In the Matter Of:

The Long-Term Care Homes Public Inquiry

DAY 31 / VOL 31

August 03, 2018

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THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 31/Volume 31 of the Public Hearings in the above Inquiry proceedings taken at the Elgin County Courthouse, Court Room 201, 4 Wellington Street, St. Thomas, Ontario, on the 3rd day of August, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

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

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

& Megan Stephens, Esq.,	Commission Counsel
& Alexandra Campbell, Esq.,	
& Lara Kinkartz, Esq.,	
& Etienne Lacombe, Student-at-Law	
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David M. Golden, Esq.,	Caressant Care Nursing and Retirement Homes Limited, Caressant Care - Woodstock
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& Alexa Mingo, Esq.,	Queen in Right of
& Kristin Smith, Esq.,	Ontario
& Meagan Williams, Esq.,	
Nicole Butt, Esq.,	Ontario Nurses Association
Jane Meadus, Esq.,	Advocacy Centre
& Suzan Fraser, Esq.,	for the Elderly

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

Jennifer L. McAleer, Esq.,	Revera Long-Term Care Inc.
Lisa Corrente, Esq.,	Jarlette Health Services, Meadow Park (London) Inc. o/a Meadow Park London Long-Term Care

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09:20:27 -- Upon commencing at 9:30 a.m.

09:25:02

09:30:12 MS. STEPHENS: Good morning,
09:30:14 Commissioner.
09:30:14 As you know, Ms. Moroney is
09:30:18 back, back for her counsel's
09:30:20 examination and then also for
09:30:21 cross-examination.
09:30:22 But with the approval and
09:30:27 okay of all counsel, there was
09:30:29 one remaining document that I
09:30:30 did want to ask Ms. Moroney
09:30:32 about. This is not yet an
09:30:37 exhibit at trial, but I would
09:30:41 like to ask Ms. Moroney about
09:30:43 this.
09:30:43 NATALIE MORONEY; Under Prior
09:30:43 Oath.
09:30:43 EXAMINATION IN-CHIEF BY
09:30:43 MS. STEPHENS (CONT'D):
09:30:44 Q. Natalie, during the course of
09:30:46 your inspections, you typically will prepare a
09:30:51 Staff Inventory List; is that correct?
09:30:52 A. Yes.
09:30:53 Q. And this is a list of who you
09:30:54 plan on interviewing?
09:30:55 A. This is the list of the staff
09:30:58 inventory that we did interview.
09:31:01 Q. That you did interview. And
09:31:02 then the staff are given basically an anonymous
09:31:06 number; is that correct?
09:31:06 A. Correct.

09:31:07 Q. Okay, and then that, in your
09:31:09 report, you ultimately end up referring to
09:31:11 staff members by that number?
09:31:13 A. Correct.
09:31:14 Q. Okay. And is this the Staff
09:31:19 Inventory List that was prepared during the
09:31:19 course of the Meadow Park inspection that we
09:31:21 discussed yesterday?
09:31:22 A. Yes.
09:31:23 MS. STEPHENS: Okay. So,
09:31:25 Commissioner, I would like to
09:31:28 ask that this be made the next
09:31:29 exhibit at the Inquiry, and the
09:31:32 reason for that is it helps us
09:31:33 make sense of all the Inspection
09:31:35 Reports so that we can see which
09:31:37 staff members Natalie spoke with
09:31:41 and just make sense of that
09:31:42 report, particularly in light of
09:31:44 the Facilities Phase where many
09:31:46 of those people testified. It
09:31:48 will just help us make sense of
09:31:49 it going forward.
09:31:50 It probably should have been
09:31:51 included in our Overview Report
09:31:53 and was included in the case of
09:31:56 Caressant Care.
09:31:57 THE COMMISSIONER: All right,
09:31:58 thank you very much. And all
09:32:00 the other counsel have seen this
09:32:01 and no problems, right?
09:32:03 Thank you.

09:32:03 Madam Clerk, am I right in
09:32:06 understanding that would be
09:32:07 Exhibit 142?
09:32:09 THE COURT CLERK: 143.
09:32:11 THE COMMISSIONER: 143. What
09:32:15 was 142?
09:32:18 THE COURT CLERK: That was the
09:32:19 Affidavit of Natalie Moroney.
09:32:20 THE COMMISSIONER: Oh, yes,
09:32:21 okay, thank you.
09:32:21 Exhibit 143 then, a several-page
09:32:25 document that is a Staff
09:32:27 Inventory List, Date of
09:32:29 Inspection October 28, 2016.
09:32:25 EXHIBIT NO. 143: Staff
09:32:27 Inventory List, Date of
09:32:29 Inspection October 28, 2016.
09:32:32 THE COMMISSIONER: So we don't
09:32:33 have any redaction issues with
09:32:34 this exhibit?
09:32:38 MS. STEPHENS: There have
09:32:38 been -- we have not redacted
09:32:40 staff names throughout, so that
09:32:41 is not an issue.
09:32:42 The only redactions that
09:32:43 appear there are ones that we
09:32:45 agreed to. They were legal
09:32:47 counsel, not actually staff at
09:32:48 the home.
09:32:49 THE COMMISSIONER: All right,
09:32:49 thank you.
09:32:50 Thank you.

MS. STEPHENS: And those are my one wrap-up question. Thank you, Madam Commissioner.
THE COMMISSIONER: Thank you very much.
EXAMINATION IN-CHIEF BY MS. MINGO:
Q. Good morning, Madam Commissioner.
Good morning, Natalie.
A. Good morning.
Q. I wanted to ask you, we heard yesterday that before joining the Ministry, you had worked as a RAI Coordinator in a home?
A. Yes, I did.
Q. And we have heard some other testimony through this proceeding about the RAI/MDS system, and we have heard some testimony about how it feeds into the Ministry's funding, but I wanted to ask you about how RAI/MDS is used in long-term care homes.
So I understand that RAI/MDS data is used to develop the Plan of Care for each resident?
A. Yes, that's correct.
Q. Can you tell us how that works?
A. If you think of the RAI/MDS as a preliminary screening process, there are questions that the registered staff or the RPN in the home or the RAI Coordinator who could be

09:33:53 1 an RN or an RPN would complete. So they are
09:33:55 2 gathering data from observation, health care
09:33:58 3 records and interviewing the resident.
09:34:01 4 Once the RAI/MDS is complete,
09:34:04 5 there are triggers, and those triggers are
09:34:06 6 identified as RAPs, which are the Resident
09:34:12 7 Assessment Protocols. The Resident Assessment
09:34:15 8 Protocols identify care areas or any concerns
09:34:17 9 that could be potential problems for the
09:34:18 10 residents, any needs that the resident requires
09:34:21 11 and any preferences.
09:34:26 12 I believe there is 18 RAPs, so
09:34:30 13 the Resident Assessment Protocols, and some of
09:34:32 14 those could be delirium, cognition,
09:34:36 15 communication, falls, continence care, et
09:34:39 16 cetera.
09:34:40 17 So for an example, during the
09:34:42 18 preliminary process, if the nurse has checked
09:34:44 19 off the box in section "J" of the RAI/MDS
09:34:46 20 assessment, so if the resident has had a fall
09:34:50 21 in the last 30 days, once the assessment is
09:34:52 22 closed, the RAPs are generated and then it will
09:34:55 23 show a triggered area of care.
09:34:58 24 So for the RAPs, there might
09:35:00 25 have also been some other issues where the
09:35:03 26 resident experienced an infection, so if the
09:35:05 27 resident was having a urinary tract infection,
09:35:08 28 that would also be identified in the RAI/MDS
09:35:10 29 assessment in the preliminary screening
09:35:12 30 process. And often you will see with a
09:35:14 31 resident who might have a urinary tract
09:35:16 32 infection, there could be causes of delirium,

09:35:17 so some confusion, unbalanced, unsteady gait.
09:35:22 So when the nurse is creating
09:35:24 the RAP, they are identifying all of these
09:35:27 areas and they are kind of pulling all that
09:35:29 information together, and it creates a picture
09:35:31 of what was happening at that time for the
09:35:33 resident.
09:35:34 Those identified areas then
09:35:37 would move into the resident's Care Plan, and
09:35:39 the Care Plan is individual and it is very
09:35:42 specific to those residents in the home and it
09:35:46 identifies, again, any care concerns, if there
09:35:49 is improvements that could be made in the
09:35:51 goal-setting. So a resident that had a fall
09:35:53 with a fractured hip, you'll have restorative
09:35:56 care involved. They might be walking them for
09:35:59 15 minutes a day. It is resident-specific.
09:36:03 The Care Plan also gives
09:36:05 direction to the frontline staff, so Personal
09:36:09 Support Workers have access to the Care Plan or
09:36:11 they have access to Point Click Care, which is
09:36:14 a computerized system, that will tell them how
09:36:18 to direct their care for that resident. It
09:36:20 will let them know and identify any safety
09:36:22 concerns, so if a resident is at risk for
09:36:25 falls, the interventions that might be in place
09:36:27 for that resident would be a high/low bed.
09:36:29 They require a chair alarm to alert staff if
09:36:32 they are trying to stand up on their own and
09:36:34 they shouldn't be.
09:36:35 For us, when we go in as
09:36:37 Inspectors, we do look at the RAI/MDS

09:36:40 assessment. If we have a critical incident
09:36:42 with us related to a fall, we want to know what
09:36:44 was in place for that resident. Did they have
09:36:47 a call bell in place? Is the resident a
09:36:50 frequent faller? And what was happening at
09:36:51 that time?
09:36:52 So if the resident was
09:36:53 experiencing delirium and they had a urinary
09:36:55 tract infection and they were forgetting to use
09:36:57 their call bell and they get up and they have a
09:37:00 fall, what did the home do with that? Did they
09:37:03 update the Plan of Care?
09:37:04 So these assessments also
09:37:06 generate what we would call outcome scores. So
09:37:10 if a resident has depression and there is
09:37:14 increase in moods and behaviours, the home has
09:37:16 that opportunity to address that issue. They
09:37:18 can look into doing a different type of
09:37:20 assessment for that resident to identify the
09:37:23 care needs.
09:37:24 If a resident is experiencing
09:37:26 pain through the preliminary process, that
09:37:29 again drives the care that the resident needs.
09:37:32 They might need to complete a pain assessment.
09:37:35 They might need to look at the medication that
09:37:37 is being provided to that resident and has it
09:37:39 been effective. They might need to contact the
09:37:42 physician.
09:37:44 Q. Okay. You have referred to
09:37:46 the preliminary process. Can you explain that,
09:37:49 what that is?
09:37:51 A. So the preliminary process is

09:37:52 a screening process. If you think about the
09:37:55 functionality of a resident and the type of
09:37:58 needs they require, so activities of daily
09:38:01 living, a resident who might be able to
09:38:05 participate in part of a transfer but still
09:38:08 requires two staff assistants, this is
09:38:11 information that would be put into the RAI
09:38:14 assessment which would generate any triggers
09:38:16 and then further Care Planned.
09:38:18 Q. Okay. And I understand that
09:38:21 RAI/MDS, this is a tool used throughout the
09:38:25 long-term care sector?
09:38:26 A. It is. The RAI/MDS
09:38:28 assessment, so if you look at a new admission
09:38:30 of a resident into a home, the home develops a
09:38:34 24-hour Plan of Care. During that time period,
09:38:37 there is an observation of the resident as to
09:38:40 how the resident is functioning in the home.
09:38:42 At 14 days, the RAI/MDS
09:38:45 assessment is required to be completed. The
09:38:47 RAI/MDS assessment is completed quarterly, any
09:38:52 significant change in status, and annually.
09:38:57 Q. Okay. Does every long-term
09:38:59 care home have a RAI Coordinator?
09:39:01 A. All long-term care homes have
09:39:02 a RAI Coordinator, but it could be different in
09:39:05 each home. So a RAI Coordinator could be an RN
09:39:11 or an RPN. Depending on the size of the home,
09:39:11 there could be three RPNs. And it is different
09:39:14 throughout the home as to who completes the
09:39:16 RAI/MDS assessment and who would further
09:39:19 complete the Care Plan and any other ongoing

assessments required.

Q. So does that mean it is up to the home to determine how they are going to do the RAI/MDS?

A. The home determines who will complete the RAI/MDS, but it will be a registered staff member.

MS. MINGO: Okay, thank you, those are all my questions.

THE COMMISSIONER: Thank you.

CROSS-EXAMINATION BY MS. CORRENTE:

Q. Good morning, Madam Commissioner. Good morning, Natalie.

A. Good morning.

Q. I didn't bring my phone with me this time, just in case.

Natalie, in your testimony yesterday, you mentioned that Inspectors can voice concerns if they are asked to inspect a home at which they were formerly employed, so if you had concerns about going into a home at which you were formerly employed, you are able to express those concerns?

A. Yes, if there was a conflict in the home, you could express those concerns to your manager.

Q. And, sorry, you would express those concerns to your manager at the London SAO?

A. Yes.

Q. And so on the flip side of

09:40:42 1 that, if a licensee had concerns about a former
09:40:47 2 employee inspecting their home as a Ministry
09:40:50 3 Inspector, can the licensee raise those types
09:40:52 4 of concerns?
09:40:53 5 A. I believe the licensee can
09:40:55 6 contact our SAO Manager and express those
09:40:58 7 concerns.
09:40:58 8 Q. And if your SAO Manager
09:41:02 9 didn't agree with the licensee's concerns about
09:41:06 10 an Inspector who was previously employed at one
09:41:09 11 of their homes, do you know if there is a
09:41:11 12 process within the Ministry for the licensee to
09:41:14 13 challenge the choice of Inspector for a home?
09:41:18 14 A. As an Inspector, I am not
09:41:20 15 aware.
09:41:20 16 Q. Okay, I have some questions
09:41:25 17 for you about the nature of the inspection at
09:41:28 18 Meadow Park London which began in October of
09:41:31 19 2016.
09:41:32 20 I don't think there is any
09:41:34 21 dispute that you, or any of the other Ministry
09:41:37 22 Inspectors, for that matter, had ever inspected
09:41:40 23 an incident involving the murder of a long-term
09:41:42 24 care resident by a staff member; is that fair?
09:41:45 25 A. That's correct.
09:41:45 26 Q. And you were appointed as the
09:41:47 27 lead Inspector at Meadow Park?
09:41:49 28 A. Yes.
09:41:49 29 Q. And you were assisted in your
09:41:51 30 inspection by Neil Kikuta?
09:41:54 31 A. That's correct.
09:41:55 32 Q. And I understand that

09:41:56 Mr. Kikuta was a fairly recent hire to the
09:42:02 Ministry. He began as an Inspector there in
09:42:02 April of 2016?
09:42:02 A. I am not sure of the date of
09:42:04 hire, but he was a newer Inspector.
09:42:06 Q. Is it fair to say that the
09:42:10 staff at Meadow Park would not have known
09:42:13 Mr. Kikuta very well in October 2016 with him
09:42:17 having worked as a Ministry Inspector for a
09:42:20 short period of time?
09:42:20 A. I don't know if I could speak
09:42:23 to if Neil was in the home as an Inspector. I
09:42:28 am not sure if he had previously inspected at
09:42:30 Meadow Park London.
09:42:31 Q. Okay, fair enough.
09:42:32 And the two of you were tasked
09:42:36 with completing what was a Critical Incident
09:42:41 System inspection of the home relating to the
09:42:45 Elizabeth Wettlaufer offences?
09:42:46 A. As well as other critical
09:42:48 incidents and complaints.
09:42:49 Q. Right, you brought I believe
09:42:51 you said it was 14 other critical incidents and
09:42:55 complaints with you as part of that larger
09:42:56 inspection?
09:42:57 A. Yes.
09:42:57 Q. Okay. In paragraph 19 of
09:43:09 your affidavit, and we can turn that up --
09:43:12 sorry, I'm just going to grab my binder,
09:43:16 because I forgot to bring it up.
09:43:18 And I just wanted to take you --
09:43:34 oh, are we already there? Great.

09:43:35 1 I wanted to take you to
09:43:36 2 paragraph 19 on page 6, and I believe you
09:43:42 3 indicated that before commencing your
09:43:48 4 inspection, you had been given -- before
09:43:52 5 commencing the on-site inspection, you had been
09:43:55 6 given a copy of Elizabeth Wettlaufer's
09:43:57 7 personnel file?
09:43:58 8 A. So on October 5th was the day
09:44:01 9 that we had completed that part of the on-site
09:44:03 10 inspection, and we were given the HR file for
09:44:05 11 Elizabeth Wettlaufer.
09:44:06 12 Q. And is it fair to say based
09:44:08 13 on --
09:44:08 14 A. Sorry, I need to correct
09:44:09 15 myself. That was October 6th, not October 5th.
09:44:12 16 Q. That's right, you did say
09:44:14 17 October the 6th.
09:44:14 18 Is it fair to say that there was
09:44:15 19 nothing in the HR file that you reviewed from
09:44:20 20 Meadow Park London that stood out to you or
09:44:22 21 that was concerning in respect of Elizabeth
09:44:25 22 Wettlaufer?
09:44:25 23 A. In respect of Elizabeth
09:44:28 24 Wettlaufer, no. In respect to the reference
09:44:31 25 letter, yes.
09:44:32 26 Q. Okay, but we are talking
09:44:36 27 about and my question to you was just about the
09:44:39 28 HR file that had been created by Meadow Park.
09:44:41 29 I wasn't referring to Caressant Care.
09:44:42 30 A. Yes.
09:44:43 31 Q. Okay. And on page 20 of your
09:44:48 32 affidavit, you also state that you reviewed

09:44:50 Meadow Park London's compliance history prior
09:44:53 to starting your inspection, and that, again,
09:44:56 nothing stood out to you regarding any previous
09:44:59 compliance history relating to Elizabeth
09:45:01 Wettlaufer?
09:45:01 A. That's correct.
09:45:02 Q. So turning now to the
09:45:11 inspection process itself at Meadow Park, so
09:45:17 you began the inspection on October the 6th,
09:45:19 2016?
09:45:20 A. Yes.
09:45:21 Q. And that portion of it was
09:45:24 when you and Ms. Kukoly first attended at the
09:45:28 home and you spoke to the Administrator?
09:45:29 A. Yes.
09:45:29 Q. And I take it that, like
09:45:32 other inspections, your attendance was not
09:45:34 announced that day; you went unannounced?
09:45:37 A. We were unannounced.
09:45:39 Q. But nevertheless, the
09:45:40 Administrator, Nicole Ross, had anticipated
09:45:43 your visit and she had ready for you a copy of
09:45:45 the personnel file for Ms. Wettlaufer and the
09:45:48 entire record for Mr. Horvath?
09:45:49 A. My understanding at that time
09:45:51 was that Nicole Ross had a conversation with
09:45:54 Karen Simpson, the Director, prior to us coming
09:45:57 to the home.
09:45:57 Q. So she would have known that
09:45:59 you were coming?
09:45:59 A. That we were requesting
09:46:01 certain documents and we would be coming to the

09:46:02 1 home.
09:46:03 2 Q. Okay. And I further
09:46:06 3 understand that you and Neil Kikuta had been
09:46:11 4 directed by Peggy Skipper not to speak to
09:46:16 5 anyone else at the home on that -- sorry, back
09:46:18 6 up.
09:46:19 7 And I understand that you and it
09:46:21 8 was Ms. Kukoly that had been directed by your
09:46:24 9 Manager, Peggy Skipper, not to speak to anyone
09:46:26 10 else at the home that day given the ongoing
09:46:29 11 police investigation?
09:46:30 12 A. The direction came from the
09:46:31 13 Director, Karen Simpson.
09:46:32 14 Q. Okay, but I am right that you
09:46:34 15 were directed to only speak to the
09:46:35 16 Administrator and not anyone else?
09:46:36 17 A. That's correct.
09:46:37 18 Q. Okay. And that was unusual
09:46:38 19 for you as an Inspector, wasn't it, to be
09:46:42 20 restricted to speaking only to the
09:46:45 21 Administrator at the home and not anyone else?
09:46:46 22 A. Yes.
09:46:46 23 Q. And you testified yesterday
09:46:52 24 that initially, given this direction, you were
09:46:55 25 getting information from staff through the
09:46:59 26 Administrator because there was still this
09:47:01 27 ongoing police investigation and you didn't
09:47:03 28 want to interfere with it?
09:47:04 29 A. That's correct.
09:47:05 30 Q. So is it fair to say that
09:47:08 31 from the outset of this inspection, both for
09:47:12 32 you and the staff at Meadow Park, this was not

09:47:14 1 the type of inspection to which you both were
09:47:17 2 accustomed?
09:47:18 3 A. This was an -- it was unusual
09:47:20 4 to not be able to speak to the staff when we
09:47:23 5 entered a home.
09:47:23 6 Q. Okay, but I am suggesting
09:47:27 7 more than that. So Ms. Kukoly testified the
09:47:30 8 other day that, you know, her words were
09:47:33 9 everything new, everything was new about this
09:47:35 10 inspection process.
09:47:35 11 And I am asking you if it is
09:47:37 12 fair to say that there were definitely new
09:47:39 13 aspects about this process that would have been
09:47:42 14 new to you and unfamiliar to the staff at
09:47:45 15 Meadow Park?
09:47:45 16 A. They were unusual and they
09:47:48 17 would have been new to the staff that we
09:47:51 18 couldn't approach them to interview them.
09:47:54 19 Q. Okay.
09:47:55 20 A. The observation and record
09:47:58 21 reviews would have been the same.
09:47:59 22 Q. Okay. It was also, and we'll
09:48:00 23 get into this a bit further, but it was also
09:48:03 24 new to the staff to be audio recorded during
09:48:06 25 their interviews?
09:48:06 26 A. Correct.
09:48:07 27 Q. And it would have also been
09:48:10 28 new to the staff that while you weren't
09:48:13 29 speaking to them, you were still making
09:48:15 30 observations around the home?
09:48:17 31 A. In a critical incident, yes.
09:48:23 32 Not necessarily in an RQI.

09:48:25 Q. Okay. But it was a critical
09:48:27 incident --
09:48:27 A. Correct.
09:48:28 Q. -- inspection?
09:48:29 A. Yes.
09:48:29 Q. Okay. So after October the
09:48:31 6th, the next time that you attended at the
09:48:34 home was on October the 28th; is that right?
09:48:36 A. Yes.
09:48:37 Q. Okay. And if we can pull up
09:48:41 from your affidavit Exhibit "C", which is
09:48:46 document 40987, and if we can go to page 1.
09:48:57 Just scroll down a little. Keep
09:49:03 going. Just a little more. Yeah, right there.
09:49:06 So listed under "The purpose of
09:49:12 this inspection was to conduct a Critical
09:49:14 Incident System inspection" are the dates, are
09:49:16 several dates. Am I correct that those are the
09:49:18 dates that you would have been in the home?
09:49:19 A. Yes, myself or Neil would
09:49:21 have been in the home.
09:49:21 Q. Okay. And by my count, there
09:49:28 are 47 separate dates, including October the
09:49:31 6th, so there would be 46 listed there plus
09:49:34 October the 6th, at which Inspectors were in
09:49:38 the home?
09:49:39 A. I haven't counted the dates,
09:49:40 but I will go by those numbers.
09:49:42 Q. Okay. And based on these
09:49:48 dates, it appears that the Ministry inspection
09:49:51 lasted from early October 2016 to late February
09:49:56 2017, so approximately five months?

09:49:58 A. Correct.
09:49:58 Q. And is it fair to say that
09:50:00 that would have been the most lengthy Ministry
09:50:03 inspection that either you or the home had ever
09:50:05 experienced?
09:50:06 A. For myself, being that I was
09:50:10 hired from 2014, and then I would assume for
09:50:12 the home.
09:50:13 Q. So for both of you, yes? I'm
09:50:16 right about that?
09:50:17 A. Yes.
09:50:17 Q. And you were not the only
09:50:22 Inspectors in the home during these months,
09:50:23 that is, the London Police Service was
09:50:25 conducting at the same time its criminal
09:50:28 investigation into Elizabeth Wettlaufer?
09:50:31 A. Yes.
09:50:31 Q. And there -- and the police
09:50:36 would have been interviewing staff members as
09:50:37 well and collecting documents?
09:50:38 A. My understanding from Karen
09:50:40 Simpson is that is what they were doing.
09:50:43 Q. And there were many days when
09:50:45 both you and the Ministry -- sorry, there were
09:50:47 many days when both police and you as the
09:50:50 Ministry Inspectors were in the home at the
09:50:52 same time gathering documents and interviewing
09:50:54 witnesses?
09:50:54 A. I can recall one time where
09:50:56 they were in at the same time we were in.
09:50:58 Q. Okay, your recollection is
09:50:59 just one time?

09:51:00 A. Just the one time.
09:51:01 Q. But there were days that you
09:51:02 said that Neil was there and you weren't?
09:51:03 A. That's correct.
09:51:04 Q. Okay. And Karen Simpson
09:51:10 testified the other day that she didn't want to
09:51:13 miss anything in relation to the inspections
09:51:16 conducted at the facilities, so you know --
09:51:20 and do you recall that testimony?
09:51:21 A. I recall her testimony, but I
09:51:24 don't recall that verbatim.
09:51:25 Q. Okay. Is it fair to say, you
09:51:29 know, in your view, do you feel that you
09:51:31 completed a thorough and comprehensive
09:51:34 inspection at Meadow Park London from October
09:51:36 to February 2017?
09:51:37 A. Yes, I do, in regards to
09:51:43 Elizabeth Wettlaufer.
09:51:44 Q. And in regards to the 14
09:51:47 other complaints and critical incidents that
09:51:49 you inspected; is that fair?
09:51:50 A. Yes.
09:51:51 Q. I think it is important for
09:51:55 the public and for the Commissioner to
09:51:56 understand just, you know, the level of
09:51:58 scrutiny that was applied to your inspection,
09:52:02 so I want to go through that a bit.
09:52:03 And maybe we can turn, we are
09:52:05 still at Exhibit "C", if we can go to the next
09:52:08 page, yes, where it starts "During the [...]
09:52:17 the inspection [...]"
09:52:21 I want to go to that second

paragraph, and please take a read of it, and then I'm going to ask you some questions about it, the paragraph that begins "During the months of October, November and December [...]"

A. [Witness reviews document.]

Q. Okay, so for based on what you have written in this Inspection Report, I gather that for the purposes of your inspection, you made observations of resident care?

A. Yes, we did.

Q. And you observed the medication rooms and the medication carts?

A. That's correct.

Q. And you observed medication administration?

A. Yes.

Q. And that would have included in fact watching nursing staff complete part of a medication pass?

A. That's correct.

Q. And you also observed drug destruction of both controlled and non-controlled substances?

A. Yes.

Q. Okay. And I understand that you also took photographs of a number of things in the home?

A. Yes, Neil Kikuta took photographs of issues in the home related to the medication.

Q. Sorry, did you say Neil?

09:53:28 A. Neil.
09:53:29 Q. You would have also reviewed
09:53:30 a number of documents as part of your
09:53:33 inspection; is that true?
09:53:34 A. Yes.
09:53:35 Q. Okay, so resident records
09:53:40 were reviewed?
09:53:41 A. Resident health care records,
09:53:42 yes.
09:53:42 Q. And documentation relating to
09:53:44 ordering and receiving medication from
09:53:47 pharmacy?
09:53:47 A. Yes.
09:53:47 Q. Documentation for medication
09:53:51 administration on the eMAR?
09:53:53 A. Correct.
09:53:54 Q. Documentation relating to
09:53:55 signage of controlled substances?
09:53:56 A. Yes.
09:53:57 Q. Numerous written policies and
09:53:59 procedures of the home, as well as from the
09:54:02 pharmacy service provider?
09:54:03 A. Yes.
09:54:03 Q. And there were other -- there
09:54:07 was other relevant documents as well,
09:54:08 documentation as well?
09:54:09 A. Correct.
09:54:09 Q. And I understand that you
09:54:11 also had access through your own computers to
09:54:14 the home's Point Click Care system through
09:54:18 which you are able to access plans of care; is
09:54:20 that true?

09:54:21 A. Yes.
09:54:21 Q. So you would agree with me
09:54:28 that you had gathered an extensive amount of
09:54:30 documentation from the home for the purposes of
09:54:33 your inspection?
09:54:34 A. Yes.
09:54:34 Q. Okay. And I also see from
09:54:38 this Inspection Report that you interviewed a
09:54:41 number of people. And I'm sorry, I don't have
09:54:43 a copy of the exhibit that we just introduced
09:54:46 today.
09:54:48 MS. STEPHENS: I don't have an
09:54:48 extra one, I'm sorry.
09:54:50 MS. CORRENTE: Okay.
09:54:52 MS. STEPHENS: You could pull it
09:54:53 up.
09:54:54 MS. CORRENTE: Okay, we can pull
09:54:55 it up, and the exhibit number
09:54:56 for that I don't have either.
09:54:58 THE COMMISSIONER: 143.
09:55:00 MS. CORRENTE: I think it was
09:55:02 143 as an exhibit number, but I
09:55:03 don't have the document number,
09:55:04 my apologies.
09:55:06 THE COURT CLERK: So that is
09:55:07 41196.
09:55:09 THE COMMISSIONER: Thank you.
09:55:09 BY MS. CORRENTE:
09:55:19 Q. Okay, so have you had a
09:55:22 chance to run through this list?
09:55:23 A. Yes, I have.
09:55:24 Q. Okay. And so on this list,

09:55:27 you would have spoken to the Chief Operating
09:55:29 Officer for Jarlette? And I will just run
09:55:35 through the list just to confirm that you had
09:55:37 spoken to these people.
09:55:38 A. Okay.
09:55:38 Q. You know what, if it is
09:55:40 easier for you, we can go back to the
09:55:42 Inspection Report for a second, because I think
09:55:44 this might make it easier.
09:55:46 So if we can go back to document
09:55:52 40987, back to page 2, okay, and the first
09:56:08 paragraph, so just scroll a little higher.
09:56:12 Okay, and in that paragraph that
09:56:15 begins after "Critical Incident Log", and it
09:56:18 starts "During the course of the inspection
09:56:20 [...]", it lists a number of people?
09:56:23 A. Correct.
09:56:23 Q. And take a minute to review
09:56:24 that, if you need to.
09:56:25 A. [Witness reviews document.]
09:56:35 Okay.
09:56:36 Q. Okay, and so this group here
09:56:38 would have included both current and former
09:56:42 staff members of Meadow Park London?
09:56:43 A. Yes.
09:56:43 Q. And it would have included
09:56:45 members from its corporate head office?
09:56:47 A. Yes.
09:56:48 Q. Members of senior management
09:56:49 at the home?
09:56:50 A. Yes.
09:56:50 Q. Nursing staff?

09:56:51 1 A. Yes.
09:56:52 2 Q. Physicians?
09:56:53 3 A. No.
09:56:54 4 Q. I thought --
09:56:55 5 A. I don't recall if I talked to
09:56:58 6 physicians --
09:56:58 7 Q. It says here physicians.
09:56:59 8 A. Oh, sorry, yes, two
09:57:00 9 physicians.
09:57:00 10 Q. Yeah, so physicians as well?
09:57:02 11 A. Yes.
09:57:02 12 Q. The Pharmacy Consultant?
09:57:03 13 A. Yes.
09:57:04 14 Q. Okay. So by my count, there
09:57:08 15 are, and I am just talking about staff, on this
09:57:12 16 list it appears about 51 current and former
09:57:15 17 staff members at Meadow Park which you would
09:57:18 18 have interviewed; is that a fairly accurate
09:57:20 19 estimate? And if you need the Exhibit 143 to
09:57:27 20 confirm that, please feel free.
09:57:28 21 A. That's okay. Yes.
09:57:29 22 Q. Okay. And in addition to
09:57:33 23 these 51 current and former staff members, you
09:57:36 24 also interviewed families?
09:57:41 25 A. One family.
09:57:41 26 Q. One family, okay, and you
09:57:43 27 also interviewed residents?
09:57:44 28 A. That's correct.
09:57:44 29 Q. Okay, and any sense of how
09:57:46 30 many residents you would have interviewed?
09:57:47 31 A. I would need to see the
09:57:49 32 resident list.

09:57:49 Q. Okay. More than one?
09:57:51 A. Yes.
09:57:51 Q. Okay. Any estimate at all?
09:57:56 A. I would be guessing.
09:57:57 Q. Okay, fair enough.
09:57:59 So and you would also agree with
09:58:02 me that some of the staff members -- and when I
09:58:05 use "staff members" going forward, I am going
09:58:07 to suggest to you that I mean both current and
09:58:09 former staff members.
09:58:10 A. Yes.
09:58:10 Q. Some of the staff members you
09:58:13 interviewed more than once?
09:58:14 A. Yes.
09:58:14 Q. And my recollection is that
09:58:19 the interviews of staff took place in a spare
09:58:23 office at the home?
09:58:24 A. Correct.
09:58:25 Q. And the staff were
09:58:28 interviewed by both you and Mr. Kikuta. You
09:58:31 asked the questions, and he typed, presumably,
09:58:34 the questions and the answers on to his
09:58:36 computer?
09:58:37 A. Yes.
09:58:37 Q. And these staff interviews
09:58:41 were also audio recorded?
09:58:43 A. Correct.
09:58:43 Q. And this was the first time
09:58:45 that you as Ministry Inspectors had ever audio
09:58:49 recorded interviews at Meadow Park London?
09:58:51 A. Yes.
09:58:52 Q. Now, Ms. Kukoly in her

affidavit mentioned training by a police officer in relation to other things, including audio recording.

Did you -- had you ever received any training on audio recording prior to conducting these interviews?

A. Yes, at the same time as Rhonda did.

Q. Okay, and do you know when that was?

A. I don't recall.

Q. And what were you -- in that training, what were you taught in terms of audio recordings?

A. I don't recall.

Q. Did you recall what you were taught at the time that you were conducting these interviews? Would you know that?

A. We had a policy as well as direction as to the type of questions that we would be asking and the direction on how we would propose those questions.

Q. Okay. Did you ever give any guidance or direction to the staff about the audio recording that was going to take place? Did you ever explain anything in relation to that?

A. I believe we did for each staff. We did tell them that we would be audio recording them, that we told them that at any time that they needed to take a break they could, if they had felt uncomfortable. If they

10:00:07 1 didn't know an answer, they could always come
10:00:09 2 back and tell us.
10:00:09 3 Q. Okay. So while the Ministry
10:00:15 4 Inspectors were able to audio record the
10:00:17 5 interviews, staff were not permitted to audio
10:00:20 6 record?
10:00:20 7 A. Staff were not permitted to
10:00:23 8 audio record.
10:00:24 9 And I just want to take a step
10:00:26 10 back, because in 2014 the audio recordings only
10:00:29 11 related to the incidents in 2014 regarding
10:00:32 12 Elizabeth Wettlaufer. The 2016 inspections
10:00:35 13 that were being concurrently investigated were
10:00:38 14 not audio recorded.
10:00:41 15 And in 2014, the staff members
10:00:44 16 at that time during the audio recording had
10:00:47 17 legal representation.
10:00:48 18 Q. Okay. But back to my
10:00:52 19 question, the staff members, whether -- when
10:00:57 20 they were being audio recorded for whatever
10:00:59 21 purpose were not also allowed to audio record
10:01:02 22 the interviews; it was only the Ministry who
10:01:05 23 could record?
10:01:05 24 A. Correct.
10:01:05 25 Q. Okay. Natalie, would you
10:01:14 26 agree with Karen Simpson's statement that she
10:01:17 27 made during her testimony that the inspection
10:01:20 28 process can be stressful and intimidating for
10:01:23 29 staff?
10:01:23 30 A. I don't recall Karen saying
10:01:27 31 that.
10:01:28 32 Q. Okay, well, in your view, can

10:01:34 the -- can an inspection process be stressful
10:01:36 and intimidating for staff?
10:01:38 A. I would hope not. We do
10:01:41 explain to them that we are there to gather
10:01:43 information, that we are not there to
10:01:46 discipline them, that we are inspecting -- we
10:01:48 explain to them exactly what we'll be
10:01:50 inspecting upon, so if it was a Critical
10:01:54 Incident Report related to a fall, we were
10:01:55 going to ask questions related to a fall.
10:01:57 If they felt uncomfortable at
10:01:59 any time, we could stop the interview,
10:02:03 interview someone else, or do the interview at
10:02:05 a later date.
10:02:06 Q. Okay, but in this particular
10:02:07 circumstance, you weren't inspecting a critical
10:02:11 incident in relation to a fall. You were
10:02:12 inspecting the offences, the murder committed
10:02:16 by Elizabeth Wettlaufer at a time when the
10:02:21 homes were or the staff at the homes were -- or
10:02:25 you know, had recently learned about what had
10:02:27 happened.
10:02:27 And so you would agree with me
10:02:29 that this was a stressful and overwhelming
10:02:35 process, not just for you as Inspectors but for
10:02:39 the staff at the home as well?
10:02:40 A. I would say that, yes.
10:02:42 Q. Do you recall some staff
10:02:48 members, at least one staff member requesting
10:02:51 to have a support person present with them
10:02:53 during the interview?
10:02:54 A. I don't recall.

10:02:56 Q. You don't recall Nicole Ross, the Administrator, requesting to have the Care Service Coordinator present during her interview?
10:03:07 A. I don't recall.
10:03:08 Q. It is possible that that may have happened, however?
10:03:12 A. It could be possible.
10:03:13 Q. Okay. And do you recall that none of the people that you had interviewed had a support person with them in the room?
10:03:27 A. This would not be abnormal. When we interview staff, we do interview them by themselves.
10:03:37 Q. Okay, and that is a fair answer, but my question to you was in this particular -- with respect to these particular interviews and this particular inspection, there was no support person offered or present for the interviews of staff?
10:03:54 A. And as for our process, there wouldn't be.
10:04:05 Q. Okay. And were you at the time familiar with the Long-Term Care Homes Act? And we can bring up the legislation at -- it is number 5, FD0005, page 899. It is under section 147, I believe. Okay, I lost it. You had it and I lost it. 147, keep going down. It is (d), yeah, (d).
10:04:54 So were you familiar with section 147(1)(d) at the time which was in place that said:

10:05:03 "An Inspector conducting an
10:05:04 inspection,
10:05:06 May question a person,
10:05:09 subject to the person [...]
10:05:11 having counsel present during
10:05:12 the [inspection]"?
10:05:14 A. I became aware of that during
10:05:16 the inspection.
10:05:18 Q. Okay. And given your
10:05:20 testimony that it would have been abnormal to
10:05:24 have a support person there given that these
10:05:27 interviews were conducted I'll say, you know,
10:05:29 two-on-one, two Inspectors with the
10:05:32 interviewee, was it your interpretation then
10:05:34 that a person was not entitled to have a
10:05:40 support person present, subject only to their
10:05:43 right to have counsel? Was that your
10:05:52 interpretation?
10:05:52 A. When I read that
10:05:54 interpretation, it says:
10:05:55 "[...] subject to the person's
10:05:57 right to have counsel present
10:05:58 during the questioning."
10:05:59 Not "a person".
10:06:00 Q. So you are not interpreting
10:06:02 "counsel" to mean a support person?
10:06:04 A. No, I am not.
10:06:05 Q. And how was it that you would
10:06:06 have interpreted "counsel"?
10:06:07 A. I would "counsel" as a legal
10:06:09 representation.
10:06:09 Q. So a lawyer?

10:06:10 A. Yes.
10:06:11 Q. And it is fair to say that
10:06:24 since staff were not permitted to bring in what
10:06:28 we will call a support person into the
10:06:31 interview, that some of the staff opted to
10:06:34 bring in legal counsel for support?
10:06:36 A. The staff did have legal
10:06:39 representation.
10:06:40 Q. Some of the staff?
10:06:41 A. Some of the staff.
10:06:42 Q. And they opted to bring in
10:06:43 that legal representation because they weren't
10:06:46 able to have a support person present?
10:06:48 A. That is not my understanding.
10:06:50 I was approached by Nicole Ross in the home,
10:06:52 who was the Administrator at that time, and I
10:06:54 was told that they would be having legal
10:06:55 representation for any of the concerns related
10:06:58 to 2014 with relation to Elizabeth Wettlaufer.
10:07:01 Q. And I am suggesting to you
10:07:02 that the reason why Nicole Ross took that
10:07:05 approach was because she requested to have a
10:07:07 support person in the form of Christina Bath,
10:07:10 and that was denied by the Ministry Inspectors?
10:07:12 A. I would not be aware of that.
10:07:14 Nicole didn't voice that to me.
10:07:15 Q. You would agree with me that
10:07:18 legal counsel was not present for the interview
10:07:20 of every staff member, were they?
10:07:23 A. There were staff members that
10:07:24 did not want legal counsel.
10:07:25 Q. And the staff members

10:07:28 actually expressed that to you, that they
10:07:31 didn't want legal counsel, or there was just no
10:07:33 legal counsel present?
10:07:34 A. The one staff member that I
10:07:35 do recall had said that they did not want legal
10:07:38 counsel from Jarlette.
10:07:38 Q. That was one staff member?
10:07:39 A. Yes.
10:07:40 Q. But the other staff members
10:07:42 didn't express that one way or another?
10:07:43 A. I don't recall any other
10:07:44 staff member expressing that.
10:07:45 Q. Right, so there were staff
10:07:46 members who opted not to have legal counsel
10:07:48 present, and there were some staff members who
10:07:51 opted to have legal counsel present?
10:07:52 A. The only one person that I
10:07:56 can recall that did not want legal counsel
10:07:58 pregnant -- present during the inspection.
10:08:02 Q. Okay, I don't know if we are
10:08:05 saying the same thing and maybe in just
10:08:09 different ways, so I'll rephrase my question.
10:08:11 There were about 51 staff
10:08:13 members that were interviewed by you, you had
10:08:15 said?
10:08:16 A. Approximately, yes.
10:08:16 Q. And not all of those staff
10:08:19 members had legal counsel present?
10:08:22 A. For the inspection in 2014.
10:08:24 This is, just to clarify, we are just
10:08:26 discussing 2014, not 2016 inspections that were
10:08:31 concurrently being -- taking place in the home.

10:08:33 Q. Okay, but I don't know how
10:08:37 these inspections may have been separated, but
10:08:40 I believe you had said for that for the 2016
10:08:44 portion, none of them had legal counsel
10:08:46 present; is that true?
10:08:47 A. That's correct.
10:08:47 Q. Okay. So you know, for the
10:08:51 purposes of matters that related to EW, again,
10:08:55 not all of the staff members had legal counsel
10:08:57 present?
10:08:58 A. I recall one staff member not
10:08:59 having legal counsel present by their choice.
10:09:02 Q. By their?
10:09:03 A. By their choice.
10:09:06 Q. Okay, but that is not what I
10:09:07 am asking you. Other than that one staff
10:09:10 member who didn't have legal counsel, there
10:09:14 were various other staff members who also did
10:09:15 not have legal counsel?
10:09:16 A. No, I don't recall that.
10:09:17 Q. Your recollection is that
10:09:18 legal counsel was present for 50 of those 51
10:09:21 staff interviews?
10:09:22 A. For the staff interviews, I
10:09:24 only recall one staff member that did not have
10:09:27 legal counsel, and that was their choice.
10:09:31 Q. I am suggesting to you that
10:09:33 less than half of the staff members that you
10:09:36 interviewed had legal counsel present.
10:09:39 A. I don't recall that.
10:09:40 Q. But it is certainly possible?
10:09:42 A. I would need to be able to

review our interviews during that time at Meadow Park London.

Q. Well, I think that this is an important point and --

MS. MINGO: I'm sorry, the witness has answered this question already.

MS. CORRENTE: Well, her answer is that she doesn't recall, and I suggest that her interview notes are going to suggest otherwise. And if she needs an opportunity to get that clarification, she should get it.

MS. MINGO: Are you suggesting we go to her interview notes, or are you just going to ask her again?

BY MS. CORRENTE:

Q. No, well, I have asked her the question. She says she doesn't remember. Is there somewhere that you can look to refresh your memory?

A. The interviews are within the Medication IP.

Q. And they would indicate whether or not legal counsel is present?

A. It would.

MS. CORRENTE: Okay, so I am in your hands, Madam Commissioner.

THE COMMISSIONER: I don't have

10:10:28 a problem with you having the --
10:10:31 directing the witness to look at
10:10:32 what she can.
10:10:33 MS. CORRENTE: Now, the
10:10:33 Medication IP, from what I
10:10:35 recall, is about a 200-page
10:10:37 document that has a lot of text
10:10:38 in it, so it is not going to be
10:10:40 easy for me to find all of those
10:10:43 references on the spot.
10:10:45 So if we need about 15
10:10:48 minutes for her to locate them
10:10:50 and satisfy herself, I am happy
10:10:51 to give her that time.
10:10:53 THE COMMISSIONER: I am too.
10:10:53 And it will also give you an
10:10:55 opportunity to discuss whether
10:10:57 or not you are going to maintain
10:10:58 an objection on that point. I
10:11:00 don't hear you objecting to
10:11:01 that.
10:11:02 MS. MINGO: I don't object to
10:11:03 going to the notes, if that is
10:11:04 where my friend wants to go.
10:11:06 Just asking the question over
10:11:07 and over again doesn't seem like
10:11:09 it is going to produce a
10:11:10 different answer.
10:11:10 THE COMMISSIONER: All right, I
10:11:11 have to say, I didn't see it as
10:11:13 badgering the witness. I saw it
10:11:14 as trying to clarify a point.

10:11:17 1 There was clearly a difference
10:11:18 2 there.
10:11:18 3 But I would suggest that if
10:11:19 4 this is an important issue, then
10:11:21 5 we should recess until 10:30,
10:11:23 6 give this witness an opportunity
10:11:25 7 to review her notes, give you an
10:11:28 8 opportunity to review them as
10:11:29 9 well, and hopefully that time
10:11:30 10 will allow us to deal with this
10:11:32 11 matter in relatively short
10:11:36 12 compass.
10:11:36 13 MS. CORRENTE: Okay, thank you.
10:11:36 14 -- RECESSED AT 10:11 A.M.
10:33:59 15 -- RESUMED AT 10:33 A.M.
10:33:59 16 MS. CORRENTE: Thank you, Madam
10:34:02 17 Commissioner, for that somewhat
10:34:03 18 brief indulgence. I think that
10:34:08 19 we are going to be able to deal
10:34:09 20 with this in a more streamlined
10:34:11 21 way, rather than having to go
10:34:13 22 back to lots of documents.
10:34:13 23 BY MS. CORRENTE:
10:34:14 24 Q. So, Natalie, I just wanted to
10:34:16 25 clarify something that came up during the
10:34:19 26 break.
10:34:20 27 Exhibit 143, just so we are
10:34:23 28 clear, you had testified earlier that this was
10:34:26 29 a list of people that were interviewed; is
10:34:30 30 that --
10:34:30 31 A. That is --
10:34:32 32 Q. That is correct?

10:34:32 A. Yes.
10:34:33 Q. But that is not actually the
10:34:34 case?
10:34:35 A. In the staff interview list,
10:34:36 there are staff members that might not have
10:34:39 been interviewed but were referenced in our
10:34:40 report or within our IPs.
10:34:42 Q. Okay. So it is fair to say
10:34:44 then that this Staff Inventory List includes
10:34:47 people that were interviewed and also includes
10:34:50 others that were referenced in the Inspection
10:34:53 Report but who were not interviewed?
10:34:54 A. Right, as well as the IPs.
10:34:57 Q. Okay.
10:34:58 THE COMMISSIONER: As well as
10:34:58 what?
10:34:59 THE WITNESS: As well as the
10:35:00 IPs, the Inspection Protocols.
10:35:02 BY MS. CORRENTE:
10:35:02 Q. Okay. And you know, an
10:35:03 obvious example of this is that Elizabeth
10:35:07 Wettlaufer is listed on this Staff Inventory
10:35:10 List, and certainly she was not a person who
10:35:11 was part of the interview process?
10:35:13 A. That's correct.
10:35:13 Q. Okay. And you know, if we
10:35:17 needed to, we could go to the audiotapes of
10:35:21 each witness to confirm whether or not legal
10:35:23 counsel was present, because the audiotapes
10:35:26 would indicate that; is that fair to say?
10:35:28 A. Yes.
10:35:28 Q. Okay. So rather than go

10:35:30 1 through that exercise, in the interests of
10:35:33 2 time, I am going to suggest to you a few things
10:35:37 3 and you can tell me whether or not you agree.
10:35:39 4 We had -- I think we have
10:35:42 5 already established that you are comfortable
10:35:44 6 somewhat with the number of 51 staff members
10:35:48 7 having been interviewed as part of your
10:35:51 8 inspection?
10:35:51 9 A. Correct.
10:35:52 10 Q. And is it fair to say then
10:35:55 11 that those staff members to whom you spoke only
10:36:00 12 about matters in 2016 unrelated to EW were not
10:36:07 13 represented by legal counsel?
10:36:09 14 A. Correct.
10:36:10 15 Q. And is it also fair to say
10:36:12 16 that from the group of individuals that were
10:36:15 17 interviewed, the representatives from
10:36:18 18 Jarlette's corporate head office also did not
10:36:21 19 have legal counsel?
10:36:22 20 A. Correct.
10:36:23 21 Q. And is it also fair to say
10:36:26 22 that the physicians, the two physicians that
10:36:32 23 were interviewed did not have legal counsel?
10:36:34 24 A. Correct.
10:36:36 25 Q. And is it also fair to say
10:36:39 26 that with the exception of Jonathan Lu, who was
10:36:45 27 the pharmacist from Silver Fox, the other
10:36:49 28 pharmacists who were interviewed from Classic
10:36:53 29 Care also did not have legal representation?
10:36:56 30 A. Yes.
10:36:58 31 Q. And I suggest to you that
10:37:02 32 there were also frontline staff, the RNs, the

10:37:07 RPNs, the PSWs, whom you interviewed and some
10:37:16 of them did not have legal counsel?
10:37:17 A. Related to the 2016
10:37:18 inspections.
10:37:19 Q. Okay, that is your
10:37:20 recollection of things?
10:37:20 A. Yes.
10:37:21 Q. Okay. So when we are talking
10:37:29 about the frontline staff, you are aware that
10:37:32 these frontline staff are unionized staff?
10:37:35 A. Yes, I am.
10:37:36 Q. And you are aware that as
10:37:38 unionized staff, and I appreciate that your
10:37:41 inspections are not disciplinary meetings, but
10:37:44 you are aware that frontline staff who are
10:37:46 unionized are typically accustomed to having a
10:37:49 support person in the form of a union rep
10:37:51 present at meetings?
10:37:52 A. Yes.
10:37:55 Q. And I may have asked you this
10:38:02 question already, and if I did, I apologize.
10:38:04 Were you aware that the police also allowed the
10:38:08 staff when being interviewed in relation to EW
10:38:10 to have a support person present? Were you
10:38:12 aware of that?
10:38:15 A. No, I was not.
10:38:16 Q. And you have noticed that in
10:38:18 these Inquiry proceedings, many of the
10:38:19 witnesses, including those from the Ministry,
10:38:21 have come here with support persons, spouses,
10:38:25 colleagues, friends; have you noticed that?
10:38:27 A. Yes.

10:38:28 Q. And so I take it that you can
10:38:31 appreciate why in these stressful and
10:38:35 overwhelming circumstances some of the staff at
10:38:39 Meadow Park London would want a support person
10:38:43 there during your inspection? You can
10:38:46 appreciate why they may have wanted that?
10:38:48 A. Wanted legal counsel present?
10:38:50 Q. A support person is what I
10:38:51 asked you.
10:38:51 A. I'm not a -- for me to say
10:38:55 yes to that, I didn't have staff come to me and
10:38:57 tell me that they wanted a support person there
10:38:59 with them.
10:39:00 Q. You can understand why then
10:39:03 they would have brought legal counsel with them
10:39:06 if that was the only support person they could
10:39:08 bring?
10:39:08 A. I could understand that.
10:39:11 Q. Thank you. Okay, so now if
10:39:15 we can turn to some of the findings that you
10:39:17 made as a result of your inspection, you
10:39:21 testified that you reviewed the entire
10:39:23 Medication IP for the purposes of your
10:39:26 inspection, and that was the first time that
10:39:28 that ever happened at a home, to review the
10:39:33 entire Medication IP?
10:39:34 A. Yes, that is my
10:39:35 understanding.
10:39:35 Q. Okay. And can we bring up
10:39:37 document number 47625. And I apologize, if
10:39:44 there was an exhibit number attached to it, I
10:39:46 don't have it, but it is 47625. I know we have

10:39:50 referenced it before in these proceedings.
10:39:54 Are you okay looking at it on
10:40:04 the screen?
10:40:05 A. Yes, that's okay.
10:40:06 Q. Okay, so was this the
10:40:07 Medication IP that you applied for the purposes
10:40:09 of your inspection?
10:40:10 A. That looks like the
10:40:11 Medication IP.
10:40:12 Q. It does? Do you want -- we
10:40:13 can scroll through it.
10:40:14 A. The "Inspection Protocol" it
10:40:17 says on the top, so yes.
10:40:18 Q. Yeah, I just want to be sure
10:40:19 it is -- you applied the current Medication IP
10:40:21 to your inspection?
10:40:21 A. Yes, I believe it is the same
10:40:22 Medication IP now, yes.
10:40:24 Q. Okay. And now if I can take
10:40:28 you to Exhibit "B" of your affidavit, which is
10:40:44 40984, and there that is the Compliance Order
10:40:50 that you issued in relation to your inspection?
10:40:53 A. Yes.
10:40:53 Q. And Ms. Stephens yesterday
10:40:59 took you through some of your findings on page
10:41:02 4. Now, are these ten -- on pages 4 and 5, are
10:41:18 these the ten findings of non-compliance that
10:41:22 you made in relation to the medication
10:41:25 management system?
10:41:25 A. Yes, these are the grounds.
10:41:27 Q. Okay. And when it says
10:41:30 various section numbers like section 114,

10:41:36 1 section 122, those are references to
10:41:39 2 non-compliance with specific portions of the
10:41:41 3 regulation under the Act?
10:41:43 4 A. Yes, within the Medication
10:41:45 5 IP.
10:41:45 6 Q. Right, but those are specific
10:41:46 7 sections in the regulation?
10:41:48 8 A. Yes.
10:41:48 9 Q. Okay. And so based on this
10:41:54 10 Compliance Order, it was your view that with
10:41:58 11 respect to the medication management system,
10:42:00 12 there were ten sections of the regulation that
10:42:04 13 had not been complied with?
10:42:05 14 A. Yes.
10:42:06 15 Q. Okay. And these sections of
10:42:11 16 the regulation - and if we can bring up the
10:42:13 17 Medication IP again, 47625 - these sections of
10:42:31 18 the regulation -- and if you need to keep your
10:42:32 19 order open to help you, because I don't think
10:42:36 20 we can do split screens, right.
10:42:37 21 So these -- this Medication IP,
10:42:41 22 if we can scroll down a bit and keep going --
10:42:58 23 yeah, we can stop there.
10:42:59 24 So this Medication IP which
10:43:01 25 references in the right-hand corner sections of
10:43:06 26 the Act and the regulation, they would
10:43:08 27 correspond to these sections in your order
10:43:14 28 where you found findings; is that fair to say?
10:43:17 29 A. Yes.
10:43:17 30 Q. Okay. So if there were ten
10:43:23 31 findings of non-compliance with sections of the
10:43:26 32 regulation, which you have said, right, that

10:43:30 1 would mean that there would be ten "no's"
10:43:34 2 ticked off on a Medication IP?
10:43:37 3 A. Either within the Medication
10:43:39 4 IP or through ad hoc, which is an ad hoc note,
10:43:42 5 so we can pull the legislation from there as
10:43:43 6 well.
10:43:43 7 Q. Okay, but what my question
10:43:45 8 is, your ten findings here, they would have
10:43:48 9 been "no's" on this, on a Medication IP such as
10:43:54 10 this?
10:43:54 11 A. Correct.
10:43:54 12 Q. Okay. And so you would agree
10:43:58 13 with me that when we look at this Medication IP
10:44:04 14 in its entirety, which is what you applied to
10:44:06 15 Meadow Park, there were ten "no's" ticked on
10:44:13 16 this form, on a form such as this?
10:44:16 17 A. So we use a computerized
10:44:18 18 system, it is within our IQS system, so it does
10:44:23 19 have questions like this that we would either
10:44:25 20 select "yes", "no", or "not applicable".
10:44:27 21 Q. They are the same questions?
10:44:28 22 A. They are.
10:44:29 23 Q. Okay. So what I am asking
10:44:31 24 is, if you found ten non-compliances with the
10:44:34 25 regulation, okay, which matched the questions
10:44:38 26 on this IP, right?
10:44:39 27 A. Uhm-hmm.
10:44:40 28 Q. There would be ten boxes
10:44:42 29 where you would have clicked or where you would
10:44:44 30 have ticked "no" on a Medication IP or you
10:44:46 31 would have written "no" on a Medication IP?
10:44:48 32 A. And in this circumstance, it

10:44:50 1 was a bit unusual because we issued everything
10:44:52 2 under 114.
10:44:54 3 So for this IP, when we would
10:44:56 4 have completed it, it would have said "no" in
10:44:59 5 114. Because we didn't issue each
10:45:03 6 non-compliance on its own, we issued under the
10:45:08 7 umbrella of 114, so those might show "not
10:45:11 8 applicable" within the IP.
10:45:13 9 Q. Okay, but even if we go
10:45:15 10 beyond that and take the references that you
10:45:20 11 have made in the order to the various sections,
10:45:23 12 right, all of these sections are referenced on
10:45:25 13 this Medication IP?
10:45:26 14 A. Yes.
10:45:27 15 Q. And so if we took the
10:45:29 16 non-compliance with a section of the
10:45:32 17 regulation, it would correspond to a "no" on
10:45:35 18 one of the -- for ten questions on this
10:45:39 19 Medication IP?
10:45:40 20 A. Yes.
10:45:40 21 Q. Okay. So then you would
10:45:41 22 agree with me that based on that analysis, in
10:45:44 23 completing the entire Medication IP, there
10:45:47 24 would have been "yes's", "yes's" indicating
10:45:51 25 compliance for 59 of the 69 questions on the
10:45:53 26 Medication IP?
10:45:54 27 A. I'm going to assume yes, but
10:45:57 28 I don't have my IP in front of me to confirm
10:46:00 29 that.
10:46:00 30 Q. Okay. And if we say yes,
10:46:03 31 that there were 59 of 69 "yes's", and you know,
10:46:09 32 I don't expect you to do the math in your head,

10:46:12 but I am going to suggest to you that there was
10:46:13 an 85 percent compliance with this Medication
10:46:16 IP?
10:46:17 A. I will agree with those
10:46:20 numbers.
10:46:20 Q. Okay, thank you. Now, the
10:46:38 other day Karen Simpson testified that she felt
10:46:44 that the findings of non-compliance in relation
10:46:47 to the medication management system, so these
10:46:50 ten findings in your order were small failures,
10:46:56 were the words she used, that were not high
10:46:58 risk and that individually they would not
10:47:02 warrant a Compliance Order. Would you agree
10:47:04 with Karen?
10:47:05 A. I don't recall Karen saying
10:47:07 it that way.
10:47:08 Q. Okay, so -- and I don't want
10:47:11 to misspeak, so I am going to pull Ms.
10:47:14 Simpson's testimony up, and it is the public
10:47:19 hearing date was July 30th, page 6263.
10:47:35 Sorry, do you need the page?
10:48:16 Sorry, 6263. I thought I said that. I'm
10:48:18 sorry.
10:48:19 Okay, so if we scroll down a
10:49:33 little to the second paragraph, okay, and yeah,
10:49:37 a little further down.
10:49:40 Okay, so it says here, and this
10:49:42 is Karen Simpson's testimony, she says:
10:49:46 "So with Meadow Park, we didn't
10:49:47 have these significant number of
10:49:49 medication errors with no
10:49:51 investigations happening. We

had -- so there are multiple requirements for the medication administration system. We had small failures in many different areas in that medication administration system.

When I [talked] to the inspectors, what [those] inspectors were saying to me, any one of those just on its own would not warrant an order because the issues were not, you know, the high risk, the scope and severity that would actually justify an order.

However, what you saw was multiple issues in many areas all associated with the medication [management] system."

Okay, so does that refresh your memory of her testimony?

A. Yes.

Q. Okay, so what I am asking -- and when she says here "when I was talking to the Inspectors", would that have been you and Mr. Kikuta?

A. That's correct.

Q. Okay. So would you agree then with Ms. Simpson that these non-compliances in relation to medication management were small failures in many different areas that were not the high risk,

10:51:06 1 the scope and severity that would actually
10:51:08 2 justify a Compliance Order? Would you agree
10:51:11 3 with that?
10:51:11 4 A. Yes, I would.
10:51:14 5 Q. Okay. Now, you had said that
10:51:21 6 all of these ten findings went under section
10:51:25 7 114 into a single compliance -- into one
10:51:28 8 Compliance Order?
10:51:28 9 A. Correct.
10:51:29 10 Q. But am I correct that in
10:51:31 11 order to lift that Compliance Order, Meadow
10:51:34 12 Park was not required to comply simply with
10:51:37 13 section 114. It would have to demonstrate
10:51:40 14 compliance in all ten of the areas?
10:51:42 15 A. Yes.
10:51:43 16 Q. Okay. And we know that that
10:51:47 17 Compliance Order was lifted?
10:51:49 18 A. It was complied this past
10:51:52 19 May, I believe, May 2018.
10:51:56 20 Q. Okay, that's correct, thank
10:51:57 21 you.
10:51:58 22 Okay, and now I want to talk
10:52:01 23 about some of the other findings that Ms.
10:52:04 24 Stephens took you through in relation to the
10:52:06 25 seven Written Notifications and Voluntary Plans
10:52:09 26 of Correction.
10:52:11 27 So and when I say "seven", I
10:52:13 28 know that there was one that was attached to
10:52:15 29 the Compliance Order, so I am not talking about
10:52:17 30 that one. I am talking about the other seven.
10:52:20 31 A. Okay.
10:52:21 32 Q. Now, you testified that in

10:52:27 1 respect to some of these findings, they had
10:52:30 2 been lowered to a Written Notification and
10:52:33 3 Voluntary Plan of Compliance due to some
10:52:36 4 mitigating factors?
10:52:38 5 A. That we were guided by the
10:52:40 6 fact that the incidents had occurred in 2014
10:52:43 7 and they related to Elizabeth Wettlaufer.
10:52:45 8 Q. And also guided by the fact,
10:52:48 9 if memory serves me correct, that in 2016 some
10:52:52 10 of these concerns no longer existed?
10:52:54 11 A. Right, and that would have --
10:52:56 12 if there was issues in 2014, it would have been
10:52:58 13 supportive evidence for findings in 2016.
10:53:00 14 Q. And today, do you stand by
10:53:05 15 your findings? Are you comfortable with those
10:53:07 16 findings you made that these non-compliances
10:53:11 17 justified Written Notifications and Voluntary
10:53:13 18 Plans of Correction?
10:53:14 19 A. Yes, I am. As a team, it
10:53:18 20 wasn't just myself that reviewed the judgment
10:53:20 21 matrix or the reports. We also, myself and
10:53:24 22 Neil, the London SAO Manager and Karen as well
10:53:28 23 agreed.
10:53:29 24 Q. Okay. And just to confirm,
10:53:32 25 when we have a Written Notification and a
10:53:36 26 Voluntary Plan of Compliance, that means we are
10:53:40 27 at a Level 1 or Level 2 in the judgment matrix,
10:53:44 28 which indicates minimum risk or minimum harm or
10:53:49 29 potential for actual harm?
10:53:50 30 A. Yes.
10:53:57 31 MS. CORRENTE: Those are my
10:53:57 32 questions, thank you.

10:53:59 THE WITNESS: Thank you.
10:54:00 THE COMMISSIONER: Thank you.
10:54:07 CROSS-EXAMINATION BY MR. GOLDEN:
10:54:31 Q. Hi, good morning.
10:54:32 A. Good morning.
10:54:33 Q. My name is David Golden, representing Caressant Care.
10:54:35 Natalie, did you receive as part of your training to be an Inspector any training in relation to how to understand or interpret employee files?
10:54:51 A. No, we did not.
10:54:53 Q. And so, sorry, you didn't receive such training?
10:54:59 A. Not in regards to employee files.
10:55:00 Q. All right, so you wouldn't have received any training on, for example, understanding the grievance process in a unionized environment and what information might be in an employee file about the grievance process?
10:55:02 A. Not as an Inspector.
10:55:14 Q. Okay. And so there wouldn't have been any training about sunset clauses in collective agreements and what potential impact that could have on how discipline is handled in a home?
10:55:17 A. No, we did not.
10:55:20 Q. Okay. And the concept of progressive discipline and how that might impact what you would see in an employee file
10:55:24
10:55:27
10:55:30
10:55:30
10:55:31
10:55:32
10:55:34

10:55:37 about the discipline, that wouldn't have been
10:55:41 trained either?
10:55:42 A. No.
10:55:42 Q. And one of the counsel in
10:55:44 this Inquiry so far has suggested that when
10:55:49 long-term care homes are hiring, that they
10:55:53 could or should pay closer attention to
10:55:57 resumés, look for gaps, and that that might
10:55:59 trigger some concerns.
10:56:01 Is that something that you have
10:56:02 been trained at when you look at an employee
10:56:04 file, to look for potential gaps in a resumé
10:56:06 that might trigger some concerns?
10:56:09 A. Not the potential gaps, no.
10:56:10 Q. Okay. And you gave some
10:56:15 evidence in your affidavit about inspecting for
10:56:18 a narcotic incident. Is there any training
10:56:24 that you have that says when you are inspecting
10:56:26 for a narcotic incident, part of the steps
10:56:30 would be to contact the College to get the full
10:56:32 prior history for that nurse?
10:56:34 A. Not that I am aware of, no.
10:56:36 Q. And I take it you would be
10:56:39 aware that from Find a Nurse, for example, a
10:56:44 long-term care home can't get the full prior
10:56:46 history of how that nurse might have been
10:56:51 disciplined or interacted with the College?
10:56:53 A. That is my understanding from
10:56:55 this Inquiry.
10:56:56 Q. All right. And I wrote this
10:57:01 down and I just want to make sure I was
10:57:04 accurate, that when you were answering

10:57:06 1 questions to Ms. Corrente, you said that with
10:57:10 2 regard to the right of an interviewee to have
10:57:14 3 counsel present in section 147 of the Long-Term
10:57:18 4 Care Homes Act, you only became aware of that
10:57:20 5 in the course of the inspection you were doing
10:57:22 6 at Meadow Park?
10:57:22 7 A. Yeah, I never had an
10:57:26 8 incident, an incident or a discussion that
10:57:27 9 legal counsel -- or that staff wanted legal
10:57:30 10 counsel present.
10:57:30 11 Q. Are you aware of any other
10:57:33 12 section other than section 147 which sets out
10:57:37 13 all the powers and authority that an Inspector
10:57:42 14 has under the Act?
10:57:42 15 A. Yes, I am.
10:57:43 16 Q. Sorry, there are others?
10:57:44 17 A. Yes, there are.
10:57:44 18 Q. Which are those?
10:57:45 19 A. I would need to review the
10:57:46 20 legislation.
10:57:47 21 Q. Can we just pull up section
10:57:49 22 147. I think it is at page 899. There we are.
10:57:59 23 Thank you.
10:58:00 24 This section 147 says:
10:58:04 25 "An Inspector conducting an
10:58:05 26 inspection".
10:58:07 27 And then it lists a whole bunch
10:58:08 28 of them.
10:58:10 29 I take it that this is the
10:58:11 30 primary section that gives you the power to go
10:58:14 31 in and do your inspection?
10:58:15 32 A. Yes, it does.

10:58:16 Q. And so would you not have
10:58:18 received training on the scope or limitations
10:58:22 on what your authority is under section 147?
10:58:25 A. We always have our inspection
10:58:28 handbook with us, so if we were unsure, we
10:58:30 could go back and read what our powers were.
10:58:32 Q. And is there anything in the
10:58:33 handbook specifically about 147(1)(d)?
10:58:41 A. And I should specify it is
10:58:42 the legislation that we carry around with us
10:58:44 and the Act, so we would have that with us to
10:58:46 look at and read. If I was unsure, I would go
10:58:49 to the Act or the legislation.
10:58:50 Q. Okay, but we know what is in
10:58:52 the Act and the legislation. Is there anything
10:58:54 that you recall about being trained about that
10:58:56 section?
10:58:56 A. I recall the powers that we
10:59:01 could go into the home and request
10:59:03 documentation and speak to anyone in the home,
10:59:05 I do recall that from training.
10:59:08 Q. And do you also recall, if
10:59:09 you look at -- just scroll down. Sorry, a
10:59:17 little too far, at (c):
10:59:19 "May demand the production of
10:59:21 records or other things that the
10:59:23 inspector believes are relevant
10:59:25 to the inspection from any
10:59:26 person."
10:59:27 I take it you have been trained
10:59:29 on the fact that you can ask any person to
10:59:30 provide documentation?

10:59:31 A. Yes.
10:59:31 Q. Have you ever used that
10:59:32 power --
10:59:33 A. If we felt --
10:59:34 Q. -- outside of the home?
10:59:35 A. I do believe I have asked
10:59:43 from CCAC, which would be outside of our home,
10:59:46 in another inspection for information.
10:59:49 Q. Have you ever asked the
10:59:50 College for information and relied on that as
10:59:52 your authority?
10:59:52 A. No, I have not.
10:59:53 Q. You were here the other day
10:59:57 when I asked Rhonda about potentially reaching
11:00:01 out and getting an expert to assist in a unique
11:00:05 situation that hadn't come up before, and I was
11:00:08 characterizing the situation on October the
11:00:12 28th, 2016, at Caressant Care as unique.
11:00:15 And I am wondering, have you
11:00:16 ever in the course of your job as an Inspector
11:00:20 used your authority to go and consult with an
11:00:22 expert to get some advice to help with your
11:00:26 inspection?
11:00:26 A. If I have contacted police in
11:00:31 regards to an inspection?
11:00:32 Q. No, I am asking if you have
11:00:33 reached out to an expert to get --
11:00:34 A. As for an expert, no.
11:00:36 Q. All right, and are you aware
11:00:37 that you have the authority to do that?
11:00:38 A. Yes.
11:00:47 Q. And we have heard some

11:00:49 evidence at least with respect to the Caressant
11:00:51 Care home in Woodstock, and this came out in
11:00:53 the course of the Inquiry, that ONA had
11:00:56 maintained a locked cabinet of documents at the
11:01:00 Woodstock home.
11:01:00 Have you ever in the course of
11:01:03 your job as an Inspector asked to see ONA
11:01:06 documents that might relate to a nurse's
11:01:09 performance?
11:01:09 A. No, I have not.
11:01:17 MR. GOLDEN: Okay, I have
11:01:18 nothing further. Thank you.
11:01:19 THE COMMISSIONER: Thank you,
11:01:20 Mr. Golden.
11:01:24 CROSS-EXAMINATION BY MS. FRASER:
11:01:32 Q. Ms. Moroney, for the record,
11:01:34 I am Suzan Fraser and I am here on behalf of
11:01:36 OARC.
11:01:37 You became an RPN in 1998; is
11:01:40 that correct?
11:01:40 A. That's correct.
11:01:40 Q. And then you became an RN in
11:01:43 2005?
11:01:43 A. Yes.
11:01:44 Q. And then following that, in
11:01:46 2006 to 2008 you were both the Assistant
11:01:51 Director of Care and Director of Care at Meadow
11:01:54 Park lodge?
11:01:54 A. Meadow Park London, yes.
11:01:55 Q. Meadow Park London, I see.
11:01:59 And then in 2014, you became an
11:02:03 Inspector?

11:02:04 A. Yes.
11:02:04 Q. And so when you were called upon to engage in the inspection at Meadow Park, did you tell your supervisor or remind your supervisor that you had worked there before?
11:02:17 A. Yes, she was aware that I worked there before.
11:02:20 Q. Okay, and did your Director know that you had worked there before?
11:02:23 A. We have had that conversation, yes.
11:02:24 Q. Okay, so she knew?
11:02:26 A. Yes.
11:02:27 Q. Okay. And I understand that you do not think that that influenced your work, but did you give consideration to the optics to any of the residents in long-term care at Meadow Park to see the former Director of Care show up to do the inspection?
11:02:45 A. I had already been in the home prior to that with inspections, so that the staff would have recognized me -- or the residents would have recognized me from previous inspections as well.
11:02:56 Q. Right, but my question related to your consideration of the optics of a former Director of Care going in as an Inspector and whether you gave consideration to those optics?
11:03:10 A. No, I did not.
11:03:10 Q. Okay. And you'll agree with

11:03:13 me that even if there is no actual bias, that
11:03:18 there can be an appearance of bias if a former
11:03:21 Director of Care shows up as the Inspector?
11:03:24 A. Yes, I can see that.
11:03:27 Q. And was there anything in
11:03:33 your training about conflict of interest or
11:03:36 appearance of bias?
11:03:37 A. No, there was not.
11:03:39 Q. Okay. And we have had a look
11:03:44 today at the staff inventory, and my question
11:03:49 for you is would you say that more than half of
11:03:51 the people on that staff inventory worked at
11:03:55 Meadow Park when you were the Director of Care?
11:03:58 A. The management team was newer
11:04:12 to the home. I was not familiar with the
11:04:14 management team besides previous inspections.
11:04:17 Q. Yes.
11:04:17 A. Some of the Personal Support
11:04:21 Workers I do recall when I worked at Meadow
11:04:23 Park London.
11:04:23 Q. Right.
11:04:33 A. And there is a possibility
11:04:34 there could be half of the Personal Support
11:04:36 Workers that I knew --
11:04:37 Q. Okay.
11:04:37 A. -- prior to.
11:04:38 Q. Right. And what about the
11:04:39 nursing staff?
11:04:40 A. The registered staff, no.
11:05:04 Q. No, okay, thank you.
11:05:05 I would like to call up doc ID
11:05:11 40984, page 2, please, and that is Exhibit "B"

11:05:14 1 to your affidavit.
11:05:18 2 And just if we could go -- thank
11:05:34 3 you.
11:05:34 4 So I understand from you
11:05:35 5 yesterday that you talked about the orders that
11:05:38 6 you made under section - and that is perfect -
11:05:44 7 114 -- and the "that's perfect" is my
11:05:46 8 instruction to Laura, so just for the record.
11:05:48 9 So just looking, I understood
11:05:51 10 your evidence was that you determined that you
11:05:53 11 were going to make your orders under section
11:05:55 12 114; that's right?
11:05:57 13 A. That's correct.
11:05:57 14 Q. Okay, and that you issued one
11:06:01 15 order rather than several?
11:06:02 16 A. That's correct.
11:06:03 17 Q. Okay. And the consequence,
11:06:08 18 one consequence of that you would agree is that
11:06:11 19 when the public looks at the compliance history
11:06:14 20 of Meadow Park, they would see one Compliance
11:06:16 21 Order rather than several?
11:06:17 22 A. Yes.
11:06:19 23 Q. Okay.
11:06:21 24 MS. CORRENTE: Well, I don't
11:06:22 25 think that that's consistent
11:06:23 26 with what she testified.
11:06:24 27 Her testimony was that on
11:06:26 28 their own, they wouldn't have
11:06:28 29 resulted in Compliance Orders.
11:06:30 30 So it is not fair to say that
11:06:32 31 the public would be seeing
11:06:33 32 several Compliance Orders. The

11:06:35 public might potentially be
11:06:37 seeing several other findings,
11:06:39 but not several Compliance
11:06:40 Orders.
11:06:41 MS. FRASER: Commissioner, I
11:06:42 understood her evidence
11:06:43 yesterday was that she could
11:06:45 have issued several Compliance
11:06:48 Orders but chose to issue one,
11:06:50 and I understood there was some
11:06:51 discussion with your counsel
11:06:53 about what the default would be.
11:06:56 And maybe I misunderstood
11:06:57 that evidence, but I understood
11:06:58 that she had the option here of
11:07:00 issuing several orders and chose
11:07:02 to issue one.
11:07:03 THE COMMISSIONER: Yes, I would
11:07:05 encourage you to pursue that. I
11:07:06 think that it is a -- there is a
11:07:09 slight difference between what
11:07:10 the two of you are saying, and
11:07:13 if you pose it with this
11:07:15 witness, it will become clear.
11:07:17 BY MS. FRASER:
11:07:17 Q. Thank you. Am I right that
11:07:20 you had the option of making several Compliance
11:07:24 Orders?
11:07:24 A. We would have to apply each
11:07:26 of those non-compliances to the judgment
11:07:29 matrix.
11:07:29 Q. Yes.

11:07:30 A. And that would give us our
11:07:31 action. I can't say for certain that every
11:07:34 single one of those ten non-compliances would
11:07:37 result in an order.
11:07:39 Q. Yes.
11:07:39 A. They could result in a
11:07:40 Voluntary Plan of Correction with a Written
11:07:43 Notification.
11:07:43 Q. Okay, so -- but you did it
11:07:49 all under one order, right?
11:07:51 A. That's correct.
11:07:51 Q. Okay. And the consequence,
11:07:54 and just now talking theoretically, about doing
11:07:57 that is if you issue one, it shows up as one on
11:08:02 the website, and whatever you do in terms of a
11:08:04 Voluntary Plan of Correction or a Compliance
11:08:08 Order, whatever your decisions are to make one
11:08:10 or more than one, that is going to go up on the
11:08:13 website, right?
11:08:14 A. The public report would show
11:08:16 all of the non-compliance under the order under
11:08:19 section 114.
11:08:20 Q. Okay, so whatever decision
11:08:21 you make in that moment, it has a potential to
11:08:24 impact the public's perception of the home?
11:08:27 A. Yes.
11:08:29 Q. Okay. And it also, as I
11:08:31 understand, impacts the LRPA, am I right about
11:08:38 that, and that is the Long-Term Care Home
11:08:41 Quality Inspection Program Risk and Performance
11:08:45 Assessment Report?
11:08:45 A. I'm not as familiar with that

11:08:47 report.
11:08:48 Q. Okay, we are going to hear
11:08:49 from Mr. Moorman about that. Do you know that
11:08:53 the decision in that moment has an impact on
11:08:56 that score?
11:08:57 A. I do not. As an Inspector,
11:09:01 it would be our managers that would have that
11:09:02 information.
11:09:03 Q. Okay. And then just finally,
11:09:07 yesterday you said that you were a bit
11:09:10 surprised to find the letter of reference in
11:09:12 the employment file?
11:09:13 A. I was.
11:09:14 Q. Is that a bit of an
11:09:16 understatement? You sounded very diplomatic
11:09:19 when you were saying that. Is it fair to say
11:09:21 that you were very surprised?
11:09:22 A. When a nurse is terminated
11:09:27 from a home related to medication incidents
11:09:31 that directly affected the residents, it is
11:09:34 surprising to see a reference letter like that.
11:09:37 Q. Right, and it is not a bit
11:09:38 surprising. It is very surprising, right?
11:09:39 A. Yes.
11:09:41 MS. FRASER: Thank you. I don't
11:09:42 have any other questions.
11:09:43 THE COMMISSIONER: Thank you,
11:09:44 Ms. Fraser.
11:09:48 MS. STEPHENS: I'm just
11:09:51 canvassing the room, and I think
11:09:52 that may be it for
11:09:53 cross-examination. Any

11:09:54 1 re-examination?
11:09:55 2 MS. MINGO: Just one question.
11:09:55 3 RE-EXAMINATION BY MS. MINGO:
11:10:01 4 Q. Just one brief question for
11:10:03 5 you, Natalie.
11:10:03 6 Mr. Golden had asked you if you
11:10:06 7 had ever received any training in interpreting
11:10:07 8 an employee file or any training on sort of
11:10:10 9 looking at a file in the context of a unionized
11:10:14 10 environment.
11:10:14 11 Now, my understanding is that
11:10:15 12 you worked in a management position at Meadow
11:10:17 13 Park London as a Director of Care and an
11:10:20 14 Assistant Director of Care; is that correct?
11:10:21 15 A. Yes.
11:10:21 16 Q. Is Meadow Park London a
11:10:23 17 unionized home?
11:10:24 18 A. Yes, it is.
11:10:25 19 Q. So you have experience
11:10:26 20 working as a manager in a unionized home?
11:10:28 21 A. Yes, I do.
11:10:29 22 MS. MINGO: Thank you, those are
11:10:30 23 all my questions.
11:10:31 24 THE COMMISSIONER: Thank you
11:10:32 25 very much.
11:10:36 26 Any re-examination?
11:10:38 27 MS. STEPHENS: I have no
11:10:39 28 re-examination, no.
11:10:40 29 THE COMMISSIONER: All right,
11:10:41 30 then that means that you are
11:10:42 31 free to go. I would like to
11:10:43 32 thank you on behalf of the

11:10:44 Inquiry for all your help.
11:10:45 THE WITNESS: Thank you very
11:10:46 much.
11:10:55 MS. STEPHENS: So our next
11:10:57 witness will be Lisa Vink.
11:10:59 I am wondering if we should
11:11:00 perhaps take a morning break and
11:11:04 we can get through Ms. Vink
11:11:09 after that.
11:11:10 I believe I will be fairly
11:11:11 brief in my examination, and my
11:11:15 understanding from counsel
11:11:16 yesterday is there are not that
11:11:18 many participants who will be
11:11:20 cross-examining today.
11:11:21 So I wonder if we take our
11:11:23 morning break and we sit a
11:11:25 little bit longer, if we might
11:11:27 be able to complete her by a
11:11:30 later lunchtime.
11:11:32 THE COMMISSIONER: That sounds
11:11:33 very nice on the part of
11:11:34 everyone, I think. It is a long
11:11:35 weekend coming up.
11:11:37 So absolutely, we'll take our
11:11:38 morning recess now.
11:11:39 -- RECESSED AT 11:11 A.M. --
11:15:34 -- RESUMED AT 11:25 A.M. --
11:18:46 MS. STEPHENS: Commissioner, I'd
11:31:34 like to call our next witness,
11:31:36 Lisa Vink.
11:31:40 THE COMMISSIONER: Come forward,

11:31:43 Ms. Vink. Thank you.
11:31:43 LISA MARIE VINK: SWORN.
11:31:43 EXAMINATION-IN-CHIEF BY
11:31:43 MS. STEPHENS:
11:32:42 Q. So good morning, Ms. Vink. As you may have noticed, we have adopted a
11:32:48 custom when a witness begins with asking them
11:32:50 what their preference is in terms of whether
11:32:51 you'd like to be addressed by your first or
11:32:55 your last name.
11:32:56 A. My first name, please.
11:32:58 Q. So Lisa. Thank you.
11:32:59 Lisa, do you recall swearing an
11:33:00 Affidavit for the purpose of this inquiry?
11:33:02 A. I do.
11:33:02 Q. Okay. And that should be
11:33:04 there in front of you. I'd just ask you to
11:33:09 flip to the final page of the Affidavit, which
11:33:10 will be right before Tab A. And can you
11:33:14 confirm that that's your signature?
11:33:15 A. That is my signature.
11:33:16 Q. Okay. And are there any
11:33:17 changes you would like to make to the Affidavit
11:33:20 at this time?
11:33:20 A. There are not, no.
11:33:22 MS. STEPHENS: So, Commissioner,
11:33:23 I'd like this to be the next
11:33:25 exhibit at our hearings.
11:33:26 THE COMMISSIONER: Yes.
11:33:27 Thank you. So Exhibit Number
11:33:28 144, Affidavit of Lisa Vink.
11:33:30 EXHIBIT NO. 144: Affidavit of

11:33:30 1 Lisa Vink.
11:33:34 2 BY MS. STEPHENS:
11:33:35 3 Q. So, Lisa, I understand you've
11:33:36 4 been a Registered Nurse since 1992; is that
11:33:39 5 right?
11:33:39 6 A. That is correct.
11:33:39 7 Q. And you have worked in both
11:33:42 8 municipal homes for the aged and a nursing home
11:33:46 9 as a Registered Nurse?
11:33:48 10 A. Yes.
11:33:48 11 Q. And you also worked as an
11:33:50 12 Acting Director of Nursing and a Director of
11:33:53 13 Nursing in those homes?
11:33:54 14 A. Not in both of the homes.
11:33:57 15 Just in the municipal homes.
11:33:57 16 Q. In the municipal homes?
11:33:57 17 A. Correct.
11:33:57 18 Q. Okay. Thank you.
11:34:00 19 A. At the nursing home, I only
11:34:01 20 worked as a Registered -- I shouldn't say
11:34:02 21 "only." I worked as a Registered Nurse.
11:34:02 22 Q. Okay. Thank you. And I
11:34:04 23 understand you joined the Ministry as a
11:34:07 24 compliance advisor back in 2000.
11:34:07 25 A. Yeah.
11:34:07 26 Q. Is that right?
11:34:10 27 And so that was actually before
11:34:13 28 the service area offices, as we know them,
11:34:16 29 existed; is that right?
11:34:17 30 A. Yes.
11:34:17 31 Q. So you were at the Central
11:34:20 32 South Regional Office, which is in Hamilton?

11:34:22 A. That's correct.
11:34:23 Q. And that office ultimately
11:34:25 became the Hamilton Service Area Office?
11:34:27 A. Yes.
11:34:28 Q. Okay. So I want to briefly
11:34:31 ask you about the role of compliance advisor
11:34:34 and what it was like to be a compliance advisor
11:34:37 as opposed to an inspector now, because we have
11:34:39 heard people asking about that process, and
11:34:42 your name has come up as someone who might be
11:34:46 able to answer some questions.
11:34:47 So we know when you were a
11:34:50 compliance advisor -- we know that compliance
11:34:50 advisors were assigned to specific homes; is
11:34:50 that right?
11:34:50 A. Yes, that is correct.
11:34:50 Q. And do you recall about how
11:34:59 many homes would have been assigned to you?
11:35:01 A. Somewhere between the
11:35:02 neighbourhood of 12 to 15. I can't remember
11:35:05 exactly for sure, but around that
11:35:07 neighbourhood.
11:35:08 Q. And you were -- as I
11:35:08 understand it, you would be responsible for
11:35:10 essentially handling everything to do with that
11:35:13 home, dealing with all the information you'd
11:35:15 received from those homes?
11:35:17 A. That is correct. We would
11:35:18 receive -- the homes would call us directly.
11:35:21 Our phone number would be posted. So we would
11:35:26 receive all of the mailings that came in from
11:35:29 that home in relation to compliance issues.

11:35:31 We would be responsible for
11:35:32 their reviews, which are now -- have evolved
11:35:38 into inspections, so yes.
11:35:39 Q. And you would also receive
11:35:41 the complaints about those homes too; is that
11:35:44 right?
11:35:44 A. That is correct.
11:35:45 Q. Okay. And can you just tell
11:35:46 us a little bit about what the nature of those
11:35:49 reviews were. When you went into a home, how
11:35:52 would you approach those reviews?
11:35:53 A. So we did a -- we had a
11:35:55 number of different types of reviews. We could
11:35:57 do annual reviews, which have evolved into the
11:36:02 Resident Quality Inspection. We also could do
11:36:05 complaint reviews, unusual occurrences which
11:36:08 have now involved (sic) into Critical Incident
11:36:13 Reports.
11:36:13 We also did pre-occupancy and
11:36:14 post-occupancy reviews. So when a home was
11:36:19 first being built or after it had first opened
11:36:22 or even if they were just renovating a section
11:36:26 of the home, we would have to go in before
11:36:27 residents moved into the home, things like
11:36:27 that.
11:36:27 We also could do other
11:36:29 inspections which could sort of be a whole
11:36:33 different variety of things. So those were the
11:36:37 type of reviews that we did at that time.
11:36:39 Q. Okay. And when you went in
11:36:41 for the annual reviews or the reviews in
11:36:45 relation to complaints or unusual occurrences,

11:36:48 you would be inspecting against those standards
11:36:51 and criteria that are in the long-term care
11:36:54 homes program manual?
11:36:57 A. The Long-Term Care Facility
11:36:57 Program Manual, yes. So we didn't have Ontario
11:37:00 Regulation 79/10 in the Long-Term Care Homes
11:37:02 Act at that time.
11:37:03 We had a Long-Term Care Facility
11:37:05 Program Manual, which set out standards, and
11:37:07 then within those standards were the specific
11:37:10 criterion to reflect those standards.
11:37:14 We also had, at that time, three
11:37:16 different pieces of legislation that were
11:37:19 specific to the different type of homes.
11:37:21 So the Nursing Home Act was
11:37:22 relevant to nursing homes, Charitable
11:37:24 Institutions Act to homes that were run by the
11:37:26 charitable institutions, and then the Homes for
11:37:31 the Aged and Rest Homes Acts, which would be
11:37:32 the municipal homes.
11:37:33 Q. Okay. And if you found that
11:37:36 a home was not complying with the standards and
11:37:40 criteria from that -- from that manual, what
11:37:44 could you do? What were the options open to
11:37:47 you?
11:37:47 A. So we would conduct a review
11:37:51 if we determined that the home was not -- I
11:37:55 don't know if we used the word "complying" back
11:37:59 then, but I don't remember what the word was.
11:38:01 But if we found that they
11:38:03 weren't consistent with that, we could issue
11:38:05 them a report of unmet standards or criteria,

11:38:05 1 or we could leave them a report of observation
11:38:08 2 and discussion. So we had two different types
11:38:11 3 of report that we could leave in the home.
11:38:13 4 Q. And explain to us, what was
11:38:16 5 the difference between those two reports?
11:38:17 6 A. Sure. So the report of unmet
11:38:19 7 standards of criteria would identify what the
11:38:21 8 issue was, the actual standard or criterion
11:38:25 9 that was not met. That's what we called them,
11:38:29 10 not met. So there you go.
11:38:31 11 Followed by what the specific
11:38:34 12 criterion was, and our examples, very
11:38:37 13 vaguely-worded examples, and then as well as it
11:38:43 14 required the home to submit a plan of
11:38:45 15 corrective action.
11:38:46 16 If we left information on an
11:38:48 17 observation discussion point, the home was not
11:38:50 18 required to submit a plan of corrective action.
11:38:53 19 And it wasn't necessarily only
11:38:57 20 concerns. We would also put on their
11:38:59 21 recommendations or positive things that we
11:39:01 22 noted while we were in the home, suggestions
11:39:04 23 for maybe future visits, things like that.
11:39:07 24 Q. Okay. So in your Affidavit
11:39:10 25 at paragraph 18, you indicate that you believe
11:39:13 26 that Critical Incident Reports received today
11:39:17 27 are more likely to be inspected than the
11:39:21 28 Unusual Occurrence Reports that were received
11:39:22 29 under the old regime. Can you explain that to
11:39:27 30 us?
11:39:27 31 A. Sure. Previously, the
11:39:30 32 Unusual Occurrence Reports -- although, they

11:39:33 1 did evolve at some time. I can't exactly say
11:39:36 2 when that was. It was a longhand written
11:39:39 3 document that the home would complete, would
11:39:41 4 tear off. They would maintain one copy. The
11:39:43 5 other copy would be usually mailed to us.
11:39:46 6 We, as compliance advisors, each
11:39:50 7 received, as I said, all the mailings for that
11:39:52 8 home. So we would receive the unusual
11:39:54 9 occurrences for each homes in our group.
11:39:56 10 And basically we looked at them
11:39:58 11 to see what was the issue? What did the home
11:40:00 12 do about it? How were they looking at
11:40:03 13 preventing reoccurrence? What are the
11:40:06 14 long-term actions and the short-term actions?
11:40:08 15 Basically what's included in the Critical
11:40:11 16 Incident Report that we see today.
11:40:13 17 And then we would look at that
11:40:15 18 and determine has appropriate action been
11:40:18 19 taken? Is everything okay? And if yes, then
11:40:20 20 we would basically sign it and put it away.
11:40:23 21 We could call the home about it
11:40:24 22 if we -- maybe there was something, and it
11:40:27 23 wasn't clear or we thought -- you know, we just
11:40:29 24 wanted to have a discussion, or we could go out
11:40:32 25 and do a review on it.
11:40:33 26 But definitely provided that all
11:40:36 27 the necessary or appropriate information was
11:40:39 28 there, would probably be a better choice of
11:40:43 29 words. Frequently it would get signed and
11:40:45 30 filed.
11:40:46 31 Q. Okay. So we've heard that
11:40:49 32 one of the big changes from the role of

compliance advisor to inspector was the elimination of the advisory role and giving of advice.

Can you tell us -- as a compliance advisor, tell us a little bit about the advice you would give to homes and even -- give us an idea of how often you would be providing homes with advice.

A. So the types of advice would vary significantly based on the questions being asked of us. It could be anything at all under the sun.

You know, I've had all this missing laundry, and what's a way to sort of sift through that and sort through it.

And you could say, "Oh, you know, I know of a home down the road that has a great form. They've given me the form. They've given me permission to share it. This might be a good tool for you to use" or something to that effect.

There might also be homes that would call and say, "Oh, you know, we've -- we're trying to review our program on getting residents to activities. How do we do that?"

And, again, we could say, "Oh, you know, this is sort of one way that that's been done."

It wouldn't be unusual as well that homes would call for -- do you know of any other resources to help with this challenging resident or things like that.

Sort of, I think, it was the thought that because we had the opportunity to go into so many different homes, we could see the different things that were out there and available.

A lot of homes were willing to share, so I did have a folder quite large of -- I wouldn't say they were, you know, the gold standard forms, but different approaches that people could consider when developing forms and tools.

Because at that time, that was sort of the day of the pen and paper and before things were electronic as well, so...

Q. Okay. And did homes find that advice useful?

A. Sometimes they did. Sometimes we didn't have information that was helpful or useful to them. It just depended.

I mean, sometimes they might have tried a part of it or none of it and found it helpful or maybe it might have been something just to help them. "Oh, yeah, I never thought of that, but I think this would work better."

Just a starting point to kick off another idea that they might have had. Just someone else to look outside the box. Different set of eyes sometimes.

Q. So then when you became an inspector, you stopped giving advice; correct?

A. I stopped giving advice to

11:43:26 1 that degree. That is correct. Still
11:43:28 2 definitely as Rhonda communicated, we ask
11:43:33 3 questions, and that definitely puts people in
11:43:36 4 a -- in a certain direction and gives them the
11:43:38 5 answers to their questions all by themselves
11:43:41 6 frequently.
11:43:41 7 Q. Can you give us an example of
11:43:44 8 that?
11:43:44 9 A. There's been lots of times
11:43:47 10 when a home will -- when we've identified
11:43:50 11 noncompliance with a concern. And I'm so
11:43:55 12 sorry. I don't remember if Rhonda spoke about
11:43:59 13 clinically appropriate skin assessment or a
11:44:02 14 falls assessment tool, but that's a frequent
11:44:02 15 one that we...
11:44:03 16 A lot of times, for example,
11:44:06 17 homes will have a falls-risk tool and think
11:44:09 18 that that is sufficient, but it's not
11:44:09 19 necessarily a clinically appropriate assessment
11:44:11 20 post falls.
11:44:11 21 So it gets to, "So what is this
11:44:14 22 tool exactly?"
11:44:16 23 "Well, that's a risk tool."
11:44:17 24 "Okay. So is that the same as
11:44:19 25 this?"
11:44:19 26 "Oh, no."
11:44:20 27 "Oh, okay then."
11:44:21 28 So then again, that leads them
11:44:23 29 to what we would expect according to the
11:44:29 30 Regulation 49.
11:44:30 31 Q. Okay. So I want to shift
11:44:34 32 gears and fast-forward to the fall of 2016 and

11:44:39 1 ask you about the inspection that you end up
11:44:43 2 conducting at Telfer Place.
11:44:46 3 So at this point, you're an
11:44:48 4 inspector?
11:44:48 5 A. I am, yes.
11:44:49 6 Q. So can you tell us how it was
11:44:52 7 that you end up being assigned to work on that
11:44:55 8 Telfer Place inspection in relation to
11:44:58 9 Elizabeth Wettlaufer?
11:44:58 10 A. Kind of like my colleagues, I
11:45:02 11 felt I was sort at the wrong place at the wrong
11:45:05 12 time. Happened to be in the office that day
11:45:06 13 when the email was received by my manager,
11:45:08 14 Karin Fairchild.
11:45:10 15 She called me into her office
11:45:12 16 and showed me the email and said this was now
11:45:17 17 my inspection to complete.
11:45:18 18 Q. Okay.
11:45:19 19 A. That was the email that
11:45:21 20 Karen Simpson had received by a lady. I'm so
11:45:31 21 sorry. I cannot remember her name right now.
11:45:32 22 Q. Is that the email from
11:45:33 23 Candace Chartier?
11:45:35 24 A. Yes. Thank you very much for
11:45:36 25 that. Yes.
11:45:37 26 Q. So we heard from both Rhonda
11:45:40 27 and Natalie that they were asked to go to the
11:45:45 28 respective homes, Caressant Care and Meadow
11:45:48 29 Park, on that same day to collect
11:45:50 30 documentation. Were you asked to do the same
11:45:51 31 thing?
11:45:52 32 A. I was not.

11:45:53 Q. Okay.
11:45:53 A. I was in the home in the
11:45:55 Hamilton Service Area -- I was not in the home.
11:45:57 I'm sorry. I was in the Hamilton Service Area
11:45:59 Office, which is located in Hamilton.
11:46:00 And we had another inspector who
11:46:03 was working much closer to Telfer Place and
11:46:06 Paris. Her name is Lesley Edwards, a respected
11:46:10 colleague of mine. She was contacted and asked
11:46:12 if she could go to the home to collect the
11:46:15 documents.
11:46:16 Q. Okay. Did she do that that
11:46:17 same day?
11:46:18 A. She did.
11:46:19 Q. Okay. And do you -- can you
11:46:24 tell us what documents she retrieved from the
11:46:27 home that day?
11:46:28 A. Sure. At the time that
11:46:30 Lesley visited the home, she asked for the
11:46:32 staffing schedules for the period of time that
11:46:38 EW worked.
11:46:39 She asked for a listing of
11:46:44 discharges or deaths in the home during the
11:46:47 time that EW was working at the home, and
11:46:51 I believe she also asked for any hospital
11:46:56 transfers during that time as well.
11:46:58 Q. Okay.
11:47:00 A. Possible transfers of
11:47:01 residents. Sorry, I should confirm that.
11:47:04 Q. And she was given all those
11:47:06 documents?
11:47:06 A. Yes, I believe she was.

11:47:07 Q. Okay. So I want to ask you a
11:47:10 little bit about the Inspection Plan that you
11:47:13 prepared for this inspection. You say in your
11:47:15 Affidavit that it was -- in fact, ends up being
11:47:18 a bit different from the plans that are
11:47:20 prepared for Caressant Care and Meadow Park.
11:47:22 Can you explain to us why that
11:47:25 was the case?
11:47:25 A. Yes. So this has also been
11:47:26 the first case that I've had the opportunity to
11:47:29 work with an inspector from another service
11:47:31 area office to develop a plan. Normally that's
11:47:34 something that we do by ourselves.
11:47:36 And during the course of Rhonda
11:47:37 and I working on the plan, it became evident
11:47:41 quite quickly that some of the issues that she
11:47:43 would have to look at were different than ours.
11:47:45 And the one that I've mentioned
11:47:47 in the Affidavit is in the case of Telfer
11:47:50 Place, a home that I knew to be a small 45-bed
11:47:54 home, she was not a regular employee of the
11:47:57 home. She was an agency staff member.
11:48:00 So there would be some
11:48:03 differences there in relation to did the home
11:48:05 still meet the burden of a 24/7 RN in the home
11:48:09 at all times, things like that.
11:48:10 So some of the questions that we
11:48:13 would ask in the IP would be different based on
11:48:15 that.
11:48:16 Q. Okay. So before -- we also
11:48:22 know there's a period of time before you
11:48:24 actually return to the home. You have the

documents from the home. Did you review those documents?

A. We did. There wasn't a lot of -- although we asked for the list of ER transfers and hospitalizations or -- and discharges and deaths, it only included a resident's name and a date. It didn't include cause of death or where they had passed away, things like that.

So there wasn't a lot of documentation to review, but definitely we were able to reference the date that she worked and the date that things happened. Whether they were related or not, we had no way of knowing at all.

So we did look at the documents, but they didn't provide us with a lot of information.

Q. Okay.

A. I should add that we did have one other thing at this stage of the game. And I'm sorry. I neglected to mention it before.

The home had also submitted a Critical Incident Report in relation to the information that they were provided by the police.

This report -- the Critical Incident Report was submitted the same day that we had received the email and then was amended, I believe, the next day or the following day with a little bit more information, so yeah.

Q. Okay. And in your Affidavit,

11:49:35 you, in fact, say that that amended Critical
11:49:40 Incident Report was perhaps one of the most
11:49:41 useful documents you reviewed?
11:49:43 A. Definitely. The original
11:49:45 email that we had received identified that --
11:49:48 that there was a murder at Telfer Place.
11:49:52 So when we received the Critical
11:49:55 Incident Report, the victim was identified as
11:49:56 well as it identified that the victim was still
11:50:00 a resident in the home.
11:50:01 It also identified that the home
11:50:03 had done a record search themselves of this
11:50:08 resident, and they were able to identify a time
11:50:09 frame where the resident had had a change in
11:50:12 condition as well as identify a Registered
11:50:15 Nurse by -- a different Registered Nurse than
11:50:19 EW who had, quote, fixed the problem or had
11:50:22 provided appropriate care and assistance to the
11:50:25 resident to manage her low blood glucose
11:50:28 levels.
11:50:29 Q. Okay. Okay. And just so
11:50:32 that we're clear, because we've heard a lot of
11:50:34 different evidence in the facilities phase, the
11:50:37 victim from this home was Sandra Towler?
11:50:43 A. That is correct.
11:50:43 Q. Okay. And the nurse who had,
11:50:45 as you said, fixed the problem, do you recall
11:50:48 her name?
11:50:50 A. I do. Diane Beauregard, and
11:50:53 she was here during the facilities phase.
11:50:55 Q. Okay. Thank you. I
11:50:56 understand you also reviewed the compliance

11:50:59 1 history from Telfer Place before going in for
11:51:02 2 the inspection?
11:51:02 3 A. I did. That's part of the
11:51:04 4 standard preparation process that we pull -- or
11:51:07 5 have the compliance history pulled. That's not
11:51:10 6 actual some -- I don't do that. That's done by
11:51:13 7 one of the administrative assistants.
11:51:15 8 Q. Okay. And when you reviewed
11:51:16 9 that, was there anything noteworthy in their
11:51:20 10 compliance history?
11:51:20 11 A. It reminded me of a few
11:51:24 12 things. It reminded me of that we had issued
11:51:27 13 previously a concern in relation to Section 31
11:51:29 14 about staffing in the home. There was also a
11:51:32 15 concern identified in there in relation to
11:51:34 16 medications.
11:51:35 17 Q. Okay.
11:51:35 18 A. Just some other -- Plan of
11:51:42 19 Care stuff, things like that.
11:51:42 20 Q. Okay.
11:51:43 21 A. Yeah. It wasn't a
11:51:44 22 comprehensive review. It was a quick scan of
11:51:47 23 the document and just to kind of see what was
11:51:51 24 there.
11:51:51 25 Q. Okay. And when you say it
11:51:54 26 reminded you, had you been in Telfer Place
11:51:57 27 before doing inspections?
11:51:58 28 A. Definitely, yes.
11:51:59 29 Q. Okay. So, Lisa, I want to
11:52:01 30 fast-forward to when you're actually back in
11:52:03 31 the home and you start your inspection. And
11:52:06 32 I'm going to ask you to walk us through what

11:52:10 1 happened when you actually go on-site for that
11:52:12 2 inspection.
11:52:12 3 I'm more interested in the stage
11:52:16 4 and the process, so the steps you took and what
11:52:17 5 you were looking for than your actual findings,
11:52:20 6 because we will go to your actual report from
11:52:23 7 the inspection to look in some detail at those
11:52:26 8 findings.
11:52:26 9 But to start off, I understand
11:52:28 10 you actually were not one of the two inspectors
11:52:31 11 that was first in the home; is that right?
11:52:34 12 A. That is accurate.
11:52:35 13 Q. Okay. So can you explain
11:52:37 14 that? And tell us how this inspection started.
11:52:39 15 A. Sure. So Lesley Edwards, who
11:52:45 16 was the inspector that first attended the home
11:52:47 17 to get those initial documents, and another
11:52:51 18 respected colleague, Phyllis Hiltz-Bontje, they
11:52:53 19 attended the home.
11:52:54 20 They met with the acting
11:52:56 21 Director of Nursing at the time. They -- I'm
11:53:06 22 so sorry. I don't recall if the Acting
11:53:09 23 Executive Director was there at the time. For
11:53:12 24 some reason, I think it was only the Acting
11:53:15 25 Director of Nursing.
11:53:17 26 They met with her. They had
11:53:21 27 collected some policies and procedures at that
11:53:22 28 time. They had requested a copy of the
11:53:25 29 victim's clinical records, her Progress Notes.
11:53:27 30 They had conducted some
11:53:29 31 medication observations with staff that were
11:53:30 32 there, although did not actually interview the

11:53:34 staff, but only conducted the observations.
11:53:37 Q. Can I pause you there?
11:53:39 A. Of course.
11:53:39 Q. We've heard that there were
11:53:43 sort of -- there was a unique approach to
11:53:46 interviews for these inspections because there
11:53:49 were some limits on who you could speak to.
11:53:52 Was that also true for Telfer Place?
11:53:54 A. Definitely, yes.
11:53:55 Q. Okay.
11:53:55 A. So initially -- and I've only
11:53:59 heard this from my colleagues, but initially
11:54:02 they were instructed not to interview anyone,
11:54:02 that they could speak with the Director of
11:54:05 Nursing or the Executive Director. I'm sorry.
11:54:06 I don't recall who the individual was. But not
11:54:09 to interview the staff.
11:54:11 And then they were also
11:54:13 instructed to -- when they were identifying
11:54:16 which staff they wanted to talk to, they would
11:54:18 need to submit the name of the staff member to
11:54:21 our manager.
11:54:22 That name or that individual
11:54:24 would be -- the name of that individual would
11:54:27 be forwarded up, and then we would later get
11:54:30 direction as to when we could talk to them.
11:54:33 Interviews typically as well,
11:54:35 when I conduct an inspection, are done starting
11:54:38 at the frontline staff and then working up to
11:54:40 registered staff or the supervisor if it's
11:54:45 housekeeping or something that I'm looking at,
11:54:47 but in this case, we also didn't start that

11:54:50 way.
11:54:50 We sort of had to start from a
11:54:53 different place in that we were very limited as
11:54:57 well as to what we could talk with the staff
11:55:00 about.
11:55:01 The difference between our
11:55:02 inspection and the other inspections that were
11:55:04 conducted is that there were no charges laid in
11:55:08 relation to Sandy Towler at this time when we
11:55:15 were in the home in October and November. It
11:55:17 wasn't until January that charges were laid.
11:55:20 So although staff in the home
11:55:25 knew that they had worked with the nurse and
11:55:26 were aware that she was in the media, it was
11:55:29 not at all related to their home at that time.
11:55:31 So we needed to be very -- we
11:55:34 were cautioned repeatedly that we don't want to
11:55:39 do anything at all to jeopardize the police
11:55:43 investigation, so you need to be cautious as to
11:55:45 what you say as to not share too much
11:55:50 information and potentially -- yeah.
11:55:52 Q. Okay. Okay. So as I
11:55:58 understand it from your Affidavit, you join
11:56:01 Lesley and --
11:56:04 A. Phyllis.
11:56:05 Q. -- Phyllis on-site on
11:56:06 November 9th; is that correct?
11:56:07 A. I would have to check my
11:56:09 Affidavit. That sounds about right, but I'm
11:56:12 sorry. I don't remember the exact date right
11:56:14 now.
11:56:14 Q. Okay. And so when did they

11:56:14 go into the home? Do you know when they went
11:56:16 in?
11:56:16 A. I'm so sorry. Dates are not
11:56:18 my... Think I could find it quickly.
11:56:44 Q. I think paragraph 66 is
11:56:46 when --
11:56:46 A. Oh, I was getting there.
11:56:48 Okay. Thank you for your assistance.
11:56:50 So I did return to work on
11:56:51 November the 9th. And did we identify earlier
11:56:56 when they attended?
11:56:56 Q. It doesn't look like --
11:57:00 A. No. However, if we go to a
11:57:01 copy of the inspection report.
11:57:04 Q. Can we pull that up maybe?
11:57:06 It is --
11:57:07 A. I've just found it actually.
11:57:08 Q. Okay.
11:57:09 A. The date on there would
11:57:12 suggest that they visited on October the 28th.
11:57:15 Q. Okay. Okay.
11:57:16 A. That was their first day to
11:57:19 actually inspect. Then they went back
11:57:21 November 1st, 3rd, and 4th. And then Phyllis
11:57:25 stepped out and did not return in that I was
11:57:30 now present.
11:57:30 Q. Okay. Okay. So by the time
11:57:34 that you had arrived on November 9th, what had
11:57:37 been completed then? You talked to us a little
11:57:40 bit. They've collected policies and
11:57:43 procedures. Had there -- what else had
11:57:45 happened?

11:57:45 A. They had done quite bit of
11:57:49 the medication IP. All that we had really left
11:57:51 to do was some final interviews.
11:57:56 Q. Okay.
11:57:57 A. I believe they'd already
11:57:58 started on reporting and complaints as well.
11:58:01 They had done a number of observations in the
11:58:03 home in relation to medications, in relation to
11:58:09 the medication room, storage of medications in
11:58:11 relation to staff-to-resident interactions,
11:58:15 things like that.
11:58:16 Q. Okay. So --
11:58:20 A. They collected more policies
11:58:21 and procedures, had started to talk to some
11:58:23 staff in relation to -- when I say "staff," I
11:58:26 mean management staff -- in relation to College
11:58:32 of Nurses, certificate of competences.
11:58:34 I believe they actually started
11:58:35 to collect some records on training as well
11:58:39 prior to my arrival.
11:58:40 Q. Okay. And why the records on
11:58:43 training? We didn't hear about that from the
11:58:46 other two inspections, so what were you looking
11:58:48 for with respect to training?
11:58:50 A. It was part of our Inspection
11:58:53 Plan, hence we wanted to ensure that the staff
11:58:55 that were working were provided the mandatory
11:59:00 training prior to starting in the home.
11:59:01 Q. Okay. Okay. Lisa, I've got
11:59:05 two different documents here. I'm going to
11:59:09 have Ms. Kinkartz bring those up. And I want
11:59:13 you to take a look -- we have three copies.

11:59:21 A. I see my colleague typed
11:59:24 those out, and ours was handwritten. So sorry
11:59:26 about that. Thank you.
11:59:30 Q. For the record, these are doc
11:59:36 ID 41654 and 41655. So, Lisa, can you tell us,
11:59:43 what are these documents?
11:59:44 A. It's actually one document,
11:59:48 page 1 and page 2 of the document.
11:59:50 Q. Okay.
11:59:50 A. And it's the staff inventory
11:59:53 list. So these were the staff that we spoke
11:59:55 with in the home at the time of the inspection.
11:59:57 Q. Okay.
11:59:57 A. They are identified by a
11:59:59 number, their name, and then their position.
12:00:02 Q. So is everyone on the list
12:00:04 someone that you spoke to in the home or --
12:00:07 A. No. A couple of the staff we
12:00:09 had only looked at their records, not
12:00:12 necessarily spoke with them, but we didn't know
12:00:15 if they would be someone that we might have to
12:00:19 speak with.
12:00:19 To identify who those were right
12:00:21 now, I can't say for sure. I believe it would
12:00:24 be some of the top registered staff.
12:00:25 Q. Okay. And I believe
12:00:27 Elizabeth Wettlaufer's name appears on that
12:00:29 list.
12:00:29 A. And we did not interview
12:00:31 Elizabeth Wettlaufer. We were instructed not
12:00:33 to. She wasn't available to us anyways.
12:00:35 Q. Okay. So as I understand it,

12:00:36 1 the list also produces -- sets a number for
12:00:41 2 each of them. And then your report -- when
12:00:44 3 you're referring to staff members by number in
12:00:47 4 the report, it corresponds to this particular
12:00:50 5 list; is that right?
12:00:51 6 A. Ideally it should, yes.
12:00:52 7 Q. Okay.
12:00:53 8 A. Yes.
12:00:54 9 Q. Okay.
12:00:54 10 MS. STEPHENS: So, Commissioner,
12:00:56 11 I would like to ask that these
12:00:57 12 be made the next exhibit.
12:00:59 13 Perhaps since we now know it's
12:01:01 14 one document, not two, perhaps
12:01:03 15 we could put it together as the
12:01:05 16 next exhibit because it will
12:01:07 17 help us make sense of the
12:01:09 18 inspection reports.
12:01:10 19 THE COMMISSIONER: All right.
12:01:12 20 Thank you. So Exhibit 145,
12:01:14 21 then, is a two-page staff
12:01:16 22 inventory list with a date of
12:01:18 23 review of October 5, 2016.
12:01:15 24 EXHIBIT NO. 145: Two-page staff
12:01:16 25 inventory list dated October 5,
12:01:26 26 2016.
12:01:29 27 BY MS. STEPHENS:
12:01:30 28 Q. So, Lisa, about how many
12:01:33 29 people would you say you interviewed in the
12:01:35 30 home while you were there?
12:01:37 31 A. When you say "people," do you
12:01:38 32 mean staff?

12:01:39 Q. Staff.
12:01:40 A. I'm going to guess, based on
12:01:43 this, that it's 31.
12:01:44 Q. 31. Okay. And what about in
12:01:48 terms of -- did you interview other people?
12:01:51 Did you interview residents?
12:01:52 A. We did interview -- we tried
12:01:56 to interview the victim. Unfortunately, she
12:01:58 was not interviewable. It wasn't for lack of
12:02:03 trying, though. Her health status prevented
12:02:05 that from happening.
12:02:07 We talked to many other
12:02:08 residents while we were there, but did we
12:02:10 record them as formal interviews? No.
12:02:12 We'd also conducted some
12:02:14 concurrent inspections, and there are resident
12:02:16 interviews in that that were of a vague nature
12:02:22 about how are things sort of in general in the
12:02:25 home, yeah.
12:02:25 Q. Okay. Okay. And what
12:02:28 about -- did you speak to any family members?
12:02:29 A. We did speak with the family
12:02:31 of the victim. It was not done until much
12:02:34 later. Almost to the end of the inspection,
12:02:37 though, and we actually did not speak with them
12:02:39 in the home but on the telephone.
12:02:41 Q. Okay. Can you give us an
12:02:43 idea how long you were at Telfer Place and
12:02:45 on-site for this inspection?
12:02:46 A. Definitely it was
12:02:50 intermittent and sporadic, but the dates from
12:02:54 the inspection report go from October the 5th

12:02:56 1 of 2016 until March the 21st of 2017; however,
12:03:00 2 for the month of January, it appears that we
12:03:04 3 were only there for one date.
12:03:07 4 Q. Okay. So when you say
12:03:09 5 "sporadic," you weren't there every single day
12:03:12 6 during --
12:03:12 7 A. Definitely not, no. We were
12:03:14 8 working on other inspections as well. And some
12:03:16 9 of them -- some of them -- some of the time --
12:03:22 10 and I would have to cross-reference this, but
12:03:26 11 maybe while we were in the home, we were
12:03:29 12 working on one of the concurrent inspections
12:03:32 13 and didn't look at this inspection at all
12:03:33 14 during that time as well. So that date would
12:03:36 15 not have been included.
12:03:37 16 Q. Okay. Okay. So I want to
12:03:39 17 turn to talking about some of the findings from
12:03:41 18 your inspection. And you'll find your
12:03:44 19 inspection report at Exhibit F to the
12:03:46 20 Affidavit.
12:03:47 21 And, Laura, I'd ask you if you
12:03:50 22 could pull up that report. It's Document
12:03:53 23 41487.
12:04:04 24 So the first thing I want to ask
12:04:06 25 you about, it looks like your report comes out
12:04:08 26 May 24th; is that correct?
12:04:10 27 A. That's what it looks like.
12:04:12 28 Q. So we know from Rhonda and
12:04:15 29 Natalie's evidence that the
12:04:17 30 Caressant Care/Meadow Park inspection reports
12:04:19 31 don't come out until later in August. Is there
12:04:23 32 any reason why you were able to issue your

12:04:25 report earlier?
12:04:26 A. I was directed that today is
12:04:29 the day it can go.
12:04:33 Q. Okay.
12:04:33 A. So I can't say why theirs
12:04:35 took longer. Definitely the report was --
12:04:39 versions of the report were prepared long
12:04:42 before this date. I was directed to hold off,
12:04:45 though, until one day.
12:04:48 Q. Okay. Okay. Who was it that
12:04:52 directed you that this is the day it can go
12:04:54 today?
12:04:54 A. I received the information
12:04:55 from my manager. Who she received it from, I
12:05:00 couldn't say for sure, though.
12:05:01 Q. Okay. So let's go -- let's
12:05:02 scroll down towards the bottom of page 2,
12:05:04 please.
12:05:06 So this is the summary of the
12:05:09 findings of noncompliance found during this
12:05:12 inspection?
12:05:12 A. That's correct. There were
12:05:14 six written notifications, each of which had a
12:05:19 Voluntary Plan of Correction attached to them.
12:05:19 Q. Okay. So what I want to do
12:05:21 now is go through some of the specific
12:05:28 findings. If we could scroll down to the first
12:05:30 finding which is here. Thank you, Laura.
12:05:32 So this here is a failure to
12:05:35 comply with Section 8 of the Long-Term Care
12:05:37 Homes Act, and this is -- this is the provision
12:05:41 that's sort of colloquially known as the 24/7

12:05:44 RN provision?
12:05:46 A. That's correct.
12:05:46 Q. So if we scroll down to the
12:05:50 next page, these are the findings here. So can
12:05:54 you explain to us why you issued that
12:05:56 particular finding of noncompliance?
12:05:58 A. Definitely. So Telfer Place,
12:06:04 as we've learned from interviews conducted by
12:06:06 staff at the facility, is a smaller home. It's
12:06:09 a 45-bed long-term care home.
12:06:11 They, because of their home
12:06:12 size, have only one Registered Nurse on usually
12:06:16 24 hours a day, 7 days a week. They have RPNs
12:06:20 on as well, though, in addition to PSWs.
12:06:22 However, there were occasions
12:06:24 when, due to a variety of reasons, they were
12:06:28 not able to have an RN who was a member of the
12:06:32 staff at the home, so an employee of Telfer
12:06:37 Place, Revera that was able to come to work,
12:06:41 although the home was able to demonstrate that
12:06:43 they did make efforts to have one of their own
12:06:46 staff.
12:06:46 So when these occasions
12:06:48 occurred -- and sometimes they were known about
12:06:50 in advance, and sometimes they happened very
12:06:53 quickly in the spur of the moment -- they
12:06:57 reached out to an agency to try to fill those
12:07:00 shifts.
12:07:00 Sometimes they were able to fill
12:07:01 the shifts with a Registered Nurse. Sometimes,
12:07:04 unfortunately, if you go a little bit further
12:07:06 down, it notes that they were not able to fill

12:07:08 it with a Registered Nurse, so they brought in
12:07:10 one of their own Registered Practical Nurses to
12:07:13 work with one of the RNs on call.
12:07:16 Q. Can you scroll down a little
12:07:18 bit, Laura?
12:07:19 A. It's actually on the page. I
12:07:23 see that now. I just -- yeah. Or with an --
12:07:23 yes, so that was one of the two things.
12:07:25 So when we spoke with the
12:07:26 Executive Director at the time, he confirmed
12:07:31 that the home was unable to fill the shifts,
12:07:36 that it was not, to the best of his knowledge,
12:07:40 related to a, quote, emergency situation,
12:07:42 emergency as defined in the legislation, and
12:07:46 that they weren't entitled to the exception
12:07:51 and, therefore, were not compliant with 8(3).
12:07:54 Q. Okay. And so if we scroll
12:07:56 down, we can see that you issue a VPC --
12:08:01 A. That's correct.
12:08:02 Q. -- along with this -- with
12:08:04 this written notification of noncompliance.
12:08:07 So this was, in fact, when you
12:08:14 assess this according to the Judgment Matrix,
12:08:18 this was the default action that the Judgment
12:08:20 Matrix suggested would be appropriate, a VPC;
12:08:24 is that correct?
12:08:24 A. I believe that's correct. I
12:08:26 don't believe we made any variance. In fact, I
12:08:30 know we did not make any variances on this one.
12:08:32 Q. Okay. Okay. So we do -- the
12:08:33 voluntary -- or, sorry, your Judgment Matrix is
12:08:36 at Tab G. And I think it would be helpful to

12:08:39 pull up.
12:08:39 I notice one thing here, we'd
12:08:42 seen with both the Caressant Care and Meadow
12:08:43 Park reports that they would typically include
12:08:45 in their reports what they had noted in terms
12:08:48 of how they were assessing the severity, the
12:08:51 scope, and the compliance issue right there.
12:08:53 So we don't see it in your
12:08:55 reports, but that is included in your Judgment
12:08:59 Matrix in this case; correct?
12:09:00 A. That's correct.
12:09:00 Q. Okay. So let's --
12:09:02 A. It's not our practice -- if I
12:09:04 can just -- I'm sorry to interrupt. It's not
12:09:06 our practice to include the statement about
12:09:07 severity, scope, and compliance history in WNs
12:09:12 unless they are attached to a compliance order.
12:09:14 And at that time, that would be
12:09:15 included as part of the grounds and not part of
12:09:19 the finding, so that's our practice.
12:09:22 Q. Okay. And that's the
12:09:25 practice in the Hamilton Service Area Office;
12:09:25 correct?
12:09:28 A. Yes, that is correct.
12:09:28 Q. Okay. So if we could pull up
12:09:31 document ID 41509, and this is in your
12:09:35 Affidavit at Tab G.
12:09:40 So if we can scroll down to that
12:09:44 first -- the first finding where it says act
12:09:48 8(3), that row.
12:09:50 So here's where we can see what
12:09:52 the Judgment Matrix has advised you; is that

12:09:55 right? So you've --
12:09:56 A. Yes.
12:09:56 Q. -- assessed the -- the
12:09:58 severity is a 1. And if we scroll -- if you
12:10:01 can just go up a little bit, Laura.
12:10:08 So the severity, if you put it
12:10:10 at a 1, that's a minimum risk?
12:10:13 A. That's correct.
12:10:13 Q. Okay. And the scope here you
12:10:16 set as a 2 showing a pattern. Can you explain
12:10:21 that?
12:10:21 A. Sure. If you look above at
12:10:22 the box beside "severity," it mentions scope's
12:10:26 pattern is greater than 5 percent or fewer than
12:10:29 30 percent of the affected population surveyed.
12:10:32 So in this case -- and I'm so
12:10:33 sorry. I'm not great at math either.
12:10:35 I believe it's approximately 25 shifts.
12:10:38 And the reason why I put
12:10:41 approximately 25 in the document is because
12:10:43 there were a few shifts that they were maybe an
12:10:47 hour without a Registered Nurse in the home,
12:10:49 and then someone was able to come in. So it
12:10:52 was approximately.
12:10:52 Q. Okay.
12:10:53 A. And there was a small
12:10:55 handful. I think it was maybe seven where
12:10:56 there was no RPN in the building. And
12:11:00 I believe we looked at a period of
12:11:01 approximately five months.
12:11:03 So if we look at three shifts
12:11:05 seven days week times that period of time, it

would be a pattern. It wouldn't be the other two options.

Q. It sounds like you're better at math than you think you are.

Okay. So let's look at the compliance history too. So we see here that you say in terms of compliance history, it says two. So -- or, sorry --

A. I'm sorry. It says three.

Q. I'm sorry. So that says they had one or more related noncompliance than the last three years.

So there had been a previous finding of noncompliance in relation to this specific provision of the act?

A. There was one previous finding of noncompliance in relation to this provision of the act. It's -- it was in relation to -- do you want me to speak about this?

Q. Sure.

A. It was in relation to an inspection that was conducted and discussed here previously as well with the former Executive Director, Dian Shannon, when Dian assisting an agency RPN because there wasn't an RN in the building.

So that was the identified shift that was identified previously as -- I'm very confident to say it was a WN 483.

Q. Okay.

A. I'm not very confident. I'm

12:12:27 highly confident.
12:12:29 Q. Okay. Thank you. If we can
12:12:30 go back to that inspection report then, 41487,
12:12:35 and let's move on to the next finding of
12:12:37 noncompliance. And you should find that at
12:12:42 page 4. And at the very bottom, if you can
12:12:50 scroll down there, Laura.
12:12:52 So this here is a failure to
12:12:55 comply with Section 75, screening measures. If
12:12:59 we can go on to the next page. Can you explain
12:13:02 to us, Lisa, what that finding was in relation
12:13:04 to?
12:13:04 A. If it's okay, I'll just read
12:13:08 it. [AS READ]
12:13:08 "The screening measure shall
12:13:10 include criminal reference
12:13:11 checks unless the person being
12:13:14 screened is under 18 years of
12:13:15 age."
12:13:15 So what this is that when you hire an employee,
12:13:21 within six months of them accepting employment,
12:13:26 they must have a valid criminal reference check
12:13:31 or police screening of a vulnerable section
12:13:35 screen. So that -- that was the issue, and if
12:13:38 they're greater than 18 years of age, so yeah.
12:13:42 Q. And so you had found that
12:13:43 there were a number of RNs who had worked in
12:13:47 the home, and there was not a valid vulnerable
12:13:50 sector check or criminal record check
12:13:53 conducted; correct?
12:13:53 A. That is correct, Megan. If I
12:13:55 could just clarify, though. So these were all

relation to agency staff that were working at the home, not regular employees of the home, so not employees of Telfer Place.

So they were employees of an agency that were brought in to work shifts in the long-term care home as an employee of the agency.

Q. Okay. And so you say here -- and this is -- when we were talking about the numbers of employees here.

A. Yes. Yes.

Q. So RN Number 610, 609, and 605, those were the RNs that had not had --

A. RN 610 is EW, yes.

Q. Okay. Okay. So that's Elizabeth Wettlaufer.

A. And RN 610, that number is used for that individual throughout the report, not just in one finding. We would never change her number. As we progress, it's always the same number.

Q. Okay.

A. Okay?

Q. Okay. Thank you. That's helpful. So we know throughout this report, RN 610 is Elizabeth Wettlaufer?

A. That's correct.

Q. She was one of the nurses that was working in that home, and the home had not confirmed that she had a criminal record check completed; is that correct?

A. The home did not have, that's

12:15:04 1 correct, a copy of her criminal reference check
12:15:07 2 on file.
12:15:07 3 Q. All right. So if we can just
12:15:09 4 scroll down to the next page. So we see that a
12:15:12 5 VPC was issued in relation to this finding.
12:15:17 6 A. That's correct.
12:15:17 7 Q. And if we could just go back,
12:15:23 8 then, to your Judgment Matrix. So that's 45109
12:15:27 9 and Tab G. Oh, sorry, 41509. I think I
12:15:45 10 misspoke.
12:15:46 11 All right. So let's -- it looks
12:16:08 12 like this was a case where you have the
12:16:12 13 severity of risk is a minimum risk?
12:16:14 14 A. That is correct.
12:16:15 15 Q. And can you explain that?
12:16:16 16 A. The home definitely was under
12:16:20 17 the impression that the agency was collecting
12:16:24 18 the criminal reference checks.
12:16:26 19 The home was completing criminal
12:16:29 20 reference checks for their own -- or not
12:16:31 21 completing. Ensuring that the criminal
12:16:34 22 reference checks were in place for their own
12:16:36 23 staff in the home.
12:16:37 24 We felt it was -- I felt it was
12:16:43 25 a minimum risk based on the fact that the home
12:16:47 26 was under the impression that that information
12:16:49 27 was available, was collected, and was desired,
12:17:00 28 i.e., that they didn't fail the check. I don't
12:17:02 29 think it's a pass or a fail. It is a pass. It
12:17:03 30 wasn't a negative check would be probably a
12:17:06 31 better word.
12:17:06 32 Q. Okay. And were you able to

confirm with the agency whether those criminal record checks had been done?

A. To be very honest with you, repeated attempts were made to speak with the agency. Unfortunately, we were not able to talk to them. They declined speaking with us on a number of -- and when I say "us," that Lesley, Lesley Edwards who had made those attempts.

Although she would have a conversation with her, it was to say, "I won't be speaking with you." There wasn't any other conversation than that, so yeah.

Q. Okay. And that agency who had placed Elizabeth Wettlaufer in the home, we heard during the facilities phase, was Lifeguard?

A. That is correct. And we had made attempts to speak with Heidi.

Q. Okay. So you set it as a minimum risk. And then in terms of the scope of the problem, we see -- you've set that as a 3, so that's widespread?

A. I did. And the reason for that was that we looked at three agency staff. We did not include in our sample any staff of the home. We were looking specifically at 3 agency staff. Sorry about that.

Q. Okay. And so all three of those had not had the criminal record check, and so --

A. That's correct.

12:18:16 Q. -- that essentially is what
12:18:18 gets you to this being a widespread problem?
12:18:22 A. Yeah. Three of three.
12:18:24 Q. In terms of the compliance
12:18:25 history, here it's a 2. So explain to us what
12:18:29 the 2 means.
12:18:30 A. The home had one or more
12:18:33 unrelated noncompliance in the past three
12:18:35 years. In other words, they had noncompliance
12:18:37 on the file in the past 36 months. And they
12:18:40 did.
12:18:40 Q. But not a finding of
12:18:42 noncompliance in relation to this particular
12:18:43 provision?
12:18:43 A. No. That's correct.
12:18:44 Q. Okay. So we see here that
12:18:47 the Judgment Matrix actually suggests that the
12:18:50 default action should have been a compliance
12:18:53 order?
12:18:53 A. Correct. A level C, a CO.
12:18:57 Q. Okay. And so ultimately, you
12:18:58 decide to issue this as a Voluntary Plan of
12:19:00 Correction?
12:19:00 A. I did.
12:19:01 Q. Explain that to us.
12:19:03 A. I'll read what I wrote, if
12:19:05 that's okay. The change to produce -- or there
12:19:08 was a change. We reduced it to a VPC as it was
12:19:13 agency staff -- as the agency who employed the
12:19:16 staff were to have completed the required
12:19:19 screening. The home did not verify that this
12:19:21 had not had been -- had not been completed, but

12:19:22 1 it was the expectation.
12:19:23 2 I guess I'm pretty good at math
12:19:26 3 but not really good at reading today.
12:19:27 4 Basically the issue came down to
12:19:28 5 the fact that the home was aware of their
12:19:31 6 responsibility. The home was conduct -- for
12:19:33 7 their own staff, the home was conducting it,
12:19:37 8 but they were under the impression that based
12:19:38 9 on the relationship that they had with the
12:19:42 10 agency, that this was being done on their
12:19:47 11 behalf.
12:19:47 12 So from that regard, the
12:19:48 13 decision was made to move it from a compliance
12:19:51 14 order to a Voluntary Plan of Correction.
12:19:54 15 Q. Okay. Is there anything
12:19:55 16 under the legislation that would require the
12:19:58 17 employment agency, that would have required
12:20:01 18 Lifeguard to complete those criminal record
12:20:04 19 checks?
12:20:04 20 A. Our legislation is
12:20:07 21 relation -- is pertinent to the long-term care
12:20:09 22 home, not to the agency. So to my knowledge,
12:20:13 23 no. Any agency isn't required to follow our
12:20:18 24 legislation. They're required to -- that's for
12:20:20 25 the long-term care home.
12:20:21 26 Q. Okay. And was there some
12:20:23 27 sort of contract or some sort of agreement
12:20:25 28 between Lifeguard and Telfer Place in relation
12:20:29 29 to the employment of the agency RNs in the
12:20:33 30 home?
12:20:33 31 A. There was a contract. I will
12:20:35 32 admit it was a very vague and small contract.

12:20:39 1 Did it specifically make mention related to
12:20:43 2 criminal reference checks? No, but that was
12:20:45 3 definitely the understanding of the individuals
12:20:47 4 that we spoke with, that that was part of what
12:20:50 5 was included in what they were getting.
12:20:55 6 Q. And was there any recognition
12:20:58 7 on the part of the home that this needed to
12:21:00 8 change?
12:21:00 9 A. Oh, definitely. Once the
12:21:03 10 question was asked, although we didn't give
12:21:06 11 direction or advice, there was a lightbulb
12:21:11 12 moment. And right away that was put into
12:21:14 13 place.
12:21:14 14 Q. Okay. Okay. So the next
12:21:18 15 finding that I want to deal with is on page 6
12:21:22 16 back in the report. So let's just scroll down
12:21:29 17 here. So this is a finding of noncompliance in
12:21:32 18 relation to the --
12:21:34 19 A. Can I retract my last
12:21:36 20 statement?
12:21:37 21 Q. Sure.
12:21:37 22 A. I'm going to try to recall
12:21:39 23 now, and I can't. It might have been that the
12:21:42 24 home, during us asking for these documents, had
12:21:47 25 figured it out just before then as well
12:21:49 26 regardless -- it was the course of this
12:21:52 27 inspection that they had identified that they
12:21:56 28 should have had these checks completed for
12:21:59 29 these individuals as well.
12:22:02 30 So whether we asked the question
12:22:03 31 first or if they came to it themselves during
12:22:06 32 us just looking at other things, I'm not a

12:22:10 1 hundred percent sure at this time.
12:22:10 2 Q. Okay. But there was a
12:22:12 3 recognition in --
12:22:13 4 A. Definitely. Definitely.
12:22:14 5 Q. Okay. Okay. So let's deal
12:22:17 6 with this finding of noncompliance. So this
12:22:20 7 was in relation to training.
12:22:21 8 Can you explain -- we haven't
12:22:25 9 actually spoken about this provision that much,
12:22:28 10 but can you explain what is required of the
12:22:29 11 licencee of a long-term care home with respect
12:22:30 12 to training?
12:22:31 13 A. Sure. You picked a long one.
12:22:31 14 [AS READ]:
12:22:34 15 "The licencee shall ensure that
12:22:34 16 all staff in the home have
12:22:35 17 received training as required by
12:22:37 18 this section."
12:22:38 19 And then there's several sections that go on
12:22:42 20 down here, and I'll just summarize them.
12:22:44 21 There's the Bill of Rights, the mission
12:22:46 22 statement, the home's policy to promote zero
12:22:50 23 tolerance of abuse and neglect of residents,
12:22:50 24 the duties under Section 24 to make mandatory
12:22:53 25 reports, the protections afforded by Section
12:22:56 26 26, which is whistle-blowing protections, the
12:22:59 27 long-term care homes policy for the minimizing
12:23:01 28 of restraining of residents, fire safety and
12:23:05 29 fire prevention, emergency and evacuation
12:23:07 30 procedures, infection prevention and control,
12:23:11 31 any other acts, regulations, policies of the
12:23:11 32 Ministry or similar documents including

12:23:13 1 policies of the licencee that are relevant to
12:23:15 2 this person's responsibilities and basically
12:23:17 3 anything else that's in the regulations.
12:23:19 4 Q. Okay. So you find there's
12:23:24 5 noncompliance in relation to this. If we go to
12:23:25 6 the next page, the reasons for that are here.
12:23:28 7 But can you just explain to us what you had
12:23:33 8 found in the home?
12:23:34 9 A. Sure. So we had -- so we
12:23:36 10 identified agency staff. And I'm just going to
12:23:40 11 double-check. They were not the same three,
12:23:45 12 and I'm not quite sure why. But that's okay.
12:23:48 13 Maybe they were...
12:23:49 14 One of them being employee 610,
12:23:53 15 which was Elizabeth Wettlaufer. We had asked
12:23:55 16 for their training records. The home was
12:23:59 17 honest and did not maintain employee records of
12:24:03 18 individuals that were not employees of the
12:24:05 19 home, so there was not an employee file of
12:24:08 20 Elizabeth Wettlaufer or the other agency staff
12:24:10 21 that we looked at; however, they had training
12:24:13 22 records and files, so were able to provide the
12:24:16 23 records.
12:24:22 24 The home used a checklist of
12:24:24 25 sorts, and when the agency staff was to come
12:24:28 26 prior to their first shift or ideally before
12:24:31 27 their first shift or if it was a short-notice
12:24:35 28 sort of situation, they would ask them to come
12:24:37 29 in approximately four hours before their shift.
12:24:39 30 And they would have one of the staff complete
12:24:41 31 the checklist with them.
12:24:43 32 We reviewed the checklist. The

12:24:46 checklist had identified a whole bunch of
12:24:49 things in addition to what was required. They
12:24:51 also had other things that they felt were
12:24:53 important that they were training them on.
12:24:55 And the checklist that we
12:24:57 reviewed for these two individuals did not
12:25:00 identify that everything was indeed completed.
12:25:01 We interviewed the staff member
12:25:02 who provided training to EW. She verified it
12:25:07 was her signature and EW's signature on the
12:25:10 form and that there were blanks on the form,
12:25:13 that she couldn't recall the orientation at all
12:25:17 being that it was in 2015, and we were speaking
12:25:20 to her approximately two years later.
12:25:23 But she verified that to her
12:25:26 knowledge, it wasn't completed, and she wasn't
12:25:28 aware of any other information that would have
12:25:30 been received.
12:25:31 So we then went on to the second
12:25:35 RN, who was RN Number 609, further down on the
12:25:38 page. And this employee had started as an
12:25:41 agency individual in the home earlier, a little
12:25:44 bit earlier in May.
12:25:45 During the course of reviewing
12:25:47 this one, though, it was identified that
12:25:52 sometime in the summer of 2016, which was
12:25:56 August, she had received retraining and, in
12:26:00 fact, training in all of the required areas.
12:26:02 So the home had identified
12:26:06 through their own internal processes prior to
12:26:10 being aware of any offences of Elizabeth
12:26:13 Wettlaufer, those even outside of Telfer Place,

that there was a little blip in their system, and they had put a plan in place to address that which included retraining of all agency and making sure that all future agency had this information.

So RN Number 6 did indeed work without full orientation from May 2014 until August 2016, but was provided the training then.

And the third agency staff that we looked at is not identified on this report, and that's because that individual was fully trained.

Q. Okay. So if we scroll down, we can see that this is issued as well with a Voluntary Plan of Correction.

A. It is.

Q. Let's very quickly toggle back to the Judgment Matrix.

A. I was anticipating that.

Q. And here we see -- if we go down to -- if we can scroll down so we can see training and orientation.

We see the severity here is 2, minimal harm or potential for actual harm. So why is this set as a level 2?

A. If someone doesn't -- if someone who is in charge of and responsible for the home doesn't have training on some of these things and having to make decisions on restraints, fire, abuse, things like that, doesn't have the knowledge as to what they

12:27:39 should do in that situation and they are the
12:27:41 person responsible for the home, that that's a
12:27:44 potential. That's a --
12:27:47 Q. A potential for actual harm
12:27:49 is what you're saying?
12:27:50 A. Yeah.
12:27:51 Q. Okay.
12:27:51 A. There was two -- oh, I should
12:27:53 let you do this, sorry.
12:27:54 Q. No, you can go ahead.
12:27:55 A. Sorry. There was two of
12:27:58 three of the staff that we looked at impacted,
12:27:59 so our scope would be patterned, and
12:28:02 acknowledging that the second staff member
12:28:04 wasn't impacted for the entire time.
12:28:06 She had received indeed training
12:28:08 prior to our revival and prior to knowledge of
12:28:12 Elizabeth Wettlaufer. And there was a level 2
12:28:17 there in relation to --
12:28:21 Q. The compliance history?
12:28:23 A. Correct, one or more
12:28:26 unrelated noncompliances in the past.
12:28:26 Q. In the previous 36 months, no
12:28:29 finding of noncompliance in relation to this
12:28:32 specific section?
12:28:33 A. To 76.
12:28:34 Q. Okay. So we do see the
12:28:35 Judgment Matrix default here was the compliance
12:28:38 order?
12:28:38 A. That's correct.
12:28:38 Q. Can you explain to us why you
12:28:40 chose to vary that and issue a VPC instead of

12:28:44 1 the compliance order?
12:28:44 2 A. Very similar to some of the
12:28:46 3 reasons that were previously given by Natalie.
12:28:48 4 The home had already identified the problem and
12:28:50 5 had corrected the problem, so it wasn't a
12:28:52 6 current problem in the home. We were able to
12:28:54 7 identify that based an employee number 3 that
12:28:56 8 we looked at and employee number 2.
12:28:57 9 So the home had, on their own,
12:29:00 10 identified the concern and put a plan in place
12:29:02 11 to address it, and we were able to verify that
12:29:05 12 the plan was indeed carried through, and the
12:29:08 13 training was provided.
12:29:09 14 Q. Okay. Okay. Thank you. So
12:29:12 15 let's go back to the report. Thank you, Laura.
12:29:18 16 And if we could go to page 8 and
12:29:22 17 scroll down a little bit further in page 8.
12:29:25 18 We'll see the next finding of noncompliance.
12:29:29 19 So that's in relation to Section 101 of the act
12:29:35 20 dealing with complaints. And I believe we've
12:29:38 21 seen this as well in the Meadow Park
12:29:40 22 inspection.
12:29:41 23 A. I believe we did as well
12:29:43 24 yesterday.
12:29:43 25 Q. So explain to us this
12:29:47 26 particular -- what the issue was that you had
12:29:50 27 found at Telfer Place in relation to how the
12:29:53 28 home was dealing with complaints.
12:29:55 29 A. So admittedly, the reporting
12:29:58 30 and complaints IP was not done by myself. It
12:30:02 31 was done by Lesley.
12:30:03 32 Q. Okay.

12:30:04 A. However, Lesley was able to
12:30:11 identify that the home failed to document --
12:30:14 failed to ensure a documents record was
12:30:16 maintained in the home that included the date
12:30:18 that the complaint was received, the type of
12:30:20 action taken to resolve the complaint, the date
12:30:22 of the action, time frame for action to be
12:30:25 taken, any follow-up reaction, the follow-up
12:30:27 resolution, the date on which any response was
12:30:29 provided to the complainant and a description
12:30:31 of that response to the complainant and made in
12:30:35 turn, as well as that the licencee failed to
12:30:38 ensure that documented complaints were
12:30:41 received -- I'm sorry. Were reviewed and
12:30:43 analyzed for trends at least quarterly.
12:30:46 So there's actually the two that
12:30:49 are included into the one finding of
12:30:51 noncompliance.
12:30:52 Q. Okay. So there were two
12:30:53 specific problems identified?
12:30:55 A. That's correct.
12:30:56 Q. So can we -- I'm sorry. I
12:30:59 have you really working a lot this morning,
12:31:03 Laura. Let's go back to -- well, so we know
12:31:04 this was issued with a Voluntary Plan of
12:31:08 Correction?
12:31:08 A. That's correct.
12:31:08 Q. Okay. So let's go back to
12:31:09 the Judgment Matrix.
12:31:11 A. Judgment Matrix.
12:31:19 Q. So we see here dealing with
12:31:21 complaints, it says here minimum risk. Why

12:31:25 1 would this be set as a minimum risk, the level
12:31:29 2 1?
12:31:29 3 A. I believe based on the
12:31:30 4 information that Lesley had collected, that it
12:31:32 5 wasn't that they weren't dealing with them. It
12:31:36 6 was that they -- their documentation was strong
12:31:37 7 in relation to the actions that they had taken
12:31:39 8 and when and things like that.
12:31:40 9 Q. Okay.
12:31:41 10 A. The scope was two, although
12:31:45 11 there was three, I believe, identified in the
12:31:48 12 report, A, B, and C.
12:31:53 13 Lesley did look at more than
12:31:55 14 three complaints. So if we do the math, it
12:32:00 15 would have probably fallen in that, between 5
12:32:03 16 and 33 percent.
12:32:03 17 Q. Okay.
12:32:03 18 A. And in relation to the
12:32:07 19 compliance history, it was a level 3, so there
12:32:10 20 was one or more related noncompliances in the
12:32:12 21 past three years.
12:32:12 22 Q. Okay. But the default action
12:32:16 23 was the Voluntary Plan of Correction, not a
12:32:20 24 compliance order; correct?
12:32:20 25 A. That's what that shows, yeah.
12:32:24 26 Q. Okay.
12:32:24 27 A. Yeah.
12:32:24 28 Q. Okay. So then let's also --
12:32:24 29 let's go back to the report again. We only
12:32:29 30 have two other findings to go through. But on
12:32:31 31 page 11 -- let's jump down to there.
12:32:36 32 So this is -- we're all getting

12:32:40 familiar with this section --
12:32:42 A. 135.
12:32:44 Q. -- of the regulation, 135.
12:32:44 So this is -- can you tell us
12:32:47 specifically what the issues were in relation
12:32:49 to medication incidents?
12:32:50 A. Sure. I can give you the
12:32:52 Coles Notes version here. So basically, the
12:32:55 concern that was identified here by Lesley was
12:32:57 that every medication incident was not reported
12:33:01 to the SDM of the resident, the substitute
12:33:06 decision maker, sorry, as well as the pharmacy
12:33:08 service provider.
12:33:09 Lesley looked at a number of
12:33:11 medication incidents, and she had identified
12:33:19 five that that information was not documented,
12:33:22 both the communication to the resident
12:33:27 substitute decision maker as well as the
12:33:29 pharmacist, or pharmacy service provider.
12:33:31 Q. Can we just scroll down a
12:33:32 little bit.
12:33:34 A. Yeah.
12:33:34 Q. So were all five of those
12:33:39 medication incidents -- did all five of those
12:33:42 take place on the same date?
12:33:44 A. They did apparently. So they
12:33:47 were all errors of omission, which means that
12:33:49 for whatever reason, a drug was not
12:33:52 administered to the resident at the time that
12:33:53 it was prescribed.
12:33:54 Q. Okay. And so we know there
12:33:58 are only 35 residents at --

12:33:59 A. 45 residents at Telfer Place.
12:34:01 Q. My apologies. So five
12:34:05 medication incidents on one day in a home with
12:34:09 45 residents, is that a high number of
12:34:12 medication incidents for one day?
12:34:14 A. I have to -- although I've
12:34:16 not discussed this with Lesley, I would have to
12:34:20 believe that that might be why she used these
12:34:23 as the example that she chose to use.
12:34:25 Q. Okay. Was there any thinking
12:34:28 about also issuing a finding of noncompliance
12:34:30 in relation to failure to provide medication --
12:34:34 A. 131.
12:34:36 Q. Yes, 131.
12:34:37 A. Yeah. At the time, was
12:34:41 there? No. The reason being Lesley and
12:34:45 Phyllis had observed a number of medication
12:34:49 passes. There were no concerns with residents
12:34:53 not receiving medications as prescribed at that
12:34:55 time.
12:34:57 We also indeed, like my
12:35:00 colleagues, were requested to do all of the
12:35:03 medication IP.
12:35:06 We were under the impression
12:35:07 that we were looking to see if there was
12:35:09 processes and systems in place. So by all
12:35:13 means, my practice is at this time and
12:35:17 continues to be, although now it's enhanced a
12:35:20 little bit, if I observe a medication error, of
12:35:22 course I'm going to further inspect upon it and
12:35:25 identify it as noncompli -- wherever it might
12:35:27 be appropriate, whether it be 131 or 131(2).

12:35:31 Nor were we given a specific
12:35:34 intake to look at a specific medication
12:35:37 incident. And for that reason, I believe the
12:35:39 decision was not made to issue under 131.
12:35:42 Q. Okay. Okay. So let's -- we
12:35:46 know this is issued with a Voluntary Plan of
12:35:48 Correction?
12:35:48 A. That's correct.
12:35:49 Q. Let's quickly go back again
12:35:52 to that Judgment Matrix.
12:35:53 A. Yeah.
12:35:53 Q. And let's look at how this is
12:36:02 completed. So the severity here is minimum
12:36:04 risk?
12:36:04 A. That's correct. So Lesley
12:36:06 not only looked at the medication incident
12:36:09 reports but into the clinical records of those
12:36:12 individuals, those residents that were impacted
12:36:15 by these errors on that identified date and
12:36:17 identified that there was no negative outcome
12:36:20 to those -- to those residents.
12:36:22 It was identified that the
12:36:24 pharmacy did receive the incident reports but
12:36:27 at a later date, whether it be at one of their
12:36:30 quarterly meetings or during a tracking,
12:36:35 sharing of a tracking tool, something to that
12:36:38 effect.
12:36:38 But the determination was that
12:36:39 basically -- just that it was a failure to
12:36:42 document that information, didn't necessarily
12:36:47 put the resident at risk. It -- the physician
12:36:52 was aware, things like that. So that was how

12:36:55 1 that decision was made.
12:36:57 2 Any more questions about that?
12:37:00 3 Q. Well, talk to us about the
12:37:04 4 scope and --
12:37:04 5 A. Sure. So, again, Lesley
12:37:05 6 looked at more than these. There was other
12:37:08 7 incidents that she looked at as well. And for
12:37:08 8 that reason, I believe that had fallen under
12:37:12 9 that place in the category, and as well, one or
12:37:14 10 more related noncompliances in the past three
12:37:19 11 years. So there was previous noncompliance in
12:37:22 12 relation to medications in the past three
12:37:24 13 years.
12:37:24 14 Q. Okay. The default action,
12:37:39 15 despite the previous history, was the Voluntary
12:37:42 16 Plan of Correction?
12:37:42 17 A. Yes.
12:37:44 18 Q. Okay. Okay. So then let's
12:37:48 19 go back to the inspection report, and let's
12:37:52 20 look at the final finding of noncompliance. So
12:37:56 21 this is on page 12, and this is in relation to
12:38:01 22 Section 234 of the regulation. So this is also
12:38:07 23 one we haven't seen previously. What's
12:38:09 24 required by Section 234?
12:38:11 25 A. Well, this was one that was
12:38:13 26 new to me as well. I hadn't issued it prior to
12:38:16 27 this inspection.
12:38:17 28 Q. Okay.
12:38:18 29 A. So this one identifies that
12:38:20 30 the home is required to keep a record of each
12:38:23 31 staff member that includes at least the
12:38:25 32 following, which would be where applicable,

12:38:29 verification of the staff member's current
12:38:31 certificate of registration with the College,
12:38:34 which would be the College of Nurses in this
12:38:34 case that we were looking at of the regulated
12:38:38 health profession to which he or she is a
12:38:39 member or verification of that staff member's
12:38:42 current registration with the regulatory body
12:38:44 governing his or her profession.
12:38:46 So the home was required to
12:38:47 maintain a record of that individual's
12:38:49 certificate of competence or some other proof
12:38:53 of that. That's what's required of that.
12:38:56 Q. Okay. Okay. And so what had
12:38:59 you found in the home that led to the finding
12:39:01 of noncompliance in relation to this? Maybe if
12:39:05 you scroll down to the next page too. You can
12:39:06 give us your version of events, if you'd like.
12:39:09 A. So the Coles Notes version
12:39:11 again is basically we had asked for did the
12:39:15 home maintain records of the agency staff in
12:39:21 relation to their certificate of competence.
12:39:25 It was identified as well that
12:39:26 the home had communicated that their agreement
12:39:31 with the agency that provided these staff would
12:39:35 ensure that the staff member was a member of
12:39:37 good standing with the CNO, the College of
12:39:40 Nurses.
12:39:42 They had identified that they
12:39:43 did not verify this. They did not have a
12:39:49 record of it for the two staff identified.
12:39:53 However, when I went on the
12:39:55 website myself to find a nurse, with the

12:39:59 1 exception of 610, the registrants were indeed
12:40:03 2 registrants in good standing with the College.
12:40:09 3 And so it wasn't that they were
12:40:12 4 not registered staff that had come into the
12:40:15 5 home working as a registered staff member. It
12:40:18 6 was that they were registered staff, but the
12:40:20 7 home did not have records of this.
12:40:22 8 Q. Okay. Okay. So let's scroll
12:40:26 9 down to the bottom there. And, again, we'll
12:40:33 10 see -- so the VPC is issued in relation to
12:40:36 11 this?
12:40:37 12 A. Yeah.
12:40:37 13 Q. We'll just one last time
12:40:40 14 toggle back to the Judgment Matrix. If you can
12:40:42 15 explain to us the severity scope compliance.
12:40:48 16 A. So we'll look at a severity
12:40:50 17 of a level 1. Again, I felt it was minimal.
12:40:53 18 These people were indeed registrants of the
12:40:56 19 College at the time that they were working in
12:40:58 20 the home.
12:40:58 21 We looked at three employees.
12:41:00 22 One of them they didn't have anything for. The
12:41:03 23 second example, very much like the example in
12:41:05 24 training, the home had verified current status
12:41:11 25 with the College on August the 22nd, 2016.
12:41:15 26 This was prior to any knowledge
12:41:17 27 of Elizabeth Wettlaufer and at that time
12:41:18 28 maintained documentation to support that the
12:41:22 29 registrant was entitled to practice with no
12:41:26 30 restrictions. So they indeed had the records
12:41:30 31 for that one.
12:41:31 32 So for that reason, we felt it

12:41:34 1 was minimum risk, that they were not un -- that
12:41:37 2 they were indeed registrants. They just didn't
12:41:41 3 have the paperwork.
12:41:43 4 We identified as the scope in
12:41:44 5 that there was two of three -- I'm sorry, two
12:41:46 6 of three registered staff, and there was one or
12:41:49 7 more unrelated noncompliance in the past three
12:41:52 8 years, hence they had noncompliance in some
12:41:56 9 area in the past 36 months.
12:41:58 10 Q. Okay. And so the default
12:41:59 11 action, again, was the Voluntary Plan of
12:42:02 12 Correction?
12:42:02 13 A. It populated as a B, as in
12:42:04 14 Bob, for a VPC. That's correct.
12:42:06 15 Q. Okay. So that essentially --
12:42:10 16 those were all your findings?
12:42:12 17 A. That is.
12:42:13 18 Q. There were no noncompliance
12:42:15 19 orders issued?
12:42:15 20 A. That's correct.
12:42:16 21 Q. There was no follow-up
12:42:17 22 inspection that's required in relation to this?
12:42:18 23 A. In relation to this
12:42:19 24 inspection report, that's correct.
12:42:20 25 Q. Okay. So I'm going to move
12:42:24 26 on, then, to just asking you to reflect a
12:42:27 27 little bit on the inspection process and the
12:42:33 28 system in place.
12:42:34 29 So based on -- you've now got 18
12:42:36 30 years' experience working as an inspector --
12:42:40 31 you've been -- well, as a compliance advisor
12:42:41 32 and then an inspector, and you've been an

12:42:44 1 inspector since this new regime came into
12:42:47 2 effect.
12:42:48 3 Can you tell us if you think
12:42:50 4 there are any mechanisms within the Long-Term
12:42:52 5 Care Homes Act and the current inspection
12:42:54 6 regime that can alert the Ministry to serious
12:42:56 7 issues in long-term care homes?
12:42:58 8 A. I feel that there are
12:43:02 9 mechanisms in place, and I think my colleagues
12:43:05 10 have shared them already. I don't know that I
12:43:07 11 have anything new to add.
12:43:08 12 But looking at, you know, the
12:43:09 13 RQI process, looking at the fact that there's
12:43:13 14 the info line that we take complaints, that
12:43:18 15 there's critical incidents, that there's
12:43:18 16 mandatory reporting, that there's those
12:43:22 17 processes and systems in place is where as well
12:43:23 18 I would feel that there are mechanisms in place
12:43:28 19 to identify concerns.
12:43:30 20 Q. And do you think there's an
12:43:33 21 ability within the current system to detect
12:43:36 22 those health care workers who would
12:43:39 23 intentionally harm residents?
12:43:41 24 A. I wish. Short of seeing the
12:43:48 25 error or short of someone reporting it to me,
12:43:51 26 it would be quite difficult for me to go there.
12:43:54 27 By all means, I have witnessed
12:43:56 28 medication errors while I was in the home.
12:43:58 29 Fortunately, they were not errors of
12:44:00 30 significance. Someone received two Tylenols
12:44:03 31 instead of one or something to that effect.
12:44:09 32 But this -- what you're talking

about isn't the case of someone making a mistake or even an error in judgment. This is someone making a terrible decision, and the desire is a terrible outcome, so yeah.

Q. Okay. So, Lisa, my last question is if you want to just let us know how you've been personally impacted by learning about Elizabeth Wettlaufer's offences.

A. I didn't really want this question. I feel that giving me the opportunity to answer the question isn't fair to those who have lost so much and been impacted so much greater than myself, meaning the victims and their families. However, I am given the opportunity.

It has impacted me personally, physically, socially. It's impacted how I feel I'm perceived by others when I go into a long-term care home, although admittedly, I feel that that has worn off quite a bit now.

I think it has impacted how people look in general at nurses, how people look in general at long-term care homes.

I've never once met anyone who said, "I can't wait to grow old and move into long-term care." And now it's just been made that much worse.

She did these actions to a population that is most vulnerable, and she was in a position of power and chose to abuse that power, and she didn't have a right to do that.

Q. Okay. Thank you, Lisa.

12:46:09 A. Thank you.
12:46:10 MS. STEPHENS: Those are all my
12:46:11 questions.
12:46:21 MR. KLOEZE: Commissioner, I
12:46:27 have no questions in chief.
12:46:30 Thank you.
12:46:30 THE COMMISSIONER: Thank you
12:46:31 very much.
12:46:37 MS. MCALEER: Good morning,
12:46:43 Commissioner.
12:46:44 THE COMMISSIONER: Good morning.
12:46:46 CROSS-EXAMINATION BY MS. MCALEER:
12:46:46 Q. Good morning, Lisa.
12:46:46 A. Good morning.
12:46:46 Q. My name is Jennifer McAleer,
12:46:48 and I'm the counsel for Telfer Place, and
12:46:50 you'll be happy to hear that I will also be
12:46:53 very brief with you this morning.
12:46:55 First of all, I just want to ask
12:46:57 you a couple of questions of clarification.
12:46:59 The Hamilton catchment area, how many long-term
12:47:03 homes are actually in that catchment area?
12:47:05 A. So I'm not sure if you're
12:47:08 aware or not. We've recently added two
12:47:11 additional service area offices to the
12:47:14 province. Previously, we were Haldimand,
12:47:16 Norfolk, Brant, Niagara, Hamilton, and homes in
12:47:16 Mississauga.
12:47:19 We no longer have many of those
12:47:24 Mississauga homes. I'm guessing around 120 or
12:47:27 more than that. I'm sorry. I don't really
12:47:30 know right now.

12:47:31 Q. That's okay. I'm just
12:47:32 looking for a rough number.
12:47:33 So I understand that previously
12:47:34 as a compliance advisor, you would have been
12:47:39 assigned, as you said, to 12 or 15 homes?
12:47:41 A. That's correct.
12:47:42 Q. Do I take it now that under
12:47:45 the current system, you may be called upon to
12:47:48 inspect any one of these 120 plus homes?
12:47:49 A. Any -- that is correct. So
12:47:52 previously, I was assigned a geographical area.
12:47:57 At the time that I started, it was a smaller
12:47:59 area. It was only Haldimand, Norfolk, Brant,
12:48:02 Niagara, and Hamilton. We had five advisors at
12:48:04 that time.
12:48:05 Now -- and although I could
12:48:09 definitely go with a colleague to another home
12:48:11 or if someone was on vacation, go visit their
12:48:13 home. But now I am required to potentially go
12:48:17 to any home.
12:48:18 As well as there's times in the
12:48:20 province where they need additional supports
12:48:23 for whatever reason. Maybe they were
12:48:25 short-staffed or maybe they have a contentious
12:48:30 inspection or something that I may be called
12:48:32 upon to go outside of the Hamilton Service Area
12:48:35 Office.
12:48:35 I've done inspections in the
12:48:36 North; I've done inspections for London; I've
12:48:37 done inspections in Toronto and Newmarket all
12:48:41 while working out of the Hamilton office.
12:48:43 Q. All right. And I also

12:48:45 1 understood from your Affidavit that there are
12:48:48 2 currently approximately 35 inspectors in the
12:48:52 3 Hamilton area. And I got to that number by
12:48:54 4 looking at paragraph 7 --
12:48:56 5 A. I believe it's 18 and 17.
12:48:57 6 Q. -- where there had been 18
12:48:59 7 and then there were 17 additional, so now we're
12:49:01 8 at 35 approximately?
12:49:03 9 A. If your math is correct, I'll
12:49:05 10 agree.
12:49:05 11 Q. Okay. I'm pretty solid on 17
12:49:09 12 plus 18.
12:49:09 13 A. Very good.
12:49:13 14 Q. All right. So you have those
12:49:14 15 35 inspectors who are responsible for 120 plus
12:49:15 16 homes who may also be called upon to go outside
12:49:19 17 of that region and do inspections in other
12:49:20 18 areas as well?
12:49:21 19 A. That's correct.
12:49:21 20 Q. And when you had been a
12:49:23 21 compliance advisor and you were assigned to
12:49:29 22 specific homes, 12 to 15, were you the only
12:49:33 23 person assigned to those 12 to 15, or would
12:49:35 24 there have been a team of you that were
12:49:37 25 assigned to those homes?
12:49:38 26 A. So I should clarify. I'd
12:49:39 27 indicated when I came that there was five
12:49:41 28 compliance advisors. That would be five
12:49:44 29 nursing advisors.
12:49:45 30 We also had an environmental
12:49:47 31 health advisor the whole time I've been in the
12:49:50 32 office and tried to always have a dietary

advisor as well.

Sometimes we had two, and sometimes we had none. Sometimes we had one. It was a position that was, for whatever reason, a little bit more difficult to fill. So I have no idea why I told you that.

Q. That's okay. I'll remind you of my question if that helps.

A. Yeah. I'm so sorry.

Q. The question was you indicated you were specifically assigned to these 12 to 15 homes?

A. That's correct.

Q. Were you the only person, or would there have been other compliance advisors within your office that were also responsible for those --

A. So there were two of us that were assigned to Hamilton, and a lot of times, we worked together to complete annual reviews, not usually complaints, but I was very familiar with her homes as well as she with mine.

So technically, they were my homes, my responsibility, but we would share if one of us had a more difficult caseload because there was more complaints or it was a larger home, and we wanted to get done in a more timely fashion, things like that.

So technically, I was responsible for that group of homes, but definitely the two of us worked together.

Q. All right. And, again, I

12:51:03 1 understand you were a compliance advisor for
12:51:05 2 ten years, and you've been an inspector now for
12:51:09 3 eight?
12:51:09 4 A. That is correct.
12:51:09 5 Q. And you talked a little bit
12:51:11 6 about the types of questions and the types
12:51:14 7 of -- the kinds of advice you provided when you
12:51:16 8 were a compliance advisor, that ten years as a
12:51:21 9 compliance advisor.
12:51:21 10 And would it be fair to say that
12:51:23 11 when you went into a particular home, that the
12:51:25 12 staff of the home felt comfortable raising
12:51:29 13 these issues with you or questions with you and
12:51:33 14 were looking for some guidance from you?
12:51:35 15 A. Yes. I feel, though, that
12:51:36 16 staff in the home today also feel comfortable
12:51:40 17 talking to me and sharing information with me.
12:51:44 18 Q. All right. Well, let me ask
12:51:47 19 you a little bit about that, because there's a
12:51:49 20 difference between sharing information with you
12:51:52 21 and then getting information --
12:51:52 22 A. Correct.
12:51:53 23 Q. -- from you.
12:51:54 24 So as I understood it and as I
12:51:57 25 understood it from listening to some of the
12:51:59 26 prior witnesses, that as a compliance advisor,
12:52:02 27 you had more freedom to provide guidance or
12:52:09 28 advice to the homes, and that as an inspector,
12:52:11 29 you don't really have as much freedom anymore
12:52:13 30 to do that?
12:52:15 31 A. I had a great deal of
12:52:18 32 autonomy previously. That's correct.

12:52:19 Q. And not as much now; is that
12:52:21 correct?
12:52:21 A. That's no longer my role.
12:52:21 That's correct.
12:52:21 Q. All right. And when you did
12:52:25 play that role, did you feel comfortable giving
12:52:27 that advice when asked?
12:52:31 A. I was much younger then,
12:52:32 maybe more naive as well. So, yeah, sure, I
12:52:36 felt comfortable. To be honest, though, I
12:52:42 don't know that it was always the best advice
12:52:43 that I had given.
12:52:45 Sometimes I was very wise and
12:52:48 would say, "I'm sorry. I really don't know, or
12:52:49 maybe you need to go talk to" -- I can think of
12:52:50 an example of dietary where I -- they had asked
12:52:53 me a question, something so simple as about
12:52:54 hydration. I said, "Oh, I really don't know."
12:52:56 So I referred them to our dietary staff.
12:53:00 But there definitely could have
12:53:02 been occasions where I might have -- did not
12:53:03 extend best practice advice, not on purpose for
12:53:08 sure.
12:53:08 Q. All right. And did you feel
12:53:10 at any point in time that hearing those
12:53:13 questions and providing that advice or handing
12:53:15 out the best policies in that folder you had
12:53:18 collected over the years, did that in any way
12:53:21 compromise your ability to determine whether or
12:53:24 not a home had, in fact, failed to meet the
12:53:27 standards and criteria of the program manual as
12:53:29 it then was?

12:53:30 A. Personally, that's -- no, I
12:53:33 don't feel it did.
12:53:34 Q. You also indicate in your
12:53:37 Affidavit at paragraphs 23 and 24 that you
12:53:39 still get questions --
12:53:41 A. I do.
12:53:42 Q. -- and I quote: [AS READ]
12:53:43 " -- whether certain things are
12:53:44 required by the act or the
12:53:45 regulation."
12:53:48 So I just want to ask you a little bit more
12:53:50 about that. So are people asking you what does
12:53:53 the act or regulation say, or are they asking
12:53:58 you to help them interpret what the act or
12:54:01 regulation says?
12:54:02 A. When I wrote that statement
12:54:06 in the Affidavit, I was thinking very
12:54:08 specifically that it's not at all uncommon for
12:54:12 PSW staff to approach us with, "Do we have to
12:54:14 do this? Is this a Ministry requirement? This
12:54:17 is how it was told to us, that we have to do
12:54:19 this because the Ministry says so."
12:54:22 And that's not an uncommon
12:54:24 question that we are asked by staff in the home
12:54:27 by unregulated, frequently PSW staff. And
12:54:32 that's why I'd indicated I will refer them to
12:54:35 the legislation.
12:54:37 I'll say, "You know what, I'll
12:54:38 be back up in 20 minutes, and I'll bring the
12:54:41 book, and we'll show you."
12:54:42 But I definitely identify as
12:54:43 well that they're required to follow the

12:54:46 1 policies and procedures in the home whether
12:54:48 2 they exceed our standards or -- or our
12:54:52 3 regulations or not. See, now standards are in
12:54:54 4 my head.
12:54:55 5 And they're also required to --
12:54:57 6 I'm definitely not their supervisor. They're
12:55:00 7 required to listen to their managers.
12:55:02 8 Q. All right. So I think I
12:55:02 9 understand that. So when a PSW asks you, "My
12:55:05 10 director says I have to do this; do I really
12:55:08 11 have to do this," you don't want to get in
12:55:11 12 between the PSW and their supervisor?
12:55:12 13 A. Definitely not.
12:55:13 14 Q. So the most you will do is
12:55:15 15 pull out a copy of the act, show them the
12:55:17 16 provision in the act, and then direct them back
12:55:20 17 to their supervisor if they have any questions;
12:55:20 18 is that fair?
12:55:24 19 A. That is very fair in that
12:55:26 20 regard.
12:55:26 21 Q. All right. What about
12:55:28 22 questions, though, from Directors of Care or
12:55:28 23 Assistant Directors of Care or registered staff
12:55:30 24 with respect to, "What does the act mean? I
12:55:34 25 have this particular provision. I'm not sure
12:55:37 26 what it means." Do you still get those kinds
12:55:39 27 of questions?
12:55:39 28 A. What does it mean? Can you
12:55:45 29 give me an example?
12:55:46 30 Q. Well, let's -- we talked a
12:55:50 31 little bit about the 24/7 requirement and the
12:55:52 32 fact that that particular section of the act

12:55:54 provides that it's only -- but for emergency
12:55:58 situations, that you're supposed to have a
12:56:01 nurse there 24/7 who's a nurse who's on your
12:56:06 permanent staff.
12:56:06 Do you recall if anyone ever
12:56:08 asked you, "Well, what constitutes an emergency
12:56:10 situation?" Did you have any discussions with
12:56:13 anyone --
12:56:14 A. I believe I had. Yeah, I
12:56:15 don't believe -- I recall I have with staff
12:56:17 from your organization.
12:56:19 Q. From Telfer Place?
12:56:20 A. Yes.
12:56:24 Q. Okay.
12:56:25 A. I'm just looking into the act
12:56:28 for Section 45, if that's okay.
12:56:33 THE COMMISSIONER: Yes.
12:56:34 THE WITNESS: Okay. I'm sorry.
12:56:36 I just...
12:56:37 Except this one is different
12:56:47 than my book.
12:56:53 MR. KLOEZE: Lisa, if you look
12:56:54 at the reg.
12:56:55 THE WITNESS: Mine is separate.
12:56:57 I have the reg first, and then
12:56:58 the act, and it is -- yes, this
12:57:01 one is a little bit different.
12:57:02 So it goes on -- Section
12:57:07 45(2) identifies in this section
12:57:10 emergency means an unforeseen
12:57:12 situation of a serious nature
12:57:13 that prevents a Registered Nurse

12:57:14 from getting to the long-term
12:57:18 care home.
12:57:18 So when we have identified
12:57:19 this noncompliance, there was
12:57:22 question about what was an
12:57:25 emergency unforeseen situation
12:57:27 that prevents the Registered
12:57:30 Nurse form getting to the home.
12:57:31 And we did identify that
12:57:32 those types of situations would
12:57:33 have to be an unforeseen, an
12:57:35 emergency, and serious.
12:57:37 So we said, so if someone
12:57:41 calls in sick with I've just
12:57:44 fallen, and I've broken my leg,
12:57:45 and I have surgery scheduled for
12:57:48 today, I'm supposed to be there
12:57:50 at 3 o'clock and it's 2:30, that
12:57:55 would meet the burden of an
12:57:55 emergency and unforeseen.
12:57:56 However, that individual now
12:57:57 can't come to work tomorrow, and
12:57:59 you know that now when she makes
12:58:01 her original phone call, that
12:58:03 would no longer be an unforeseen
12:58:06 situation.
12:58:07 So we spoke about should
12:58:09 there be a snowstorm, another
12:58:11 example that Karen Simpson gave,
12:58:13 and the roads were closed. The
12:58:15 ice storm that recently had had.
12:58:17 So we talked about that those

12:58:19 1 indeed could be considered an
12:58:23 2 emergency situation.
12:58:24 3 BY MS. MCALEER:
12:58:24 4 Q. All right. And those were
12:58:26 5 discussions that you had with individuals at
12:58:29 6 Telfer Place when you were carrying out the
12:58:31 7 inspection that was just reviewed with you in
12:58:33 8 detail?
12:58:33 9 A. That is correct. And when
12:58:34 10 you say "individuals," I will say it was with
12:58:37 11 the Executive Director that was there at the
12:58:40 12 time, Jim Eagleton.
12:58:41 13 Q. So that's the type of
12:58:43 14 discussion or the type of question to which I
12:58:45 15 was referring to earlier when I asked you
12:58:47 16 whether or not nurses or Directors of Care or
12:58:51 17 Executive Directors, if they ask you for
12:58:53 18 assistance in interpreting the legislation. Do
12:58:55 19 you still get those kinds of questions?
12:58:57 20 A. Obviously I did, and I
12:58:58 21 provided some information about that. And I
12:59:02 22 needed to provide that information to help him
12:59:05 23 make decisions about the vacant shifts that
12:59:11 24 they had and why they needed to fill them.
12:59:14 25 So if he didn't have that
12:59:17 26 information -- by all means, the exception
12:59:20 27 would be if there was a two-week period of time
12:59:24 28 because someone was on vacation, obviously he
12:59:27 29 can figure out that wasn't an emergency
12:59:30 30 situation, but if there was sort of one-offs in
12:59:31 31 there, it would be difficult to tell without
12:59:33 32 knowing the definition of the emergency.

12:59:35 Q. And more generally speaking, not just with respect to the Telfer inspection but more generally speaking, are people at any of the 120 plus homes that you inspect, are the registered staff or the Directors of Care asking you for assistance with interpretation of the legislation? Does that happen frequently? Infrequently? Not at all?

12:59:59 A. I'm going to say with registered staff, very infrequently. I don't know -- I don't recall a recent occasion. With Directors of Nursing, maybe a little more frequently, but frequently what I would do then or on those occasions is pull out the legislation and read it with them, comparing it to their own policies or protocols or form or whatever they've got and having them walk through it as we read together.

13:00:33 MS. MCALEER: All right. Those are all my questions. Thank you very much.

13:00:36 THE WITNESS: Thank you.

13:00:36 THE COMMISSIONER: Thank you, Ms. McAleer.

13:00:37 CROSS-EXAMINATION BY MS. FRASER:

13:01:12 Q. Ms. Vink, my name is Suzan Fraser. I'm here on behalf of OARC. I think you've been following the proceedings in the room for most of the week; is that fair?

13:01:22 A. I've been here for the last two days, yes.

13:01:26 Q. Okay. Thank you. I just

13:01:28 1 want to start with the issue about registration
13:01:33 2 and find a nurse and the process of checking
13:01:35 3 that.
13:01:36 4 In the course of any of your
13:01:37 5 inspections, not just at Telfer Place but in
13:01:41 6 the course of your duties as an inspector, have
13:01:43 7 you ever come across situations where somebody
13:01:46 8 isn't properly registered and is working as a
13:01:48 9 Registered Nurse or a Registered Practical
13:01:52 10 Nurse?
13:01:52 11 A. Unfortunately, yes.
13:01:53 12 Q. So there are circumstances
13:01:55 13 where somebody has been working without proper
13:01:58 14 qualifications?
13:01:59 15 A. I know of one Registered
13:02:03 16 Practical Nurse -- I'm sorry. One person who
13:02:04 17 was working as a Registered Practical Nurse
13:02:08 18 that was not registered with the College.
13:02:09 19 And I know of one RN who was a
13:02:14 20 foreign-trained nurse, had submitted paperwork
13:02:17 21 to the College, but due to some issues, did not
13:02:23 22 have all of the correct information in place,
13:02:25 23 and was working without a registration as well.
13:02:27 24 Q. Okay. And were those issues
13:02:29 25 that were uncovered through the inspection
13:02:30 26 process?
13:02:31 27 A. No.
13:02:33 28 Q. No.
13:02:34 29 A. One of them was identified
13:02:36 30 by the media and brought to our attention by
13:02:39 31 the home post media becoming aware of it. And
13:02:43 32 the second was identified by the home during a

13:02:46 quality check that they were doing.
13:02:47 Q. Okay. Thank you. I want to
13:02:52 speak a little bit about agency staff. I
13:02:54 understand from reading the act, that Section
13:02:59 74 limits the use of agency staff; is that
13:03:03 right?
13:03:03 A. I'm going to check for you --
13:03:05 Q. Sure.
13:03:06 A. -- if that's all right.
13:03:14 Section 74?
13:03:15 Q. Yes.
13:03:16 A. It does say limited. I've
13:03:19 always looked at this as ensuring consistency
13:03:23 of staff, but it indeed does say: [AS READ]
13:03:25 "Casual and agency staff is
13:03:29 limited in accordance with the
13:03:29 regulations."
13:03:30 Q. Okay. Thank you for that. I
13:03:30 guess I could have read that to you, so thank
13:03:31 you for looking it up for me --
13:03:31 A. No, that's --
13:03:32 Q. -- and doing my work.
13:03:33 But you've understood that as
13:03:36 that's being important. If we limit the use of
13:03:38 agency staff, that has a corollary effect of
13:03:40 ensuring continuity of care for the residents;
13:03:40 is that fair?
13:03:43 A. I feel that staff that know
13:03:46 the residents well not always, but are
13:03:52 frequently -- I feel that there's value in
13:03:57 staff knowing the residents, their care needs,
13:04:05 the residents knowing the staff, that there's a

13:04:07 1 different rapport that's being built.
13:04:10 2 If this is the same person that
13:04:11 3 you see every morning or five days a week
13:04:11 4 providing care to you, that there's a different
13:04:14 5 relationship there than when someone comes in
13:04:17 6 intermittently, and you don't know their name,
13:04:19 7 yes.
13:04:19 8 Q. Okay. Thank you. And with
13:04:21 9 respect to conducting investigations that
13:04:25 10 relate to agency staff, you could use your
13:04:30 11 inspection powers, could you not, to compel
13:04:34 12 documents from agency staff in the course of an
13:04:38 13 inspection or from the agency itself? We can
13:04:41 14 turn to Section 147, if you like.
13:04:44 15 A. I will first comment. You
13:04:46 16 identified when I'm doing investigations, and
13:04:48 17 I've never done an investigation.
13:04:50 18 Q. I meant to say inspections.
13:04:52 19 A. Okay. There's a
13:04:54 20 differentiation there, so I just wanted to
13:04:56 21 clarify that. I'm so sorry. I don't know
13:05:01 22 remember what leg. ref. you provided me, or
13:05:01 23 legislative reference.
13:05:02 24 Q. So section 147.
13:05:02 25 A. Thank you.
13:05:03 26 Q. Mr. Golden took us to that.
13:05:05 27 A. Yes.
13:05:05 28 Q. Although it wasn't teed up in
13:05:11 29 my document list, Laura, it would be at, I
13:05:11 30 believe, page --
13:05:11 31 MS. STEPHENS: She's already got
13:05:11 32 it.

13:05:11 MS. FRASER: Wow. Can I just
13:05:12 say wow. Thank you very much,
13:05:17 Laura.
13:05:18 THE WITNESS: I am so sorry.
13:05:21 Meagan is already aware I'm not
13:05:23 the best with numbers. Did you
13:05:24 say 147 or 174?
13:05:27 BY MS. FRASER:
13:05:27 Q. 147.
13:05:28 A. Thank you.
13:05:28 Q. I have the exact same problem
13:05:28 in terms of --
13:05:29 A. I'm delighted to hear I'm not
13:05:31 the only one because it's a little bit
13:05:34 embarrassing.
13:05:34 Q. Not everything can play to
13:05:37 our strengths.
13:05:38 Have you got 147?
13:05:39 A. I do. Thank you very much
13:05:40 for your assistance.
13:05:41 Q. So the powers that you have
13:05:45 on an inspection are quite broad, and you
13:05:54 may -- under part D: [AS READ]
13:05:57 "May question a person subject
13:05:58 to the person's right to have
13:06:00 counsel during the questioning."
13:06:03 And my question for you -- [AS READ]:
13:06:08 "You may inspect a copy or a
13:06:10 record under B. You may demand
13:06:12 the production of records or
13:06:15 other things. You may --"
13:06:19 Under part 2, just going down, so subsection 2:

13:06:25 [AS READ]
13:06:25 "You may make a written demand."
13:06:29 And I understand under Section 148, which is
13:06:34 the section below, you have -- you may apply
13:06:40 for a warrant.
13:06:40 So I guess my question is have you
13:06:44 ever used these powers against an agency?
13:06:48 A. Against an employment agency?
13:06:51 Q. Yes.
13:06:51 A. I have not.
13:06:52 Q. Okay. You have not?
13:06:53 A. I have definitely sought --
13:06:57 I've used a written demand letter to get
13:07:00 information from a long-term care home. One
13:07:00 had a video of something that they weren't
13:07:03 willing to share, and we were able to get the
13:07:05 video of...
13:07:09 I've been aware of situations
13:07:11 where we've received records from the hospital
13:07:13 and from the LHIN as well in a similar sort of
13:07:16 situation. In relation to --
13:07:17 Q. I'm going to stop you there.
13:07:17 A. Yeah.
13:07:19 Q. So you haven't interpreted
13:07:20 these powers as being capable of being used
13:07:23 against agencies other -- sorry, organizations
13:07:26 other than the long-term care home; right?
13:07:32 A. I have in that I've gotten
13:07:35 records from the hospital as well as from the
13:07:38 LHIN, so CCAC, initial MDS assessments, and
13:07:38 things like that.
13:07:40 Q. Okay. Thank you very much.

13:07:46 If I could turn you to page --
13:07:48 or, sorry, paragraph 79 of your Affidavit. I
13:08:10 understand that in the course of your
13:08:13 investigation, that you interviewed -- and this
13:08:16 is spelled out in paragraph 79 of your
13:08:20 Affidavit. You interviewed a Dr. Williams?
13:08:23 A. I did.
13:08:24 Q. And Dr. Williams told you
13:08:26 that he did not recall Elizabeth Wettlaufer,
13:08:28 but he observed a nurse one night swearing and
13:08:32 being verbally abusive to some residents, but
13:08:35 he did not know the nurse. He did not give you
13:08:38 specific examples about to who or what was
13:08:43 said. He did not witness any physical abuse.
13:08:46 And you write in your Affidavit:
13:08:46 [AS READ]
13:08:48 "I was shocked by this new
13:08:51 allegation which I considered to
13:08:53 be an allegation of abuse."
13:08:54 A. That is correct.
13:08:54 Q. Okay. And I understand that
13:08:58 you took further steps to explore this with
13:09:03 both Ms. Cornelissen and Mr. Eagleton so that
13:09:07 they could investigate.
13:09:09 But you go on at paragraph 80 of
13:09:12 your Affidavit to say that: [AS READ]
13:09:17 "In order to make a finding
13:09:20 against the home, the home did
13:09:22 not report Dr. Williams'
13:09:25 allegation of abuse to the
13:09:26 Ministry of Health and long-term
13:09:27 care home, that you would have

13:09:29 1 needed more information such as
13:09:32 2 what was the alleged abuse, who
13:09:35 3 the resident was, when it
13:09:36 4 occurred, and who the nurse
13:09:40 5 was."
13:09:41 6 And just going from there, you did not make
13:09:43 7 such a finding against the home?
13:09:45 8 A. That's correct.
13:09:45 9 Q. And so my question for you
13:09:49 10 really is why? When you have the admission
13:09:53 11 from the physician who witnesses something that
13:09:55 12 constitutes abuse and did not report that
13:09:59 13 abuse, why would you need anything else at that
13:10:02 14 point in time?
13:10:02 15 A. This was a very difficult
13:10:08 16 piece of the inspection. We had started with
13:10:11 17 an email that Michelle Cornelissen had sent to
13:10:17 18 Heidi Wilmot-Smith indicating that there
13:10:30 19 were -- I'm just looking for the verbiage that
13:10:35 20 was used about EW's -- no, no, I take that
13:10:39 21 back.
13:10:40 22 That failure too adequately
13:10:41 23 assess or check a resident -- oh, no, that's
13:10:44 24 not it either.
13:10:45 25 Q. Tab H of your Affidavit.
13:10:47 26 A. Oh, thank you.
13:10:48 27 Q. The document number is 41461.
13:11:02 28 A. Can I start reading or --
13:11:04 29 Q. Let's just wait until it's up
13:11:06 30 on the screen so everybody can have it. Okay.
13:11:11 31 So go ahead.
13:11:12 32 A. Scroll down. The very

last -- yeah, the bullet point number 2 there. So this an email from Michelle Cornelissen April the 20th of 2016, addressed to Heidi. [AS READ]:

"Further, the physician was in today and brought up concerns related to Bethe as well and did not feel confident in her abilities to assess our residents and carrying out basic nursing duties.

The physician also mentioned that he felt she lacked accountability as a nurse to the residents of the home."

So Michelle Cornelissen was in the home for approximately two weeks when she received this information. I had spoke with --

Q. Her job for two weeks?

A. So in the home. She was a new employee to the home, so wasn't familiar with the residents, even the building, things like that.

So when we interviewed her in -- I believe it was November, we asked her, "Who was the physician? What exactly did he say? What made you say that he did not feel comfortable in her abilities to assess the residents, carry out basic nursing?"

Basically what was said was the gist of our question and who said it. She said, "Honestly, I don't remember."

13:12:30 And in all fairness, being in a
13:12:33 brand new home at that time, I understood that.
13:12:36 But she said, "It's definitely one of two
13:12:37 physicians." And she identified Dr. Williams
13:12:39 as being one of the two.
13:12:43 So we went to the physicians to
13:12:47 speak with them about what they had potentially
13:12:51 reported.
13:12:52 Q. Yes.
13:12:53 A. We spoke with the first
13:12:54 physician, Dr. McDonald, and he had indicated
13:13:00 that although he had voiced some concerns about
13:13:03 something, it was not at all about one person
13:13:06 in particular, hence we thought that it was not
13:13:08 him that had made this concern.
13:13:13 I spoke with the second
13:13:15 physician, Dr. Williams, who had indicated what
13:13:21 I have here. Basically, no, they weren't
13:13:25 concerns about her assessment or carrying out
13:13:28 basic nursing duties or her -- that there was
13:13:32 an allegation -- that I had witnessed her
13:13:35 talking roughly to a resident or -- and I'm so
13:13:41 sorry. I don't have the exact words in front
13:13:44 of me now, but something that made me think it
13:13:47 was abuse.
13:13:48 So that was not what I was
13:13:50 expecting to hear at all. I was expecting to
13:13:52 hear that maybe she wasn't good at assessing
13:13:57 when a resident had congestive heart failure or
13:14:00 something to that degree. I was not
13:14:03 anticipating this information at all.
13:14:05 He couldn't give me any

specifics as to who the resident was, what was said. He knew he had come in later in an evening, and that's when it had happened. He couldn't -- he couldn't recall that information.

But he went on to say that he was aware that the police had had an email where there was another concern about her, about her, the nurse, as well, that he didn't know it was that nurse until sort of he put two and two together after sort of everything had come to light. And I'm paraphrasing here, and I apologize for that.

Q. Right, but he was -- he did not -- even though he didn't know the identity, and he was sort of speculating by putting the two and two together, he was certain of what he witnessed in terms of witnessing this verbal abuse towards a resident?

A. I don't know who the resident was. I don't know the date. I don't know what was said. I don't know if it's then verbal abuse or emotional abuse. I -- there were so many things I didn't know.

So at that time, I called Michelle Cornelissen back, as you mentioned, and I said, "Michelle, this is what I've now heard."

And she said, "No, no, no, no, no, no, no, that's not what was told to me at all. Although I don't remember exactly what was shared with me, it wasn't that."

13:15:34 Q. But she could have been
13:15:36 speaking about Dr. McDonald because we've heard
13:15:36 from Dr. McDonald here that he had concerns
13:15:36 about her when he was talking to Elizabeth
13:15:36 Wettlaufer, and she had sort of I think -- I'm
13:15:46 paraphrasing, but a blank look on her face like
13:15:47 as if she didn't know what she was doing.
13:15:51 But what concerns me is that
13:15:54 your statement essentially is that you have to
13:15:57 look for other evidence to support this when on
13:16:00 the face of it, there's abuse, and that's
13:16:03 the -- let me just finish. And that's the
13:16:09 uncontroverted part.
13:16:10 A. I apologize for jumping in.
13:16:13 Q. No trouble.
13:16:14 A. I think that in order for me
13:16:14 to leave a finding of noncompliance, I need to
13:16:15 inspect it. I need to be able to inspect the
13:16:28 issue that is given to me to be able to
13:16:28 identify it as noncompliant.
13:16:28 And for me to have one person at
13:16:29 some time did something -- in order for me to
13:16:37 potentially inspect this, I spoke with the
13:16:38 current Executive Director in the home at the
13:16:40 time, and he was aware of the email, although
13:16:42 was not the recipient of it, the Michelle
13:16:48 Cornelissen email. And I shared with him what
13:16:50 was shared with me by Dr. Williams.
13:16:51 And I asked him to please follow
13:16:52 up with the physician. He made efforts to do
13:16:57 that, and unfortunately, the physician at this
13:17:00 time, which was, of course, after my discussion

13:17:03 with him -- so even a little bit later after
13:17:05 the fact -- could not provide any specifics as
13:17:08 well. So I had nothing to inspect, no specific
13:17:14 information to inspect upon.
13:17:17 If I could also add -- and I've
13:17:19 acknowledged here that I do have a couple of
13:17:21 issues with numbers in my life. There was a
13:17:23 typo in my error of my note with Dr. Williams.
13:17:28 I had identified it was a
13:17:29 discussion in relation to an incident in 2015.
13:17:33 That should have said 2016.
13:17:36 Q. Okay. All right. I don't
13:17:43 know if we're going to get any further ahead on
13:17:45 my question because I would think that the
13:17:48 issue is really about the reporting, where
13:17:54 somebody feels that the -- sorry, I'll word it
13:18:00 again.
13:18:00 Is that in terms of time or
13:18:02 place, that may not matter. The issue here was
13:18:04 you have a member of the professional staff who
13:18:08 witnesses what you consider to be abuse, which
13:18:12 he calls verbally abusive, and they don't
13:18:14 report, and all of that seems uncontroverted,
13:18:19 and you can't make a finding about it.
13:18:22 You'd agree that that's sort of
13:18:23 where we're at with what you've told us?
13:18:26 A. I will say the decision I
13:18:28 made at that time was that I could not inspect
13:18:30 it further or I could not inspect it. And you
13:18:33 are correct. I did not make a finding of
13:18:36 noncompliance in that regard.
13:18:37 Q. Okay. So if we could --

13:18:44 A. And I apologize that I
13:18:45 paraphrased what was said to me, but that's to
13:18:48 the best of my recall.
13:18:48 Q. That's okay. I'd like to
13:18:50 take you to Exhibit I of your Affidavit,
13:18:52 Document 41407, please.
13:19:00 A. Yes.
13:19:01 Q. We're going to go to page 30
13:19:02 of that document which I understand detail your
13:19:07 notes of your conversation with the family?
13:19:15 A. Yes. I'm there.
13:19:17 Q. And does this -- the notes
13:19:23 that are found here in your Ad Hoc Notes, do
13:19:27 they represent a summary of the trans -- your
13:19:29 notes of the call that you had with the family?
13:19:31 A. So we, myself as the speaker
13:19:37 and Lesley Edwards as the scribe, made this
13:19:41 phone call in a secured area in the Hamilton
13:19:44 Service Area Office where we have privacy.
13:19:46 The phone call was made on the
13:19:47 phone. The family were aware that there was
13:19:50 two of us on the call. Lesley took notes as I
13:19:54 spoke with the family. And this is a type of
13:19:56 our written notes.
13:19:58 Q. Okay. And you made them at
13:19:59 the time?
13:19:59 A. Lesley recorded them as I
13:20:01 spoke.
13:20:02 Q. Okay. And did you get a
13:20:04 chance to look at them afterwards to see if
13:20:06 they reflected what happened in the call?
13:20:08 A. I have no reason to believe

13:20:10 they did not reflect what happened in the call.
13:20:13 Q. Okay. And there --
13:20:16 A. They're my -- they're my
13:20:19 Ad Hoc Notes, so I indeed wrote them. If I
13:20:22 would have had -- although Lesley handwrote
13:20:25 them, I typed them. If I would have had
13:20:27 concerns, I would have brought them to her
13:20:27 attention.
13:20:30 So, yes, it would have been
13:20:32 accurate and true to my recall at the time that
13:20:33 I typed them out, which would have been quite
13:20:35 shortly after our call.
13:20:36 Q. Okay. So I'm wondering if
13:20:37 you can just tell us -- I'm interested in terms
13:20:43 of the part starting with -- so the family
13:20:52 talks about the hospital transfer that I'm not
13:20:55 going to take you to.
13:20:56 They talk about how they
13:20:59 historically had no care concerns, and they're
13:21:01 realistic, and they make some comments about
13:21:04 the home, that the home was never dirty. Her
13:21:08 briefs are changed. Her room is clean. No
13:21:11 orders in the home. The care and the empathy
13:21:14 of the staff is excellent. So they were
13:21:17 content with the care?
13:21:18 A. They were.
13:21:19 Q. But they did identify that he
13:21:23 knows now that the nurse still worked at the
13:21:25 home after this. And he did note that at
13:21:27 times -- what he meant by "after this," you
13:21:32 understood that to be after the incident?
13:21:34 A. Correct, so after the

incident of low blood sugars.

Q. Yes.

A. Yes.

Q. As a consequence of Ms. Wettlaufer's --

A. Yes.

Q. -- injection of medication.

So after -- I'm just trying to find my place. After this -- and he did note that: [AS READ]

"At times, his mom, Sandy, was agitated when he would come to visit and wonders. He did identify that his mom's condition had changed drastically over the years and that she no longer demonstrated agitation."

And I just wanted to confirm with you that what I understood is that following this incident, when Ms. Wettlaufer was still working in the home, he was looking back, thought the times when his mother was agitated related to her being in the home.

A. My recall of the conversation is that he was aware -- this was a difficult phone call in that the home -- I'm so sorry. The family were not aware exactly what had happened to mom, and we reached out to them to talk to them. And they wanted answers for us, and I, of course, couldn't give them.

Q. Right.

13:22:52 A. So there was a little bit of
13:22:57 circling because I couldn't -- and they were
13:23:02 lovely, gracious people who only want what's
13:23:07 best for mom, of course.
13:23:09 So he -- they had reflected.
13:23:12 They now knew that something untoward had
13:23:15 happened to mom. And then they said, "Oh, but
13:23:17 we also know that this individual continued to
13:23:19 work with mom. And sometimes when we would
13:23:25 visit mom, she was agitated, but we didn't know
13:23:29 why. And maybe, maybe did something else
13:23:31 happen to her? We don't know now. We're, of
13:23:34 course, speculating, but, again, she's our mom,
13:23:36 and we only want what's best for her." At
13:23:41 least that's how I understood the conversation.
13:23:42 Q. Thank you. I also understand
13:23:43 in the course of your interviews with
13:23:46 Ms. Cornelissen, that you had an opportunity to
13:23:48 address inappropriate comments that were made
13:23:51 by Ms. Wettlaufer?
13:23:53 A. Inappropriate comments to
13:23:56 whom?
13:23:56 Q. Towards staff.
13:23:59 MS. FRASER: And, Madam
13:24:00 Commissioner, they're not nice,
13:24:01 and they're rude, but I think
13:24:03 it's important for you to know
13:24:05 them, and I think it's important
13:24:06 to know because they're going to
13:24:08 relate to what the obligations
13:24:09 are when somebody is making
13:24:11 inappropriate remarks to staff.

13:24:13 Okay?
13:24:13 THE COMMISSIONER: I'm
13:24:17 listening.
13:24:17 BY MS. FRASER:
13:24:17 Q. So if you could go to Tab J,
13:24:19 which is Document 41409. And I am going to
13:24:31 take you to -- so it's page 35. Actually, if
13:24:38 we could start at the bottom of page 34,
13:24:42 please, Laura.
13:24:49 A. I'm so sorry. You said
13:24:52 Tab J? There's no -- it stops at 27.
13:24:56 I believe you probably mean my Ad Hoc Notes.
13:24:58 Q. Yes.
13:24:59 A. Which would then be Tab I.
13:25:02 Q. Yes. Thank you.
13:25:14 MS. STEPHENS: Laura, that's
13:25:15 41407.
13:25:16 MS. FRASER: Thank you. See, I
13:25:19 told you, I also have trouble
13:25:23 with numbers.
13:25:26 BY MS. FRASER:
13:25:28 Q. Okay. So we're going to go
13:25:29 to the bottom of page 34. So you're talking to
13:25:32 the Director of Care. And you're -- at
13:25:38 question 10, you ask her: [AS READ]
13:25:40 "Do you recall if the agency
13:25:41 staff nurse EW ever worked at
13:25:45 the long-term care home, LTCH,
13:25:46 and did you have any concerns
13:25:48 related to her practice?"
13:25:50 And then she starts off with some concerns --
13:25:52 or some introductory comments. And then you

13:25:55 1 put in capital letters: [AS READ]
13:25:57 2 "She was then given her email to
13:25:59 3 review."
13:25:59 4 You're nodding your head yes?
13:26:03 5 A. Yes.
13:26:03 6 Q. Okay. And that's the email
13:26:03 7 we just looked at?
13:26:04 8 A. Yes. Can I just add one
13:26:06 9 comment, though? So Michelle Cornelissen
13:26:08 10 was -- you'd indicated she was the DOC. She
13:26:08 11 was no longer the DOC at the home at this time.
13:26:11 12 She had now moved to another home and was DOC
13:26:15 13 there, and we went to her other home to
13:26:17 14 interview her. So she was the former DOC at
13:26:21 15 the home at the time.
13:26:22 16 Q. But you're talking to
13:26:23 17 Michelle in this interview?
13:26:25 18 A. Correct.
13:26:25 19 Q. Okay. So then she heard from
13:26:28 20 staff rumours, and I just want to identify what
13:26:31 21 the rumours were. Lynn Jackson, PSW, she
13:26:38 22 thinks there may have been otherwise in the
13:26:39 23 union rep regarding on nights. And then it
13:26:41 24 says in brackets: [AS READ]
13:26:42 25 "EW worked mostly nights at the
13:26:45 26 home, and the union rep worked
13:26:47 27 evenings. Most off-the-cuff
13:26:48 28 statements and comments. She,
13:26:51 29 the RN" --
13:26:52 30 And that means Ms. Wettlaufer?
13:26:53 31 A. Yes.
13:26:53 32 Q. [AS READ]:

"-- made statements about requesting sperm from male staff and from Lynn putting Tic Tacs in her vagina when med went down on her so that she was fresh when they went down on her."

A. I have to apologize. There's another typo error. That should say "men went down on her" and not "med."

Q. I see. [AS READ]:

"There were signs posted in the staff bathroom."

And then it goes on to describe concerns that they had finding feces all over and on the stall walls, and staff were thinking that it was from RN EW, although the ADOC identified there was no proof. Just staff saying that.

So whether or not that's true or not, my concern is is that -- my question for you is is there something in your inspection protocol where there's what I would call inappropriate behaviour identified with a professional staff towards another staff, does that get triggered anywhere in your inspection protocols?

A. It does not. Our regulations are related to the safeguards of residents in long-term care homes and not in relation to staff-to-staff interactions that are outside of a resident.

Q. Right. Just so you know -- this isn't the -- and I'm going to set up the

13:28:24 1 question. Isn't the first time we've heard of
13:28:26 2 her -- at Caressant Care, there was an
13:28:28 3 allegation that she was hitting on the students
13:28:31 4 who worked in the home.
13:28:32 5 And so I'm just wondering
13:28:34 6 whether you think it would be a good idea for
13:28:38 7 an inspection to draw out issues relating to a
13:28:44 8 professional staff of harassing behaviour
13:28:47 9 towards another as part of your evaluation of
13:28:50 10 the care that's being provided.
13:28:53 11 I guess my thinking is is that
13:28:54 12 if somebody is making these comments towards a
13:28:58 13 professional staff, what might they be doing
13:29:03 14 towards a resident who might not be able to
13:29:06 15 speak up.
13:29:06 16 So just with that sort of
13:29:07 17 backdrop, do you think it's a good idea for the
13:29:10 18 inspection protocol to kind of draw out this
13:29:11 19 kind of conduct?
13:29:14 20 A. In my opinion, most long-term
13:29:19 21 care homes have other avenues to deal with
13:29:22 22 staff issues, whether it be a unionized
13:29:31 23 environment or even non-unionized environment
13:29:35 24 have other mechanisms of dealing with employee
13:29:40 25 issues.
13:29:46 26 I've always looked at my role as
13:29:48 27 one of advocating for the resident. I'm not
13:29:52 28 saying that indeed if you would conduct
13:29:57 29 yourself this way with a staff member that you
13:30:00 30 would be totally different with a resident.
13:30:03 31 I'm not saying that at all, but I don't know
13:30:05 32 that necessarily one means the other, in my

opinion.

Q. All right.

MS. FRASER: Just -- I'm looking at Ms. Meadus because we're always thinking about our time, Commissioner.

BY MS. FRASER:

Q. We have heard testimony -- I'm leaving this topic that we were on -- from the Executive Director, who is not a nurse, including insulin under the supervision of an RPN. You're aware of that testimony?

A. I was here when Dian Shannon testified, as well as I was previously aware of the finding of noncompliance.

Q. Right. And I think you deal with that in your Affidavit. I -- just for the record --

A. I don't believe I deal with it in my Affidavit.

Q. Okay. I'm mistaken then.

My question for you is it's clear that the regulations to the Long-Term Care Homes Act prohibit a nurse from delegating anything but a topical; am I right about that?

A. The medication should not -- the insulin should not have been administered by the Director of -- or by the Executive Director who was not a registrant of the College. You are correct.

Q. Okay.

A. There are certain people in

13:31:41 1 the legislation who are allowed to administer
13:31:43 2 medications: Registered staff with the
13:31:46 3 College, dentist, and a physician I believe is
13:31:49 4 the entire group of individuals who are able to
13:31:54 5 do that.
13:31:55 6 Q. Okay. And I understand --
13:32:02 7 and just looking at Exhibit F to your
13:32:05 8 Affidavit, which is Document 41487.
13:32:16 9 A. Yes.
13:32:16 10 Q. And this is just leaving the
13:32:21 11 topic of that. Is that over the identified --
13:32:28 12 sorry, a review of the schedules is where I'm
13:32:30 13 interested in. So this is page 4 of this
13:32:33 14 document. [AS READ]
13:32:43 15 "A review of the schedules by
13:32:45 16 Scheduler 616" --
13:32:48 17 So that's a little bit further down the page.
13:32:50 18 Yeah. [AS READ]:
13:32:52 19 " -- confirmed that over the
13:32:53 20 identified period of time, there
13:32:55 21 were over 25 occasions where the
13:32:59 22 only RN in the home was an
13:33:01 23 agency RN and 7 occasions where
13:33:03 24 there was only an RPN employed
13:33:05 25 in the home."
13:33:05 26 Right?
13:33:07 27 A. Maybe it shouldn't say
13:33:09 28 employed, but working.
13:33:10 29 Q. Working?
13:33:11 30 A. Yeah.
13:33:11 31 Q. Okay.
13:33:12 32 A. Sorry, that maybe wasn't the

13:33:14 1 best word choice there.
13:33:15 2 Q. All right. [AS READ]:
13:33:15 3 "And it was verified by the ED
13:33:18 4 that agency RNs were not members
13:33:20 5 of the regular nursing staff and
13:33:22 6 that no circumstances were
13:33:24 7 present to their knowledge which
13:33:26 8 permitted an exception to the
13:33:28 9 requirements of Section 8(3)."
13:33:32 10 And can you just remind me what 8(3) is again?
13:33:35 11 A. That's this legislative
13:33:38 12 reference, 24/7 RN, an RN in the building at
13:33:42 13 all times who's a member of the regular
13:33:42 14 registered nursing staff.
13:33:42 15 Q. And are you aware of
13:33:43 16 inspections that have been conducted subsequent
13:33:46 17 to yours that Telfer Place is still having
13:33:49 18 trouble meeting that RN --
13:33:51 19 A. I'm actually aware there was
13:33:52 20 a follow-up inspection to this one. It was --
13:33:52 21 I'm so sorry. That's a poor choice of words.
13:33:57 22 There was a subsequent
13:33:58 23 inspection to this one where the issue was
13:34:00 24 still identified. A compliance order was
13:34:03 25 identified at that time. Just prior to
13:34:06 26 Christmas at this year, that order was
13:34:08 27 complied. And more recently, they --
13:34:13 28 Q. Go ahead.
13:34:14 29 A. I probably shouldn't -- I
13:34:15 30 don't know if the report has been released yet
13:34:17 31 or not.
13:34:17 32 Q. Okay. Well, we have -- I

13:34:18 1 think I have the order that you're referring to
13:34:20 2 in my document notice, which is Document 42348.
13:34:30 3 And I'm going to show it to you.
13:34:38 4 A. Thank you.
13:34:39 5 Q. Is this the compliance order
13:34:56 6 to which you're referring?
13:34:58 7 A. Yes, it is.
13:34:59 8 MS. FRASER: Commissioner, may
13:35:00 9 that be the next exhibit?
13:35:01 10 THE COMMISSIONER: Yes.
13:35:02 11 Madam Clerk, I think that's
13:35:04 12 Exhibit 146; is that correct?
13:35:06 13 THE REGISTRAR: That's right.
13:35:07 14 THE COMMISSIONER: Thank you.
13:35:08 15 Exhibit 146, then, is
13:35:12 16 Document 42348, an inspector's
13:35:16 17 order dated -- what's the date
13:35:16 18 of it? Not the inspection date.
13:35:16 19 MS. FRASER: I've given all my
13:35:27 20 copies away, Commissioner.
13:35:27 21 MS. MEADUS: August 3rd.
13:35:28 22 THE COMMISSIONER: Thank you.
13:35:29 23 Dated August 3, 2017.
13:35:31 24 Thank you.
13:35:15 25 EXHIBIT NO. 146: Inspector's
13:35:16 26 Order dated August 3, 2017,
13:35:11 27 Document 42348.
13:35:33 28 MS. FRASER: Commissioner, those
13:35:35 29 are my questions, and I'm
13:35:36 30 grateful to one of the other
13:35:38 31 participants who's given us some
13:35:40 32 of their time.

13:35:42 THE COMMISSIONER: Thank you.
13:35:47 MS. STEPHENS: I think we
13:35:49 should, just for record keeping
13:35:51 purposes because we are
13:35:52 circulating time at the end of
13:35:54 each day, that was CNO who had
13:35:57 agreed to give some of their
13:35:58 extra time. Okay. Thank you.
13:36:01 And I'm not sure. Is anyone
13:36:03 else --
13:36:08 MS. COONEY: Good afternoon,
13:36:14 Commissioner.
13:36:10 CROSS-EXAMINATION BY MS. COONEY:
13:36:10 Q. Good afternoon, Lisa. I just
13:36:17 have one very brief question for you.
13:36:19 Ms. Fraser asked you about circumstances in
13:36:21 which you had found individuals who were
13:36:24 practicing nursing but who were not registered
13:36:27 with the College?
13:36:29 A. Yes.
13:36:29 Q. To your knowledge, were those
13:36:31 matters ever reported to the College?
13:36:32 A. So I'll -- I'll change your
13:36:35 statement slightly in you said circumstance
13:36:38 which I had found, but I had become aware of.
13:36:40 I didn't find them. Where they reported to the
13:36:44 College? Yes, the College was aware in both
13:36:47 situations. The College was involved in that,
13:36:50 yes. And although I did not have direct
13:36:52 conversation with the College, I had written
13:36:55 communication from the College.
13:36:59 MS. COONEY: Thank you.

13:36:59 THE COMMISSIONER: Thank you very much.
13:37:04 MR. KLOEZE: Good afternoon, Commissioner.
13:37:09 THE COMMISSIONER: Good afternoon.
13:37:10 RE-EXAMINATION BY MR. KLOEZE:
13:37:10 Q. Good afternoon, Lisa. I just have one area of questions. If you can turn to Tab I of the document in front of you of your brief, and that -- these are your Ad Hoc Notes. And I'm going to -- it's Document 41407, Laura. And I'm going to ask you to turn up page 18 of that in the middle of the page.
13:37:37 And, Lisa, Ms. Fraser was asking you questions about a conversation you had with Dr. Williams?
13:37:44 A. Yes.
13:37:44 Q. And I just wanted to put your notes on the screen so that you could look at them and let us know what information Dr. Williams gave you. And that's starting the paragraph "he confirmed." These are your notes of your conversation with Dr. Williams?
13:38:07 A. They are my notes of my conversation with Dr. Williams. It is acknowledged that they are not verbatim. And that is the sentence as well that -- it should read back in 2016, not back in 2015. But you would like me to read the statement?
13:38:25 Q. So the information -- we don't have to read it, but the information he

13:38:28 gave you, from what I can see here, is that he
13:38:31 noted a nurse to be swearing and verbally
13:38:34 abusive to some residents.
13:38:38 A. [AS READ]:
13:38:38 "He came in to do evening rounds
13:38:39 one night and noted a nurse was
13:38:40 swearing and verbally abusive to
13:38:42 some residents. He did not know
13:38:43 who she was. Her behaviour was
13:38:44 not acceptable. There was
13:38:45 no" --
13:38:46 So I then attempted to probe for additional
13:38:48 information. [AS READ]:
13:38:50 "There was no physical abuse,
13:38:51 swearing, and threatening. He
13:38:53 could" --
13:38:54 It said he did not, but he could not give me
13:38:56 any specific examples regarding who or what was
13:39:00 said.
13:39:00 Q. Okay. That was sort of the
13:39:03 whole information -- go ahead.
13:39:05 A. That was the gist -- I'm
13:39:07 sorry. I shouldn't have spoke over you. That
13:39:09 was the gist of the conversation, yes.
13:39:10 Q. You reported that, as I
13:39:12 understand, to the administrator?
13:39:14 A. Initially, I spoke with
13:39:17 Michelle Cornelissen, the former Director of
13:39:18 Nursing, and the reason I did that is because
13:39:18 she was the one who was in receipt of this
13:39:22 information, and I thought it might help jog
13:39:24 her memory a little bit.

13:39:26 Because my original conversation
13:39:27 was she couldn't really remember, so I thought,
13:39:30 oh, now I have a little bit more information.
13:39:31 It's definitely different information, but it's
13:39:34 different, and this might help her.
13:39:37 And she said, "No, no, not at
13:39:40 all." She knew right away that was something
13:39:42 that was reportable and that that -- she would
13:39:44 have dealt with much differently.
13:39:46 Q. And so as I understand it,
13:39:47 she told you that she did not recall getting
13:39:50 this information from the doctor?
13:39:51 A. She did not receive this
13:39:53 information to the doctor -- from the
13:39:54 physician. She was quite firm on that. In
13:39:56 fact, at the end of that second conversation
13:39:58 with Michelle, she had said, "In fact, now
13:40:01 I think it was probably Dr. McDonald that
13:40:08 shared the concern with me, not Dr. Williams."
13:40:08 Q. And you also advised the
13:40:08 administrator that you had received this
13:40:12 information from Dr. Williams?
13:40:12 A. I did. So the day that we
13:40:14 had spoke with -- or the day that I had spoke
13:40:17 with Dr. Williams, I had received this
13:40:19 information. I then called Michelle
13:40:22 Cornelissen. Fortunately, I was able to speak
13:40:25 with her. She shared me with (sic) what she
13:40:26 knew, which was that was not to her recall at
13:40:28 all.
13:40:28 So I then that very same day
13:40:30 that I received the information took it to the

13:40:32 current Executive Director at the home, shared
13:40:35 with him what was shared with me in an effort
13:40:38 to him -- for him to be able to get some --
13:40:41 hopefully get some more specific information
13:40:43 about the who, what, where, when, and why as
13:40:48 Rhonda has shared.
13:40:49 Q. And did you get any more
13:40:50 specific information from Mr. Eagleton?
13:40:50 A. We -- unfortunately --
13:40:51 unfortunately, Jim was not able to -- I'm
13:40:55 sorry. Mr. Eagleton was not able to talk to
13:40:55 the physician that day.
13:40:56 He did follow -- this was near
13:40:59 the holiday season, Christmas, and I believe
13:41:02 approximately a week later, he followed up with
13:41:05 my colleague, Lesley Edwards, and told her that
13:41:09 he could not get any additional information,
13:41:13 that -- that although he was able to speak with
13:41:16 the physician, the physician did not have any
13:41:19 specific information to share at that time.
13:41:20 Q. Now, you told Ms. Fraser that
13:41:23 normally, if you get an allegation of abuse,
13:41:26 you would need to inspect it -- or you would
13:41:28 inspect it, but you would need more
13:41:30 information?
13:41:30 A. If I get an allegation of
13:41:32 abuse, it would be inspected upon. In order
13:41:39 for me to make a finding of noncompliance, I
13:41:42 would need to be able to inspect it, so I would
13:41:45 need sufficient information to conduct an
13:41:47 inspection.
13:41:48 Q. And can you describe that a

bit? What kinds of -- what kinds of information would you need and what kinds of questions would you be asking or information you'd be looking for?

A. So even if he didn't know who was the nurse, who was the resident? Who was around? Who was maybe a witness? Who else would be able to tell me when this happened, what was said, who it was said to?

We have, as Karen Simpson pointed out, some definitions of abuse under the act, and there's a difference between verbal abuse and emotional abuse. And sometimes that differentiation comes down to does the resident understand what's going on.

If it's -- it's hard to consider it to be verbal abuse if the resident maybe hasn't heard what you said or can't understand what you said. So for that reason, it might be a more appropriate fit as emotional abuse.

So I would need some basic tombstone information to be able to inspect upon that. I needed to know more than some evening, something was said to somebody, and I don't really have any specifics.

Q. Okay. Thank you for that clarification. That's the only question I had.

MR. KLOEZE: Thank you, Commissioner.

THE COMMISSIONER: Thank you so much.

MS. STEPHENS: I believe that's

it, Commissioner. And we have no further questions for Lisa.
THE COMMISSIONER: All right. Thank you so much, Ms. Vink. That means you're free to go. We appreciate your help very much.
THE WITNESS: Thank you very much.
MS. STEPHENS: Commissioner, I think Mr. Scott maybe has one brief request.
THE COMMISSIONER: All right.
MR. SCOTT: Good afternoon, Commissioner.
THE COMMISSIONER: Good afternoon.
MR. SCOTT: In the words of Justice Laskin, I'm going to disbench with the wind-up and just make my pitch.
THE COMMISSIONER: All right.
MR. SCOTT: We are out of time. The families have used up the two hours that was allotted to us for this block.
Now, I haven't had an opportunity to go to my colleagues and see if they've got some access.
And part of that is a number of them are not here at this

13:44:01 stage, so I thought perhaps I
13:44:03 would come directly to you and
13:44:06 request an additional hour.
13:44:09 One of the things next
13:44:10 week -- I believe we have four
13:44:11 witnesses to hear from, and two
13:44:15 of them will be directly related
13:44:16 to the home care and community
13:44:20 provision of nursing services.
13:44:23 And so I have a bit of a
13:44:25 specific interest in being able
13:44:26 to cross-examine those
13:44:28 witnesses.
13:44:29 I may not need a full hour.
13:44:31 I think, as we saw earlier this
13:44:33 week, the general perception is
13:44:35 that I tend to be brief in my
13:44:37 cross-examination.
13:44:37 THE COMMISSIONER: Who would say
13:44:38 such a thing?
13:44:42 MR. SCOTT: I just felt a vibe
13:44:42 in the room, Your Honour.
13:44:43 But in any event, I would
13:44:44 request an additional hour for
13:44:46 the coming week.
13:44:47 THE COMMISSIONER: Have you
13:44:48 talked to Commission Counsel?
13:44:50 Do they feel that we can
13:44:52 accommodate this?
13:44:52 MS. STEPHENS: Yes. We had a
13:44:53 conversation about this earlier,
13:44:54 and I certainly think that it's

clear Mr. Scott has an interest in that stage of -- the stage of our evidence in a way that I think very few other people in the room have indicated they do.

I expect -- as you can see, the room has gotten light. I think that's, in part, a Friday-afternoon issue, but I don't think we will have that many parties sticking around for that part, and I certainly think it would be appropriate for Mr. Scott to get that additional hour.

And I believe we'll have no problem accommodating those four witnesses next week.

THE COMMISSIONER: I don't have any problem for two reasons: One, given the client base you have, it's important that you have that opportunity.

Secondly, it is such a different area, but still one of the victims is within the scope of the inquiry, and we need some probing, and at least I need the assurance that the opportunity for probing in that area has been extended to the participants, so I have no

13:45:54 problem with that.
13:45:55 MR. SCOTT: Thank you,
13:45:56 Commissioner.
13:45:57 MS. STEPHENS: So, Commissioner,
13:46:00 I think that completes what we
13:46:02 have for this week. I will give
13:46:05 you an idea going into next week
13:46:07 where we're at.
13:46:08 THE COMMISSIONER: All right.
13:46:09 MS. STEPHENS: We have -- the
13:46:11 participants have all been very
13:46:14 helpful in working towards
13:46:15 agreements with respect to which
13:46:17 witnesses we actually need here
13:46:18 and which we don't.
13:46:20 So next week, we'll be
13:46:22 tendering the Affidavits of two
13:46:23 witnesses who will not be coming
13:46:25 to provide viva voce evidence.
13:46:28 That will be Aislinn McNally,
13:46:32 who is a triage inspector at
13:46:33 CIATT, and then it will also be
13:46:35 Karen Mitchell, who's a care
13:46:38 coordinator at the Southwest --
13:46:39 now the Southwest LHIN, formerly
13:46:42 of the Southwest CCAC. So that
13:46:46 will go in by Affidavit only.
13:46:49 The other witnesses who will
13:46:50 be attending will be Mr. Philip
13:46:56 Moorman. He will be our first
13:46:56 witness on Tuesday morning. And
13:46:56 then we will have Karin

13:47:00 Fairchild, the manager of the
13:47:01 Hamilton SAO.
13:47:03 Everyone has had copies of
13:47:05 their Affidavits: Karin's as of
13:47:10 Tuesday, Mr. Moorman's as of
13:47:14 sometime last week.
13:47:15 And that will complete the
13:47:17 portion in relation to the
13:47:18 long-term care homes and that
13:47:20 regime governing that.
13:47:22 We will then move on to the
13:47:23 two witnesses in relation to the
13:47:26 oversight of the provision of
13:47:28 home care.
13:47:30 That will be Donna Ladouceur,
13:47:34 currently of the Southwest LHIN,
13:47:34 formerly the Southwest CCAC, and
13:47:36 then also Steven Carswell, also
13:47:39 with the Southwest LHIN at this
13:47:41 point.
13:47:41 So that's where we're at. We
13:47:44 feel very good about what we
13:47:46 managed to make it through this
13:47:47 week, and we are very confident
13:47:49 we'll certainly be able to fit
13:47:50 that into the four days next
13:47:52 week. So that wraps things up
13:47:54 for this week.
13:47:54 Before we conclude, I do have
13:47:57 one thing I would like to say.
13:47:58 I've had three members of my
13:48:00 team come back this week to help

13:48:02 us out, as you know,
13:48:03 Commissioner.
13:48:04 Greg Furmaniuk, Etienne
13:48:09 Lacombe, and Sean Pierce were
13:48:09 all very invaluable in pouring
13:48:11 through the many, many, many
13:48:12 documents that we received this
13:48:14 winter and helping put together
13:48:16 the Overview Report.
13:48:17 They had left us to go write
13:48:20 the bar admission course, have
13:48:22 come back for this week of the
13:48:24 hearings, and they've been very
13:48:25 helpful to me this week.
13:48:27 And they will not be here
13:48:29 next week as they begin their
13:48:32 articles, but I did want to say
13:48:33 a thank you to them.
13:48:34 THE COMMISSIONER: Thank you
13:48:35 very much. I think one of the
13:48:36 most salutary things that you
13:48:38 could ever have at the beginning
13:48:39 of your careers as lawyers is to
13:48:42 watch very professional, highly
13:48:45 skilled people at work, and
13:48:46 you've had the benefit of that
13:48:48 in spades from this group.
13:48:50 So I'm glad that you're here,
13:48:52 and I'm glad you can see the
13:48:55 value of your work to the
13:48:56 inquiry. So thank you.
13:48:57 So thank you very much. It

13:48:58 was a very full week, but it was
13:49:00 a very productive week. And,
13:49:01 again, it could not have been
13:49:03 done without the cooperation and
13:49:05 professionalism in this room of
13:49:07 everybody, including everybody
13:49:08 in that tier right in front of
13:49:10 me.
13:49:10 So thank you so much. And I
13:49:13 hope that people will have some
13:49:15 time on the weekend not to just
13:49:18 read Affidavits but perhaps get
13:49:19 some sleep, and I'll see you on
13:49:19 Tuesday.
13:49:24 Oh, don't forget to clean the
13:49:25 room, right. It's all going to
13:49:25 get cleaned, so you need to take
13:49:26 all papers. Nothing will be
13:49:29 here, or, you know, it will be
13:49:30 open to the public.
13:49:31 THE REGISTRAR: This Public
13:49:40 Inquiry is adjourned until
13:49:43 Tuesday at 9:30 a.m.
-- ADJOURNED AT 1:49 P.M. --

REPORTER'S CERTIFICATE

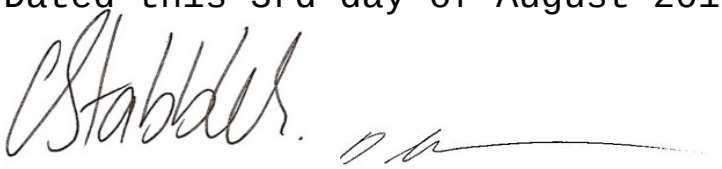
We, DEANA SANTEDICOLA, RPR, CRR, CSR, Certified Shorthand Reporter, and CARISSA STABBLER, RPR, CSR, Certified Shorthand Reporters, do certify:

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

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

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

Dated this 3rd day of August 2018.



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& CARISSA STABBLER, RPR, CSR

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