LTCI00069599
10.	February 14, 2016	Lifeguard invoice indicates that EW works a 6.75 hour shift.	LTCI00069600
11.	May 1, 2016	EW works 22:15 to 06:15.	LTCI00056231 LTCI00056233 LTCI00056268
12.	May 2, 2016	EW works 22:15 to 06:15.	LTCI00056231 LTCI00056233 LTCI00056268
13.	May 4, 2016	EW works 06:15 to 14:15.	LTCI00056231 LTCI00056233 LTCI00056268
14.	May 7, 2016	EW works 06:15 to 10:15.	LTCI00056231 LTCI00056233 LTCI00056268
15.	May 8, 2016	EW works 06:15 to 14:15.	LTCI00056231 LTCI00056233 LTCI00056268
16.	May 9, 2016	EW works 06:15 to 14:15.	LTCI00056231 LTCI00056233 LTCI00056268
17.	May 11, 2016	EW works 06:15 to 14:15.	LTCI00056231 LTCI00056233 LTCI00056268
18.	May 12, 2016	EW works 06:15 to 14:15.	LTCI00056231 LTCI00056233 LTCI00056268
19.	May 13, 2016	EW works 22:15 to 06:15.	LTCI00056231 LTCI00056233 LTCI00056268
20.	May 14, 2016	EW works 22:15 to 06:15.	LTCI00056232 LTCI00056233 LTCI00056268
21.	May 15,	EW works 22:15 to 06:15. [Noted as May 16 on Lifeguard invoice].	LTCI00056232

	2016		LTCI00056233
22.	May 20, 2016	EW works 22:15 to 06:15. [Noted as May 21 on Lifeguard invoice]	LTCI00056232 LTCI00056233
23.	May 21, 2016	EW works 22:15 to 06:15. [Noted as May 22 on Lifeguard invoice]	LTCI00056232 LTCI00056233 LTCI00056269

VOLUME 7(viii): DOVER CLIFFS
CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Dover Cliffs is a long-term care home located in Port Dover, Ontario ("Dover Cliffs"), licensed to Revera Long Term Care Inc. ("Revera"). Elizabeth (Bethe) Wettlaufer ("EW") was assigned by Lifeguard Homecare Inc. ("Lifeguard") to Dover Cliffs for three shifts in August, 2016.

The chronology below outlines EW's work history at Dover Cliffs.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	July 28, 2016	Dover Cliffs and Lifeguard enter into a Service Contract and Agreement for Payment. Lifeguard is to provide the services of professional health care staff, including Registered Nurses and Registered Practical Nurses. All staff provided by Lifeguard are to be in "Good standing with the College of Nurses where applicable, and have a valid registration certificate. Additionally, Lifeguard is to submit, upon request, proof of WSIB and liability insurance coverage. Pauline Robinson signs the contract on behalf of Dover Cliffs. There is no signatory for Lifeguard.	LTCI00054938
2.	August 5, 2016	EW works 18:00 – 24:00 where she completes orientation and is on floor with Dover Cliffs staff.	LTCI00054921
3.	August 5, 2016	EW signs Acknowledgement and Understanding of Obligations Related to Revera's Resident Non-Abuse Policy, that she has read and understood all requirements of Revera's Resident Non-Abuse Policy, and that she commits to providing care in keeping with its requirements. EW acknowledges that she has been informed of her obligation to report unlawful conduct, improper or incompetent treatment or care. In the case of abuse, suspected abuse, or witness of abuse, or having knowledge of an incident, EW agrees to report the incident immediately to the Department Manager or most senior supervisor available.	LTCI00054922 LTCI00054923 LTCI00054924 LTCI00054901 LTCI00054927 LTCI00054903 LTCI00054930 LTCI00054908
4.	August 5, 2016	Certificate of Completion, Revera Resident Non-Abuse Program, is issued for EW, stating that she has attended the re-certification training.	LTCI00054904

5.	August 6, 2016	EW works 10:00 – 06:00.	LTCI00054914 LTCI00054916 LTCI00054921
6.	August 7, 2016	EW works 10:00 – 06:00.	LTCI00054917 LTCI00054915 LTCI00054921

VOLUME 8: SAINT ELIZABETH HEALTH CARE CHRONOLOGY AND SOURCE DOCUMENTS

SUMMARY:

Saint Elizabeth Health Care ("Saint Elizabeth") is a not-for-profit charitable organization that is the largest community home care provider in Ontario. Saint Elizabeth is a Service Provider under the *Home Care and Community Services Act, 1994*, S.O. 1994, c. 26. Saint Elizabeth employed Elizabeth (Bethe) Wettlaufer ("EW") between June, 2016 and August, 2016. During that time period, EW was assigned to shifts at private homes, including the home of Ms. Beverly Bertram. EW admitted unlawfully injecting Beverly Bertram with insulin on August 20, 2016. The insulin had been stolen from the home of another individual for whom EW was providing services on behalf of Saint Elizabeth.

The chronology below outlines EW's employment with Saint Elizabeth and her attempted murder of Ms. Bertram.

CHRONOLOGY:

	DATE	EVENT	SOURCE DOC ID
1.	April 3, 2014	EW registers online as a candidate for employment with Saint Elizabeth. EW provides Saint Elizabeth with her Resume – date unknown	LTCI00065455 LTCI00065455
2.	April 11, 2014	EW's online "Requisition Specific Status" has been changed from "New" to "Declined". Reason for Rejection is noted as follows: *Met basic qualifications, more qualified candidate selected. Comments: As per Tamara Condy, she does not want to arrange interview due to reasons why applicant left last position*	LTCI00065455
3.	January 16, 2016	EW's online status indicates "Candidate added self to requisition Registered Nurse (Visiting and Clinic]".	LTCI00065455
4.	June 1, 2016	An email is sent to EW regarding opportunities at Saint Elizabeth.	LTCI00065455
5.	June 2, 2016	In a Pre-Interview Questionnaire EW states that she is interested in joining Saint Elizabeth because she enjoys community nursing and one-on-one care with patients, noting that it helps to take the load off of hospitals. She believes her last or current manager would say that her clinical skills are good but that she should continue to strive toward professionalism. When asked to describe a time when someone passed away in long term care	LTCI00065420

	DATE	EVENT	SOURCE DOC ID
		and she didn't know the procedures. She followed procedure as per her experience. She called the family, informed authorities, documented everything, and looked through the books. She made sure she had "followed the list."	
6.	June 3, 2016	Online requisition for Registered Nurse completed by Saint Elizabeth.	LTCI00065455
7.	June 6, 2016	In a Pre-Hire Report completed by Saint Elizabeth staff, it is noted that EW's references commented, among other things, as follows: *WORK RELATED STRENGTHS:* *Elizabeth showed adaptability and was able to work with strength in our model of nursing. We are computerized with EMAR and work in a pod system that she was very capable of doing, while also being in charge of the whole unit. We have a lot of needy and challenging residents that are very distracting and she coped amazingly well with them with interaction and redirection. She was always where she was supposed to be, she was prompt and efficient. The one issue that sticks out is that I witnessed when she fell off one of our rolling chairs first thing in the morning, could have had many issues from that bad fall, but she jumped to her feet and kept on going all day, I did not hear any more about it. I am sorry that we could not hire her because she would be an asset to anyone's team. I wish her well.* ****** *Beth is a caring individual who deals well with the elderly. She works well with others. Beth took and interest in the students that worked here and would educate on different practices.* *WORK-RELATED AREAS FOR IMPROVEMENT:* *Elizabeth is an honest and hard worker. I really cannot critique how she could improve. She worked in our facility in absence of our day charge nurse while we were in our Annual Inspection from the MOH and she was an absolute professional. She showed integrity because we did try to pirate her to our staff but she was under contract with her agency and maintained that stance.* ****** *There was an issue with attendance at the time. She did have some medical issues which I believe are resolved at the present time.* The references that participated were: • Ms. Adkin – Brierwood Gardens, RAI Coordinator • Ms. Fluttert – Caressant Care, Assistant Director of Nursing	LTCI00071983

	DATE	EVENT	SOURCE DOC ID
		• Ms. Laycock – Caressant Care, RPN	
8.	June 3, 2016	Saint Elizabeth receives confirmation from the Canadian Red Cross that EW holds certifications in CPR and Standard First Aid.	LTCI00065431
9.	June 17, 2016	EW's online status changed from "New" to "Declined". Reason for Rejection noted as "Accepted offer from another employer".	LTCI00065455
10.	June 27, 2016	Online requisition for Registered Nurse completed by Saint Elizabeth. Status Change changed from "Available" to "Hired".	LTCI00065455
11.	June 27, 2016	EW is offered employment at Saint Elizabeth in the position of part-time Registered Nurse. Her start date is identified as July 11, 2016. The offer provides that she is to comply with all of the professional obligations of her Regulatory College and "In addition, you agree to comply with our Code of Conduct and policies, procedures, and practice guidelines ("Policies") as amended from time to time (access to which is immediately available upon request)". EW signs off on the offer of employment on July 14, 2016.	LTCI00065442 LTCI00065411
12.	June 29, 2016	Confirmation is obtained from the Woodstock Police Service that "A search of the National Criminal Records Repository maintained by the RCMP did not identify any records for a person with the name and the date of birth of the applicant" nor was a record of a sexual offence for which a pardon has been granted identified. Clearance is for employment with the vulnerable sector.	LTCI00065441
13.	July 1, 2016 - July, 2016	EW completes various Saint Elizabeth Human Resource courses, including courses on documentation, medication administration, workplace violence, and others. EW completes an RN Nursing Practice Questionnaire.	LTCI00065457 LTCI00065461
14.	July 11, 2016	EW completes a "New Hire – Required Info" sheet from Saint Elizabeth.	LTCI00065426
15.	July 14, 2016	Saint Elizabeth obtains information from the "Find a Nurse" section of the College of Nurses of Ontario's website, which indicates that EW is licensed to practice with no restrictions.	LTCI00065429
16.	August 8, 2016	Saint Elizabeth is approved to provide services to a client ["Client A"] who resides in Ingersoll and is in need of pain and symptom management and health teaching re medications etc. Client A is diabetic and insulin-dependent.	LTCI00065832

	DATE	EVENT	SOURCE DOC ID
17.	August 12, 2016	Tamara Condy completes a Probation Observation Visit with EW, which includes a visit to Client A.	LTCI00065466 LTCI00065474 LTCI00065477 LTCI00065808
18.	August 12, 2016	EW is scheduled to visit Client A. EW makes a note in the client's "Best Possible Medication List" that the pharmacy sent the wrong dose of hydromorph contin. Progress Note entered by EW as follows: *Client seen for complex symptom management. Given Proviodine to put on toe. VSS today. Blood sugar is 15 today. Pharmacy gave 9mg hydromorph BID when she has 18mg BID ordered. She will pick up difference tomorrow.* EW records Client A's blood glucose as 15.	LTCI00065477 LTCI00065808 LTCI00065828 LTCI00065844 LTCI00065848
19.	August 13, 2016	Another RN, Patricia Harmer, visits Client A. Progress Note entered as follows: *Met with pt for pain & symptom management. Pt was on 15 mg Hydromorph Contin BID (9mg + 6mg) not 9mg BID. With new blister pack [increased] to 18 mg po BID as per Dr. Collins. Pt unsure if mind was unclear today due to [increased] HC or [decreased] BS. Pt reports BS 3.9 @ 16:30. Pt ate glucose, peanut butter & jam sandwich oatmeal cookie & an orange.* *HT re how to correct hypoglycemia w 15g retest in 10 – 15 min if below 4 must take another 15mg retest if N & not eating a meal in 1 hr take another 15g. reviewed what is 15g. BS 5.7 @ present. Pt to retest tonight & may need to [decrease] insulin as ____ done back to pre chemo doses. To have a snack before bed and test. BS 6.2 @ present. 0 other concerns today. Cont [with] daily visits.* Client A's blood glucose is recorded as 5.	LTCI00065808 LTCI00065848
20.	August 14, 2016	EW is scheduled to visit Client A. Progress Note entered by EW as follows: *Client seen for symptom & medication management. Had "just woke up" & had not yet taken meds & pain was 8/10. Client took meds & breakthrough for pain while I was present. Reviewed when & how much to take re breakthrough.* EW records Client A's blood glucose as 5.7 and then 8.	LTCI00065477 LTCI00065808 LTCI00065848
21.	August 16, 2016	EW is scheduled to visit Client A. Noted – client refused service.	LTCI00065477 LTCI00065808 LTCI00065848
22.	August 17, 2016	EW is scheduled to visit Client A. Progress note entered by EW as follows: *Client seen for picc dressing change & symptom & medication management. Client has skipped 2 doses of meds this week & was vague as to why. Blood pressure low at 92/61 but had just taken her breakthrough, 0 other concerns.* EW records Client A's blood glucose as 10.3.	LTCI00065477 LTCI00065808 LTCI00065848

	DATE	EVENT	SOURCE DOC ID
23.	August 18, 2016	EW is scheduled to visit Client A. Progress Note entered by EW as follows: *Client seen for complex symptom management. Very drowsy today. Had just taken meds. Toenail intact.* EW records Client A's blood glucose as 10.	LTCI00065477 LTCI00065808 LTCI00065848
24.	August 19, 2016	EW is scheduled to visit Client A. Progress Note entered by EW as follows: *Client is seen for complex symptom management. C/o extreme tiredness & drowsiness all day. States it is from the morphine routine dose. She is going to ask Dr. to reduce it. She has only had to take 1 breakthrough today. Health teaching re: side effects of morphine.* EW records Client A's blood glucose as 13. Notes mild confusion.	LTCI00065477 LTCI00065808 LTCI00065848
25.	August 19, 2016	Beverly Bertram is hospitalized in August, 2016 and discharged on August 19, 2016, returning home. Nursing visits from Saint Elizabeth are arranged with CCAC to assist her with wound care (diabetic ulcer – foot.) She is to have antibiotics via PICC line and help with the dressing change.	LTCI00065740 LTCI00065743 LTCI00065746 LTCI00065749 LTCI00065778
26.	August 20, 2016	EW is scheduled to visit Ms. Bertram. EW completes a Progress Note, stating that she completed the admission process (including obtaining consent for treatment) and administered IV antibiotics via PICC line. EW also signs a Master Signature List and Medical Administration Record. Insulin is not recorded. EW records Ms. Bertram's blood glucose as 6.3. Education on blood glucose monitoring is noted. Ms. Bertram signs multiple forms for care: Consent for Collection, Use, and Disclosure of Personal/Health Information; and Consent for Treatment and Plan of Care. She agrees to, among other things, provide a safe environment for Saint Elizabeth staff.	LTCI00065477 LTCI00065505 LTCI00065506 LTCI00065507 LTCI00065508 LTCI00065510 LTCI00065511 LTCI00065513 LTCI00065779
27.	August 20, 2016	EW admits that she went to Client A's house, unannounced and unscheduled. She entered the residence while Client A was in the shower. Client A heard a noise and called out. There was no answer. Client A ended her shower and found EW going through her medications on the table. EW told Client A that she was merely looking for an oxygen meter she had left there. Client A's insulin was on the table along with her morphine. EW later confirmed that what she was actually doing was stealing insulin because she intended to use it to kill Ms. Bertram. She also admitted to stealing other medication for herself, namely, "hydromorphs".	LTCI00057683

	DATE	EVENT	SOURCE DOC ID
28.	August 21, 2016	EW is scheduled to visit Ms. Bertram. EW notes that Ms. Bertram has a blood glucose level of 8.5. Although EW's Progress Note states that Bertram is seen for the administration of IV antibiotics via her PICC line, EW later admits to administering three separate doses of 60 units of insulin through Ms. Bertram's PICC line. EW does not sign the Saint Elizabeth Master Signature List for her visit this day.	LTCI00065477 LTCI00065504 LTCI00065510 LTCI00065511 LTCI00065513 LTCI00065779
29.	August 21, 2016	EW admits that she gave Ms. Bertram a large amount of insulin – approximately 180 units (3 x 60 units) – via Ms. Bertram's PICC line.	LTCI00057683
30.	August 22 to August 31/16	Saint Elizabeth nurses attend at Ms. Bertram's home to provide care on August 24, 26, 30, 31 and September 1.	LTCI00065477
31.	August 22, 2016	EW completes three visits for Saint Elizabeth on August 22, 2016. Those visits do not include either Client A or Ms. Bertram. This is the last time that EW performed patient visits for Saint Elizabeth.	LTCI00065477
32.	August 29, 2016	EW resigns from Saint Elizabeth, providing a hand-written note that states: *Effective immediately I am resigning my position at Saint Elizabeth. Please know that I am thankful for all I have learned & done while being an employee here.* *In the box are the contents of my trunk kit.* *In the backpack is my phone & charger, my tablet & charger & the thermometer & BP cuff issued to me by Saint Elizabeth. My badge is also in there. There is also a good Littman stethoscope. Hopefully it can be used by the clinic or by the next new nurse who doesn't have their own.* *I can no longer work as a registered nurse.* *Sincerely Elizabeth Wettlaufer*	LTCI00065612
33.	October 27, 2016	Saint Elizabeth prepares a list of orientation/online learning/supervised visits and visits made by EW while in their employ.	LTCI00065459
34.	December 5, 2016	Saint Elizabeth receives a letter from the College of Nurses of Ontario identifying that an investigation has commenced pursuant to Section 75(a) of the Health Professions Procedural Code of the *Nursing Act, 1991* and requesting various documents.	LTCI00065483 LTCI00065484 LTCI00065485 LTCI00065488
35.	December 22, 2016	Saint Elizabeth sends the CNO the documentation requested.	LTCI00065490

VOLUME 8(C): SAINT ELIZABETH
RELEVANT STANDARDS, GUIDELINES, POLICIES AND PROCEDURES

No.	DOCUMENT	SOURCE DOC ID
A. Rights of Clients		
1.	Client Care and Safety Handbook - Declaration of Values	LTCI00067046
2.	Client Care - Policy. Revision #3. Last Updated: 05/08/13.	LTCI00067048
3.	Client Care and Well-Being - Policy. Version #2. 12-12-2014.	LTCI00067051
4.	Therapeutic Relationships – Guideline. Version #2. 06-02-2015.	LTCI00067174
5.	Therapeutic Relationships – Guideline. Version #3. 03-11-2017.	LTCI00067176
B. Staffing		
6.	Hiring Process – Procedure. Version #3. 15-05-2015.	LTCI00066987
7.	RN/RPN Visiting/Shift Nurse Interview Tool. Rev. Nov. 2013.	LTCI00066933
8.	Reference Checks – Policy. Version #2. 08-02-2015.	LTCI00067022
9.	Obtaining Employment References - Procedure. Version #3. 04-03-2016.	LTCI00067029
10.	Criminal Record/Child Abuse Registry/Vulnerable Sector Checks - Policy. Version #2. 06-02-2015.	LTCI00066952
11.	Criminal Record/Child Abuse Registry/Vulnerable Sector Checks – Procedure. Version #3. 29-07-2016.	LTCI00066962
12.	Criminal Record/Child Abuse Registry/Vulnerable Sector Checks – Procedure. Version #4. 25-07-2017.	LTCI00066965
13.	Requirements for Appointments to Staff – Procedure. Version #2. 29-10-2014.	LTCI00067041
C. Training and Orientation		
14.	Saint Elizabeth (SE) Nursing Orientation, Preceptee Learning/Development Plan (PLP)	LTCI00071984
15.	Regulated Health Professional – Nursing – Orientation.	LTCI00067018
16.	Orientation – Procedure. Version #2. 05-02-2015.	LTCI00067036
17.	Observation Visit – Procedure. Version #1. 26-11-2016.	LTCI00067271
18.	Nursing Practice Questionnaire – Guideline. Version #1. 23-05-2017.	LTCI00067043
19.	Professional Development – Policy. Version #2. 10-02-2015.	LTCI00067294

No.	DOCUMENT	SOURCE DOC ID
20.	Professional Development – Procedure. Version #2. 10-02-2015.	LTCI00067298
D. Nursing		
21.	Scope of Practice for Regulated Health Professionals – Policy. Version #2. 09-02-2015.	LTCI00067311
E. Administration of Drugs		
22.	Medication: Dangerous Abbreviations, Symbols, and Dose Designation - Guideline. Revision #1. Last Updated 06/13/2013.	LTCI00067412
23.	Administering and Monitoring Medication – Procedure. Revision #6. Last Updated 05/22/2013.	LTCI00067329
24.	Administering and Monitoring Medication. Version #2. 14-03-2017.	LTCI00067343
25.	Administering Range Doses – Procedure. Revision #8. Last Updated 04/04/2013.	LTCI00067348
26.	Administering Range Doses – Procedure. Version #2. 22-08-2017.	LTCI00067363
27.	Medication: Independent Double-Check - Guideline. Revision #1. Last Updated 05/13/2013.	LTCI00067512
28.	Medication: Independent Double-Check - Guideline. Version #2. 03-11-2017.	LTCI00067520
29.	Authorization of Parenteral Medications – Procedure. Revision #7. Last Updated 05/03/2013.	LTCI00067366
30.	Authorization of Parenteral Medications - Procedure. Version #2. 10-01-2017.	LTCI00067376
31.	Peripheral Venous Access Device (PVAD) Infusion – Procedure. Revision #4. Last Updated 05/23/2013.	LTCI00067567
32.	Peripheral Venous Access Device (PVAD) Infusion – Procedure. Version #2. 23-05-2017.	LTCI00067587
33.	Hypoglycemia Treatment – Procedure. Revision #7. Last Updated 01/28/2014.	LTCI00067485
34.	Central Venous Access Device (CVAD) Infusion – Procedure. Revision #8. Last Updated 04/04/2013.	LTCI00067379
35.	Central Venous Access Device (CVAD) Infusion – Procedure. Version #3. 09-05-2017.	LTCI00067402
F. Medication Incidents and Adverse Drug Reactions		
36.	Disclosure of Adverse Events – Procedure. Version #3. 01-06-2015.	LTCI00067263
37.	Disclosure of Adverse Events – Procedure. Version #4. 14-02-2017.	LTCI00067265
38.	Incident Management - Procedure. Version #2. 29-10-2014.	LTCI00067068
39.	Incident Management - Procedure. Version #3. 11-08-2016.	LTCI00067071
40.	Incident Management - Procedure. Version #4. 14-07-2017.	LTCI00067074
G. Drug Destruction and Disposal		
41.	Disposal and/or Transportation of Client Medications – Procedure. Version #2. 04-02-2015.	LTCI00067443
42.	Disposal and/or Transportation of Client Medications – Procedure. Version #3. 10-01-2017.	LTCI00067446

No.	DOCUMENT	SOURCE DOC ID
H. Abuse and Neglect		
43.	Client Abuse – Adult – Procedure. Version #2. 09-02-2015.	LTCI00067086
44.	Client/Resident Abuse – Elder – Procedure. Version #2. 15-07-2014	LTCI00067125
45.	Prevention of Client/Resident Abuse – Policy. Version #2. 13-08-2014.	LTCI00067165
46.	Client Abuse – Child – Procedure. Version #2. 09-02-2015	LTCI00067089
47.	Client Abuse – Child – Procedure. Version #3. 10-01-2017	LTCI00067095
I. Concerns, Complaints		
48.	Feedback Monitoring - Procedure. Version #2. 22-09-2014	LTCI00067056
49.	Complaints/Compliments Procedure. Version #3. 05-08-15.	LTCI00067058
50.	Complaints/Compliments Procedure. Version #4. 27-09-2016.	LTCI00067060
51.	Managing Risk and Complaints. Powerpoint presentation. June 2016.	LTCI00067759
J. Reporting		
52.	Regulated Health Professionals Reporting Requirements – Policy. Version #2. 09-02-2015.	LTCI00067629
K. Quality and Risk Management		
53.	Quality Council – Terms of Reference. Last Updated June 20, 2016.	LTCI00067187
54.	Quality Council – Terms of Reference. Last Updated September 26, 2017.	LTCI00067189
55.	Client Quality and Safety Advisory Committee Terms of Reference - May, 2014.	LTCI00067193
56.	Multidisciplinary Ethis Committee – Terms of Reference Dec. 2003, multiple revisions, reviewed Jan. 2014	LTCI00067195
57.	Risk Management – Policy. Version #2. 12-12-2014.	LTCI00067303
58.	Risk Management – Policy. Version #3. 06-11-2017.	LTCI00067305
59.	Corporate Performance Management – Policy. Version #2. 12-12-2014.	LTCI00067213
60.	Ethical Dilemmas Identification and Management – Procedure. Version #2. 30-09-2014.	LTCI00067148
61.	Ethical Dilemmas Identification and Management – Procedure. Version #3. 30-06-2016.	LTCI00067150
62.	Ethics – Policy. Version #2. 12-12-2014.	LTCI00067155
L. Human Resources		
63.	Performance Management – Policy. Version #2. 03-02-2015.	LTCI00067219
64.	Performance Development – Procedure. Version #2. 05-02-2015.	LTCI00067282
65.	Performance Development – Procedure. Version #3. 12-10-2016.	LTCI00067286
66.	Code of Conduct – Policy. Version #2. 03-02-2015.	LTCI00067133

VOLUME 9:
RELEVANT LEGISLATION

A. The Duties and Responsibilities of Long-term Care Homes (2007 – 2010)

The *Nursing Homes Act* ("NHA") and its general regulation governed the provision and oversight of long-term care in nursing homes from the date that Caressant Care hired Elizabeth Wettlaufer ("EW") on June 25, 2007 until July 1, 2010, when the *Long-term Care Homes Act, 2007* came into force. During this period, EW committed the first six offences for which she was found guilty. The summary below provides a general outline of certain relevant portions of the NHA during the time in question.

June 25, 2007– July 1, 2010

(Period during which EW commits the first six offences, all of which occurred at Caressant Care)

***Nursing Homes Act*, R.S.O. 1990, c. N.7| R.R.O. 832**

RIGHTS OF RESIDENTS

- **The fundamental principle** to be applied in interpreting the act, the regulations and service agreements is that a nursing home is primarily the home of its residents and is to be operated in such a way that the physical, psychological, social, cultural and spiritual needs of each of its residents are adequately met. (s. 2(1) NHA)

- **Licensees are responsible for ensuring that the rights of residents** are fully respected and promoted, including the right:
    - To be treated with courtesy and respect;
    - To be free from mental and physical abuse;
    - To be properly sheltered, fed, clothed groomed and cared for;
    - To be told who is responsible for and who is providing the resident's direct care;
    - If being considered for restraints, to be fully informed about the procedures and the consequences of receiving or refusing them;
    - To raise concerns and recommend policy changes without fear of restraint, interference, coercion, discrimination or reprisal;
    - To be advised of the procedures for initiating complaints;
    - To live in a safe and clean environment. (s.2(2) NHA)

- **Licensees are deemed to have entered into a contract** with each resident agreeing to respect and promote the rights of residents as set out in the legislation. (s.2(4) NHA)

STAFFING AND ADMINISTRATION

- **Each home must have**:
    - An administrator who shall be responsible for its administration. (s. 79, Reg. 832)
    - A registered nurse who is designated as the director of nurses, and who is responsible for:
        - The organization direction and evaluation of nursing care;
        - Directing the work of the nursing staff;
        - The organization and direction of training programs for nursing staff. (s. 60, Reg. 832)
    - A medical director who must be a physician to advise the administrator of the home on matters relating to medical care in the home. (s. 50(1), Reg. 832)
    - A licensee may also appoint one or more registered nurses in the extended class for the nursing home to advise the administrator on care matters within the scope of competence of a registered nurse in the extended class. (s. 50(5), Reg. 832)

- **Licensees must ensure that** in addition to any time spent on duty as a registered nurse, the director of nurses works in his or her capacity as director of nurses for at least twenty hours a week if the nursing home has sixty beds or less and at least thirty-seven hours a week if the nursing home has more than sixty beds. (s. 60(3), Reg. 832)

TRAINING

- **Licensees must ensure**:
    - That when a person becomes a member of the staff of the home, the person is given in-service training to orient him or her to the home;
    - That in-service training programs for the purpose of continuing education are conducted for all of the staff of the home. (s. 61.2, Reg. 832)

NURSING AND MEDICAL SERVICES

- **Licensees must ensure that**:
    - There is 24 hour nursing care;
    - At least one registered nurse who is a member of the regular nursing staff is on duty and present at all times;
    - The nursing staff is organized into shifts. (s. 59, Reg. 832)

- **While a director of nurses works in his or her capacity as director of nurses** he or she shall not be considered to be a registered nurse on duty and present in the home pursuant to section 59(1.1). (s. 60(4), Reg. 832)

- **Licensees must ensure that** there is a sufficient number of registered nurses, registered practical nurses and health care aides on duty in the home at all times to provide the nursing care required by the residents of the home. (s. 60(6), Reg. 832)

- **A physician or registered nurse in the extended class providing medical care to a resident shall**:
    - Visit the resident and review the resident's medication and diet at least once every three months;
    - Make an annual physical examination of the resident and file with the administrator a written report of the examination and his or her findings on the examination; and
    - Make an additional attendances as the resident's condition requires. (s. 51(4), Reg.832)

- **Every administrator shall make arrangements** for a physician to be on call to provide emergency services when a resident's physician or substitute physician is not available. An administrator may also arrange for a registered nurse in the extended class to be part of the on call team. (s. 53, Reg. 832)

- **Where a resident suffers an injury, the administrator sh**all retain a physician or a registered nurse in the extended class as soon as possible to examine and report on the resident and provide necessary treatment. (s. 54(1), Reg. 832)

- **Where a resident suffers a serious injury, the administrator shall forthwith** give notice of the injury to the SDM and to such other person as the resident may designate. (s. 54(2), Reg. 832)

ADMINISTRATION OF DRUGS

- **Administrators are responsible for the administration and enforcement** of the provisions relating to drugs. (s. 63(1), Reg. 832)

- **No drug shall be taken by or administered to a resident excep**t if it is prescribed or taken on the written direction of the prescriber attending the resident (s. 63(2), Reg. 832)

- **Administration of drugs to residents is limited to** physicians, dentists, registered nurses or registered practical nurses. (s. 63(3), Reg. 832)

- **No administrator shall permit** more than a three months' supply of a drug to be stored for a resident. (s. 63(4) Reg. 832)

- **Where a drug is temporarily discontinued or modified, the prescriber who directs the discontinuation or modification shall** record this fact on an order sheet kept for that purpose and where a permanent change in dosage is order, the direction for use on the container label shall be changed in accordance

with the new directions. (s. 63(6), Reg. 832)

DRUG STORAGE

- **Residents' drugs are to be kept in the original container with the original label unless** transferred or relabelled under the direct supervision of a prescriber or pharmacist. (s. 63(5), Reg. 832)

- **Every resident's individual prescription container shall be marked** in accordance with section 156 of the *Health Discipline's Act*. (s. 64(1), Reg.832)

- **Drugs that that are for external use only shall** be labelled accordingly (s. 64(2) Reg. 832)

- **A drug for a resident shall be stored** in a locked drug cabinet or storeroom that is conveniently located for nursing staff. The keys of the cabinet or storeroom shall be under the control of a registered nurse or registered practical nurse on duty or the administrator. Every drug shall be stored so that it is protected from environmental conditions that will adversely affect the drug. (s. 65(1), (3) and (4) Reg. 832)

- **A drug requiring refrigeration shall** be kept in a locked box in the refrigerator. (s. 65(2) Reg. 832)

- **Every drug for external use only shall** be stored only in a separate locked cabinet within the general drug cabinet or storeroom. (s. 65(5) Reg. 832)

- **Narcotics and controlled drugs shall be stored** on their own in a locked box or cabinet to be known as the narcotic cabinet and the narcotic cabinet shall be inside the general drug cabinet or storeroom. (s. 65(6) and (7), Reg. 832)

- **A Resident cannot keep** a drug on his or person or in his or her room unless authorized by the attending physician or nurse in the extended class. (s.65(8), Reg. 832)

- **A prescription drug not obtained for a resident shall not** be kept or used in a nursing home unless the prescription drug is under the direct control of a pharmacist, physician or a registered nurse in the extended class and shall be kept in a locked cabinet accessible only to the pharmacist, physician or registered nurse in the extended class. (s. 68(1) and (3), Reg. 832)

- **Where a nursing home keeps or uses a prescription drug that is not obtained for a resident, the pharmacist, physician or registered nurse in the extended class shall** keep a record of the name, strength and quantity of the drug and other information required by the *Regulated Health Professions Act, 1991*, the *Food and Drugs Act* (Canada) and the *Controlled Drugs and Substances Act* (Canada). (s. 68(2) Reg. 832)

DRUG RECORD (ORDERING AND RECEIVING)

- **Every nursing home shall maintain a drug record book** and shall record the following information:
    - The date the drug is ordered;
    - The signature of the person placing the order;
    - The name, strength and quantity of the drug;
    - The name of the place from which the drug is ordered;
    - The name of the resident for whom the drug is prescribed, where applicable;

- The prescription number where applicable;
- The date the drug is received;
- The signature of the person acknowledging receipt of the drug on behalf of the nursing home. (s. 66, Reg. 832)

DRUG DESTRUCTION AND DISPOSAL

- **A drug provided for a resident shall be destroyed** by the director of nurses in the presence of an inspector or by a pharmacist or a physician or removed from the nursing home by an inspector when the physician attending the resident orders that it be discontinued or when the resident is discharged or dies. (s. 69 (1) Reg. 832)

- **Where a resident dies, the person who signed the medial certificate of death must** provide written approval before the deceased resident's drug is destroyed or removed (s. 69(2), Reg 832)

- **When a drug is destroyed or removed** the director of nurses will note it in the resident's records and record the following in the prescription drug record book together with his or her signature and the signature of the inspector or pharmacist:
  - The date of destruction or removal;
  - The prescription number;
  - The pharmacy name;
  - The resident's name
  - The drug name, strength and quantity; and
  - The reason for destruction or removal. (s. 69(3), Reg. 832)

- **Where a resident is discharged or transferred, a drug that has been provided for him or her may be sent** with him or her after an entry is made in the drug record bood that shall be signed by the resident's physician or dentist stating:
  - The date;
  - The prescription number;
  - The pharmacy name;
  - The resident's name; and
  - The words "sent with resident". (s. 69(5), Reg. 832)

REPORTING

- **A person other than a resident who has reasonable grounds to suspect that a resident has suffered or may suffer harm as a result of unlawful conduct, improper or incompetent treatment or care or neglect shall forthwith** report the suspicion and the information upon which it is based to the Director. (s.25(1), NHA)

- **The duty to report applies to medical practitioners or any other person who is a member of a College** as defined in the *Regulated Health Professions Act* even if the information on which the report may be based

is confidential or privileged and no action for making the report shall be commenced against a practitioner unless that person acts maliciously or without reasonable grounds for the suspicion. (s. 25(5), NHA)

- **Licensees are required to promptly report** to the Director in full detail the following:
  - A fire;
  - An assault;
  - An injury in respect of which a person is taken to a hospital;
  - A communicable disease outbreak;
  - A death resulting from an accident or an undetermined cause. (s. 96, Reg. 832)

- **Whistle-blowing protection** is provided for as follows:
  - No person shall do or refrain from doing anything in retaliation for another person making a disclosure to an inspector as long as the disclosure was made in good faith (s.24.3 NHA)
  - No person shall seek to compel another person from making a disclosure to an inspector (s.24.3(2) NHA)
  - No person shall:
    - dismiss, discipline or penalize another person; or
    - coerce, intimidate or attempt to coerce another person who reports a matter to the Director, including the abuse of a resident or a breach of the Act or its Regulations. (s. 25(2) and (3), NHA)

REPORTING THE DEATH OF A RESIDENT

- **Where a resident dies in a nursing home, the resident's death shall be reported** immediately to,
  - A coroner by the person in charge of the nursing home at the time of the resident's death;
  - The resident's physician; and
  - Any registered nurse in the extended class who attended the resident. (s.78(1), Reg. 832)

- **The attending physician or registered nurse in the extended class must prepare** a written report indicating the cause and time of death of the resident and the report shall be retained in the resident's file. (s. 78(3), Reg. 832)

- **A report of** the time, date and circumstances of the death of a resident, the name and address of the person who claims the body and the date that notice of death is given to the coroner shall be attached to the deceased resident's records. (s.78(4), Reg 832)

COMPLAINTS

- **A licensee must immediately forward** any written complaints it receives concerning the care of a resident or the operation of a nursing home to the Director. (s. 26(1) NHA)

- **Together with the complaint, the licensee must forward** a statement of reply setting out:
    - What the licensee has done to remedy the complaint
    - What the licensee proposes to do to remedy the complaint and within what time the licensee proposes to do it.
    - Where the licensee believes the complaint to be unfounded, the reasons for the belief. (s. 26(2), NHA)

INVESTIGATIONS

- **The Director will investigate** any report made. He or she shall investigate a report about abuse forthwith. (s. 26(3) and 27 NHA)

- **Where the Director receives a report from any Source that gives the Director reasonable grounds to believe that the health, safety or welfare of a resident may be at risk, the Director shall cause an investigation** to be commenced and the nursing home in which the resident lives to be visited forthwith. (s.27, NHA)

QUALITY IMPROVEMENT

- **A licensee shall ensure that a quality management system** is developed and implemented for monitoring, evaluating and improving the quality of the accommodation, care, services, programs and goods provided to the residents of the nursing home (s. 20.11, NHA)
- **A licensee shall ensure that the quality management system implemented** for the home under section 20.11 of the Act includes:
    - The regular monitoring of the satisfaction of the residents, the residents' family members and substitute decision makers with the accommodation, care, services, programs and goods provided to the residents.
    - The participation of the members of the staff of the home in quality management activities
    - The keeping of a record of all the quality management activities undertaken in relation to the home. (s. 128, Reg. 832)

B. The Duties and Responsibilities of Long-term Care Homes (2010 - 2016)

The *Long-term Care Homes Act, 2007* ("LTCHA, 2007") and its general regulation have governed the provision and oversight of long-term care since July 1, 2010. During this period, EW committed the next 7 offences for which she was found guilty. The LTCHA, 2007 therefore governed the provision of services by Caressant Care, Meadow Park and Telfer Place (even though EW was not an employee of Telfer Place but had been placed there through Lifeguard Homecare Inc. (an employment agency to which the legislation did not apply). The summary below provides a general outline of certain relevant portions of the *LTCHA, 2007* during the time in question.

July 1, 2010 – September 2015

(Period during which EW commits the next seven offences while working in 3 different LTC homes:

(5 in Caressant Care, 1 in Meadow Park and 1 in Telfer Place)

***Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8 | O. Reg. 79/10**

DEFINITIONS:

- "**Emotional abuse**" means:
    - Any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident; or
    - Any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviours or remarks understands and appreciates their consequences. (s. 2, O. Reg. 79/10)

- "**Medication Incident**" means a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes:
    - An act of omission or commission, whether or not it results in harm, injury or death to a resident, or
    - A near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted. (s. 1, O. Reg. 79/10)

- "**Neglect**" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. (s. 5, O. Reg. 79/10)

- "**Physical abuse**" means:
    - The use of physical force by anyone other than a resident that causes physical injury or

pain,

- Administering or withholding a drug for an inappropriate purpose; or
- The use of physical force by a resident that causes physical injury to another resident. (s. 2 O. Reg. 79/10)

[does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances]

- "**Regular nursing staff**" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals. (s. 1, O. Reg. 79/10)

- "**Responsive Behaviours**" means behaviours that often indicate;
  - an unmet need in a person, whether cognitive, physical, emotional, environmental, or other;
  - or, a response to circumstances within the social or physical environment that may be frustrating, frightening, or confusing to a person.

- "**Staff**" means persons who work in the home:
  - As employees of the licensee;
  - Pursuant to a contract or agreement with the licensee; or
  - Pursuant to a contract or agreement between the licensee and an employment agency or other third party. (s. 2, LTCHA, 2007)

- "**Verbal abuse**" means:
  - Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident; or
  - Any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. (s. 2, O. Reg. 79/10)

RIGHTS OF RESIDENTS

- **Licensees are responsible for ensuring that the rights of residents** are fully respected and promoted, including the right**:**
  - To be treated with courtesy and respect;
  - To be protected from abuse;
  - To not be neglected by staff;
  - To live in a safe and clean environment;

- To receive care and assistance towards independence based on a restorative care philosophy; and
- To not be restrained, except in limited circumstances (s.3, LTCHA, 2007)

STAFFING AND ADMINISTRATION

- **Each home must have**:
  - An Administrator, who is in charge of the home and responsible for its management;
  - A Director of Nursing and Personal Care, who must be a Registered Nurse and who shall supervise the nursing staff and personal care staff; and
  - A Medical Director, who must be a physician and shall advise the Licensee on matters relating to medical care and who must consult with the Director of Nursing and other health professionals in the home (s.70 – 72, LTCHA, 2007)

- **Administrators must work regularly** in that position on site for the following amount of time per week:
  - If 64 beds or fewer – at least 16 hours per week;
  - If more than 64 beds but fewer than 97 – at least 24 hours a week;
  - If 97 beds or more – at least 35 hours per week. (s. 212, O. Reg. 79/10)

- **Directors of Nursing and Personal Care must work** regularly in that position on site for the following amount of time per week:
  - If 19 beds or fewer – at least 4 hours per week;
  - If more than 19 beds but fewer than 30 beds – at least 8 hours per week;
  - If more than 29 beds but fewer than 40 beds – at least 16 hours per week;
  - If more than 39 beds but fewer than 65 beds – at least 24 hours per week;
  - If more than 65 beds – at least 35 hours per week (s. 213, O. Reg. 79/10)

- **Medical Directors** have the following duties and responsibilities:
  - Development, implementation, monitoring, and evaluation of medical services;
  - Advising on clinical policies and procedures, where appropriate;
  - Communication of expectations to attending physicians and RNs in the extended class;
  - Addressing issues relating to resident care, after-hours coverage, and on-call coverage; and
  - Participation in interdisciplinary committees and quality improvement activities.

- **Every licensee shall ensure that every member of staff** who performs duties in the capacity of a nurse, registered practical nurse or registered nurse in the extended class has the appropriate current

certificate of registration from the College of Nurses of Ontario (s. 46, O. Reg. 79/10)

- **Each licensee must have a written staffing plan** in respect of its organized program of nursing services and organized program of personal support services that must:
    - Provide for a staffing mix consistent with the residents' assessed care and safety needs;
    - Set out the organization and scheduling of staff shifts;
    - Promote continuity of care by minimizing the number of different staff members that provide nursing and personal support to each resident;
    - Include a back-up plan when staff cannot come to work;
    - Be evaluated and updated annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practice; and
    - Keep a written record of the evaluation. (s. 31, O. Reg. 79/10)

- **Every licensee must limit the use of Agency Staff in accordance with the regulations in order to** improve continuity of care for residents and to provide a stable and consistent workforce. (s. 74, LTCHA, 2007)

- **In terms of staff, every licensee shall ensure** that all staff have the proper skills and qualifications to perform their duties and possess the qualifications provided for in the regulations. (s. 73, LTCHA, 2007)

- **Every licensee must ensure that screening measures** are conducted in accordance with the regulations before hiring staff and accepting volunteers and those screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. (s. 75, LTCHA, 2007). The criminal reference check must be:
    - Conducted by a police force;
    - Conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.
    - Must include a vulnerable sector screen to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect. (s. 215, O. Reg. 79/10)

- **Criminal reference checks are not required** if the person who will perform work at the home:
    - work in the home pursuant to a contract or agreement with the licensee or pursuant to a contract or agreement between the licensee and an employment agency or other third party;
    - or only provides occasional maintenance or repair services to the home;
    - or does not provide direct care to residents; and
    - will be monitored and supervised, in accordance with the licensees' policies and procedures regarding persons who provide occasional maintenance or repair services to

the home pursuant to a written agreement between the home and the service provided (s. 86, s. 215, O. Reg. 79/10)

- **Criminal record checks are not required** for Medical Directors or physicians or registered nurses in the extended class retained by a resident or the resident's SDM or retained by the licensee. (s. 82, O. Reg. 79/10)

TRAINING

- **Licensees must ensure that a training and orientation program** is developed and implemented, annually evaluated and updated and a record is kept of the evaluation (s. 216, O. Reg. 79/10)
- **All Staff must receive, among others,** the following training before performing their responsibilities**:**
    - The Residents' Bill of Rights;
    - The long-term care homes policy to promote zero tolerance of abuse and neglect of residents;
    - The duty under section 24 to make mandatory reports; and
    - The protections afforded by section 26 (whistle-blowing) (s. 76, LTCHA, 2007)
- **Additional orientation training shall be provided** in, among other things, the licensee's written procedures for handling complaints and the role of staff in dealing with complaints. (s. 218, O. Reg. 79/10)
- **All direct care staff must receive,** among others, the following additional training as a condition of continuing to have contact with residents:
    - Abuse recognition and prevention;
    - Mental health issues, including caring for persons with dementia;
    - Behaviour management;
    - How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the LTCHA, 2007 and the regulations; and
    - Palliative care. (s. 76, LTCHA, 2007)

NURSING AND MEDICAL SERVICES

- **Each home must have an organized program of nursing services** to meet the needs of the residents and licensees must ensure that**:**
    - There is 24-Hour nursing care;
    - There is at least one registered nurse who is both an employee of the Licensee and member of the regular nursing staff of home on duty and present in home at all times, except as provided for in the regulations;
    - During the hours that an Administrator or Director of Nursing and Personal Care works in

that capacity, he or she is not considered to be a registered nurse on duty except as provided for in the regulations. (s. 8, LTCHA, 2007).

- **The exceptions to the requirement that each home must have at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff on duty at all times is based on the bed capacity of the home:**
    - 64 beds or fewer – in the case of an emergency, where the back-up plan fails, a registered nurse who works at the home pursuant to a contract with an employment agency or other third party, **or** an RPN who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone; or
    - 64 beds but fewer than 129 beds – in the case of an emergency, where the back-up plan fails, a registered nurse who works at the home pursuant to a contract with an employment agency or other third party, may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone **and** an RPN who is a member of the regular nursing staff is on duty and present in the home. (s. 45, O. Reg. 79/10)

- **Residents of a home must have access to medical services 24 hours a day** and every licensee is to ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's conditions and needs. (s. 80 – 81, O. Reg. 79/10)

- **Every licensee shall ensure that** either a physician or a registered nurse in the extended class:
    - Conducts a physical examination of each resident upon admission and an annual physical examination thereafter, and produces a written report of the findings of the examination;
    - Attends regularly at the home to provide services, including assessments; and
    - Participates in after-hours coverage and on-call coverage. (s. 82., O. Reg. 79/10)

MEDICATION MANAGEMENT

- **In terms of medication management**:
    - Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.
    - The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.
    - The written policies and protocols must be:
        - developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
        - reviewed and approved by the Director of Nursing and Personal Care and the

pharmacy service provider and, where appropriate, the Medical Director. (s. 114, O. Reg. 79/10)

- **Every licensee shall ensure**:

  - That an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system;
  - Where the pharmacy service provider is a corporation, that a pharmacist from the pharmacy service provider participates in the quarterly evaluation.
  - That the quarterly evaluation of the medication management system includes at least:
    - reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk;
    - reviewing reports of any medication incidents and adverse drug reactions and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm to a resident or to others pursuant; and
    - identifying changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
  - That the changes identified in the quarterly evaluation are implemented; and
  - That a written record is kept of the results of the quarterly evaluation and of any changes that were implemented. (s. 115, O. Reg. 79/10)

- **Every licensee shall ensure**:

  - that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.
  - Where the pharmacy service provider is a corporation, the licensee shall ensure that a pharmacist from the pharmacy service provider participates in the annual evaluation.
  - That the annual evaluation:
    - includes a review of the quarterly evaluations in the previous year;
    - be undertaken using an assessment instrument designed specifically for this purpose; and
    - identifies changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
  - That the changes identified in the annual evaluation are implemented.

- That a written record is kept of the results of the annual evaluation and of any changes that were implemented. (s. 116, O. Reg. 79/10)

MEDICAL DIRECTIVES

- **Every licensee shall ensure that**:
  - all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
  - no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. (s. 117, O. Reg. 79/10)

PHARMACY SERVICE PROVIDER

- **Every licensee shall retain a pharmacy service provider** for the home and ensure that there is a written contract that the pharmacy service provider shall:
  - provide drugs to the home on a 24-hour basis, seven days a week, or arrange for their provision by another holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the *Drug and Pharmacies Regulation Act*; and
  - perform all the other responsibilities of the pharmacy service provider under this Regulation. (s. 119, O. Reg. 79/10).
- **Licensees must ensure that the pharmacy service provider participates** in the following activities:
  - For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
  - Evaluation of therapeutic outcomes of drugs for residents.
  - Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
  - Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
  - Educational support to the staff of the home in relation to drugs.
  - Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. (s. 120, O. Reg. 79/10)
- **Licensees shall ensure that a system** is developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident. (. S. 121, O. Reg. 79/10)

PURCHASING AND HANDLING OF DRUGS

- **Every licensee shall ensure that no drug is acquired, received or stored by or in the home** or kept by

a resident under subsection 131 (7) unless the drug;

- has been prescribed for a resident or obtained for the purposes of the emergency drug supply;
- has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. (s. 122, O. Reg. 79/10)

- **Every licensee who maintains an emergency drug supply** for the home shall ensure;

  - that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
  - that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
  - that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
  - that any recommended changes resulting from the evaluation are implemented. (s. 123, O. Reg. 79/10).

- **Every licensee shall ensure that drugs obtained for use in the home**, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. (s. 124, Reg. 79/10)

- **Every licensee shall ensure that a monitored dosage system is used in the home** for the administration of drugs and the monitored dosage system must promote the ease and accuracy of the administration of drugs to residents and support monitoring and drug verification activities. (s. 125, O. Reg. 79/10).

- **Every licensee shall ensure that drugs remain in the original labelled container or package** provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. (s. 126, O. Reg. 79/10)

- **Every licensee shall ensure that a policy** is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation. (s. 127, O. Reg. 79/10)

SAFE STORAGE OF DRUGS

- **Every licensee of a long-term care home shall ensure that**;

  - drugs are stored in an area or a medication cart:

    - that is used exclusively for drugs and drug-related supplies;
    - that is secure and locked;
    - that protects the drugs from heat, light, humidity or other environmental

conditions in order to maintain efficacy; and

- that complies with manufacturer's instructions for the storage of the drugs.

- controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. (s. 129, 0. Reg. 79/10)

- **Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply**, including the following:

  - All areas where drugs are stored shall be kept locked at all times, when not in use.
  - Access to these areas shall be restricted to:
    - persons who may dispense, prescribe or administer drugs in the home; and
    - the Administrator.
  - A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. (s. 130, O. Reg. 79/10)

ADMINISTRATION OF DRUGS

- **Every licensee shall ensure that**:

  - no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.
  - The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
  - No person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. (s. 131, O. Reg. 79/10)

- **A member of the registered nursing staff** may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical under certain conditions (s. 131, O. Reg. 79/10)

- **A member of the registered nursing staff** may permit a nursing student to administer drugs to residents under certain circumstances. (s. 1(2) O. Reg. 218/13)

- **Every licensee shall ensure that**:

  - when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
  - appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
  - there is, at least quarterly, a documented reassessment of each resident's drug

regime. O. Reg. 79/10, s. 134.

DRUG RECORD (ORDERING AND RECEIVING)

- **Every licensee shall ensure that a drug record** is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

    - The date the drug is ordered;
    - The signature of the person placing the order;
    - The name, strength and quantity of the drug;
    - The name of the place from which the drug is ordered;
    - The name of the resident for whom the drug is prescribed, where applicable;
    - The prescription number, where applicable;
    - The date the drug is received in the home;
    - The signature of the person acknowledging receipt of the drug on behalf of the home;
    - Where applicable, the information required under subsection (s. 136 O. Reg. 79/10)

MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

- **Every licensee home shall ensure that every medication incident** involving a resident and every adverse drug reaction is:

    - documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
    - reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).
    - In addition to the requirement under clause (1) (a), the licensee shall ensure that:
    - all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
    - corrective action is taken as necessary; and
    - a written record is kept (s. 135, O. Reg. 79/10)

- **Every licensee shall ensure that**:

    - a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
    - any changes and improvements identified in the review are implemented; and
    - a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

DRUG DESTRUCTION AND DISPOSAL

- **Every licensee shall ensure, as part of the medication management system**, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of:
    - all expired drugs;
    - all drugs with illegible labels;
    - all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the *Drug and Pharmacies Regulation Act*; and
    - a resident's drugs where;
        - the prescriber attending the resident orders that the use of the drug be discontinued;
        - the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the *Vital Statistics Act* or the resident's attending physician; or
        - the resident is discharged and the drugs prescribed for the resident are not sent with the resident.
- **The drug destruction and disposal policy** must also provide for the following:
    - That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs;
    - That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs;
    - That drugs are destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. (s. 136, O. Reg. 79/10)
- **Drugs that are to be destroyed** must be destroyed by a team acting together and composed of:
    - in the case of a controlled substance, subject to any applicable requirements under the *Controlled Drugs and Substances Act*(Canada) or the *Food and Drugs Act* (Canada):
        - one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist
    - in every other case by:
        - one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
        - one other staff member appointed by the Director of Nursing and Personal Care. s. 136, O. Reg. 79/10)
- **Where a drug that is to be destroyed is a controlled substance**, the drug destruction and disposal

policy must provide that the team document the following in the drug record:

- The date of removal of the drug from the drug storage area.
- The name of the resident for whom the drug was prescribed, where applicable.
- The prescription number of the drug, where applicable.
- The drug's name, strength and quantity.
- The reason for destruction.
- The date when the drug was destroyed.
- The names of the members of the team who destroyed the drug.
- The manner of destruction of the drug. (s. 136, O. Reg. 79/10)

- **The licensee shall ensure**:
  - That the drug destruction and disposal system is audited at least annually to verify that the licensee's procedures are being followed and are effective;
  - That any changes identified in the audit are implemented; and
  - That a written record is kept.
  - A drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. (s. 136, O. Reg. 79/10)

RESPONSIVE BEHAVIOURS

- **In terms of responsive behaviours,** every licensee must:
  - Ensure that written approaches to care and strategies, techniques and interventions are developed;
  - Ensure the development of resident monitoring and internal reporting protocols are developed;
  - Develop protocols for the referral of residents to specialized resources where required;
  - At least annually evaluate and update the above in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;
  - Maintain a written record of each evaluation;
  - Ensure that behavioural triggers are identified, strategies developed to respond to these behaviours and actions taken to respond to the needs of the resident. (s. 53, O. Reg. 79/10)

- **Each licensee must ensure that**, in respect of behaviours and altercations;
  - Procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmfull interactions between and among residents; and

- All direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive, behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. (s. 55, O. Reg. 79/10)

ABUSE AND NEGLECT

- **Each licensee shall protect residents** from abuse and ensure that residents are not neglected and shall ensure that:
  - There is a written policy in place to promote zero tolerance of abuse and neglect of residents;
  - There is compliance with the policy;
  - There is a program for preventing abuse and neglect;
  - There is an explanation of the duty to make mandatory reports;
  - There are procedures for investigating and responding to alleged suspected or witnessed abuse or neglect;
  - The policy is communicated to all staff, residents and residents' substitute decision maker ("SDM") (s. 19 – 20, LTCHA, 2007):

- **Written polices to promote zero tolerance of abuse and neglect** of residents must**:**
  - Contain procedures and interventions procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
  - contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
  - identifies measures and strategies to prevent abuse and neglect;
  - identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
  - identifies the training and retraining requirements for all staff, including,
  - training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and
  - situations that may lead to abuse and neglect and how to avoid such situations. (s. 96, O. Reg. 79/10)

- **Notifications to the resident or the resident's SDM**, if any, or any other person specified by the resident must be made:
  - immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

- within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
- of the results of the investigation immediately upon the completion of the investigation. (s. 97, O. Reg. 79/10)

- **Every licensee shall ensure** that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. (s. 98, O. Reg. 79/10)

- **Every licensee of a long-term care home shall** ensure:
  - that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
  - that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
  - that the results of the analysis undertaken are considered in the evaluation;
  - that the changes and improvements are promptly implemented; and
  - that, among other things, a written record of the evaluation, changes and improvements promptly prepared. (s. 99, O. Reg. 79/10)

COMPLAINTS AND INVESTIGATIONS

- **In terms of handling Complaints,** licensees must:
  - Have written procedures for initiating complaints and for how they are dealt with; and
  - Forward any written complaint about a resident's care or about the operation of the facility immediately to the Director, along with any documentation as provided for in the regulations; (s. 22, LTCHA, 2007)

- **Every licensee shall ensure** that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
  - The complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately;
  - For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response shall be provided as soon as possible in the circumstances.
  - A response shall be made to the person who made the complaint, indicating:

- what the licensee has done to resolve the complaint; or
- that the licensee believes the complaint to be unfounded and the reasons for the belief. (s. 101, O. Reg. 79/10)

- **The licensee shall ensure that a documented record is kept in the home that includes:**
    - the nature of each verbal or written complaint;
    - the date the complaint was received;
    - the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
    - the final resolution, if any;
    - every date on which any response was provided to the complainant and a description of the response;
    - any response made in turn by the complainant;
    - This requirement does not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received. (s. 101, O. Reg. 79/10)

The licensee shall ensure that:

- the documented record is reviewed and analyzed for trends at least quarterly;
- the results of the review and analysis are taken into account in determining what improvements are required in the home; and
- a written record is kept of each review and of the improvements made in response.
- This requirement does apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received. (s. 101, O. Reg. 79/10)

REPORTING

- **Licensees have a duty to investigate, report and act,** ensuring that, in respect of every alleged, suspected or witnessed incident of abuse or neglect of a resident, or anything else provided for in the regulations;
    - It is immediately investigated;
    - Appropriate action is taken in response;
    - The regulations are complied with; and
    - The Director is notified of the results of every investigation of the alleged abuse of a resident and every action taken in respect of the alleged neglect of a resident (s. 23, LTCHA, 2007)

- **In terms of reporting the results of every investigation** with respect to the alleged, suspected or witnessed incident of abuse of a resident or neglect of a resident, licensees shall include:

- A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
- A description of the individuals involved in the incident, including:
  - names of all residents involved in the incident,
  - names of any staff members or other persons who were present at or discovered the incident; and
  - names of staff members who responded or are responding to the incident.
- Actions taken in response to the incident, including:
  - what care was given or action taken as a result of the incident, and by whom;
  - whether a physician or registered nurse in the extended class was contacted
  - what other authorities were contacted about the incident, if any,
  - whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons: and
  - the outcome or current status of the individual or individuals who were involved in the incident.
- Analysis and follow-up action, including:
  - the immediate actions that have been taken to prevent recurrence; and
  - the long-term actions planned to correct the situation and prevent recurrence.
  - The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
- The licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director;
- If not everything required above can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. (s. 104, O. Reg. 79/10)

- **Mandatory and immediate reporting to the Director** when a person has reasonable grounds to suspect**:**
  - improper or incompetent treatment of a resident that resulted in harm or risk of harm to the resident;
  - abuse of a resident by anyone or neglect of a resident by the Licensee or staff that resulted in harm or risk of harm to the resident;
  - unlawful conduct that resulted in harm or risk of harm to a resident;
  - misuse or appropriation of a resident's money; or
  - misuse or misappropriation of funding provided to a licensee under the Act or the *Local Health System Integration Act*. (s. 24, LTCHA, 2007)

- **It is an offence to fail to make a mandatory report** if a person is, among others:
    - The licensee;
    - If the licensee is a corporation, an officer or director of the corporation;
    - A staff member (excluding those persons who work in the home pursuant to a contract or agreement with the licensee or pursuant to a contract or agreement between the licensee and an employment agency or other third party; or only provides occasional maintenance or repair services to the home; or does not provide direct care to residents (s. 105, O. Reg. 79/10)
    - A person who provides professional services to a resident in the areas of health, social work or social services work; or
    - A person who provides professional services to the licensee in the areas of health, social work or social services work (s. 24, LTCHA, 2007)

- **Every licensee has a duty to submit a copy of the complaint leading to the mandatory report** to the Director along with a written report documenting the response the licensee made to the complainant immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director (s. 101, 103, O. Reg. 79/10).

- **Whistle-blowing protection** is provided for under the LTCHA, 2007 as follows:
    - No person can be retaliated against for anything that has been disclosed to an inspector, or the Director, or has been given as evidence in a proceeding in respect of the enforcement of the LTCHA, 2007 or an inquest under the *Coroner's Act*;
    - No resident can be discharged, threatened with discharge or be subjected to discriminatory treatment, even if the resident acted maliciously or in bad faith;
    - No licensee, or officer or director of a licensee or a staff member may do anything to discourage or which is aimed at discouraging or that has the effect of discouraging a person from disclosing to an Inspector, the Director or giving evidence; and
    - No licensee, or officer or director of a licensee or a staff member may encourage a person to fail to disclose to an Inspector, the Director or give evidence. (s. 26, LTCHA, 2007)

CRITICAL INCIDENT REPORTING

- **Every licensee must immediately inform the Director** of the following (using the Ministry's method for after-hours emergency contact if applicable) among others:
    - An unexpected or sudden death, including a death resulting from an accident or suicide;

- **Every licensee must inform the Director within one business day** of the following incidents, among:
    - A missing or unaccounted for controlled substance;
    - An incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition. If the licensee is unable to determine within one business day whether the injury has resulted in a

significant change in the resident's health condition, the licensee shall:

- contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
- where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report. (s. 9 (3), O. Reg. 246/13)

o A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. (s. 107, 79/10)

- **If a license is required to inform the Director of an incident**, either immediately or within 24 hours, the licensee must, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

o A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident;

o A description of the individuals involved in the incident, including;

- names of any residents involved in the incident;
- names of any staff members or other persons who were present at or discovered the incident; and
- names of staff members who responded or are responding to the incident.

o Actions taken in response to the incident, including:

- what care was given or action taken as a result of the incident, and by whom;
- whether a physician or registered nurse in the extended class was contacted;
- what other authorities were contacted about the incident, if any;
- for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons; and
- the outcome or current status of the individual or individuals who were involved in the incident.

o Analysis and follow-up action, including;

- the immediate actions that have been taken to prevent recurrence; and
- the long-term actions planned to correct the situation and prevent recurrence.

o The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. (s. 9 (3), O. Reg. 246/13)

o The licensee shall ensure that the resident's substitute decision-maker, if any, or any

person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. (s. 107, O. Reg. 79/10)

INVESTIGATIONS

- **The Director must have an inspector conduct an inspection or make inquiries** where the Director receives information from any source indicating that, among other things, the following may have occurred:
    - Improper or incompetent treatment or care of a resident, or abuse of a resident, or neglect of a resident by the licensee or staff or any unlawful conduct that resulted in harm or a risk of harm to the resident;
    - A violation of s. 26 (whistle-blowing protection);
    - A failure to comply with the LTCHA, 2007; or
    - Any other matter as required by the regulations (s. 25, LTCHA, 2007)

- **An immediate visit to the home** is triggered if the information received is related to:
    - The improper or incompetent treatment of a resident that resulted in harm or risk of harm to resident;
    - The abuse of resident by anyone or neglect of resident by Licensee or staff that resulted in harm or risk of harm to the resident;
    - Any unlawful conduct that resulted in harm or risk of harm to a resident;
    - A violation of whistle-blowing protections in the Act; or
    - Any other matter provided for in the Regulations (s. 24, LTCHA, 2007)

CONTINUOUS QUALITY IMPROVEMENT

- **Each licensee has a duty for** continuous quality improvement and must:
    - Develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of accommodation, care, services, programs and goods provided to the residents;
    - Ensure that, at least once in every year, a satisfaction survey is taken by the residents and their families;
    - Make every reasonable effort to act on the results of the survey and improve the home and the care, services, programs and goods accordingly;
    - Seek the advice of the Residents' Council and Family Council, if any, in developing and carrying out the survey and acting on the results; and
    - Document and make available the results and the actions taken to the Residents' Council

and Family Council, if any. (s. 84 – 85, LTCHA, 2007)

- **The quality improvement and utilization review system** must comply with the following requirements:
  - There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
  - The system must be ongoing and interdisciplinary.
  - The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
  - A record of the above, including the names of the person who participated in the evaluations and the dates the improvements were implemented, must be maintained by the licensee. (s. 228, O. Reg. 79/10)

C. THE DUTIES AND RESPONSIBILITIES OF PROVIDERS OF PUBLICLY-FUNDED HOME CARE SERVICES (2016)

The *Home Care and Community Services Act, 1994* ("HCCSA") governs the provision of home care services in Ontario and is applicable to the final offence committed by EW for which she was found guilty. When EW committed her final offence, she was providing home care services through Saint Elizabeth Health Care ("Saint Elizabeth"). The HCCSA governs the provision of home care services by "approved agencies" and "service providers". Saint Elizabeth was a "service provider" under the HCCSA. At the relevant time, Community Care Access Corporations, each of which operated a Community Care Access Centre ("**CCAC**"), were approved agencies and service providers under the *HCCSA*. Under the HCCSA, nursing services are "professional services", which is in turn a subset of "community services" (s. 2(3, 7) of the HCCSA). The summary below provides a general outline of certain relevant portions of the HCCSA during the time in question.

August 2016

(Period during which EW commits her final offence, providing homecare services to a victim in her home)

***Home Care and Community Services Act, 1994*, S.O. 1994, c. 26 | O. Reg. 179/95 | O. Reg. 386/99**

- **Service providers must ensure that persons receiving community services have certain enumerated rights respected and promoted**, including (but not limited to) the right:
    - To be dealt with by the service provider in a courteous and respectful manner and to be free from mental, physical, and financial abuse
    - To be dealt with by the service provider in a manner that respects the person's dignity and privacy and that promotes the person's autonomy
    - To information about the community services provided to him or her and to be told who will be providing the community services
    - To give or refuse consent to the provision of any community services
    - To raise concerns or recommend changes in connection with the community service provided to him or her and in connection with policies and decisions that affect his or her interests
    - To be informed of the laws, rules and policies affecting the operation of the service provider and to be informed in writing of the procedures for initiating complaints about the service provider (s. 3(1), *HCCSA*)

- **Approved agencies must develop and implement a plan for preventing, recognizing and addressing physical, mental and financial abuse** of persons who receive community services provided by the agency or purchased by the agency from other service providers (s. 26, *HCCSA*)

- **Approved agencies must ensure a quality management system is developed and implemented** for monitoring, evaluating and improving the quality of the community services provided or arranged by

the agency (s. 27, *HCCSA*)

- **Service providers must give the Minister prescribed reports, documents and information** at prescribed times or at the time specified by the Minister (s. 30, *HCCSA*)

- **Service providers must post** a copy of s. 3 of the *HCCSA* [outlining the rights of those who receive community services], a copy of the agreement between the service provider and the Minister or a service accountability agreement with a LHIN, and such other documents or information as are prescribed (s. 31, *HCCSA*)

- **Service providers must comply with the prescribed rules and standards** regarding the provision of community services (s. 38, *HCCSA*)

- **Creates offences and imposes penalties** for various contraventions of the *HCCSA*, including (but not limited to):
    - Knowingly furnishing false information in an application under the *HCCSA* or in a report, notice or other document required under the *HCCSA*
    - Failing to give the Minister the required reports, documents and information at the required times
    - Failing to post the information required under s. 31 of the *HCCSA*
    - Failing to comply with the prescribed rules, standards, and procedures for the provision of community services or the performance of a service provider's other functions and duties under the *HCCSA*
    - Failing to produce records and provide assistance to program supervisors under s. 62(6-7) of the *HCCSA*
    - Hindering, obstructing, or attempting to hinder or obstruct a program supervisor or knowingly giving false information to a program supervisor about a matter relevant to an inspection (s. 66, *HCCSA*)

- **Service providers** that are providing professional services **must ensure there is a written plan of care** for each person receiving the services. If the professional services provided involve treating or advising the person within the scope of practice of a health profession under the *Regulated Health Professions Act, 1991*, the service provider must ensure the plan of care is developed, evaluated, and revised as necessary by a member of the College that relates to the professional services provided (s. 3.2 O. Reg. 386/99)

D. THE DUTIES AND RESPONSIBILITIES OF FACILITIES AND OTHER REGULATED HEALTH PROFESSIONALS UNDER THE *REGULATED HEALTH PROFESSIONS ACT*

As a Registered Nurse between the years 1995 and 2017, the scope and regulation of EW's nursing practice were governed by the *Nursing Act, 1991,* as amended (the "*Nursing Act*") and the *Regulated Health Professions Act, 1991,* as amended (the "*RHPA*").

The **RHPA** and its regulations governed the regulation and co-ordination of the health professions in Ontario, including nursing. The *Health Professions Procedural Code* (the "*Code*"), which is Schedule 2 to the *RHPA*, is incorporated into the *Nursing Act* by virtue of s. 2(1) of the *Nursing Act*.

The *Health Professions Procedural Code* identifies certain situations pursuant to which mandatory reports must be made to the College of Nurses of Ontario.

2007 – 2016 (The period during which the Offences were committed)
REPORTING BY MEMBERS • **A member shall file a report** in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same or a different College has sexually abused a patient. (s. 85.1, *Code***)** **REPORTING BY FACILITIES** • Prior to June 4, 2009: **A person who operates a facility** where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility has sexually abused a patient. (s. 85.2, *Code*) • Post June 4, 2009: **A person who operates a facility** where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds to believe that a member who practises at the facility is incompetent, incapacitated, or has sexually abused a patient. (s. 85.2, *Code,* 2007, c. 10, Sched. M, s. 61) • **A person who operates a facility but who is not an individual** shall be deemed to have reasonable grounds if the individual who is responsible for the operation of the facility has reasonable grounds. (s.85.2, *Code*)

REQUIREMENTS OF REQUIRED REPORTS

- **A report required** under section 85.1 or 85.2 must be filed in writing with the Registrar of the College of the member who is the subject of the report. (s. 85.3, *Code***)**

TIMING OF REPORT

- Prior to June 4, 2009:

  The report must be filed within 30 days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, in which case the report must be filed forthwith. (s. 85.3, *Code*)

- Post June 4, 2009:

  The report must be filed within 30 days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, or that the incompetence or the incapacity of the member is likely to expose a patient to harm or injury and there is urgent need for intervention, in which case the report must be filed forthwith. (s. 85.3, *Code*, 2007, c. 10, Sched. M, s. 62).

CONTENTS OF REPORT

- Prior to June 4, 2009:

  The report must contain:

  - the name of the person filing the report;
  - the name of the member who is the subject of the report;
  - an explanation of the alleged sexual abuse;
  - if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4). (s. 85.3, *Code*)

- Post June 4, 2009:

  The report must contain:

  - the name of the person filing the report;
  - the name of the member who is the subject of the report;
  - an explanation of the alleged sexual abuse, incompetence or incapacity;
  - if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4). (s. 85.3, Code, 2007, c. 10, Sched. M, s. 62

(4) **The name of a patient** who may have been sexually abused must not be included in a report unless

the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name. (s. 85.3, *Code*)

REPORTING BY EMPLOYERS, ETC.

- **A person who terminates the employment** or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons. (s. 85.5, *Code*)
- Prior to August 1, 2016:

  If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act. (s. 85.5, *Code*)
- Post August 1, 2016:

  Where a member resigns, or voluntarily relinquishes or restricts his or her privileges or practice, and the circumstances set out in paragraph 1 or 2 apply, a person referred to in subsection (3) shall act in accordance with those paragraphs:

  1. Where a person referred to in subsection (3) has reasonable grounds to believe that the resignation, relinquishment or restriction, as the case may be, is related to the member's professional misconduct, incompetence or incapacity, the person shall file with the Registrar within 30 days after the resignation, relinquishment or restriction a written report setting out the grounds upon which the person's belief is based.

  2. Where the resignation, relinquishment or restriction, as the case may be, takes place during the course of, or as a result of, an investigation conducted by or on behalf of a person referred to in subsection (3) into allegations related to professional misconduct, incompetence or incapacity on the part of the member, the person referred to in subsection (3) shall file with the Registrar within 30 days after the resignation, relinquishment or restriction a written report setting out the nature of the allegations being investigated.

  (3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services. (s. 85.5, *Code* - 2014, c. 14, Sched. 2, s. 12)

Immunity for reports

- **No action or other proceeding** shall be instituted against a person for filing a report in good faith under section 85.1, 85.2, 85.4 or 85.5. (s. 85.6, *Code*)