In the Matter Of:

The Long-Term Care Homes Public Inquiry

Standing Hearings

DAY 15/VOLUME 15

June 26, 2018

---

neesons

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

THE LONG-TERM CARE HOMES PUBLIC INQUIRY

PUBLIC HEARINGS

--- This is Day 15/Volume 15 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 26th day of June, 2018, commencing at 9:30 a.m.

BEFORE: The Honourable Justice Eileen E. Gillese, Commissioner

REPORTED BY: Deana Santedicola, RPR, CRR, CSR & Helen Martineau, CSR

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

Elizabeth Hewitt, Esq., & Lindsay Merrifield, Esq., & Lara Kinkartz, Esq., & Mark Zigler, Esq.	Commission Counsel
Jane Meadus, Esq.,	Ontario Association of Residents' Councils
David M. Golden, Esq.,	Caressant Care Nursing and Retirement Homes Limited, Caressant Care - Woodstock.
Denise Cooney, Esq., & Megan Schwartzentruber, Esq.,	College of Nurses
Paul H. Scott, Esq.,	Jon Matheson, Pat Houde, Beverly Bertram
Alexa Mingo, Esq., & Meagan Williams, Esq.,	Her Majesty the Queen in Right of Ontario
Shaun Singh, Esq.,	Registered Practical Nurses Association

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

Alex Van Kralingen, Esq.,	Arpad Jr. Horvath, Laura Jackson, Don Martin, Andrea Silcox, Adam Silcox-Vanwyk, Shannon Lee Emmerton, Jeffrey Millard, Judy Millard, Sandra Lee Millard, Stanley Henry Millard, Susie Horvath.
Nicole Butt, Esq.,	Ontario Nurses Association
Lauren Binhammer, Esq.,	Registered Nurses' Association of Ontario
Lisa Corrente, Esq.,	Jarlette Health Services, Meadow Park (London) Inc. o/a Meadow Park London Long-Term Care
Jennifer McAleer, Esq. & Michelle Laurion, Esq.,	Revera

INDEX OF WITNESSES

INDEX OF EXHIBITS

--- Upon commencing at 9:31 a.m.

THE COMMISSIONER: Good morning, Ms. Hewitt.

MS. HEWITT: Morning, Commissioner. We have just a couple of things to clean up first. I believe that you now have the two exhibits that you were missing yesterday. Is that right, Madam Clerk?

THE COMMISSIONER: Yup, thank you.

MS. HEWITT: And in my absence yesterday I think there was another document that was referred to that may be made an exhibit. I believe Ms. Merrifield has more information on that.

THE COMMISSIONER: All right.

MS. MERRIFIELD: Good morning, Commissioner.

You might recall that we had a discussion yesterday over document ID 71819, which was the "Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities"?

THE COMMISSIONER: Yes.

MS. MERRIFIELD: And although the witnesses I don't think were asked direct questions about it was referred to in their testimony.

09:32:45 So it might make the most sense to
09:32:47 enter it as an exhibit, which I
09:32:48 believe would be Exhibit number
09:32:49 80.
09:32:51 THE COMMISSIONER: All right. So
09:32:52 do I have a copy of that then?
09:32:55 MS. MERRIFIELD: Yes.
09:33:12 THE COMMISSIONER: Is that Exhibit
09:33:13 80? Is that right, Madam Clerk?
09:33:16 THE CLERK: Yes.
09:33:16 THE COMMISSIONER: Okay, Exhibit
09:33:16 80 then. The "Standards for
09:33:16 Pharmacists Providing Services to
09:33:16 Licenced Long-Term Care
09:33:16 Facilities", effective January 1,
09:33:16 2007.
09:33:17 EXHIBIT NO. 80: Document entitle
09:33:19 standards for Pharmacists Providing
09:33:22 Services for Long-Term Care
09:33:24 Facilities, dated October 1, 2007.
09:33:29 MS. MERRIFIELD: Thank you.
09:33:29 THE COMMISSIONER: Thank you.
09:33:30 MS. HEWITT: And this morning
09:33:30 before we start into any witness
09:33:32 evidence we have a Motion that's
09:33:34 being brought by the family group.
09:33:37 And Mr. Scott, are you speaking to
09:33:39 that?
09:33:41 MR. SCOTT: Yes.
09:33:46 Good morning, Commissioner.
09:33:48 THE COMMISSIONER: Good morning.
09:33:59 MS. HEWITT: The paper copy of the

09:34:00 Notice of Motion, Commissioner.
09:34:02 THE COMMISSIONER: Thank you.
09:34:03 Thank you very much.
09:34:04 MR. SCOTT: Commissioner, the
09:34:04 family group are seeking some
09:34:06 additional time. I've requested
09:34:07 90 minutes in the motion
09:34:10 materials, I suspected 60 would be
09:34:13 plenty. When I drafted the
09:34:14 materials I didn't yet have the
09:34:16 time remaining so 90 is what I'd
09:34:21 asked for but I suspect 60 would
09:34:23 be enough.
09:34:25 The three main points I would make
09:34:27 in support of our Motion would be
09:34:29 that we still have all of the
09:34:31 witnesses from St. Elizabeth to be
09:34:32 heard, we hope that's Wednesday.
09:34:35 And we haven't had any witness from
09:34:36 that organization yet so that could
09:34:40 take a little bit of time for the
09:34:41 family groups to cross-examine
09:34:43 them.
09:34:44 In addition, there is one more
09:34:46 witness I believe for Caressant
09:34:48 Care that we'll hear from tomorrow
09:34:51 as well and that may take a little
09:34:52 bit of time, in excess of our 25 or
09:34:56 30 minutes that we have remaining.
09:34:58 I believe it's fair to say that the
09:35:00 families' group have cross-examined
09:35:03 first throughout, which I think

09:35:05 1 means that a lot of the questions
09:35:06 2 that others may have asked have
09:35:09 3 already been asked, so that's
09:35:11 4 substantially reduced the amount of
09:35:12 5 time that other parties would have
09:35:14 6 had to have been at the podium.
09:35:17 7 And I also believe that we've used
09:35:20 8 our time judicially, if you will, I
09:35:23 9 don't think we've wasted any of it.
09:35:26 10 When we started out we were
09:35:28 11 allotted nine hours, and that was
09:35:29 12 just based on some estimates, or
09:35:32 13 best estimates made before we
09:35:35 14 started.
09:35:36 15 But I think under the circumstances
09:35:37 16 an extra 60 minutes would be very
09:35:40 17 helpful for us.
09:35:43 18 THE COMMISSIONER: Does anyone
09:35:44 19 have a comment on Mr. Scott's
09:35:47 20 Motion this morning?
09:35:50 21 MS. HEWITT: Just for your
09:35:51 22 information, Commissioner, we have
09:35:54 23 still more allocated than we have
09:35:55 24 technically time for, but we only
09:35:58 25 have six witnesses left. We hope
09:36:01 26 to get through two, perhaps three
09:36:03 27 today.
09:36:04 28 Everybody has been very judicious,
09:36:07 29 including the family groups, of
09:36:08 30 using their time.
09:36:09 31 And we do have a major client or
09:36:14 32 major portion of our story coming

09:36:16 1 up, which is St. Elizabeth, and
09:36:17 2 Mr. Scott does represent the one
09:36:20 3 victim of St. Elizabeth. So I just
09:36:21 4 wanted you to have that information
09:36:23 5 as well.
09:36:24 6 THE COURT: Thank you. Yeah, I
09:36:25 7 don't have any problem granting
09:36:27 8 you this extra time. I think all
09:36:29 9 the points you make are entirely
09:36:30 10 fair.
09:36:31 11 The cross-examinations by the
09:36:34 12 victims' family have led the way
09:36:38 13 and have been very crisp and to the
09:36:40 14 point and so on.
09:36:42 15 And I also take fully the point that St.
09:36:45 16 Elizabeth, in particular for your group,
09:36:49 17 there needs to be a proper amount of
09:36:51 18 time allowed for you to be able to
09:36:53 19 cross-examine as necessary on that so I
09:36:54 20 don't have any problem.
09:36:56 21 I'm happier to do the 60 minute
09:37:00 22 extension. So I will grant your
09:37:03 23 motion and give you an extra --
09:37:05 24 both obviously, the totality of the
09:37:09 25 family victims 60 minutes.
09:37:15 26 MR. SCOTT: Thank you,
09:37:16 27 Commissioner.
09:37:16 28 THE COMMISSIONER: Thank you,
09:37:16 29 Mr. Scott.
09:37:17 30 Go ahead, Ms. Hewitt.
09:37:31 31 MS. HEWITT: I'd like to call the
09:37:32 32 next witness, Dian Shannon.

09:37:36 1 DIAN SHANNON: SWORN
09:37:53 2 EXAMINATION IN-CHIEF BY MS. HEWITT:
09:38:39 3 Q. Good morning, Ms. Shannon, we
09:38:40 4 have been asking people whether they would
09:38:42 5 prefer to be called by their first name or
09:38:45 6 their formal name so what do you prefer?
09:38:48 7 A. First name is fine, thanks.
09:38:50 8 Q. And do you pronounce it
09:38:51 9 [Dee-Yan] Dian?
09:38:52 10 A. That's correct.
09:38:53 11 Q. Now, you have in front of you
09:38:54 12 I believe an affidavit that you swore in
09:38:57 13 this matter?
09:38:58 14 A. Yes.
09:38:58 15 Q. And if you just turn to page
09:39:00 16 number 18, which is right before tab A, is
09:39:04 17 that your signature?
09:39:05 18 A. It is.
09:39:06 19 Q. Now, I understand that
09:39:08 20 following the swearing of this, there is one
09:39:12 21 correction to be made to one of the
09:39:14 22 exhibits; is that correct?
09:39:16 23 A. Yes.
09:39:16 24 MS. HEWITT: And I believe,
09:39:17 25 Commissioner, it's Exhibit C. We
09:39:21 26 don't have to put it up yet,
09:39:22 27 Amanda, but it's document 72535
09:39:27 28 THE COMMISSIONER: Yes.
09:39:28 29 BY MS. HEWITT:
09:39:28 30 Q. And, Dian, I understand that
09:39:29 31 under the schedule December 2017, at the
09:39:33 32 bottom of the page, is that to read "1X7.5

hrs" at the very bottom for the PSW?
A. Yes.
Q. Okay. And subject to that correction is there any other corrections you'd like to make at this time?
A. Um, I think there was a correction about period of time when I left.
Q. Yes, that was --
A. And that's already been corrected.
Q. That's already been corrected?
A. Then there are no other corrections.
Q. We're good to go on that one. Thank you. I'd like to make this the next exhibit?
THE COMMISSIONER: Thank you. So the affidavit of Dian Shannon is Exhibit 81 in these proceedings.
EXHIBIT NO. 81: Affidavit of Dian Shannon.
MS. HEWITT: Thank you, Commissioner.
BY MS. HEWITT:
Q. Now, Dian, I understand that you were with Revera between 1989 and 2016?
A. Yes.
Q. And you received your administrator qualifications in 2004?
A. Yes.
Q. And you went to Telfer Place

09:40:27 in 2011?
09:40:28 A. Yes.
09:40:29 Q. Okay. And what was your
09:40:31 position at Telfer Place?
09:40:32 A. I was the Executive Director.
09:40:35 Q. And we've heard within these
09:40:37 proceedings the word "administrator" being
09:40:39 used. Is that similar to the executive
09:40:41 director? Is it the same thing?
09:40:43 A. It's the same thing.
09:40:46 Q. And you're not a nurse?
09:40:47 A. I'm not a nurse.
09:40:49 Q. Can you just take a couple of
09:40:51 minutes to describe Telfer Place for us?
09:40:54 A. Telfer Place is a multi-level
09:40:56 retirement community. It consists of four
09:41:00 different levels of accommodation. From the
09:41:03 most independent, which would be senior's
09:41:05 apartments, then it had independent living
09:41:09 suites for elders, assisted living and
09:41:13 long-term care.
09:41:16 Q. And so is it fair to say that
09:41:18 people could graduate from one to the other
09:41:20 as their care needs increased?
09:41:23 A. Yes.
09:41:23 Q. And what were your duties as
09:41:27 Executive Director in the long-term care
09:41:30 setting?
09:41:30 A. So in long-term care I was in
09:41:37 charge of the overall operation for
09:41:44 long-term care. I had to make sure that we
09:41:46 were meeting regulatory standards from our

09:41:49 1 external stakeholders, including Ministry of
09:41:50 2 Health, Public Health Unit, Fire Department,
09:41:53 3 et cetera.
09:41:53 4 Responsible for day-to-day
09:41:59 5 operations. Making sure that the management
09:42:01 6 team was responsible; the front line staff
09:42:05 7 were doing their job appropriately and well;
09:42:07 8 maintaining documentation on identified, for
09:42:12 9 example, risk indicators, quality control or
09:42:21 10 quality improvement measures. Basically
09:42:25 11 making sure that the residents had a safe,
09:42:26 12 comfortable place to live request staff that
09:42:33 13 cared about them.
09:42:34 14 Q. And did you split any of your
09:42:35 15 time between long-term care and the other
09:42:37 16 facets of Telfer Place?
09:42:39 17 A. I did.
09:42:39 18 Q. And how did you split your
09:42:40 19 time?
09:42:41 20 A. Three days -- the equivalent
09:42:43 21 of three days a week was to be devoted to
09:42:45 22 long-term care, and that's under the Act.
09:42:51 23 Q. The Long-Term Care Homes Act
09:42:51 24 2007?
09:42:53 25 A. Yes, yes.
09:42:54 26 Q. And that, as I understand it,
09:42:55 27 was implemented in 2010; is that your
09:42:58 28 understanding?
09:42:59 29 A. Yes.
09:42:59 30 Q. And did you get any training,
09:43:03 31 specific training on the Act and the
09:43:04 32 interpretation of the regulations?

09:43:06 A. We would periodically have
09:43:08 education that was provided through Revera.
09:43:14 I had -- when I went through my
09:43:18 course to become an administrator we did look
09:43:20 at the provincial requirements and
09:43:23 regulations at that point.
09:43:25 Q. Would that have been under
09:43:26 the Nursing Homes Act at that point in time?
09:43:28 A. The old Nursing Homes Act.
09:43:30 Q. And you talked about
09:43:31 management, what would be the management in
09:43:33 the long-term care section of Telfer Place?
09:43:36 A. Food Service Manager,
09:43:38 Director Of Care, Associate Director of
09:43:39 Care, Program or Activities Manager. There
09:43:46 could be Restorative Care Manager, there
09:43:49 could be a Resident Services Co-ordinator
09:43:54 who provided support for residents.
09:43:56 Q. And as of 2015 were any of
09:43:58 those positions filled by Registered Nurses?
09:44:01 A. The Director of care, the
09:44:02 Associate Director of Care.
09:44:04 Q. And the Director of Care was
09:44:06 who?
09:44:06 A. Sherri Toleff.
09:44:08 Q. And the Associate Director of
09:44:08 Care?
09:44:10 A. Lindsay Astley.
09:44:16 Q. And how old is Telfer Place?
09:44:18 A. It's about 40 years old.
09:44:20 Part of it is 35, part of it is 40.
09:44:25 Q. And does it have a

09:44:26 combination of room size in terms of
09:44:28 private, semi-private and ward rooms?
09:44:31 A. Yes, it has all three.
09:44:33 Q. And now I'm talking
09:44:34 specifically about the long-term care side?
09:44:37 A. Long term, yes.
09:44:38 Q. And it has 45 beds?
09:44:40 A. Correct.
09:44:40 Q. That we've heard formerly.
09:44:42 And is that -- we've heard from a
09:44:45 another -- a couple of different homes that
09:44:46 they had per resident area 32 beds. And so
09:44:50 is there a difference then between Telfer
09:44:52 Place and places such as Caressant Care,
09:44:56 Meadow Park?
09:44:58 A. Depending on the age of the
09:44:59 home when it was first constructed. Prior
09:45:01 to 2002 -- I'm not sure if it was in about
09:45:05 2000 new design standards came out. New
09:45:09 beds were put into the long-term care. So
09:45:13 those new beds are -- those are called "new
09:45:16 builds" and they are "A" classification
09:45:20 beds. Telfer Place was a "C"
09:45:22 classification.
09:45:23 Q. And what did that mean?
09:45:24 A. It meant that the design
09:45:28 standards for the time, when Telfer Place
09:45:32 was built, that we were still -- we were
09:45:36 still operating with those same old designs
09:45:38 as opposed to the new designs.
09:45:40 There was a plan from the Ministry
09:45:43 of Health that at a certain point all homes

would have to be upgraded to "A" qualifications I believe.

Q. And has that come and gone or is that still to be reached?

A. Well, there's still homes operating that are C builds so...

Q. And own of the things that we noticed or -- in Caressant Care there are narrower hallways in the older sections?

A. The entire design is different. For example, in the new -- in the new builds a ward room or a basic room, which in the old homes would have three or four beds in it, now have a maximum of two, and sometimes they're single beds. The hallways are wider, often they are carpeted. They have special odour management systems in place; they're brighter, much more attractive.

Q. And I'm sorry, Ms. McAleer, I just referred to Caressant Care because it had an older section and a newer section as well.

Now, if we can look at Exhibit B to your affidavit, Amanda, which is document number 72533? And do you recognize this document?

A. Yes.

Q. And is this the floor plan for the long-term care section of Telfer Place?

A. Yes, it is.

09:47:15 Q. And so the -- where would the
09:47:18 nurses station be located?
09:47:19 A. The nurses station is in the
09:47:22 centre area.
09:47:28 Q. We see where the medication
09:47:29 room is.
09:47:30 A. Yes. You see where it says
09:47:32 "Emergency Exit Main Door" when you come
09:47:36 in --
09:47:36 Q. Yes.
09:47:37 A. -- and you're heading down --
09:47:37 straight ahead down the corridor the nurses
09:47:40 desk is right along that wall to the right.
09:47:44 Q. All right. And is it --
09:47:46 THE COMMISSIONER: Sorry, can we
09:47:47 just highlight it or something?
09:47:48 I'm not sure I follow.
09:47:50 BY MS. HEWITT:
09:47:50 Q. So down at the bottom you
09:47:51 start at is the Emergency Exit Main Door?
09:47:53 A. Yes, so you come in.
09:47:55 Q. And you come up the hallway?
09:47:56 A. Sorry. I'm sorry, my eyes
09:47:59 aren't that great to see where your little
09:48:00 cursor is. Right there. So the nurses
09:48:06 desks is against that first wall on the
09:48:09 right-hand side. Correct.
09:48:13 Q. Have we got it now
09:48:14 highlighted?
09:48:15 A. That's it.
09:48:17 Q. And there's one medication
09:48:18 room?

09:48:18 A. There is one medication room
09:48:19 and it's indicated on the map with an arrow.
09:48:23 Q. And is there a chart room as
09:48:25 well?
09:48:26 A. Immediately to left of the
09:48:27 medication room.
09:48:27 Q. So that other small room?
09:48:29 A. That's right.
09:48:29 Q. And are both those rooms
09:48:31 locked?
09:48:32 A. Yes.
09:48:32 Q. And who would have the key to
09:48:34 the medication room and the chart room?
09:48:36 A. Only the Registered Nurse
09:48:38 would have the key to the medication room,
09:48:41 the nurse who's on duty. And the charting
09:48:45 room when I left we had installed a
09:48:48 combination lock on the door.
09:48:50 Q. And who had the combination?
09:48:53 A. People who needed to go into
09:48:55 that room to do documentation. So the
09:48:58 nurses would have it, the Director of Care,
09:49:00 the ADOC, the Dietician would have it, for
09:49:08 example.
09:49:09 Q. Would the PSWs be entitled to
09:49:11 go into that room.
09:49:13 A. PSWs did not do documentation
09:49:16 in there so no.
09:49:18 Q. And where would the
09:49:19 medications cart or carts be located if not
09:49:22 in use?
09:49:22 A. They would be in the

09:49:24 medication room.
09:49:25 Q. So, again, only accessible by
09:49:26 registered staff?
09:49:27 A. Correct. By the registered
09:49:30 staff person who was working who had the
09:49:33 key.
09:49:33 Q. And those keys would be
09:49:35 transferred over at shift change?
09:49:37 A. Yes.
09:49:39 Q. And we heard that there's no
09:49:41 window that looks into the medication room;
09:49:44 is that correct, from your recollection?
09:49:46 A. Correct.
09:49:47 Q. And at the time that you were
09:49:49 there were you aware as to whether there was
09:49:53 any surveillance within Telfer Place?
09:49:56 A. Yes, we had closed circuit TV
09:49:57 cameras.
09:49:59 Q. And were they recording?
09:50:01 A. Yes, they recorded. We had
09:50:03 16 cameras, they monitored -- sorry, you
09:50:06 didn't ask that.
09:50:08 Q. I will next though. So you
09:50:13 had 16 closed circuit television cameras?
09:50:15 A. Yes.
09:50:16 Q. And where were they located?
09:50:18 A. They were located at the
09:50:19 building exits and entrances. Sorry, let me
09:50:30 restate that. If it was an exit/entrance
09:50:33 combined that's where they were stationed
09:50:36 that and that was all around Telfer Place.
09:50:39 They were also located -- there was

09:50:40 1 one located above the nurses desk so that you
09:50:43 2 could generally see down the hallway. You
09:50:46 3 couldn't see all the way down the hallway but
09:50:49 4 you could see sort of enough to track.
09:50:53 5 Q. And so when you say that they
09:50:56 6 were around the exits and entrances that
09:50:58 7 wouldn't be not only the long-term care but
09:51:00 8 the other entrances to the other phases of
09:51:03 9 Telfer Place?
09:51:04 10 A. That's right.
09:51:04 11 Q. And the one that you
09:51:05 12 indicated was by the nurse's desk. Would it
09:51:08 13 actually be surveilling what the nurse is
09:51:10 14 doing or surveilling the hallways?
09:51:14 15 A. It had a -- almost 180-degree
09:51:19 16 view or close to that. So it was higher on
09:51:24 17 the -- quite high on the wall above the
09:51:27 18 nurses desk so you couldn't see what they
09:51:31 19 were doing but you could see people moving
09:51:33 20 around the nurses desk, and down both
09:51:35 21 hallways, and a little bit of a view into
09:51:37 22 the lounge which is sort of kitty corner to
09:51:39 23 the nurses desk.
09:51:42 24 Q. And in respect of that one
09:51:45 25 that was by the nurses desk could you see
09:51:47 26 into the medication room from that camera?
09:51:50 27 A. No.
09:52:01 28 Q. And did you have those
09:52:02 29 cameras in place when the offences became
09:52:06 30 known in late 2016?
09:52:07 31 A. Yes, they were in place at
09:52:09 32 that time.

09:52:09 Q. And did the police come to
09:52:11 determine whether or not there was any
09:52:12 footage on those cameras that was relevant
09:52:14 to the offences?
09:52:15 A. I wasn't at Telfer Place at
09:52:17 that point.
09:52:21 Q. Do you know whether or not
09:52:22 those cameras actually had a memory stored
09:52:25 on them?
09:52:25 A. They would have a memory.
09:52:26 I'm trying to think if it was -- I believe
09:52:29 it was a 30-day memory. We had requested
09:52:33 that it record longer. Or, sorry, that it
09:52:39 hold the recording longer.
09:52:41 Q. When did you make that
09:52:42 request?
09:52:42 A. I'm sorry, I don't remember
09:52:44 the exact date.
09:52:46 Q. And do you know whether that
09:52:47 was ever changed to beyond 30 days?
09:52:50 A. Yes. It was a matter of
09:52:51 having the correct memory card or memory
09:52:55 chip for it.
09:52:56 Q. Okay. And do you know how
09:52:57 long it then began to record memory?
09:53:00 A. Well, it would hold the
09:53:02 memory for 30 days.
09:53:03 Q. Okay. So that was the length
09:53:05 of time?
09:53:06 A. That's right.
09:53:06 Q. The maximum?
09:53:07 A. I think prior to that it was

about one week.

Q. And then would it record over itself?

A. Yes.

Q. Thank you.

Now, if we can look at tab number C, Exhibit number C of your affidavit then, and that is document number 72535. And I understand this to be the staffing levels of Telfer Place from September onwards to April of 2018; is that your understanding?

A. Yes.

Q. And it identifies that in September of 2015, which is the timing of Elizabeth Wettlaufer's offence towards Ms. Towler that on each shift you had a Registered Nurse; is that correct?

A. Correct.

Q. And on the day shift there would be some assistance from an RPN on certain days of the week?

A. Yes.

Q. But no other registered staff on evenings or nights other than the Registered Nurse?

A. That's correct.

Q. Okay. And did that -- it appears that that stayed the same in terms of the evening and the night shift until December of 2017? And you were gone by then; is that correct.

A. That's correct.

09:54:45 Q. But the time that you were there, which was until approximately July of 2016, that was the staffing levels; is that correct?
09:54:49 A. Yes.
09:54:50 Q. And so what were the hours of work for each of the shifts? Do you remember what the hours of work were for day shift?
09:55:06 A. They used -- when I first came they were doing 6:00 to 2:00, and then the afternoon shift was 2 o'clock to 10 o'clock, and then it was 10 o'clock to 6 o'clock in the morning. And it changed at one point so that it was 7:00 to 3:00, 3:00 to 11:00 and 11:00 to 7:00.
09:55:32 Q. And during the evening shift -- so when you were there, and I believe this is within 2015, during the 2:00 to 10:00 shift would there be any management staff present?
09:55:44 A. On a Monday through Friday there would typically be -- the Director of Care was there until 4 o'clock, perhaps 5 o'clock, depending on what time she started in the morning. And as the Executive Director I was typically there until 6 o'clock in the evening.
09:56:07 Q. Now, you did indicate that you devoted approximately three days a week to the long-term care side. Did you physically have offices in different

09:56:14 1 locations in Telfer Place?
09:56:16 2 A. My office was outside of
09:56:17 3 long-term care but adjacent to it. The
09:56:24 4 Director of Care's office was in long-term
09:56:26 5 care.
09:56:28 6 Q. So when you were devoting
09:56:29 7 your time to long-term care you're devoting
09:56:33 8 your -- you're not spending those three days
09:56:36 9 physically, potentially, within the
09:56:38 10 long-term care section?
09:56:39 11 A. Correct.
09:56:44 12 Q. And were they three specific
09:56:46 13 days devoted to long-term care or just a
09:56:49 14 total of three days a week?
09:56:50 15 A. A total of three days.
09:57:03 16 Q. And any other members of
09:57:04 17 management present past approximately 5:00
09:57:07 18 p.m. on the evening shift during the
09:57:07 19 weekdays?
09:57:08 20 A. Periodically the Food Service
09:57:09 21 Manager would be on site.
09:57:17 22 Q. And how about weekends? Any
09:57:18 23 presence of management staff on weekends?
09:57:20 24 A. There -- periodically
09:57:24 25 managers would be in on the weekend
09:57:27 26 depending on what their schedule was and
09:57:28 27 what they were doing, if they had a specific
09:57:32 28 task to complete on the weekend.
09:57:34 29 Q. So they wouldn't be scheduled
09:57:36 30 to work they would sporadically come in to
09:57:39 31 do work; is that fair?
09:57:40 32 A. Correct.

09:57:41 Q. So in terms of staff in
09:57:42 charge of PSWs and in charge of direct care,
09:57:46 is it fair to say that after 5:00 p.m.
09:57:48 during weekdays, and most times on the
09:57:50 weekends, it would be the Registered Nurse
09:57:52 in charge of the long-term care section?
09:57:55 A. That's correct. We would
09:57:57 have a manager on call.
09:57:59 Q. And would the manager on call
09:58:01 be a Registered Nurse at all times?
09:58:04 A. The manager on call -- we
09:58:05 rotated the duty of who would be the manager
09:58:08 on call. The Director of Care was deemed to
09:58:11 always be on call for long-term care.
09:58:22 Q. Now, just talk a bit about
09:58:24 mandatory training. As I understand the
09:58:27 evidence then the PSWs would report directly
09:58:30 to the Registered Nurse; is that correct?
09:58:32 A. Correct.
09:58:32 Q. And would your staff get
09:58:34 training on the mandatory reporting under
09:58:38 the Long-Term Care Act on abuse, neglect and
09:58:42 whistle blowing?
09:58:43 A. Yes. They had annual
09:58:44 training on it and if they were a new staff
09:58:47 person it was covered during orientation,
09:58:49 and as well we had posters in the home that
09:58:52 reminded the staff.
09:58:53 Q. And who was responsible to
09:58:55 make sure that that training took place?
09:58:57 A. The designated staff
09:58:58 educator.

09:59:00 Q. And in 2015, 2016 do you know
09:59:03 who that was?
09:59:04 A. 2016 it became -- Sherri
09:59:12 Toleff picked it up as an extra day per
09:59:15 week.
09:59:15 Q. And prior to 2016?
09:59:17 A. It was Joanne Forest.
09:59:25 Q. Do you know -- would the
09:59:27 staff educator be responsible for training
09:59:29 and familiarizing the staff with the
09:59:31 medication policies within the home?
09:59:33 A. Any new policies that were
09:59:36 released that were related to long-term care
09:59:39 for the nursing would go to the Director of
09:59:40 Care, and that would be the Director of
09:59:42 Care's responsibility for that.
09:59:54 Q. We've heard from two staff so
09:59:58 far within this hearing, Dianne Beauregard
10:00:05 and Tracy Raney. You're familiar with both
10:00:08 of those staff?
10:00:09 A. Yes.
10:00:10 Q. Both long-term, seasoned
10:00:10 staff?
10:00:11 A. Yes.
10:00:11 Q. Both of them indicated, and I
10:00:11 won't take you to it, because I'll refer to
10:00:12 it to Ms. Toleff, but both of them indicated
10:00:14 that in respect to a high-alert medication
10:00:16 policy they had not seen that policy within
10:00:21 their time at Telfer Place.
10:00:24 And do you have any information as
10:00:26 to what controls were in place to make sure

10:00:29 1 that the staff were aware of the policies
10:00:33 2 that were being rolled out by Revera?
10:00:36 3 A. The process that Sherri had
10:00:40 4 adopted was she would -- Sherri Toleff, the
10:00:44 5 Director of Care, is she would bring
10:00:48 6 information on new policies to staff
10:00:50 7 meetings; if staff weren't able to attend
10:00:53 8 those meetings then she would share them at
10:00:55 9 shift change on occasion. Staff would be
10:00:59 10 notified of the policy and they, staff, were
10:01:03 11 to sign off on the policy that they had read
10:01:06 12 and understood it.
10:01:10 13 Q. We'll hear perhaps some more
10:01:13 14 of that from Ms. Toleff.
10:01:15 15 We also heard from Ms. Beauregard
10:01:18 16 that in 2015 and 2016 on the night shift it
10:01:20 17 would only be her and one PSW; is that your
10:01:24 18 recollection?
10:01:24 19 A. That's correct.
10:01:25 20 Q. And that she would physically
10:01:26 21 be assisting the PSW in terms of
10:01:29 22 transferring, toileting, continence change,
10:01:32 23 repositioning, is that --
10:01:34 24 A. That's correct.
10:01:35 25 Q. That would be part of the
10:01:35 26 Registered Nurse's job?
10:01:39 27 A. That's right.
10:01:39 28 Q. And she indicated that it was
10:01:40 29 a physically demanding position?
10:01:42 30 A. Oh yes.
10:01:43 31 Q. And from your experience was
10:01:45 32 that unusual within the long-term care

10:01:48 sector to have an RN be participating with a
10:01:54 PSW in that type of care?
10:01:56 A. If you have a smaller,
10:01:58 long-term care home then the nurse does get
10:02:01 involved with that element of care.
10:02:05 Q. And in your experience at
10:02:07 Telfer Place did you see a change in the
10:02:10 acuity level of the residents?
10:02:12 A. Over time yes.
10:02:15 Q. And what type of changes
10:02:16 would you have seen?
10:02:17 A. Residents coming to us were
10:02:19 frailer. Residents coming to us were people
10:02:24 who could not be managed in the community
10:02:27 any longer with the existing resources.
10:02:31 They typically were in crisis when they came
10:02:34 to us, frequently from the hospital.
10:02:38 Because they were in the -- the hospital
10:02:40 needed to discharge people so they could
10:02:42 open up those beds for other people in the
10:02:45 community. So we would see people who were
10:02:51 not only very frail and elderly but who had
10:02:54 a lot of dementia.
10:02:56 And then we could see as well a
10:02:57 number of people coming to us who were -- you
10:02:59 would not normally see in long-term care
10:03:01 historically. I've been in long-term care 27
10:03:05 years so I've seen a fairly significant
10:03:06 shift.
10:03:07 So people who require 24 hour
10:03:09 supervision, and often in a -- an environment
10:03:14 where somebody handled their medications for

10:03:16 them, and in an environment that they could
10:03:19 afford.
10:03:21 THE COMMISSIONER: I'm sorry, I
10:03:21 didn't hear the last word.
10:03:24 THE WITNESS: And afford.
10:03:25 THE COMMISSIONER: Afford.
10:03:26 THE WITNESS: So in long-term care
10:03:28 everyone can afford a basic
10:03:30 accommodation room.
10:03:31 So you would see people who would
10:03:35 come to us where their primary
10:03:38 diagnosis may be alcoholism and
10:03:40 mental illness and then further
10:03:42 diagnoses might be renal failure,
10:03:47 it might be poorly-managed
10:03:50 diabetes, post-stroke.
10:03:54 Sometimes they lived on the street,
10:03:56 got sick, went into the hospital
10:03:57 and there's no place else for them
10:03:59 to go but long-term care.
10:04:01 BY MS. HEWITT:
10:04:03 Q. And with that did the
10:04:05 physical demands of the positions increase?
10:04:08 A. Oh, we were getting people
10:04:10 who were so heavy care that it was
10:04:19 significant. Long-term care homes now see
10:04:22 bariatric clients that weigh 500 pounds.
10:04:27 Very difficult to provided adequate care for
10:04:31 people when you don't have a long-term care
10:04:33 home that was designed or built to handle
10:04:36 folks that were so different.
10:04:37 Q. And was there an increase in

10:04:39 type of mechanics that you would require
10:04:43 within Telfer Place in terms of lifts, et
10:04:46 cetera?
10:04:46 A. You required -- well, you
10:04:50 required mechanical lifts if you were moving
10:04:53 people who were unable to weight-bear. You
10:04:59 could have quite a few lifts if you needed
10:05:01 them, but you still needed two people to
10:05:04 operate every lift. So there would be very
10:05:06 little point in having eight lifts because
10:05:08 you don't have 16 people at any time, any
10:05:11 given moment to operate them.
10:05:13 Q. In terms of your staffing
10:05:14 levels?
10:05:14 A. In terms of staffing levels.
10:05:16 Q. Now, were your -- was your
10:05:18 funding based on the -- what we've heard
10:05:21 about the "case mix index" that result from
10:05:23 the RAI/MDS?
10:05:25 A. Yes.
10:05:25 Q. And you would get funding
10:05:26 through your nursing and personal care
10:05:28 envelope?
10:05:29 A. Correct.
10:05:29 Q. And did you spend all that
10:05:32 envelope every year on staff?
10:05:33 A. Oh, we spent the envelope
10:05:37 every year, yes.
10:05:38 Q. And were you constrained in
10:05:42 any way by the fact that you had to have an
10:05:45 RN on shift 24 hours?
10:05:50 A. I don't understand what you

10:05:51 1 mean by "constrained".
10:05:53 2 Q. You were required to have a
10:05:53 3 Registered Nurse on shift, correct?
10:05:55 4 A. Yes.
10:05:56 5 Q. And the funding for the
10:05:58 6 Registered Nurse would that be more or less
10:06:00 7 than funding for an RPN?
10:06:03 8 A. It's more.
10:06:06 9 Q. And so if that was more
10:06:08 10 flexible, if that requirement was more
10:06:10 11 flexible would you be able to provide more
10:06:11 12 care? More hands-on care?
10:06:14 13 A. Um, if you elected not to
10:06:17 14 have an RN, and you were allowed to operate
10:06:20 15 an a full-time basis with an RPN then, yes,
10:06:24 16 you would have cost savings. That was not
10:06:25 17 an option.
10:06:33 18 Q. We heard that in 2015 and '16
10:06:34 19 Telfer Place was using agency staff; is that
10:06:37 20 correct?
10:06:43 21 A. Yes.
10:06:43 22 Q. And one of those agencies was
10:06:45 23 Lifeguard?
10:06:45 24 A. Yes.
10:06:46 25 Q. And on what basis would
10:06:47 26 Telfer Place be using agency staff?
10:06:50 27 A. We would use an agency staff
10:06:51 28 person if there was no way we could cover a
10:06:53 29 registered staff shift, and we couldn't
10:06:55 30 bring in an RPN with an RN on call, one of
10:06:59 31 our own RPNs.
10:07:01 32 Q. And as I understand it there

10:07:02 were regulations surrounding the use of
10:07:04 agency nurses; is that correct?
10:07:06 A. Yes.
10:07:06 Q. And what was your
10:07:07 understanding of the regulation?
10:07:12 A. You were to use an agency
10:07:13 nurse only in an emergency.
10:07:20 Q. And from your perspective is
10:07:22 that the way that Telfer Place operated in
10:07:25 terms of only using in cases of emergency?
10:07:28 A. I would say that we used them
10:07:29 because we urgently needed to have a nurse
10:07:32 who would cover. It might not meet that
10:07:35 same definition of emergency but we were
10:07:37 still required to have a nurse.
10:07:43 Q. And why was there a need as
10:07:44 of 2015 to use agency nurses?
10:07:48 A. We were really struggling
10:07:49 with our nursing compliment in the fact that
10:07:53 we had one of our night nurses off on
10:07:58 long-term illness; we had had another nurse
10:08:02 during that period of time who had resigned,
10:08:05 and she worked nights as well; we had
10:08:10 another nurse who was on long-term medical
10:08:14 leave as well that she was just getting
10:08:17 ready to come back but couldn't work a shift
10:08:21 independently yet because of her mobility.
10:08:25 So in a very short period of time
10:08:28 we lost several nurses. And it was
10:08:32 challenging to recruit nurses.
10:08:35 Q. And what factors, from your
10:08:37 experience, made it challenging to recruit

10:08:40 nurses to Telfer Place?
10:08:41 A. Um, we're a rural location so
10:08:44 you'll find more nurses available in larger
10:08:47 Metropolitan areas; and people didn't want
10:08:50 to drive 45 minutes or an hour to come to
10:08:53 work as a nurse, that was one of them.
10:08:56 Second part of it was hospitals
10:08:58 were also hiring. Hospitals paid higher
10:09:01 wages. A lot of people -- a lot of nurses
10:09:05 who came to us found that long-term care work
10:09:09 was much more demanding than they
10:09:15 anticipated.
10:09:15 Q. Would this be nurses that
10:09:17 hadn't had previous experience in long-term
10:09:19 care?
10:09:20 A. Yes.
10:09:23 Q. And Telfer Place is in Paris?
10:09:25 A. In Paris.
10:09:28 Q. Ontario.
10:09:29 A. Ontario.
10:09:35 Q. Any other factors, from your
10:09:37 perspective, Dian, in terms -- that made it
10:09:40 difficult in or around that time to recruit
10:09:42 nurses?
10:09:43 A. A lot of nurses don't want to
10:09:45 work nights all the time either. It's a
10:09:46 lifestyle piece if they have children.
10:09:52 Q. And the nurse that went on
10:09:53 long-term -- that went on leave, the night
10:10:01 nurse, was she strictly a night nurse?
10:10:04 A. She worked -- she would work
10:10:07 different shifts for us but she preferred

nights. So while she was -- I'm sorry.

Q. No, go ahead.

A. While she was off the full-time night line opened up. She was the part-time night line so she applied for the full-time night line, although she had no idea when she would be able to return. So we had both our full-time and our part-time, in essence our entire night line was empty.

We're a small home. We didn't have that many nurses that could plug in an extra 14 shifts in a pay period.

Q. And did you have casual and part-time nurses that you would attempt to pull from?

A. We would, yeah.

Q. And in that point in time why couldn't you simply hire more part-time or casual nurses?

A. We tried. Yes, we did try.

Q. And in terms of this difficulty in recruiting nurses was that simply in or around 2015 or 2016 or was that an ongoing situation?

A. It's always challenging to find long-term care nurses. At this point in time it seemed much harder I think because we had two night lines that -- every, every shift on nights was wide open at that point with the combination of a nurse departing and a nurse on leave.

Q. All right. And how did

10:11:38 Lifeguard get involved? Did they come to
10:11:41 you or did you go to Lifeguard?
10:11:44 A. Oh, I'm sorry, I don't recall
10:11:45 how that connection was made.
10:11:47 Q. We do have a contract that
10:11:48 was executed in July of 2015. If we can
10:11:54 turn tab Exhibit D of your affidavit and
10:11:58 document number 24136? Do you see that
10:12:12 document?
10:12:12 A. I do.
10:12:12 Q. And is that your signature
10:12:14 on -- when it gets up here. Just a second.
10:12:32 Is that your signature?
10:12:33 A. It is.
10:12:33 Q. Now we know Telfer Place was
10:12:35 using Lifeguard staff before July of 2015.
10:12:37 Are you aware as to whether there was any
10:12:39 earlier contract signed between the parties?
10:12:42 A. Yes, we would have had an
10:12:43 earlier contract.
10:12:45 Q. And do you know -- because
10:12:46 neither Telfer Place nor Lifeguard were able
10:12:49 to locate that. Do you know where that
10:12:52 particular contract would have gone?
10:12:53 A. I don't know where it went
10:12:54 to, no.
10:12:56 Q. Now, this form of contract
10:12:57 was this something that Lifeguard produced
10:13:00 or was it something drafted by Telfer Place?
10:13:04 A. This was provided by
10:13:05 Lifeguard.
10:13:05 Q. Did you vet this document

10:13:07 with anybody at head office?
10:13:10 A. I don't recall if I did or
10:13:16 not. We didn't have a standard contract for
10:13:18 agencies for Revera at that time.
10:13:25 Q. And you indicate in your
10:13:26 affidavit that shortly before you left they
10:13:28 did roll out a standard contract; is that
10:13:29 correct?
10:13:30 A. They rolled out -- yes.
10:13:32 Q. And that would have been at
10:13:33 some point before July of 2016?
10:13:35 A. I believe it was in June.
10:13:42 Q. But at the time you -- did
10:13:43 you ask for any changes to be made in the
10:13:47 template that was provided to you by
10:13:49 Lifeguard?
10:13:50 A. I don't recall that I asked
10:13:52 for any changes.
10:13:53 Q. All right. And this
10:13:57 identifies that the services Lifeguard are
10:14:00 to provide are:
10:14:01 "The services of professional
10:14:03 healthcare staff, including
10:14:08 Registered Nurses and Registered
10:14:09 Practical Nurses, and when
10:14:12 requested, P.S.W.'s within the set
10:14:14 rate schedule as attached[...]All
10:14:17 staff provided by The Company will
10:14:19 be in Good Standing with the
10:14:20 College of Nurses where applicable,
10:14:21 and have a valid registration
10:14:24 certificate."

10:14:24 And then:
10:14:24 "[...]The Company would submit,
10:14:27 upon request, proof of WSIB and
10:14:29 liability insurance[...]"
10:14:31 Is that your recollection of the
10:14:32 services that they were to provide to you?
10:14:34 A. Yes.
10:14:38 Q. And I did not see within this
10:14:40 particular agreement any requirement for
10:14:43 them to provide you with any type of resume
10:14:48 for the staff, reference checks, or criminal
10:14:52 checks and vulnerable sector checks. Was
10:14:56 that part of your agreement with Lifeguard?
10:14:58 A. Well, I'm surprised that I
10:15:00 missed that the police check, vulnerable
10:15:03 sector police check wasn't in there, quite
10:15:06 frankly, because that was very important to
10:15:08 us.
10:15:08 We would not have asked for that
10:15:11 staff person's resume. I'm sorry, you said
10:15:18 something else.
10:15:19 Q. Not that's fine.
10:15:19 A. Resume, police check and --
10:15:19 Q. So you wouldn't have asked
10:15:21 for the resume?
10:15:22 A. And references. And we
10:15:23 wouldn't have asked for the references.
10:15:24 Q. And so is it fair then to say
10:15:32 that you were relying on Lifeguard to do all
10:15:34 the -- to vet references and to obtain a
10:15:36 resume?
10:15:37 A. Absolutely.

10:15:39 Q. But you didn't require them
10:15:40 to show you any proof that they'd actually
10:15:43 done that?
10:15:43 A. No.
10:15:44 Q. Had you heard of Lifeguard
10:15:46 before you entered into this contract?
10:15:50 A. I don't remember. I'm so
10:15:53 sorry.
10:15:55 Q. Did you meet with -- we've
10:15:58 heard that the president of Lifeguard was
10:16:00 Ms. Wilmot-Smith. Did you meet with her
10:16:03 before entering into a contract to obtain
10:16:05 her staff?
10:16:07 A. I recall meeting with her in
10:16:10 my office.
10:16:11 Q. And throughout that meeting
10:16:12 did you inquire as to how the company
10:16:17 started, and what processes were in place,
10:16:19 and internal controls were in place that
10:16:22 would make sure that you got qualified,
10:16:24 experienced staff?
10:16:26 A. I don't recall the content of
10:16:27 the discussion.
10:16:33 Q. And at the time I understand
10:16:34 that Revera had an external agency service
10:16:37 provider policy? Are you aware of that?
10:16:42 A. Yes.
10:16:42 Q. And that's at tab number E,
10:16:44 document number 25535.
10:17:05 I thought it was here,
10:17:11 Commissioner.
10:17:11 This is a document dated April

10:17:19 2011, revised August 2012; do you see that?
10:17:24 THE COMMISSIONER: Maybe tab I.
10:17:35 BY MS. HEWITT:
10:17:35 Q. Yes, tab I.
10:17:37 Thank you Commissioner.
10:17:38 Now, were you familiar with this
10:17:40 particular document?
10:17:41 A. Yes.
10:17:43 Q. If we go to the second page
10:17:45 of that document under "National Operating
10:17:48 Procedure" it says:
10:17:53 "The Home will maintain a list of
10:17:56 alternate external service provider
10:17:58 agency within their respective
10:18:00 communities that meet Revera's
10:18:02 standard. The agency must provide
10:18:04 evidence of the following
10:18:05 requirements:"
10:18:05 And one of those requirements is the criminal
10:18:08 record check. It states:
10:18:09 "A process is in place to ensure
10:18:11 that all employees assigned to a
10:18:13 Revera Home have a clear criminal
10:18:16 record check and vulnerable persons
10:18:18 screening."
10:18:19 Do you see that?
10:18:20 A. Yes.
10:18:20 Q. And so that would have been a
10:18:21 requirement of Revera at the time that you
10:18:27 entered into this relationship with
10:18:30 Lifeguard?
10:18:30 A. Yes.

10:18:32 Q. And my understanding, from
10:18:33 your affidavit, is that you did not require
10:18:34 Lifeguard to provide you with proof that
10:18:36 they'd actually done those particular
10:18:39 checks; is that correct?
10:18:40 A. Correct.
10:18:41 Q. And so at the time that
10:18:43 Elizabeth Wettlaufer came to Telfer Place
10:18:46 you would not have had proof that she had
10:18:48 actually had a criminal record and
10:18:51 vulnerable sector clearance?
10:18:53 A. Correct.
10:18:59 Q. And I won't take you there
10:19:01 but Revera has a policy to check references
10:19:03 for its regular staff; correct?
10:19:05 A. Yes.
10:19:06 Q. And -- but there was no -- so
10:19:09 you would check reference of any candidates
10:19:11 that were applying for a position at Telfer
10:19:14 Place; correct?
10:19:15 A. Correct.
10:19:16 Q. But nothing for those
10:19:23 individuals coming to Telfer Place from the
10:19:24 agency staff?
10:19:26 A. No.
10:19:30 Q. And we talked earlier about
10:19:31 the requirement of annual, mandatory
10:19:33 reporting of long-term care staff, and you
10:19:37 indicated that Telfer Place would do that
10:19:39 for its regular employees?
10:19:41 A. Yes.
10:19:42 Q. And do you know whether

10:19:44 Lifeguard provided any of its staff with
10:19:47 similar education before they would enter
10:19:49 into a long-term care home?
10:19:51 A. I don't know if Lifeguard did
10:19:53 or not.
10:19:53 Q. And in terms of Telfer Place,
10:19:55 once a registered staff member --
10:20:12 A. So sorry, excuse me.
10:20:14 Q. That sounded like my phone so
10:20:14 I'm just glad it wasn't mine.
10:20:14 A. My apologies.
10:20:14 Q. That's okay.
10:20:16 You indicated that you weren't
10:20:19 aware of whether or not Lifeguard provided
10:20:22 any education to its staff coming into
10:20:24 long-term care, but other than orientation,
10:20:26 and we'll talk about orientation in a moment
10:20:28 did Telfer Place as of 2015 provide any
10:20:34 additional education to agency staff?
10:20:37 A. We provided -- we had an
10:20:40 orientation process for agency staff.
10:20:47 Q. And my understanding, and
10:20:48 we'll get to that in a minute, is that they
10:20:51 would go and have orientation and then they
10:20:53 could subsequently be assigned to a shift at
10:20:57 Telfer Place; correct?
10:20:58 A. Right.
10:20:59 Q. And then we saw from
10:21:00 Ms. Wettlaufer, for instance, that she was
10:21:02 at Telfer Place I believe between February
10:21:05 2015 and April of 2016, is that the best of
10:21:09 your recollection?

10:21:09 A. Yes.
10:21:10 Q. And so during that period of
10:21:12 time, other than orientation, would there
10:21:15 have been any additional education provided
10:21:18 to agency staff members, or Ms. Wettlaufer,
10:21:22 on the reporting requirements?
10:21:26 A. I don't know that there was
10:21:27 any additional education provided beyond
10:21:29 what was in orientation.
10:21:33 Q. And did you have a system in
10:21:34 place to conduct performance reviews of
10:21:38 Telfer Place staff?
10:21:39 A. Yes.
10:21:40 Q. And was that an annual
10:21:41 process; do you recall?
10:21:43 A. Yes.
10:21:44 Q. Was there any system in place
10:21:45 to evaluate the performance of agency staff?
10:21:49 A. No.
10:21:59 Q. Now, just before we get to
10:22:01 Elizabeth Wettlaufer, you did indicate in
10:22:02 your affidavit that there was an occasion
10:22:07 when an agency staff member did not come in.
10:22:09 Do you recall that?
10:22:12 A. In December of --
10:22:14 Q. In December of 2015?
10:22:15 A. Yes.
10:22:16 Q. And I think actually we've
10:22:17 determined through Ms. Toleff that that was
10:22:21 Ms. Elizabeth Wettlaufer that didn't show up
10:22:23 for that shift. Do you recall that?
10:22:23 A. I didn't know that it was

her.

Q. Right. But in any event, an individual did not come in for their shift in December 2015. And what steps, if any, were taken at that point in time by Telfer Place to replace that Registered Nurse?

A. So we tried all of our own nurses but we knew that we weren't able to use our own nurses because that's why we had to call an agency.

So the Director of Care was unable to come in, the Associate Director of Care was out of town. Even the Assistant Executive Director who is an RPN was unable to come in, she had a family member in the hospital that she was with.

So I called the agency and -- I was -- I believe I was the on-call manager at that time.

Q. And would that have been Lifeguard?

A. Yes.

Q. Uhm hmm.

A. So I called and said, You have to find somebody else. And they said, Well we, don't have anybody else. The person who was responsible for scheduled was I think in Florida.

And I said, I have nobody. You need to find somebody. So eventually what happened is they found a Registered Practical Nurse, and she'd never been in Telfer Place

10:23:49 1 before.
10:23:50 2 Q. Was she experienced in
10:23:51 3 long-term care?
10:23:52 4 A. She had worked in long-term
10:23:54 5 care, she told me.
10:23:59 6 Q. And did anyone go in with
10:24:01 7 this Registered Practical Nurse at this
10:24:03 8 time?
10:24:04 9 A. Yes, I went in with her
10:24:07 10 because there wasn't time to provide her
10:24:08 11 with a four-hour orientation prior to her
10:24:11 12 shift starting.
10:24:15 13 Q. So at that point in time you
10:24:16 14 would not have been meeting the Ministry's
10:24:20 15 regulations in terms of having a Registered
10:24:21 16 Nurse on duty at all times?
10:24:26 17 A. No. Oh no -- that's true, we
10:24:29 18 didn't have a Registered Nurse on duty at
10:24:31 19 all times. We did have an RPN, but because
10:24:34 20 it wasn't an RPN employed routinely at the
10:24:38 21 home, like on our regular staff roster, then
10:24:41 22 we did not meet the Ministry requirements.
10:24:43 23 Q. Now, can you tell us what
10:24:45 24 happened on that shift? Because I
10:24:46 25 understand from your affidavit there was an
10:24:47 26 issue with -- there ended up being an issue
10:24:51 27 with the way that medication was handed out?
10:24:53 28 A. Yes. So I believe it was a
10:24:56 29 3:00 to 11:00 shift. So the nurse came in,
10:25:01 30 I was alongside her so I could make sure she
10:25:04 31 was -- she knew who the resident were that
10:25:05 32 she was providing medications to.

10:25:09 1 I was there so that she could do
10:25:14 2 her medication pass and I could manage any
10:25:17 3 other, non-nursing elements that came up.
10:25:20 4 Like if there's a family concern, or
10:25:22 5 answering the phone, things like that.
10:25:26 6 Towards the -- it's a very heavy
10:25:30 7 medication pass because it's one person doing
10:25:32 8 meds for up to 45 residents.
10:25:36 9 Q. Is that the dinner pass?
10:25:37 10 A. That would be the -- yeah,
10:25:38 11 yeah, the meal pass. And she was getting
10:25:44 12 further and further behind and the residents
10:25:46 13 were getting very anxious and distressed.
10:25:51 14 And she was far behind at that point. And
10:25:56 15 so she would pour the medications, I would
10:25:58 16 carry them to the residents, not narcotics
10:26:01 17 but the -- like if somebody had, I don't
10:26:04 18 know, stool softener, or whatever the
10:26:07 19 medication was, I would carry it to the
10:26:09 20 resident.
10:26:10 21 Q. So the noncontrolled drugs?
10:26:12 22 A. That's right.
10:26:12 23 So at one point one of the
10:26:14 24 residents who had been following the RPN up
10:26:17 25 and down the hallway she was very upset. She
10:26:20 26 said, I need my insulin and I need it now.
10:26:23 27 And the nurse was very engaged with another
10:26:26 28 resident and so I said, I'm diabetic. I do
10:26:28 29 my own insulin. If you dial it do you want
10:26:32 30 me to give it to her? And she said, Yes.
10:26:34 31 And so I did.
10:26:35 32 Q. And was that something that

10:26:37 was -- it was appropriate for either you or
10:26:39 her to do?
10:26:40 A. Oh, it was not appropriate at
10:26:42 all.
10:26:44 Q. And so why did you do it?
10:26:46 A. I did it because I was so
10:26:52 concerned about that resident, about the
10:26:58 other residents.
10:26:59 Q. And did you report that
10:27:00 yourself afterwards?
10:27:01 A. I did.
10:27:02 Q. And did the Ministry come in
10:27:03 and do an investigation?
10:27:05 A. They did.
10:27:05 Q. And did they make findings of
10:27:08 noncompliance in that investigation?
10:27:10 A. They did.
10:27:11 Q. All right. So let's talk
10:27:16 then about Elizabeth Wettlaufer.
10:27:18 Now, I understand, and we've seen
10:27:20 her shift schedule before, she was first
10:27:22 assigned to shifts at Telfer Place in
10:27:25 February of 2015, is that your recollection?
10:27:27 A. Yes.
10:27:28 Q. And you talked just a moment
10:27:30 ago about orientation for agency nurses.
10:27:33 What did that entail?
10:27:34 A. There was an orientation
10:27:36 checklist for agency nurses, for agencies
10:27:44 who -- like for service providers who were
10:27:46 non-Telfer Place, non-Revera employees.
10:27:51 So the Registered Nurse who was

10:27:57 1 responsible for that orientation in the sense
10:27:59 2 of that that person -- the agency nurse was
10:28:02 3 shadowing them and getting the orientation,
10:28:03 4 would go through the items and they would
10:28:06 5 both sign off when they were completed.
10:28:12 6 Q. And how many hours of
10:28:13 7 orientation would an agency staff member
10:28:16 8 get?
10:28:17 9 A. If it was a rush it would be
10:28:18 10 four hours, if we had the luxury of time it
10:28:22 11 would be eight hours.
10:28:28 12 Q. And how many hours of
10:28:30 13 orientation would your regular staff members
10:28:35 14 get?
10:28:35 15 A. There would be classroom
10:28:39 16 orientation and then they would have usually
10:28:45 17 one day per shift, it could be two days per
10:28:49 18 shift that they were being orientated for.
10:28:51 19 So if somebody was working days it could be
10:28:54 20 one or two days. If the person felt that
10:28:56 21 they required more then we would arrange for
10:28:58 22 an additional day of orientation.
10:29:00 23 Q. And we did hear from both I
10:29:03 24 believe Ms. Raney and Ms. Beauregard that
10:29:07 25 regular staff members that were coming on
10:29:09 26 board got approximately two days per shift,
10:29:11 27 so days, evenings and nights; but in respect
10:29:17 28 of Ms. Wettlaufer or agency nurses they got
10:29:19 29 only four to eight hours of orientation.
10:29:22 30 And so why such a difference between the
10:29:26 31 orientation that is being provided to new
10:29:28 32 employees of Revera or Telfer Place and

10:29:31 1 those that are coming in and -- from an
10:29:35 2 agency?
10:29:35 3 A. Agency nurses were not viewed
10:29:40 4 as a member of the staff, for one thing.
10:29:50 5 Also, when we're using an agency nurse in
10:29:55 6 general it tended to be sort of a
10:29:57 7 last-minute emergency or urgent-type of
10:30:01 8 scenario. So we wouldn't train somebody for
10:30:03 9 two days and then maybe never use them
10:30:06 10 again.
10:30:07 11 And I'm going to say that has
10:30:08 12 happened where we would train agency nurses
10:30:13 13 in anticipation that we knew we were going to
10:30:16 14 book some shifts with them, because there was
10:30:19 15 absolutely no way we could cover them, and I
10:30:22 16 believe on at least one occasion that agency
10:30:24 17 nurse never came back again. So it was --
10:30:27 18 Q. Sorry, don't mean to
10:30:27 19 interrupt you, but was there ever a reason
10:30:32 20 given as to why after orientation that
10:30:34 21 particular nurse did not come back?
10:30:36 22 A. I can think of various
10:30:38 23 reasons why agency nurses didn't come back.
10:30:42 24 Sometimes they were coming from Hamilton or
10:30:45 25 Toronto and they didn't want to drive the
10:30:47 26 distance; sometimes they didn't like being
10:30:55 27 the only nurse, that was a fairly
10:30:58 28 significant issue for them. But we were
10:31:02 29 such a small nursing home that we didn't
10:31:06 30 have two or three nurses on.
10:31:08 31 Q. Okay.
10:31:08 32 A. So that was quite often that

they felt, I can't do this. I'm not going to be able to get through this shift.

Q. Now, you met Elizabeth Wettlaufer?

A. Yes.

Q. Did you have much interaction with her?

A. It's a small home. I had some interaction with her.

Q. And what did -- what was your experience with her? What was she like?

A. Initially we were very happy to have a nurse who understood long-term care, who knew long-term care.

She was outwardly very pleasant to the families and to staff, at least initially.

She made herself right at home at Telfer Place.

Q. And the nature of your interaction, how much interaction would you normally have with somebody that's coming in on evenings and/or nights?

A. I don't usually have that much interaction with the night team, although I would make a point of going in to see them or talking to them about different programs that we had.

The evening shift I usually had a fair amount of interaction with.

Q. And you said that she was -- she was fairly friendly with family,

10:32:41 residents and staff; is that correct?
10:32:43 A. Yes.
10:32:43 Q. But you said "initially"?
10:32:45 A. Initially.
10:32:46 Q. And what did you mean by
10:32:47 that? Did that change? And if so with
10:32:49 whom?
10:32:50 A. Staff began to grow
10:32:54 frustrated with her. Some of the nurses
10:32:56 reported -- one of the nurses reported that
10:32:59 she had talked to others and the consensus
10:33:03 was that Ms. Wettlaufer wasn't completing
10:33:07 all of the assigned duties. And through
10:33:11 that I mean making referrals that were
10:33:13 required, completing paperwork. There were
10:33:22 allegations that she was lazy, she wasn't
10:33:25 doing things that she needed to do, she
10:33:28 would put things off.
10:33:31 Q. And would these allegations
10:33:33 in terms of not completing some of the task
10:33:38 and that she was lazy, were those early on
10:33:41 in her experience with Telfer Place or
10:33:43 towards the end? Or do you recall?
10:33:45 A. I would say towards the end.
10:33:51 Q. And what if any steps did you
10:33:53 take in response to those issues?
10:33:55 A. One of the nurses came to me
10:33:57 and said, I was left with all kinds of
10:33:59 things the last time that she worked and I'm
10:34:02 very unhappy with it. And I said, Okay.
10:34:04 I'll go and talk to her because she's not
10:34:07 being paid to do only part of the work. She

10:34:12 1 has the same obligations as anybody who
10:34:14 2 works that shift.
10:34:15 3 Q. Do you recall which nurse
10:34:17 4 that was?
10:34:17 5 A. It was Tracy, Tracy Raney.
10:34:22 6 Q. And you said earlier that one
10:34:23 7 of the nurses said she had talked to the
10:34:24 8 other staff and come to you. Would that be
10:34:26 9 Tracy as well?
10:34:27 10 A. That would be Tracy as well.
10:34:30 11 Q. And did you go talk to
10:34:32 12 Ms. Wettlaufer?
10:34:33 13 A. I did.
10:34:35 14 Q. And what was her response?
10:34:37 15 A. She said, Oh, I didn't mean
10:34:38 16 to leave it for people. I think she said --
10:34:41 17 because I said to her, Do you have all the
10:34:44 18 information that you need to get that done?
10:34:45 19 And she says, Oh, I was just waiting for a
10:34:48 20 little bit more information but I'll
10:34:49 21 definitely step up and do it. And I said,
10:34:52 22 It needs to be done. You're working as the
10:34:56 23 nurse. You have this responsibility. You
10:34:58 24 must complete those responsibilities.
10:35:01 25 Q. Did she accept -- did she
10:35:04 26 acknowledge her shortcomings?
10:35:06 27 A. She said she would get -- she
10:35:09 28 would do a better job and get things done.
10:35:11 29 Q. Did you make any notes or
10:35:13 30 document that conversation at all?
10:35:17 31 A. I may have made a note in my
10:35:20 32 notebook but I didn't document it in terms

10:35:24 of keeping a file on it.
10:35:29 Q. Did you have any training
10:35:31 on -- at Telfer Place, or with Revera, in
10:35:35 terms of completing investigations and the
10:35:38 appropriate way to document incidents, that
10:35:41 type of thing?
10:35:42 A. Yes.
10:35:47 Q. And would that have been
10:35:49 before Ms. Wettlaufer would start to come to
10:35:51 Telfer Place, or after, or during?
10:35:58 A. Oh, it would have been
10:35:59 before.
10:36:00 Q. And in this particular
10:36:00 situation why would there not be a document
10:36:03 kept of what you said, what she said, et
10:36:05 cetera?
10:36:05 A. I would expect that is
10:36:05 because she was not our employee.
10:36:11 Q. And would you have done that
10:36:15 if it was your own employee?
10:36:17 A. If it was our own employee we
10:36:19 would keep track of those conversations.
10:36:21 Q. And why not keep track of it
10:36:23 for an agency staff member?
10:36:25 A. If we found an agency staff
10:36:27 member wasn't satisfactory, for whatever
10:36:29 reason, then we would say to the agency, We
10:36:35 don't want to person back.
10:36:36 Q. And at this point in time, in
10:36:39 relation to her laziness and her not
10:36:43 completing her assigned tasks, that wasn't
10:36:46 sufficient to say you didn't want her back?

10:36:49 A. I think that was the first
10:36:51 time that somebody had brought forward a
10:36:53 concern about her.
10:36:54 Q. Now, did you go back to
10:36:55 Ms. Raney and say, you know, thank you for
10:37:00 coming forward. I've got the information.
10:37:00 I've taken the action and you should see a
10:37:03 change. Any closure?
10:37:06 A. What I typically would say to
10:37:07 the -- if a staff person brought forward a
10:37:09 concern about another, a person who worked
10:37:11 at the home, I would say, what I do is I
10:37:14 will meet with this person and I will
10:37:16 address this issue. I'm not going to tell
10:37:19 you what the outcome is for it because
10:37:23 that's confidential. However, I want you to
10:37:26 rest assured that I'm dealing with it. If
10:37:29 you notice that it continues I'll need to
10:37:32 know that. Please do let me know that so I
10:37:35 can follow-up again.
10:37:36 Q. And would you follow that up
10:37:37 in writing with that same message to that
10:37:39 employee?
10:37:41 A. No, no, that would be a
10:37:42 verbal conversation.
10:37:45 Q. And would you document that
10:37:47 conversation as well?
10:37:50 A. In the notes that I was
10:37:51 taking, absolutely.
10:37:53 Q. And those notes they would
10:37:54 not make their way into the employee's file?
10:37:58 A. The notes that we would

10:38:00 take -- so are you talking about an employee
10:38:02 as a Telfer Place employee?
10:38:05 Q. No, as an agency nurse. Did
10:38:07 you keep a file on the agency nurses?
10:38:09 A. We did not keep files on
10:38:11 agency nurses.
10:38:12 Q. And Ms. Raney testified that
10:38:14 she did bring some verbal concerns forward
10:38:16 and then started to document her concerns in
10:38:19 e-mails. Do you recall her sending e-mails?
10:38:22 A. I don't believe I received
10:38:24 any of those e-mails. I think they were
10:38:26 directed to others.
10:38:27 Q. And so we'll just have a look
10:38:28 at them in any event. At tab number J to
10:38:33 your affidavit there's a document dated
10:38:36 January the 6th, and it is Exhibit 72536.
10:38:42 Have you seen this e-mail in
10:38:57 preparation for this Inquiry?
10:38:59 A. In preparation, yes.
10:39:01 Q. Do you remember whether or
10:39:02 not you would have seen it in or about
10:39:04 January of 2016?
10:39:06 A. I don't recall seeing it
10:39:07 previously.
10:39:07 Q. And this is an e-mail that
10:39:09 was sent to Ms. Toleff indicating that
10:39:12 Ms. Wettlaufer continued to leave the med
10:39:15 door -- room door and the chart room door
10:39:17 wide open and walk away. Do you see that?
10:39:20 A. Yes.
10:39:21 Q. Would that have been

10:39:21 appropriate for an agency nurse?
10:39:23 A. Not appropriate for any
10:39:24 nurse.
10:39:25 Q. And do you recall whether or
10:39:26 not, despite not seeing this document, did
10:39:28 Ms. Toleff bring that to your attention?
10:39:32 A. I don't recall, I'm sorry.
10:39:34 Q. Would you have expected her
10:39:35 to bring something like this your attention?
10:39:39 A. I would expect Sherri to
10:39:41 manage the staffing issues on -- in
10:39:45 long-term care relatively independently,
10:39:47 unless it was very significant. Although we
10:39:52 did talk back-and-forth quite a bit about
10:39:54 things I don't remember that.
10:39:56 Q. And there's a second document
10:39:59 that's dated January the 10th, 2016, and
10:40:07 it's at Exhibit K, and it's document number
10:40:14 24212. Do you see this document?
10:40:32 A. Yes.
10:40:33 Q. And it was sent to Ms. Toleff
10:40:35 and copied as well to the Associate Director
10:40:36 of Care, Lindsay Astley?
10:40:40 A. Uhm hmm.
10:40:41 Q. Sorry, you have to say yes or
10:40:42 no.
10:40:43 A. I'm sorry, yes.
10:40:44 Q. That's okay.
10:40:45 And in respect of this document do
10:40:48 you recall whether you saw it before
10:40:49 preparation for this inquiry?
10:40:52 A. I don't recall if I saw it

10:40:53 1 before.
10:40:53 2 Q. And it relates to issues
10:40:55 3 regarding two of your residents, one for
10:40:59 4 whom a report wasn't made at shift change
10:41:02 5 that there was an issue with a resident's
10:41:06 6 nail care; and the other was about a doctor
10:41:09 7 not having been called in relation to
10:41:13 8 potentially putting a resident on palliative
10:41:16 9 measures. Did you see that?
10:41:18 10 A. Yes.
10:41:18 11 Q. And do you recall whether or
10:41:20 12 not those two situations were brought to
10:41:22 13 your attention?
10:41:27 14 A. Was the resident with the
10:41:28 15 nail care a gentleman?
10:41:31 16 Q. It was. We're not -- we're
10:41:33 17 hiding the --
10:41:34 18 A. No, no, I appreciate that.
10:41:35 19 Q. Yes, it was a gentleman.
10:41:38 20 A. I recall -- I sort of vaguely
10:41:41 21 recall it. I'm going to tell you I don't
10:41:44 22 recall a lot of specific details about it.
10:41:46 23 Q. All right. And now that
10:41:47 24 you've had an opportunity to review this
10:41:49 25 document were you concerned about the level
10:41:50 26 of care that was being given by
10:41:53 27 Ms. Wettlaufer, as reported by Ms. Raney?
10:42:01 28 A. I'm sorry, say that again.
10:42:04 29 Q. Now that you've had an
10:42:05 30 opportunity to review what had happened in
10:42:07 31 terms of Bethe Wettlaufer not relaying
10:42:10 32 information to other registered staff, about

10:42:12 1 the nail care, for instance, and not having
10:42:15 2 called the doctor, were you concerned having
10:42:18 3 seen that with the level of care she was
10:42:21 4 providing?
10:42:22 5 A. This is concerning.
10:42:23 6 Q. Right. And you don't know
10:42:26 7 what steps if anywhere taken after this was
10:42:29 8 received by Ms. Toleff?
10:42:30 9 A. Sorry, I don't remember.
10:42:33 10 Q. And, again, this is not
10:42:34 11 something, from your perspective, that would
10:42:37 12 be documented and put in a file for an
10:42:40 13 agency nurse?
10:42:42 14 A. We did not keep files on
10:42:44 15 agency nurses.
10:42:47 16 Q. And we know that
10:42:49 17 Ms. Wettlaufer continued to work at Telfer
10:42:51 18 Place past this. So it fair to assume that
10:42:54 19 this wasn't sufficient to stop that
10:42:55 20 relationship?
10:43:00 21 A. I would expect that the
10:43:06 22 Director of Care would have looked at it and
10:43:09 23 tried to assess was this -- you know, get
10:43:11 24 some more information on the episodes to
10:43:13 25 find out if there was a gap that was
10:43:16 26 actually there. Because this is an initial
10:43:20 27 report that somebody -- a concerned somebody
10:43:22 28 has brought forward, and so then to
10:43:24 29 investigate and find out what actually
10:43:26 30 happened. That would be my expectation.
10:43:28 31 Q. And was there a process put
10:43:29 32 in place that if these types of issues were

10:43:33 reported to the Director of Care and
10:43:35 potentially investigate that they would make
10:43:38 their way to your desk?
10:43:40 A. Yes.
10:43:40 Q. And was that both in respect
10:43:42 of both agency nurses and regular staff?
10:43:44 A. Yes.
10:43:45 Q. And would you have expected
10:43:46 either of these situations to potentially
10:43:48 have been a situation of neglect? And I'm
10:43:56 just saying "potentially" because we don't
10:43:59 know the investigation, but based upon your
10:44:03 reading of this could it have potentially
10:44:06 identified a situation of neglect?
10:44:08 A. It could have potentially
10:44:09 identified.
10:44:10 Q. And if that was the decision
10:44:11 that was made would that need to be reported
10:44:13 to the Ministry?
10:44:14 A. If it was neglect then yes.
10:44:16 Q. And you'd have to report that
10:44:18 whether it was agency staff or your regular
10:44:21 staff; is that correct?
10:44:22 A. Oh yes.
10:44:23 Q. And we don't believe, and I
10:44:24 can be corrected by my Ministry friends, I
10:44:27 don't believe any report was initiated with
10:44:30 respect to these two matters?
10:44:32 A. I don't recall a report being
10:44:33 initiated for this.
10:44:36 Q. And then finally I'd like to
10:44:38 take you to Tracy Raney's e-mail February

10:44:40 7th, 2016, back to document 72536 at Exhibit
10:44:47 J.
10:45:12 Sorry, Commissioner, it appears
10:45:13 that only one page of that document
10:45:15 is at Exhibit J. Do you have two
10:45:18 pages of one?
10:45:20 THE COMMISSIONER: I have just
10:45:20 one.
10:45:21 BY MS. HEWITT:
10:45:21 Q. This has already been entered
10:45:23 into evidence but if we can just look at the
10:45:25 screen? February 7, 2016, an e-mail from
10:45:29 Tracy to Ms. Astley regarding a situation
10:45:32 with two agency nurses, Ms. Raney testified.
10:45:37 The first in relation to an issue with an
10:45:40 agency nurse not giving out all the
10:45:44 narcotics, putting feed into the water bag
10:45:46 of a resident; and the second in relation to
10:45:49 Ms. Wettlaufer wanting to know if other
10:45:51 agencies are being used.
10:45:53 Do you recall prior to this Inquiry
10:45:57 seeing this particular e-mail of February
10:46:00 7th, 2016?
10:46:01 A. I don't recall seeing it.
10:46:03 Q. All right. And now that you
10:46:05 have had an opportunity to review it, in
10:46:07 preparation for this Inquiry, did those two
10:46:10 situations provide you with any cause for
10:46:12 concern?
10:46:14 A. Yes.
10:46:15 Q. And would you have expected
10:46:15 those two situations to have been

10:46:18 investigated?
10:46:19 A. Yes.
10:46:20 Q. But at the time none of this
10:46:22 was brought -- to the best of your
10:46:24 recollection this was not brought to your
10:46:26 attention?
10:46:26 A. I don't recall it coming to
10:46:28 my attention.
10:46:29 Q. All right. And is it a
10:46:31 concern regarding the nurse not giving out
10:46:34 all of the narcotics to Telfer Place
10:46:37 residents?
10:46:38 A. I'm not really familiar with
10:46:42 all of the specific details related to when
10:46:47 medication errors occur. I'm concerned that
10:46:51 narcotics weren't given out and that
10:46:54 residents were experiencing -- potentially
10:46:57 experiencing pain.
10:46:58 Q. And to the best of your
10:46:59 knowledge this didn't come to your attention
10:47:01 as a situation -- an investigated situation
10:47:04 of neglect?
10:47:05 A. Not to my knowledge.
10:47:06 Q. And no report made to the
10:47:07 Ministry in respect of any of these issues?
10:47:11 A. No, not that I'm aware of.
10:47:13 Q. Now, in February 2016 you
10:47:16 identified within your affidavit that you
10:47:18 actually worked with Ms. Wettlaufer for a
10:47:21 shift; is that correct?
10:47:22 A. I did.
10:47:23 Q. All right. So can you tell

10:47:24 us a bit about what led you to having -- to
10:47:28 working with her and what happened on that
10:47:29 shift?
10:47:29 A. We had a very large enteric
10:47:36 outbreak and it affected not only residents
10:47:40 but staff.
10:47:42 Q. And when you say "enteric"
10:47:43 for the lay person what does that mean?
10:47:45 A. It's a stomach bug, usually
10:47:47 involved vomiting and diarrhea, often at the
10:47:50 same time.
10:47:53 Q. Okay.
10:47:53 A. And I believe it was a
10:47:54 Norovirus determined by public health that
10:47:57 it was a Norovirus. So that's the cruise
10:48:01 ship Norwalk that people get.
10:48:05 Q. Okay.
10:48:06 A. So it was particularly
10:48:08 virulent. We had to enact our Pandemic
10:48:11 Plan, which means that if -- I believe if
10:48:13 it's 60 percent of your staff are affected
10:48:16 that you bring other staff in who can do the
10:48:20 bare minimum to maintain resident safety and
10:48:23 well being.
10:48:26 So it was -- I believe it was on a
10:48:32 weekend I came in. And I have done quite a
10:48:36 bit of attendant care when I was going
10:48:41 through university and such so I knew how to
10:48:46 do personal care. So I came in and worked
10:48:49 the night shift as the PSW in place of the
10:48:52 PSW.
10:48:53 Q. And Elizabeth Wettlaufer

10:48:53 would have been the night shift RN on?
10:48:56 A. She was.
10:48:58 Q. And did you have an
10:48:59 opportunity, I understand from your
10:49:00 affidavit, to interact with both her and
10:49:02 Sandra Towler; is that correct?
10:49:05 A. We did, yeah.
10:49:06 Q. So can you tell us about that
10:49:07 interaction?
10:49:08 A. Sure. I was working -- I was
10:49:10 responsible for the residents on -- during
10:49:13 rounds on the end of the hall where Sandy
10:49:15 was, Sandy Towler.
10:49:18 And I went into her room and we
10:49:20 were wearing personal protective equipment,
10:49:23 gloves, gowns and a mask that had a face
10:49:28 shield on it, a clear face shield. And Sandy
10:49:31 was frightened so I pulled my mask down and I
10:49:32 said, It's just me, Sandy, because she knew
10:49:35 me. And Bethe was with me.
10:49:36 And Sandy had been incontinent with
10:49:40 this stomach bug. So she had watery diarrhea
10:49:44 that was probably at least mid-back or higher
10:49:48 down to her knees on her back.
10:49:50 So Bethe stood on the -- I was on
10:49:52 the right side of the bed, Bethe was on the
10:49:54 left, rolled her over. I washed her down and
10:49:58 Bethe said, Okay, that's good enough. And I
10:50:00 looked and I could still see on Sandy's back,
10:50:05 you could see that, you know, where there was
10:50:07 still some soiling there. And I said, It's
10:50:08 not good enough. She's not clean yet.

10:50:12 And I was already quite impatient
10:50:15 with her because she just comes into the
10:50:17 room, loud, when it's night.
10:50:18 Q. You're impatient not with
10:50:20 Ms. Towler but with Ms. Wettlaufer?
10:50:22 A. With Ms. Wettlaufer. Because
10:50:24 she came into the room talking loudly, it's
10:50:26 night time, it's a four bedroom, she doesn't
10:50:28 need to wake everybody up.
10:50:29 So I said, no, she's not done until
10:50:31 she's fresh and clean and she's got new
10:50:34 bedding and a new nightgown. She said, Oh --
10:50:37 I said, She still has feces on her. And she
10:50:41 said, Oh, I didn't see that.
10:50:42 Q. What was the lighting like in
10:50:44 the room?
10:50:45 A. There's one light above the
10:50:48 bed that casts down towards the wall.
10:50:51 Q. And what you were seeing was
10:50:52 that on your side of the bed or on her side
10:50:55 of the bed?
10:50:56 A. Her side.
10:50:58 Q. And were you concerned about
10:50:59 the fact that she hadn't picked up that
10:51:01 there was still some cleanliness and
10:51:06 personal care to be given to Ms. Towler?
10:51:10 A. I was concerned and I
10:51:12 suspected she was just being lazy. Like,
10:51:15 this is good enough. And it's not good
10:51:17 enough. So we stayed until Ms. Towler was
10:51:20 completely clean and changed and everything
10:51:22 was done.

10:51:23 And then I said, We'll go down and
10:51:25 look at your other residents now. Because I
10:51:27 suspect that she hasn't done proper care.
10:51:29 Q. And what did you find when
10:51:30 you looked at the other residents?
10:51:32 A. Some residents were fine.
10:51:34 Some residents did have feces, diarrhea in
10:51:37 their incontinent product. However this was
10:51:41 such a virulent bug that people would have
10:51:45 diarrhea sometimes -- it could happen
10:51:48 minutes after you walked away from them.
10:51:54 Like we were just seeing it. It was just
10:51:55 such a terrible bug.
10:51:57 So it could have -- there was like
10:51:59 absolutely a large area of doubt. Did she
10:52:05 change -- she said, Well, I changed her. She
10:52:10 was dry when I looked at her. Which could
10:52:13 have been. It's not one of these things you
10:52:15 can definitely prove.
10:52:16 Q. But you had concern about the
10:52:18 level of care at least that you had seen her
10:52:19 give to Ms. Towler, is that correct?
10:52:20 A. I thought she was lazy with
10:52:22 it.
10:52:23 Q. And did you follow-up after
10:52:24 the outbreak was finished? Did you
10:52:27 follow-up with Ms. Wettlaufer to discuss
10:52:28 this issue with her?
10:52:30 A. We both got sick after
10:52:31 working that shift. I didn't see her for a
10:52:33 while. I don't know when the next time was
10:52:36 that I saw her.

10:52:36 At that point in time Dan Relik [ph] who was the DOC, had given his notice and so I was engaged with trying to find another DOC.

So it was -- yeah, there was a period of time. But I had said to her, you know, when we were doing the -- doing the shift, I'll do all of the rounds now with you.

Q. Okay. So one of the concerns that may arise out of this situation is that you are the actual top management person within Telfer Place at that period of time, correct?

A. Yes.

Q. And you're doing work with her, correct?

A. Yes.

Q. And she's being noisy and she's not, from your perspective, giving appropriate care, correct?

A. Yes.

Q. And yet when she's generally on shift on the night shift she's simply with a PSW?

A. Yes.

Q. And did you have any concern that if she would do this in front of you as her -- the person in charge of the entire Telfer Place, would she actually be performing these duties, the same level of care with the PSWs in attendance?

10:53:46 A. I think when you have a nurse
10:53:53 who's not great at what he or she does that
10:53:57 you have concerns like that, whether it's
10:54:04 your own employee or whether it's another
10:54:06 employee.
10:54:06 On nights you have less opportunity
10:54:09 to supervise to see exactly what's happening,
10:54:12 because there's that expectation that they'll
10:54:14 be able to independently do their work. So I
10:54:20 think there are concerns about that.
10:54:22 Were those concerns so significant
10:54:28 that -- or were they one off? So that's all
10:54:32 the different pieces of information that you
10:54:34 balance when you're looking at it. And when
10:54:37 you say to somebody, you make sure people are
10:54:39 clean, you make sure that you get your work
10:54:41 done. And then you don't hear back that it's
10:54:44 another issue again.
10:54:45 And I will tell you the night staff
10:54:47 and the evening staff at Telfer Place would
10:54:49 bring forward concerns that they felt
10:54:51 affected the care of the residents.
10:54:53 Q. Right. So you weren't
10:54:54 concerned that if they were -- did have
10:54:57 issues that they wouldn't report it? Is
10:54:59 that correct?
10:55:00 A. I was not concerned that they
10:55:01 wouldn't report it, I knew they would.
10:55:03 Q. And that's based on your
10:55:05 experience?
10:55:05 A. Based on my experience with
10:55:06 that team.

10:55:07 Q. And would they report regular
10:55:09 staff? An issue with a regular staff?
10:55:15 A. Oh yes.
10:55:15 Q. And from your perspective
10:55:17 they wouldn't have an issue reporting agency
10:55:20 staff?
10:55:20 A. That's right.
10:55:21 Q. And did anybody come forward
10:55:22 in relation to your staff with -- in
10:55:25 relation to the care that was given by
10:55:27 Ms. Wettlaufer, other than what we've seen
10:55:30 by Ms. Raney?
10:55:32 A. At the very end of
10:55:34 Ms. Wettlaufer's time with us one of the
10:55:38 PSWs, Lauren, had come forward and had said
10:55:42 that her back was starting to get sore
10:55:45 because Bethe wasn't doing rounds with her.
10:55:55 And that was quite a concern because we have
10:55:58 heavy people.
10:55:59 Q. And would that have been on
10:56:01 the night shift when there was only one PSW
10:56:04 and Ms. Telfer?
10:56:05 A. That's correct.
10:56:07 Q. And so just take you back to
10:56:09 this enteric outbreak, did you have any
10:56:12 discussions with Ms. Wilmot-Smith at that
10:56:16 point in time as to the level of care you
10:56:17 had seen Ms. Wettlaufer giving?
10:56:19 A. No.
10:56:20 Q. Did you alert Ms. Toleff as
10:56:22 to what you had experienced while on this
10:56:25 particular shift?

10:56:25 A. I think Dan was with us at
10:56:27 that point.
10:56:28 Q. Ms. Toleff had left? Is that
10:56:30 correct?
10:56:31 A. Yes.
10:56:40 Q. In any of your interactions
10:56:40 with Ms. Wettlaufer did you notice the smell
10:56:44 of alcohol at all?
10:56:45 A. Never.
10:56:46 Q. Did she ever slur her words?
10:56:48 A. Never.
10:56:48 Q. Did she ever stumble?
10:56:50 A. No.
10:56:50 Q. Did you ever suspect that she
10:56:52 was under the influence of alcohol?
10:56:53 A. No.
10:56:54 Q. Did any staff member come to
10:56:56 you with any concerns in relation to the use
10:57:00 of drugs or alcohol by Ms. Wettlaufer?
10:57:02 A. No.
10:57:03 Q. Now, we have heard that she
10:57:05 did make a comment to one staff member that
10:57:07 she was one year sober. Do you recall
10:57:10 whether that was brought to your attention?
10:57:13 A. No. No. I vaguely recall a
10:57:17 comment about that she didn't drink. I
10:57:20 don't know if she made that comment to me
10:57:23 or -- I think she did.
10:57:25 Q. Did she ever share with you
10:57:26 that she had mental health issues?
10:57:29 A. Never.
10:57:29 Q. Did any other staff member

10:57:32 1 come forward indicating that she had shared
10:57:34 2 mental health issues with them?
10:57:36 3 A. No. No, not that I'm aware
10:57:38 4 of.
10:57:39 5 Q. Now, if we move forward to
10:57:43 6 April 2016 as I understand it you had a new
10:57:47 7 Director of Care in place; is that correct?
10:57:51 8 A. In April?
10:57:51 9 Q. Yes.
10:57:52 10 A. Yes.
10:57:52 11 Q. And that was Michelle
10:57:54 12 Cornelissen.
10:57:55 13 A. Yes.
10:57:55 14 Q. I may not be pronouncing her
10:57:55 15 name right.
10:57:55 16 And did you become aware that she
10:58:01 17 had advised Lifeguard she no longer wanted
10:58:04 18 Ms. Wettlaufer at Telfer Place?
10:58:07 19 A. Yes. I believe we had a
10:58:08 20 conversation and it was right when Lauren
10:58:11 21 had come to me and said that her back was
10:58:14 22 getting sore and Bethe wasn't helping her,
10:58:16 23 and I think there was something about that
10:58:18 24 she'd injured -- she may have injured her
10:58:21 25 wrist. I'm so sorry I don't recall all of
10:58:25 26 those details about it.
10:58:26 27 Q. Did Michelle take care of
10:58:28 28 that?
10:58:30 29 A. I believe -- I believe that
10:58:34 30 Michelle at that point in time had -- she'd
10:58:38 31 heard about it. She called Lifeguard and
10:58:40 32 said, Forget it. Because I was going to

10:58:42 tell, if I didn't already at that moment,
10:58:45 tell her she's gone. I'm done with her.
10:58:49 Q. And what was the tipping
10:58:50 point for you?
10:58:51 A. The issues that Lauren had
10:58:54 reported, and the other thing is that Lauren
10:58:56 had said that she -- that Bethe had spoken
10:59:00 what she thought was sharply to a resident.
10:59:03 Something about, I'll get there.
10:59:05 Q. And when this was reported to
10:59:06 you that she had spoken sharply to a
10:59:08 resident, was that investigated to determine
10:59:11 whether or not that was an instance of
10:59:14 verbal abuse at all?
10:59:16 A. I didn't investigate it as an
10:59:18 incident of verbal abuse, I looked at it and
10:59:22 thought it was not a respectful way to
10:59:25 relate to the residents.
10:59:26 Q. And this would have been in
10:59:27 or around the time that Ms. -- that Michelle
10:59:30 advised Lifeguard no longer to assign
10:59:33 Ms. Wettlaufer shifts?
10:59:34 A. I think everything happened
10:59:36 in the same day, probably within the same
10:59:39 hour or two.
10:59:40 Q. And then you left Telfer
10:59:41 Place, as I understand it, in or around July
10:59:44 of 2016?
10:59:44 A. Yes.
10:59:48 Q. Now, one of the difficult
10:59:49 questions that I'm asking everybody within
10:59:53 the Commission is what impact, if any, the

knowledge of what Elizabeth Wettlaufer would have done at Telfer Place has had? Are you able to provide us with a little insight?

A. Sure. Sorry.

Q. The Commissioner has advised us that taking a glass of water is helpful, a drink of water is helpful, but only if you can continue.

A. No, I would like to.

I was devastated and just horrified to hear about the crimes and that it was Sandy, because everybody adored Sandy. Why would anybody want to do this? I can't imagine how awful this is for all of the families. It breaks my heart for them. I'm very sad for them.

It's overwhelming because we worked alongside somebody who was evil and we didn't know it. We thought she was lazy. We didn't know that this was her thing. She wanted to get rid of somebody, these people that we cherished.

And we worked really hard at Telfer Place to create an environment where people were honoured and their humanity was recognized, and where they felt safe and where the families would say, It's an old home but we really love the staff there and they love us. We know they do. Which is true.

So the other thing is I'm so angry at her because long-term care is not the

11:01:50 place where people want to go to any how.
11:01:54 Pretty much everybody wants to die before you
11:01:56 move into long-term care, given the option.
11:01:59 And we're trying really hard to
11:02:03 create that environment where people felt
11:02:06 good about moving into long-term care, and
11:02:08 she stole that away from everybody. That
11:02:13 idea of this can be okay. I am not betraying
11:02:17 my parent. I'm not betraying my loved one.
11:02:20 This is going to be okay. There will not be
11:02:25 anything bad that happens to my mom or my
11:02:27 dad. And she took that away from everybody.
11:02:30 And we're underfunded. There
11:02:35 should never be a nursing home where you just
11:02:38 have two people on at night. But that's --
11:02:41 that happens all the time.
11:02:42 And now I'm worried that at the end
11:02:46 of the Inquiry what will happen is that there
11:02:49 will be a demand that we have more staff but
11:02:53 the demand will be to supervise other staff
11:02:57 not to give care to the residents.
11:03:01 Q. And you have long-term staff
11:03:03 at Telfer Place?
11:03:04 A. We have staff that have been
11:03:06 there since practically the day it opened.
11:03:08 There's many staff that have been there 20
11:03:11 years.
11:03:11 Q. Were the residents supportive
11:03:13 when everything became known?
11:03:15 A. I wasn't at the home at that
11:03:16 time.
11:03:17 Q. All right.

11:03:22 A. But I know what the staff are
11:03:24 like at that home there, fantastic.
11:03:26 Q. And had Revera or yourself
11:03:32 taken any steps prior to your leaving to
11:03:35 decrease the use of agency staff?
11:03:37 A. We had spent a ton of time
11:03:40 trying to develop different strategies.
11:03:43 We'd gotten involved with the new grad
11:03:46 initiative so that we could have RNs who
11:03:50 were on staff who could be there as
11:03:52 additional support. So, for example, they
11:03:54 would do part of the med pass. They would
11:03:59 learn how to do all the referrals and to do
11:04:02 the assessments.
11:04:03 And they would do those pieces of
11:04:05 the RN job so the RN could take a break, so
11:04:09 the RN didn't have to stay for an hour after
11:04:12 the end of her shift.
11:04:14 Q. Now, we've heard a little bit
11:04:16 about that initiative but my recollection,
11:04:17 from the testimony, is that you had to offer
11:04:21 a position with those new graduates after
11:04:24 they were done their stint; is that correct?
11:04:27 A. The expectation was that you
11:04:29 would do your best to offer them a position.
11:04:31 Q. And were you able to at
11:04:34 Telfer place?
11:04:35 A. I wasn't there at the end of
11:04:37 that. We were really looking at those night
11:04:40 lines that we had as -- would that be able
11:04:44 to -- we were going to offer everyone at
11:04:46 least part-time, but we were trying to put

11:04:48 1 together full-time.
11:04:50 2 Q. All right. And did --
11:04:51 3 before -- did it decrease before you left
11:04:55 4 the use of agency nurses?
11:04:59 5 A. I honestly couldn't tell you
11:05:01 6 how much it did decrease if it did.
11:05:03 7 Q. Okay. Those are all my
11:05:05 8 questions Commissioner?
11:05:06 9 THE COMMISSIONER: Thank you very
11:05:07 10 much.
11:05:10 11 MS. HEWITT: Ms. McAleer.
11:05:13 12 MS. MCALEER: I have no questions
11:05:16 13 in-chief, thank you.
11:05:16 14 THE COMMISSIONER: Thank you.
11:05:17 15 MS. HEWITT: Mr. Van Kralingen?
11:05:19 16 MR. VAN KRALINGEN: No question.
11:05:20 17 MS. HEWITT: Mr. Scott?
11:05:21 18 MR. SCOTT: No questions.
11:05:21 19 MS. HEWITT: Ministry.
11:05:23 20 MS. MINGO: Just a few.
11:05:33 21 CROSS-EXAMINATION BY MS. MINGO:
11:05:45 22 Q. Good morning, Ms. Shannon.
11:05:47 23 Good morning, Madam Commissioner.
11:05:48 24 My name is Alex Mingo, I'm counsel
11:05:53 25 for the Province of Ontario. I want to ask
11:05:55 26 you just a few things that are in your
11:05:56 27 affidavit. But first I wanted to ask you a
11:05:58 28 bit more about education and support provided
11:06:00 29 for staff in Telfer Place.
11:06:02 30 A. Yes.
11:06:02 31 Q. So I recall you saying Revera
11:06:05 32 provides some training on the requirements

11:06:08 of the Long-Term Care Home Act; is that
11:06:10 right?
11:06:12 A. Yes.
11:06:12 Q. Okay. Could you describe
11:06:14 that a little bit more?
11:06:15 A. So we would talk about
11:06:17 residents' rights; we would -- we would
11:06:22 provide training on residents' rights; we
11:06:26 would provide training on non-abuse; we
11:06:29 would provide training on duty to report.
11:06:33 Q. And this was annual; is that
11:06:34 right?
11:06:35 A. Annual training.
11:06:37 Q. And if you had any questions
11:06:39 about compliance were you able to seek any
11:06:41 guidance on that from within Revera?
11:06:44 A. Yes.
11:06:44 Q. And who in Revera would you
11:06:46 speak to?
11:06:47 A. I would contact the Regional
11:06:48 Manager for Clinical Services, that was
11:06:52 Cheryl Muse [ph].
11:06:53 Q. Okay. Did -- to your
11:06:56 knowledge did Revera ever retain consultants
11:06:59 to advise on the requirements of the
11:07:01 legislation?
11:07:02 A. At our head office?
11:07:04 Q. Yeah. Or in your experience?
11:07:06 A. I don't know about
11:07:08 consultants but we had people at head office
11:07:11 who were able to provide us with
11:07:13 information.

11:07:14 Q. Okay. To your knowledge did
11:07:17 Revera ever seek any legal advice on
11:07:20 compliance questions?
11:07:21 A. Oh, I don't know if Revera
11:07:23 sought it.
11:07:24 Q. But you had resources
11:07:25 internally if you had questions about
11:07:27 compliance?
11:07:28 A. That's correct.
11:07:29 Q. And are any resources on the
11:07:32 requirements of the legislation available
11:07:34 through the Ontario Long-Term Care Homes
11:07:34 Association?
11:07:39 A. I imagine, yes.
11:07:40 Q. Okay. Do you have any
11:07:41 experience with those yourself?
11:07:42 A. For the reaching out to the
11:07:45 OLTCA? We would typically use the Revera
11:07:50 resources if we had questions.
11:07:52 Q. Does the Local Health
11:07:53 Integration Network in the area where Telfer
11:07:56 Place is located hold meetings with
11:07:59 Administrators and Directors of Care?
11:08:02 A. Yes.
11:08:02 Q. Have you ever attended one?
11:08:04 A. Yes.
11:08:04 Q. At those meetings can you ask
11:08:06 questions about how to comply with the Act?
11:08:09 A. Yes.
11:08:09 Q. Did you ever attend any
11:08:11 meetings where that was discussed?
11:08:13 A. Typically the meetings that I

attended there would be discussion about either surveys that were occurring right at that time or that had finished.

Q. Surveys of the homes?

A. Sorry, I should say yeah, inspections.

Q. Oh inspections, okay.

A. We used to call them "surveys".

Q. But you had the opportunity to speak with other Administrators and DOCs at these meetings?

A. Yes.

Q. And exchange information about best practices?

A. Yes.

Q. In your affidavit at paragraphs 26 and 27 you discuss what it's like when the Ministry comes in to conduct an inspection of a home. Now, my understanding is that Telfer Place is a home for vulnerable adults that require a lot of care; is that correct?

A. Do you mean the long-term care.

Q. Yes, sorry.

A. It's a long-term care home.

Q. And because the residents need a lot of care they're at risk of harm if that care is not provided properly?

A. Correct.

Q. So there's an obligation to

document any errors that are made?

A. Errors? Like medication do you mean?

Q. Medication error or -- yeah.

A. There is an obligation. Absolutely they need to document medication errors.

Q. And to document any complaints that are made?

A. Yes.

Q. And to document any incidents that might cause harm to a resident?

A. Yes.

Q. And so it's important to ensure that standards and policies regarding resident care are being met in long-term care homes?

A. Correct.

Q. Now you mentioned the old compliance advisory regime in here, now under that regime the Ministry would conduct a review of the home's documentation to see whether a home was complaint; is that correct?

A. Yes.

Q. And if something hadn't been documented the Ministry wasn't able to tell whether there had been compliance; is that correct?

A. Yes.

Q. Because they were only looking at the home's documents not the

paper record?

A. I'm sorry, they were only looking at --

Q. Because the Ministry was only looking at the home's documents and not the paper record provided?

A. What paper record?

Q. When the Ministry would conduct a review under the compliance advisory regime they would look at the homes documentation?

A. Yes.

Q. So it was just a paper review?

A. No, no, they would come into the home. Is that what you mean? I'm sorry I don't understand.

MS. HEWITT: To be fair for witness, you're asking what the Ministry would do or know but perhaps ask what the witness knows, her experience with the Ministry.

BY MS. MINGO:

Q. Sure, fair enough.

Let me try this a different way. In assessing whether care is being properly provided a long-term care home it's important to be able to speak to the residents to assess the quality of that care?

A. Yes.

Q. And to speak to family

11:11:08 members?
11:11:08 A. Yes.
11:11:09 Q. And to observe activities in
11:11:10 the homes such as medication passes?
11:11:12 A. Uhm hmm.
11:11:13 Q. This is to ensure that the
11:11:15 home is providing safe and secure care for
11:11:17 its residents?
11:11:18 A. Correct.
11:11:18 Q. And so in order to assess
11:11:20 this quality of care it's important to
11:11:22 observe all operations in the home?
11:11:25 A. Yes.
11:11:27 Q. And, finally, are you aware
11:11:31 that the Ministry conducted an inspection of
11:11:34 Telfer Place between October 2016 and March
11:11:38 2017 regarding the period of time
11:11:40 Ms. Wettlaufer worked there?
11:11:41 A. I'm aware of that, yes.
11:11:43 Q. You were interviewed as part
11:11:44 of that inspection?
11:11:45 A. I was interviewed.
11:11:46 Q. And you are aware that an
11:11:48 inspection report was issued following that
11:11:50 inspection?
11:11:50 A. I became aware of it with
11:11:52 this proceeding.
11:11:53 Q. Okay. Now my understanding,
11:11:55 and feel free to correct me, is that this is
11:11:58 included in the health -- Ministry of Health
11:12:01 Overview Report but it is not on the website
11:12:02 so I will put this in as an exhibit; is that

11:12:07 correct?
11:12:08 MS. HEWITT: That's correct.
11:12:08 Unless it's been previously put to
11:12:10 any witness but I do not believe
11:12:11 so.
11:12:11 MS. MINGO: I don't believe so.
11:12:23 MS. HEWITT: Do you have an
11:12:24 additional copy as an exhibit?
11:12:28 Thank you.
11:12:37 MS. MINGO: This is DOC ID 41478
11:12:45 please?
11:12:46 THE COMMISSIONER: And were you
11:12:47 tendering it as an exhibit?
11:12:55 MS. MINGO: Yes, please.
11:12:56 THE COMMISSIONER: Madam Clerk,
11:12:56 what's our next exhibit number
11:12:57 please?
11:12:58 THE REGISTRAR: 82.
11:12:59 THE COMMISSIONER: Exhibit 82
11:12:59 then. It's a document, Ministry
11:12:59 of Health and Long-Term Care
11:13:02 inspection report dated May 24
11:13:04 2017 document 41487.
10:11:39 EXHIBIT NO. 82: Ministry of Health
10:11:39 and Long-Term Care inspection
10:11:39 report dated May 24 2017, document
10:11:39 number 41487.
11:13:22 MS. MCALEER: Madam Commissioner,
11:13:22 I have no objection to this
11:13:23 document being entered as an
11:13:23 exhibit at this point, but I don't
11:13:23 think it's clear that this witness

has actually ever seen this document before or that she saw it at the time that it was released. Just to be clear.

THE COMMISSIONER: Ms. Mingo is going to establish that but thank you.

BY MS. MINGO:

Q. Have you have seen a copy of this report before?

A. I saw it within the last week.

Q. Are you aware that the report identified a number of areas of noncompliance within Telfer Place during this time?

A. Yes.

Q. So you're aware that the report found that the home had failed to conduct criminal reference checks before hiring staff with regard to agency staff?

A. I wasn't clear on whether or not that was agency staff or if it was employees at Telfer Place.

Q. Sure. Could we go to page 5 please?

A. Yes.

Q. So take a second to review this if you want, but you'd agree that the finding here is that:

"The licensee failed to ensure that screening measures, including

11:14:12 criminal reference checks, were
11:14:14 conducted in accordance with
11:14:15 regulations before they hired
11:14:18 staff."
11:14:18 And before beau that you'll see
11:14:20 details of agency Registered Nurses?
11:14:22 A. Okay. Yes.
11:14:26 Q. And are you aware the report
11:14:28 found that the home had failed to ensure
11:14:30 that agency staff received training as
11:14:32 required? Including training on zero
11:14:34 tolerance of abuse and neglect and the duty
11:14:38 to report?
11:14:39 A. I saw that.
11:14:43 Q. And you were aware that the
11:14:45 report found that:
11:14:46 "The home failed to ensure that a
11:14:47 record was kept for each staff
11:14:49 member of the home that included at
11:14:51 least verification of their current
11:14:53 certification of registration with
11:14:54 the College with regard to agency
11:14:55 nurses."
11:14:57 A. I saw that.
11:14:58 Q. Thank you, those are am my
11:14:59 questions.
11:15:01 THE COMMISSIONER: Ms. Mingo, was
11:15:02 that last one also in relation to
11:15:04 staff at --
11:15:04 MS. MINGO: Yes.
11:15:04 THE COMMISSIONER: -- the
11:15:04 agency --

11:15:06 MS. MINGO: Yes.
11:15:06 THE COMMISSIONER: So all those
11:15:07 three findings are in relation --
11:15:10 MS. MINGO: Yes. These findings
11:15:10 are all in relation and that you
11:15:11 can find at page 12.
11:15:13 THE COMMISSIONER: We both spoke
11:15:14 at the same time so if I can just
11:15:15 ask my question and then you could
11:15:17 answer I would be grateful.
11:15:18 So each of the 3 areas of
11:15:20 noncompliance that you just asked
11:15:23 the witness about were all in
11:15:25 relation to agency staff; is that
11:15:26 correct.
11:15:29 MS. MINGO: Yes, that's correct.
11:15:30 THE COMMISSIONER: Thank you.
11:15:34 MS. MINGO: Thank you.
11:15:35 MS. HEWITT: Commissioner, would
11:15:38 you like me to continue canvassing
11:15:40 or would you like to take the
11:15:41 morning break.
11:15:42 THE COMMISSIONER: Well, I think
11:15:43 based on our experience yesterday
11:15:45 we should canvass because then if
11:15:47 people are almost done then we
11:15:49 would be able to let the witness
11:15:50 go.
11:15:51 MS. HEWITT: Happy to do that.
11:15:55 ONA.
11:15:55 MR. BUTT: I do have some
11:15:58 questions but I can't be more than

7 minutes so it will be brief.
MS. HEWITT: OARC? Do you have many? Oh sorry, College.
MS. BINHAMMER: Five minutes.
MS. HEWITT: Five minutes. OARC?
MS. MEADUS: I probably have five minutes and I would like a break.
THE COMMISSIONER: All right. I was just going to say, as soon as I see there is that number this would be an appropriate time to take the morning break. Thank you, counsel.
-- RECESSED AT 11:16 A.M.
-- RESUMED AT 11:35 A.M.
CROSS-EXAMINATION BY MS. BUTT:
Q. Thank you, Madam Commissioner.
Dian, my name is Nicole Butt, and I am counsel for the Ontario Nurses Association and I just have a few questions for you.
You were asked at the very beginning, which I'm sure seems a long time ago, about how many Registered Nurses you had in management, and you said that you had two, Sherri Toleff, the DOC, and then the ADOC, and was that Lindsay Astley?
A. Yes.
Q. Okay, and are you aware that she is actually a Registered Practical Nurse?

11:33:16 A. Yes.
11:33:17 Q. Okay, so --
11:33:19 A. Registered staff I meant.
11:33:21 Q. Registered staff is what you meant?
11:33:22 A. She was registered.
11:33:23 Q. Okay, so when there is the managers rotating on call, there was really only one Registered Nurse in management and one Registered Practical Nurse?
11:33:31 A. Yes.
11:33:32 Q. Okay. And you were also asked about the cost savings between RNs and RPNs. Are you aware of the difference in practice between an RN and an RPN?
11:33:40 A. Yes.
11:33:42 Q. Okay, and if you could bring up Exhibit 31, which is document 54989. So are you aware then that RNs have a four-year university degree, whereas RPNs have a two-year college diploma?
11:33:55 A. Yes.
11:33:55 Q. Okay, and if you could go to page 3, are you familiar with this document I guess is the first question? This is the Practice Standard from the College of Nurses.
11:34:05 A. Yes, I have seen it.
11:34:06 Q. Okay. And so the guiding principles, if you could stop right there:
11:34:12 "The basis for decision-making when

working within interprofessional teams:"

And the second bullet point on the right-hand side:

"RNs and RPNs study from the same body of nursing knowledge. RNs study for a longer period of time, allowing for greater foundational knowledge and clinical practice, decision-making, critical thinking, leadership [...] As a result [...], the level of autonomous practice of RNs differs from that of RPNs."

Is that your understanding of the difference?

A. Yes.

Q. Okay. And do you also understand they have different entry to practice competencies as a result of their education?

A. I am not familiar with the term "entry to practice competencies".

Q. Okay, so when they write their exams and to become licensed, they have to have a certain number of practice competencies, and they differ. Are you aware that they differ for RNs?

A. No.

Q. Okay. And in terms of costs, we have heard evidence earlier in this proceeding that the cost of an agency nurse

11:35:17 1 was between $62 and $65 an hour; is that
11:35:20 2 your understanding?
11:35:21 3 A. That sounds right.
11:35:22 4 Q. Okay. And what do the
11:35:24 5 Registered Nurses at Telfer Place make?
11:35:28 6 A. I believe if they were at the
11:35:29 7 top of the wage grid, they were making about
11:35:33 8 $42 an hour perhaps.
11:35:35 9 Q. So there would be around a
11:35:37 10 $20 to $25 difference between the cost of an
11:35:40 11 agency nurse and the cost of a Staff Nurse?
11:35:42 12 A. Correct.
11:35:42 13 MS. BUTT: Okay, those are all my
11:35:44 14 questions, thank you.
11:35:44 15 THE WITNESS: Thank you.
11:35:44 16 THE COMMISSIONER: Thank you, Ms.
11:35:45 17 Butt.
11:35:48 18 MS. HEWITT: The College of
11:35:49 19 Nurses.
11:35:58 20 MS. SCHWARTZENTRUBER: Good
11:35:58 21 morning, Commissioner.
11:35:59 22 THE COMMISSIONER: Good morning.
11:35:59 23 CROSS-EXAMINATION BY MS. SCHWARTZENTRUBER:
11:35:59 24 Q. Good morning, Dian. Is it
11:36:03 25 okay if I continue to call you Dian?
11:36:05 26 A. Please do.
11:36:05 27 Q. Okay. My name is Meagan
11:36:06 28 Schwartzentruber. I am one of the lawyers
11:36:08 29 in relation to -- here representing the
11:36:10 30 College of Nurses of Ontario, and so it is
11:36:11 31 from that background that I am going to ask
11:36:13 32 you just a few questions.

Ms. Hewitt had asked you some questions about an incident where you had performed or you were on shift with a PSW -- or sorry, with the -- yeah, I think it was the PSW where you administered the insulin?

A. I was on shift with an RPN from the agency.

Q. With an RPN, thank you.

Now, I understand you had already given some evidence that you are not trained as a nurse?

A. Correct.

Q. And you don't have any other training as any other kind of regulated health professional?

A. Correct.

Q. Thank you. And I understand as a result, you have never been registered with the College of Nurses of Ontario?

A. Correct.

Q. The insulin that you administered to the resident on that one occasion, that was by injection?

A. Yes, it was an insulin pen.

Q. Okay. And I understand or is it fair to say that you understand that giving a resident insulin is a controlled act under the regulation and the legislation?

A. Well, I do now. I didn't realize it at the time.

Q. Okay. So at the time that

11:37:17 you were on shift that day, did you realize
11:37:21 that it was only persons authorized under
11:37:23 the statute that were supposed to be
11:37:25 providing insulin in that capacity?
11:37:28 A. It should have been only the
11:37:29 nurse giving any medication.
11:37:33 Q. And I understand the only
11:37:35 reason that incident arose was because you
11:37:37 were short-staffed and you were trying to
11:37:39 cover the shift, you were trying to assist?
11:37:42 A. That is why we had the RPN,
11:37:43 correct.
11:37:44 Q. Right, and then you were also
11:37:45 working because you were --
11:37:46 A. I was helping the RPN because
11:37:47 she was so desperately behind.
11:37:49 Q. Okay. And I understand at
11:37:53 the time you understood that it wasn't the
11:37:56 proper procedure, which is why eventually
11:37:58 you reported it to your superior?
11:37:59 A. Yes.
11:38:01 Q. The fact that you had
11:38:01 administered the insulin?
11:38:02 A. Yes.
11:38:03 Q. Who did you report it to?
11:38:06 A. I spoke about it with Cheryl
11:38:06 Muise and then I contacted John Beaney, who
11:38:10 was the VP of Operations for Long-Term Care.
11:38:12
11:38:13 Q. And, sorry, what was the name
11:38:14 of the VP Operations?
11:38:15 A. John Beaney.

11:38:19 Q. So after you reported that,
11:38:21 were you aware of what steps they were going
11:38:23 to take in relation to the information you
11:38:24 provided?
11:38:27 A. Of which steps that who was
11:38:28 going to take, sorry?
11:38:29 Q. When you reported it to the
11:38:31 two individuals you just talked about --
11:38:32 A. Yes.
11:38:32 Q. -- did you know what they
11:38:34 were going to do with that information?
11:38:40 A. No, I don't know what they
11:38:41 would do with it.
11:38:42 Q. Okay, so you were just
11:38:43 following your obligations to report it to
11:38:44 your superiors?
11:38:45 A. Yes.
11:38:45 Q. And I understand at some
11:38:46 later point you did realize that they had
11:38:48 reported it to the Ministry of Health and
11:38:50 Long-Term Care?
11:38:52 A. I can't remember who reported
11:38:53 it to the Ministry, to be honest.
11:38:54 Q. But at some point it was
11:38:55 reported?
11:38:56 A. It was.
11:38:56 Q. And are you aware of whether
11:38:59 anyone at Telfer Place ever reported or I
11:39:02 should say ever alerted the College of
11:39:04 Nurses as to what had taken place with
11:39:06 respect to you providing the insulin?
11:39:08 A. I don't know.

11:39:08 Q. You don't know, okay. Did
11:39:10 you ever hear anything about the College
11:39:13 becoming involved?
11:39:13 A. No.
11:39:14 MS. SCHWARTZENTRUBER: Okay, those
11:39:16 are all my questions.
11:39:17 THE COMMISSIONER: Thank you, Ms.
11:39:18 Schwartzentruber.
11:39:21 MS. HEWITT: OARC?
11:39:21 CROSS-EXAMINATION BY MS. MEADUS:
11:39:21 Q. Good morning. My name is
11:39:43 Jane Meadus. I am here on behalf of the
11:39:45 Ontario Association of Residents' Councils,
11:39:47 and I am sure you are aware that there is
11:39:49 Residents' Councils in all long-term care
11:39:51 homes in Ontario?
11:39:51 A. Yes.
11:39:52 Q. And that the organization
11:39:54 that I represent is an umbrella organization
11:39:56 for those groups?
11:39:57 A. Yes.
11:39:59 Q. Okay. All right, so I'm just
11:40:01 going to follow up just for a minute on some
11:40:03 questions that the Ministry asked you.
11:40:05 You had indicated and there was
11:40:09 talk about the old system, and there was
11:40:10 some questions around it being a paper
11:40:11 review, so I just wanted to just ask a
11:40:14 couple of questions about that.
11:40:15 So under the old system under the
11:40:18 Nursing Homes Act, when the Compliance
11:40:19 Advisor came in, they would come in and go

11:40:21 into like a boardroom or some room; is that
11:40:23 correct?
11:40:25 A. In my experience --
11:40:27 Q. Yes.
11:40:27 A. -- when they would come in,
11:40:29 they would be out in the home areas and they
11:40:30 would be talking to residents and families.
11:40:32 Q. And that was under the old
11:40:33 system?
11:40:34 A. Yes, they would -- they would
11:40:36 get information. I believe their process
11:40:39 has changed, but I have never seen an
11:40:41 inspection where they only looked at paper
11:40:43 and never spoke with anybody.
11:40:45 Q. Okay, so that was not your
11:40:46 experience?
11:40:46 A. That was not my experience at
11:40:48 all.
11:40:48 Q. Okay, all right. And you
11:40:49 were also indicating that you were concerned
11:40:51 about the fact that you could no longer
11:40:54 contact the Ministry and ask questions; is
11:40:56 that correct?
11:40:57 A. Yes.
11:40:59 Q. And in fact, I think you said
11:41:00 that at one point you had spoken to the
11:41:02 Ministry and you were told to just look at
11:41:04 the regulations and do what it says; is that
11:41:07 correct?
11:41:08 A. Pretty much, yes.
11:41:08 Q. Okay. So would you agree
11:41:09 that one recommendation that the Commission

11:41:12 could make would be to have maybe a separate
11:41:15 department that could answer those kinds of
11:41:17 questions for long-term care homes?
11:41:19 A. I think that would be very
11:41:20 helpful.
11:41:21 Q. Okay, thanks. All right, so
11:41:22 I'm going to talk to you about this incident
11:41:24 that occurred, and I understand you have
11:41:27 already indicated that you are not an RN or
11:41:30 an RPN; is that correct?
11:41:31 A. Correct.
11:41:32 Q. And you are also not a PSW;
11:41:33 is that correct?
11:41:34 A. Correct.
11:41:34 Q. And there are requirements to
11:41:35 be a PSW as well under the legislation?
11:41:38 A. That's right.
11:41:39 Q. Okay. All right, so in the
11:41:41 incident, and I'm just going to bring up
11:41:45 documents for you, and this is the
11:41:46 compliance -- the Inspection Order
11:41:52 from that specific incident.
11:41:54 A. Uhm-hmm.
11:41:55 Q. Okay, and I'm presuming that
11:41:56 you have seen this document before? Did I
11:41:58 give you three documents there?
11:42:00 MS. HEWITT: You did.
11:42:02 BY MS. MEADUS:
11:42:02 Q. Okay. So this is document
11:42:11 41823, and I don't believe that it has been
11:42:16 put in before. And have you seen this
11:42:18 document before?

11:42:19 A. I have seen the document
11:42:20 but --
11:42:22 Q. Okay, so this would have come
11:42:25 to you when you were --
11:42:26 A. Do you mean as evidence
11:42:27 already?
11:42:28 Q. No, no, this would have come
11:42:29 to you when you were at the home; is that
11:42:31 correct?
11:42:31 A. Yes.
11:42:31 Q. Okay, so you are familiar
11:42:32 with the document?
11:42:33 A. Yes.
11:42:33 MS. MEADUS: All right, so could
11:42:34 we get this put in as the next
11:42:36 exhibit?
11:42:36 THE COMMISSIONER: Yes, we can,
11:42:37 thank you.
11:42:37 I think that is Exhibit 83, is it,
11:42:40 Madam Clerk?
11:42:40 THE COURT CLERK: Yes,
11:42:40 Commissioner.
11:42:40 THE COMMISSIONER: Yes, Exhibit 83
11:42:41 then, a multi-page document from
11:42:43 the Ministry and it is -- have we
11:42:46 got a date on here?
11:42:48 MS. MEADUS: I believe the date is
11:42:49 March the 8th, 2016.
11:42:52 THE COMMISSIONER: Is that on --
11:42:57 oh, yes, thank you.
11:42:58 MS. MEADUS: It is on the front
11:42:59 page.

11:42:59 1 THE COMMISSIONER: Thank you, Ms.
11:43:00 2 Meadus, yes, absolutely. The
11:43:01 3 report date is March 8, 2016,
11:43:03 4 thank you.
10:11:39 5 EXHIBIT NO. 83: Ministry of Health
10:11:39 6 and Long-Term Care, Orders of the
10:11:39 7 Inspector, dated March 8, 2016.
11:43:04 8 BY MS. MEADUS:
11:43:04 9 Q. And so I'm going to bring you
11:43:05 10 to page 11, which is the specific order
11:43:08 11 which relates to this incident, all right.
11:43:17 12 And so in fact, in your affidavit you
11:43:22 13 indicated that there was a finding with
11:43:24 14 respect to not having a 24/7 nurse; is that
11:43:27 15 correct?
11:43:29 16 A. Yes.
11:43:29 17 Q. Was that your recollection?
11:43:30 18 Okay, so if you look at this
11:43:33 19 order, you can see under "Order" in fact it
11:43:36 20 actually says that:
11:43:37 21 "The licensee shall ensure that the
11:43:39 22 Executive Director does not
11:43:40 23 administer a drug to a resident in
11:43:41 24 the home unless that person is a
11:43:42 25 physician, dentist, registered
11:43:45 26 nurse or a registered practical
11:43:47 27 nurse."
11:43:48 28 Do you see that?
11:43:49 29 A. Yes.
11:43:49 30 Q. So that was the actual order;
11:43:51 31 is that correct?
11:43:52 32 A. Yes.

11:43:52 Q. And you indicated that you
11:43:53 did report it to your superiors at Revera;
11:43:56 is that correct?
11:43:57 A. Uhm-hmm.
11:43:57 Q. And was there any
11:43:58 consequences for you from that from Revera?
11:44:02 A. When I spoke with John Beaney
11:44:04 and I explained the situation, he said he
11:44:08 understood why I did it, but John is also
11:44:11 not a nurse.
11:44:12 Q. Okay, so there was no -- you
11:44:13 were not disciplined at all for this?
11:44:15 A. I was not disciplined for it.
11:44:16 Q. Okay. And if you look at the
11:44:17 next part under the "Grounds", so you can
11:44:22 see at the end it says:
11:44:23 "This noncompliance was issued with
11:44:25 a severity of risk of harm with a
11:44:27 scope of pattern."
11:44:29 And I understand that to mean that
11:44:31 this was a serious issue; would you agree?
11:44:33 A. A serious issue, yes.
11:44:34 Q. Okay, thank you, but there
11:44:35 was -- they said they understood and there
11:44:38 was no consequences to you at all?
11:44:40 A. Yes.
11:44:40 Q. Okay, thank you. And you
11:44:42 also indicated that later on you worked with
11:44:46 Ms. Wettlaufer as a Personal Support Worker;
11:44:49 is that correct?
11:44:49 A. That's correct.
11:44:50 Q. But you are not a Personal

Support Worker?

A. I am not a Personal Support Worker.

Q. And did you report this incident to Revera?

A. Well, Revera was involved. Our Regional Manager for Clinical Services was aware of what our staffing pattern was.

Q. Okay, so did you report that you were working as a PSW even though you were not one?

A. Well, I believe that they knew that I was doing the night shift.

Q. And was there any discipline for that for you?

A. There was no discipline required. We were following our pandemic act -- or our pandemic process.

Q. And did you report to the Ministry that you were acting as a PSW even though you were not entitled to do so?

A. I didn't. I don't know who reported it to the Ministry, but they did an investigation and said no, because we were following our pandemic plan.

MS. MEADUS: Okay, thank you, those are my questions.

THE COMMISSIONER: Thank you, Ms. Meadus.

MS. HEWITT: AdvantAge.

CROSS-EXAMINATION BY MR. SCHWARTZ:

Q. Good morning, Madam

11:45:54 Commissioner. Good morning, Dian. My name
11:45:56 is Jared Schwartz, and I am here asking
11:45:59 questions on behalf of AdvantAge Ontario.
11:46:02 Amanda, if you wouldn't mind just
11:46:04 pulling up the witness's affidavit, please.
11:46:05 Thank you. And looking for paragraph 19,
11:46:19 which would be at page 6. Thank you.
11:46:25 So, Dian, I just want to ask you
11:46:27 about this one area of your affidavit here
11:46:29 where you talk about the sort of workload
11:46:31 for RNs and the regulations that they have
11:46:33 to comply with.
11:46:34 So I'll just take a second to read
11:46:36 paragraph 19 and part of 20. You state:
11:46:39 "There are a lot of regulations and
11:46:41 demands for documentation under the
11:46:42 [Long-Term Care Homes Act]. Nurses
11:46:45 are very concerned about completing
11:46:47 all of their documentation
11:46:48 requirements because of their fear
11:46:49 of not meeting Ministry and policy
11:46:51 requirements or compromising their
11:46:53 nursing licence. There are
11:46:54 numerous policies for registered
11:46:55 staff to follow.
11:46:57 In terms of the RN's shift
11:46:59 routine, documentation probably takes two
11:47:01 hours of the nurse's time per shift."
11:47:04 So my question relating to that
11:47:05 is, in your own observations, did the amount
11:47:09 of paperwork and the amount of regulation
11:47:12 and requirements, did that interfere in any

11:47:15 way with the RN's ability to deliver actual
11:47:19 hands-on care?
11:47:20 And just for context, before you
11:47:22 answer my question, I am not suggesting in
11:47:25 any way that care fell below a standard at
11:47:28 Telfer Place, but what I am trying to
11:47:30 understand and to have the Commissioner
11:47:31 understand is whether the amount of
11:47:36 administrative kind of work and regulation
11:47:39 compliance kind of work that RNs do
11:47:41 interferes with what might otherwise be
11:47:43 their core function, which is delivering
11:47:44 care?
11:47:47 A. I think the more
11:47:49 administrative work that nurses are required
11:47:50 to do, the less time they have with
11:47:54 residents, yes.
11:47:55 Q. And that applies to what you
11:47:56 have stated here about spending the time on
11:47:59 shift trying to make sure that they have
11:48:01 complied with all of the applicable rules
11:48:03 and regulations?
11:48:05 A. There are extensive
11:48:06 requirements for documentation by the
11:48:08 nurses. If a resident falls, there could be
11:48:13 an additional two hours' worth of
11:48:15 documentation by the time they wrap up all
11:48:17 of the assessments, the referrals, sending a
11:48:20 resident out to the hospital, bringing a
11:48:22 resident back in, notifying everyone. It is
11:48:26 an extraordinary amount of paperwork that
11:48:28 they are required to do.

Do I think that it interferes with the way that they are able or wish to give care to the resident? I think it does. I think the amount of face time that nurses get with residents is diminished.

MR. SCHWARTZ: Thank you, those are my questions.

THE COMMISSIONER: Thank you, Mr. Schwartz.

MS. HEWITT: ONA?

MS. BINHAMMER: No questions.

MS. HEWITT: And RPNAO.

CROSS-EXAMINATION BY MR. SINGH:

Q. I do have some questions. It still is morning, so good morning, Dian.

A. Good morning.

Q. My name is Shaun Singh. I am counsel on behalf of the Registered Practical Nurses Association of Ontario, and so I just have a few quick questions hopefully.

At paragraph 17 of your affidavit, you state that Registered Nurses need to do medication passes. Would you agree with me that RPNs can also perform med passes?

A. Yes.

Q. Now, I'll just turn now to the Nursing and Personal Care Envelope. You were responsible for budgeting the Nursing and Personal Care Envelope; correct?

A. Correct.

11:49:37 Q. And the Ministry does set out some eligible expenditures with respect to the envelope; correct?
11:49:43 A. Yes.
11:49:45 Q. So one of those eligible expenditures is for nursing and personal care direct care staff, and so this would include RNs, RPNs, PSWs, as well as some other nursing aides and other direct care staff; correct?
11:49:48 A. Correct.
11:49:50 Q. Additionally, the Ministry also permits the use of the envelope for nursing and personal care direct care administration staff; correct?
11:49:52 A. Sorry, can you say that again?
11:49:55 Q. So the Ministry, one of the eligible expenditures that the Ministry outlines for the envelope also includes the administration staff, so Director of --
11:50:00 A. Like a ward clerk -- or I'm sorry, you were talking about a Director of the -- yes, that's correct.
11:50:03 Q. And so management or managerial staff?
11:50:04 A. Yes.
11:50:08 Q. Additionally, the Ministry permits the use of the envelope for nursing and personal care supplies, so for example, masks, tubing, pumps, diapers, pads, liners, catheters, et cetera?
11:50:10
11:50:14
11:50:17
11:50:20
11:50:21
11:50:21
11:50:24
11:50:27
11:50:31
11:50:32
11:50:35
11:50:37
11:50:38
11:50:39
11:50:40
11:50:43
11:50:47
11:50:49
11:50:53
11:50:57

11:50:59 A. Yes. Briefs, not diapers.
11:51:07 Q. Correct, I apologize.
11:51:08 On the same lines, the Ministry
11:51:10 also permits the use of the envelope for
11:51:12 certain equipment, so for example, computer
11:51:15 equipment, toileting equipment, nursing and
11:51:17 medical, for personal hygiene and grooming?
11:51:21 A. Yes.
11:51:24 Q. And on the same token, the
11:51:25 Ministry also permits the use of that
11:51:27 envelope for education and training with
11:51:29 respect to nurses, so for example, workbooks
11:51:32 and manuals, reference materials, the cost
11:51:35 of educators, attendance costs for approved
11:51:38 NPC education, so mileage, transportation,
11:51:43 hotels, meals; correct?
11:51:45 A. That sounds correct.
11:51:47 Q. So I'm going to just quickly
11:51:50 go through those again. Did Telfer Place
11:51:53 use the envelope for staffing of RNs, RPNs
11:51:57 and PSWs, so direct care nursing?
11:51:59 A. Yes.
11:52:00 Q. Did Telfer Place use the
11:52:02 envelope for the direct care administration
11:52:05 staff?
11:52:07 A. For the Director of Care and
11:52:08 the Associate Director of Care, yes.
11:52:12 Q. Did Telfer Place use the
11:52:14 envelope for NPC supplies, so that would be
11:52:18 the masks, tubing, pumps --
11:52:20 A. Yes.
11:52:21 Q. On the same token, did Telfer

11:52:23 Place use the envelope for equipment?
11:52:27 A. Yes.
11:52:28 Q. Computer, toileting, et
11:52:29 cetera?
11:52:30 A. Uhm-hmm, yes.
11:52:32 Q. And so finally, did Telfer
11:52:35 Place use the envelope for any education and
11:52:38 training?
11:52:39 A. Yes.
11:52:43 Q. So approximately how much of
11:52:45 the envelope was spent on NPC direct care
11:52:50 staff, so your RNs, RPNs, PSWs, nursing
11:52:52 aides, et cetera, versus all of the other
11:52:56 categories of eligible expenditures?
11:52:58 A. It probably ranged from about
11:53:00 85 to 95 percent, in my experience.
11:53:04 Q. And that was --
11:53:06 A. That you would use for your
11:53:07 labour costs.
11:53:07 Q. Thank you.
11:53:08 A. The labour costs would
11:53:09 include your WSIB and associated expenses
11:53:16 that are related to labour.
11:53:17 Q. Correct, and any other
11:53:18 benefits that are outlined by the Ministry?
11:53:21 A. That's correct.
11:53:24 Q. So turning very quickly to
11:53:26 the incident where you administered insulin,
11:53:31 the nurse -- the RPN that was on staff was
11:53:35 an agency RPN?
11:53:37 A. Correct.
11:53:38 Q. And you did testify that she

didn't receive any orientation prior to starting her shift; is that correct?

A. She came in and I met her there and did walk her through some of the orientation pieces, absolutely, but told her I would be there, if the fire alarm went off, that I would be there to take care of those kind of pieces.

Q. Okay, and approximately how long does that orientation generally take?

A. It is normally a four-hour orientation process.

Q. And what is covered in that orientation, just generally?

A. So you would talk about the building itself. You would talk about home-specific policies. You would talk about non-abuse. You would talk about emergency codes, for example, code red, code blue, code yellow, et cetera.

You would review who different people are in the building, like in the home. How do you access services. How do you -- like if something happened with the maintenance department or a toilet broke, how would you handle that situation, as well as all of the mandatory requirements.

MR. SINGH: Okay. And those are all my questions. Thank you, Dian.

THE WITNESS: Thank you.

MR. SINGH: Thank you,

11:54:55 Commissioner.
11:54:55 THE COMMISSIONER: Thank you,
11:54:56 Mr. Singh.
11:54:59 MS. HEWITT: Ms. McAleer?
11:54:59 MS. McALEER: No re-examination,
11:55:00 thank you.
11:55:01 THE COMMISSIONER: Thank you.
11:55:02 MS. HEWITT: I have no
11:55:02 re-examination.
11:55:03 THE COMMISSIONER: All right,
11:55:03 thank you very much. That means
11:55:04 you are free to go. I just want
11:55:05 to thank you on behalf of the
11:55:07 Inquiry. We know it is difficult,
11:55:08 but it is very important and we
11:55:10 appreciate your candour and help.
11:55:15 THE WITNESS: Thank you.
11:55:25 THE COMMISSIONER: Madam Clerk,
11:55:26 just before we move on, did I say
11:55:28 that that last exhibit that went
11:55:30 in, the Ministry of Health one,
11:55:33 the March 8th, 2016, did I
11:55:35 identify that as Exhibit 83?
11:55:38 THE COURT CLERK: Yes.
11:55:39 THE COMMISSIONER: All right,
11:55:39 thank you.
11:55:45 MS. HEWITT: I am just trying to
11:55:46 find my questions for the next
11:55:47 witness, Commissioner, which might
11:55:49 help.
11:55:51 MS. McALEER: And I think we need
11:55:52 to find the witness.

11:55:53 MS. HEWITT: And find the witness
11:55:53 as well.
11:56:26 THE COMMISSIONER: The gremlins
11:56:27 got in your documents, did they?
11:56:29 MS. HEWITT: Apparently, and I
11:56:29 thought I was just actually
11:56:31 scribbling on it, Commissioner, so
11:56:32 --
11:56:33 THE COMMISSIONER: Take a minute
11:56:33 and get yourself organized, and if
11:56:35 you need a brief recess, just tell
11:56:37 me, please.
11:56:41 MS. HEWITT: Could we just have
11:56:42 five minutes?
11:56:44 THE COMMISSIONER: Yes. Serious
11:56:45 gremlin issues today, folks.
11:56:54 MS. HEWITT: Maybe I handed it up
11:56:54 with one of the documents.
11:56:56 -- RECESSED AT 11:56 A.M.
11:56:59 -- RESUMED AT 12:00 A.M.
12:00:07 Ms. HEWITT: They appeared
12:00:07 magically.
12:00:07 THE COMMISSIONER: Good gremlins,
12:00:07 then.
12:00:08 MS. HEWITT: If we could call Ms.
12:00:11 Sherri Toleff to the stand, please.
12:00:18 SHERRI LEE TOLEFF: SWORN.
12:00:56 EXAMINATION IN-CHIEF BY MS. HEWITT:
12:00:56 Q. Ms. Toleff, would you prefer
12:01:03 Sherri or Ms. Toleff?
12:01:04 A. Sherri is fine.
12:01:05 Q. Okay. And I understand that

12:01:06 1 you swore an affidavit in this matter;
12:01:08 2 correct?
12:01:09 3 A. Correct.
12:01:09 4 Q. And it should be in front of
12:01:11 5 you. If I can turn you to page 16, right
12:01:14 6 before tab "A".
12:01:15 7 A. Okay.
12:01:19 8 Q. Is that your signature?
12:01:20 9 A. It is.
12:01:21 10 Q. Now, Commissioner, I
12:01:23 11 understand, and Sherri, I understand that
12:01:25 12 there is one correction to take place. It
12:01:27 13 is to the same exhibit that we corrected in
12:01:29 14 Ms. Shannon's affidavit. It is also Exhibit
12:01:32 15 "C" in respect of Sherri's affidavit.
12:01:35 16 So if you can just turn to tab
12:01:38 17 "C", Sherri?
12:01:40 18 A. Yes.
12:01:41 19 Q. My understanding is that the
12:01:43 20 hours on the bottom of that sheet under
12:01:46 21 December 2007 under "PSW", the very last
12:01:52 22 line should say "1 x 7.5 hours"; is that
12:01:56 23 correct?
12:01:57 24 A. Correct, yes.
12:01:57 25 Q. So subject to that
12:01:58 26 correction, are there any other corrections
12:02:00 27 for your affidavit?
12:02:01 28 A. No.
12:02:02 29 MS. HEWITT: All right, so I
12:02:02 30 would like to make this the next
12:02:04 31 exhibit, Commissioner.
12:02:05 32 THE COMMISSIONER: All right,

12:02:05 thank you, the affidavit of Sherri
12:02:06 Toleff, Exhibit No. 84.
10:11:39 EXHIBIT NO. 84: Affidavit of
12:02:12 Sherri Toleff.
12:02:13 BY MS. HEWITT:
12:02:13 Q. And, Sherri, I understand
12:02:14 from your affidavit that you have been a
12:02:16 Registered Nurse since 2004?
12:02:17 A. Yes.
12:02:18 Q. And you joined Telfer Place
12:02:20 as Director of Care in 2008?
12:02:22 A. Yes.
12:02:22 Q. And in general, what were
12:02:23 your duties as Director of Care at Telfer
12:02:25 Place?
12:02:27 A. So I would manage the Nursing
12:02:28 Department in long-term care and any hiring,
12:02:33 HR, maintaining Ministry compliance
12:02:39 guidelines, following Revera policy.
12:02:45 Q. Now, we have heard this
12:02:46 morning from Dian Shannon about the
12:02:48 difficulty that Telfer Place ran into in
12:02:52 recruiting and retaining staff and the
12:02:55 subsequent use of agency staff; do you
12:02:56 recall that?
12:02:57 A. Yes.
12:02:58 Q. All right. And from your
12:02:59 perspective, can you shed any further light
12:03:03 on the difficulties that Telfer Place was
12:03:05 having in respect of recruiting and
12:03:09 maintaining staff, regular staff versus the
12:03:11 use of agency nurses?

12:03:13 A. So I think a lot of the
12:03:15 struggle was the ratio of 45 residents to
12:03:17 one staff, one Registered Nurse.
12:03:24 Q. Did you hear that from any
12:03:26 potential staff members themselves, or is
12:03:28 that an assumption on your part?
12:03:30 A. No, we heard that.
12:03:31 Q. From people that had come in
12:03:33 to be oriented?
12:03:34 A. Oriented and then quit or
12:03:37 staff that were not staff, I guess, but
12:03:40 potential staff that we were interviewing.
12:03:44 Q. And did you take any steps or
12:03:45 were there any steps that you could take to
12:03:48 change that particular situation in terms of
12:03:50 the ratio of nursing staff to residents?
12:03:56 A. We had reviewed possible
12:03:59 alternative nursing models where there was
12:04:04 another RPN in addition to the RN.
12:04:09 Q. And were you able to put that
12:04:11 into effect in or about 2015 or '16?
12:04:14 A. No.
12:04:15 Q. All right, and why not?
12:04:17 A. It wasn't in the budget. We
12:04:18 didn't have the extra funds in the nursing
12:04:21 budget to do that at that time.
12:04:24 Q. And when you say the "nursing
12:04:25 budget", is that what we have been hearing
12:04:27 about as the Nursing and Personal Care
12:04:29 Envelope?
12:04:30 A. Correct, yes.
12:04:31 Q. And were you responsible in

12:04:32 part for allocating that budget?
12:04:36 A. I was responsible to try to
12:04:38 follow it as best I could and had input into
12:04:41 developing it, but ultimately it was the
12:04:45 Executive Director.
12:04:45 Q. And each year that you were
12:04:46 there, did you use that budget up in full?
12:04:49 A. Yes.
12:04:54 Q. Now, your affidavit goes
12:04:56 through again background in terms of agency
12:04:59 nurses, et cetera, but what I want to talk
12:05:02 to you about is your role in the actual
12:05:05 scheduling and education of those nurses; is
12:05:08 that okay?
12:05:12 Were you involved at all in the
12:05:15 negotiation of the contract with Lifeguard
12:05:18 for the supply of agency nurses?
12:05:20 A. No.
12:05:21 Q. That would have been Ms.
12:05:22 Shannon?
12:05:23 A. Yes.
12:05:24 Q. Did you ever meet with Ms.
12:05:25 Heidi Wilmot-Smith in terms of attempting to
12:05:30 vet her or her agency?
12:05:32 A. Not in attempts to vet her,
12:05:34 no. I did meet her at one point in time.
12:05:36 Q. All right. And was Lifeguard
12:05:43 able to provide you at all times with staff
12:05:45 that had experience in long-term care?
12:05:48 A. I believe so. We requested
12:05:50 that. I don't recall nurses that didn't
12:05:53 have experience in long-term care.

12:05:56 Q. And what would be the process
12:05:58 that you would undertake if you needed an
12:06:01 agency staff member from Lifeguard?
12:06:04 A. So I would review the
12:06:05 schedule at Telfer to see shifts that were
12:06:08 needed, and then I would call the scheduler
12:06:10 at Lifeguard.
12:06:15 Q. And was the scheduling of
12:06:20 agency staff -- Your Honour, I am not
12:06:25 feeling very well. Could we just take a
12:06:26 brief break?
12:06:27 THE COMMISSIONER: Absolutely.
12:06:28 MS. HEWITT: Thank you.
12:06:28 -- RECESSED AT 12:06 P.M.
12:06:28 -- RESUMED AT 12:14 P.M.
12:14:26 MR. ZIGLER: Madam Commissioner,
12:14:27 having spoken with Ms. Hewitt and
12:14:28 Ms. Merrifield, we think it might
12:14:30 be best to take an early lunch if
12:14:32 we could, and at that point we'll
12:14:33 see where we are. We should be
12:14:34 able to resume at that point.
12:14:36 THE COMMISSIONER: All right, I am
12:14:37 certainly happy to do that. So it
12:14:38 is quarter after 12:00. What time
12:14:41 would we --
12:14:41 MR. ZIGLER: Come back at 1:30?
12:14:45 THE COMMISSIONER: I'm happy with
12:14:46 that.
12:14:47 So could I just have a sense of
12:14:48 what we are planning for the
12:14:49 balance of the day? Assuming that

12:14:50 1 we just carry right on starting at
12:14:52 2 1:30, we have Ms. Toleff, and was
12:14:54 3 she our last witness for the day,
12:14:55 4 do you know?
12:14:57 5 MR. ZIGLER: There was one more.
12:14:58 6 MS. MERRIFIELD: There is one
12:14:58 7 more, Michelle Cornelissen, for
12:15:00 8 today.
12:15:00 9 THE COMMISSIONER: Okay, and is
12:15:01 10 she here?
12:15:04 11 MS. McALEER: Yes, she is. She is
12:15:05 12 physically in the building.
12:15:06 13 THE COMMISSIONER: All right, so
12:15:06 14 we'll try to take that into
12:15:08 15 consideration when we come back at
12:15:10 16 1:30 as well.
12:15:10 17 MR. ZIGLER: Yes.
12:15:10 18 THE COMMISSIONER: Thank you very
12:15:11 19 much.
12:15:12 20 -- RECESSED AT 12:15 P.M.
12:15:12 21 -- RESUMED AT 1:30 P.M.
12:15:12 22 MR. ZIGLER: Commissioner, out of
01:30:49 23 an abundance of caution, Ms.
01:30:51 24 Hewitt thought she should have
01:30:53 25 whatever is bothering her checked
01:30:55 26 out, but Ms. Merrifield is quite
01:30:57 27 capable of finishing the
01:30:59 28 examinations today and Ms. Hewitt
01:31:00 29 has urged that we press on.
01:31:02 30 THE COMMISSIONER: All right,
01:31:02 31 thank you so much.
10:11:39 32 EXAMINATION IN-CHIEF BY MS. MERRIFIELD:

10:11:39 Q. Thank you. Thank you,
01:31:07 Commissioner.
01:31:16 Thank you. Thank you, Sherri.
01:31:18 So I would like to ask you couple
01:31:21 of questions right now about the scheduling
01:31:24 process of agency nurses in Lifeguard. Are
01:31:27 you able to walk us through the process for
01:31:30 bringing agency nurses into the home?
01:31:33 A. Sure. So I would review the
01:31:35 schedule, see what shifts needed to be
01:31:37 covered, and then I would call the agency
01:31:40 scheduler and let her know. And then
01:31:43 typically there was some wait time, and she
01:31:45 would get back to us to see what shifts that
01:31:47 they could cover.
01:31:49 Q. And that was the process that
01:31:50 you followed with Lifeguard?
01:31:52 A. Yes.
01:31:54 Q. And did you make any requests
01:31:56 whether or not the nurse be familiar working
01:31:58 in a long-term care home setting?
01:32:00 A. Yes. Yeah, we requested
01:32:02 that.
01:32:03 Q. And would you also inform the
01:32:04 agency nurse of the resident-to-staff ratio
01:32:08 at Telfer Place?
01:32:09 A. Yes.
01:32:11 Q. And as far as you know, was
01:32:13 Lifeguard always able in 2015 and 2016 to
01:32:16 provide agency nurses when you requested it?
01:32:20 A. Not always. Typically, yes,
01:32:22 but there were some occasions that they

01:32:23 didn't have staff available.
01:32:25 Q. Okay. Were they always able
01:32:26 to provide nurses that were familiar working
01:32:28 in long-term care?
01:32:30 A. I believe so, yes.
01:32:35 Q. And I understand that the
01:32:36 process for orienting agency nurses at
01:32:39 Telfer Place was not quite as long as with
01:32:43 regular staff that was brought on; is that
01:32:45 right?
01:32:46 A. That's correct.
01:32:46 Q. And you are familiar with the
01:32:48 orientation process for Telfer Place's
01:32:52 regular staff?
01:32:53 A. Yes.
01:32:53 Q. And so we have heard that it
01:32:57 consisted of, among other things, two shifts
01:33:00 on days, evenings and nights; is that right?
01:33:04 A. To my recollection, yes.
01:33:07 Q. And by comparison, we have
01:33:08 heard that the orientation for agency nurses
01:33:11 was considerably shorter, that it was
01:33:13 between four and eight hours; is that your
01:33:15 understanding as well?
01:33:16 A. Correct.
01:33:18 Q. So why would the orientation
01:33:20 for agency nurses be so much shorter than
01:33:22 that of regular staff?
01:33:24 A. With agency nurses, the
01:33:26 turn-around time to on-board them was much
01:33:29 shorter, and we didn't know if we were going
01:33:32 to be using a particular nurse again.

01:33:39 Q. But they would still need to have the same knowledge and be familiar with the systems and processes and the residents as the regular staff would?
01:33:48 A. Yes.
01:33:48 Q. And agency nurses were expected to complete the same aspects of the job as the regular Telfer Place nurse?
01:33:58 A. Yes.
01:34:01 Q. And within the same time frame as well?
01:34:03 A. Yes.
01:34:04 Q. So for example, if on evenings the agency nurse was expected to give out medications and complete the medication pass during the dinner time, which I understand is the busiest medication pass, they would have to ensure that they were able to do that in the appropriate amount of time and that the proper resident had been identified as well?
01:34:30 A. Yes.
01:34:30 Q. And so would it be difficult for an agency nurse that was new to Telfer Place and who had only had four to eight hours of orientation to be able to do that?
01:34:42 A. I think it would have taken them a longer time, yeah.
01:34:46 Q. Okay. And we have heard that in 2015 and 2016 Telfer Place typically did not receive a copy of the agency nurse's resume, reference checks, including criminal

01:35:02 record checks or vulnerable sector checks;
01:35:04 is that your recollection as well?
01:35:05 A. That's correct.
01:35:08 Q. And you indicate I think at
01:35:10 paragraph 18 of your affidavit that you
01:35:15 would typically do a College of Nurses of
01:35:17 Ontario registration review to make sure
01:35:20 that the RN or RPN was in good standing with
01:35:23 the College of Nurses; is that right?
01:35:25 A. Correct.
01:35:26 Q. And so what would that review
01:35:29 entail?
01:35:30 A. So it would be just using the
01:35:32 Find a Nurse and looking up the nurse by
01:35:33 their name.
01:35:34 Q. Okay, so you are referring to
01:35:36 going on to the College of Nurses' website
01:35:41 where they have a "Find a Nurse" section and
01:35:43 seeing that the agency nurse is listed
01:35:46 there?
01:35:47 A. Yes.
01:35:47 Q. Would it entail anything
01:35:48 else?
01:35:49 A. For their registration?
01:35:52 Q. Yes.
01:35:53 A. So I would usually look them
01:35:55 up on Find a Nurse, and then I believe I
01:35:57 would print out their registration.
01:35:59 Q. Okay, did you do any other
01:36:01 checks?
01:36:02 A. No.
01:36:05 Q. And in these proceedings we

haven't been able to locate the Find a Nurse for Elizabeth Wettlaufer. Do you know why that might be?

A. No.

Q. If we can take a look at Exhibit "E", please, which is doc ID 25545, and this is the "Annual Education for Contracted Services". Do you recognize this document?

A. Yes.

Q. And I understand from your affidavit that you recall providing this document to contracted staff, such as physiotherapists and hairdressers and so on?

A. Yes.

Q. And was it also provided to agency staff?

A. Yes.

Q. Is there a process in place for ensuring that that was done?

A. So the back page is the sign-off that they have reviewed the contracted services booklet, so we would receive that page back.

Q. Okay. And similarly, there hasn't been a copy of this document for Elizabeth Wettlaufer that has been located. Do you know why that might be?

A. No, I don't.

Q. Before we move on to Elizabeth Wettlaufer, I want to discuss your role as staff educator in the home.

01:37:48 So you indicated earlier that your
01:37:50 role included providing mandatory education
01:37:55 under the Long-Term Care Homes Act; is that
01:37:58 right?
01:37:59 A. Correct, yes.
01:38:00 Q. Would it also entail ensuring
01:38:02 that the staff were familiar with the
01:38:04 policies and procedures of Revera?
01:38:05 A. Yes.
01:38:08 Q. And so we have heard from
01:38:10 both Tracy Raney and Dianne Beauregard that
01:38:14 they were unaware of Revera's "High
01:38:17 Alert/High Risk Medication - Independent
01:38:19 Double Check"; is that -- did you hear that
01:38:23 testimony?
01:38:24 A. No, I didn't hear their
01:38:25 testimony.
01:38:29 Q. So were you aware that Revera
01:38:30 had such a policy?
01:38:31 A. Yes.
01:38:32 Q. And were you trained on it?
01:38:35 A. I don't recall if I was
01:38:36 trained on it.
01:38:43 Q. How were staff --
01:38:44 THE COMMISSIONER: Sorry, can you
01:38:45 just let me know when she was
01:38:46 aware of it?
01:38:48 BY MS. MERRIFIELD:
01:38:48 Q. Sure, sorry. When did you
01:38:50 become aware of it?
01:38:55 A. I don't know. Before this
01:39:00 Inquiry started.

01:39:00 Q. Before these proceedings?
01:39:01 A. Yes, yeah.
01:39:01 Q. Okay.
01:39:01 A. But I don't know exactly when
01:39:03 I became aware of it.
01:39:04 Q. Okay. Do you know if --
01:39:07 THE COMMISSIONER: Sorry, but
01:39:08 while you were Director of Care?
01:39:09 THE WITNESS: Yes.
01:39:09 THE COMMISSIONER: Yes, okay,
01:39:10 thank you.
01:39:10 BY MS. MERRIFIELD:
01:39:10 Q. How were staff typically made
01:39:20 aware of policies coming into place at
01:39:25 Telfer Place?
01:39:26 A. So typically, we would review
01:39:29 at shift change, at staff meetings. A lot
01:39:34 of communication happened at shift change.
01:39:38 Q. Can you tell us more about
01:39:39 that?
01:39:39 A. So typically, the shift
01:39:41 change was that they would review resident,
01:39:45 any type of resident issues, and then myself
01:39:48 or Lindsay Astley, who was the Associate
01:39:52 Director of Care at the time, would review
01:39:55 any information that we had to relay to the
01:39:58 staff, because we had two shifts there.
01:39:59 Q. So would the education on new
01:40:01 policies then only happen at shift change,
01:40:03 or were there other means as well?
01:40:05 A. It could be staff meetings
01:40:06 that it could be reviewed at, emails

sometimes.

Q. Was there a process in place for alerting new staff to new policies?

A. A formal process that we followed that these are the directions every time?

Q. Yes.

A. No.

Q. Were staff alerted in any other way?

A. Not that I can recall.

Q. And did you employ any sort of controls to ensure that the policies were both communicated and understood by the staff?

A. So we would review items as they came across our desk, and if it wasn't in line with policies, then we would speak with staff or review with staff.

Q. And, sorry, if what wasn't in line with the policies?

A. Anything that came across our desk.

Q. Okay, can you give us --

A. So if it was a report, we would review a report or documentation.

Q. Okay, can you give us an example, documentation or a report of what?

A. So every shift they had their shift report, so they would record what was happening with residents. So maybe a resident fell, and then we would have to

01:41:26 check the documentation of the fall to make
01:41:29 sure that it was complete and accurate and
01:41:33 everything according to policy was filled
01:41:34 out.
01:41:35 Q. Okay. And so did you do
01:41:37 anything to ensure that staff were actually
01:41:39 following the policies then?
01:41:47 A. Other than following up on
01:41:48 their work?
01:41:49 Q. Yes. Would it be after an
01:41:54 incident had occurred or --
01:41:55 A. Yes, so it would be
01:41:57 afterwards we would review any of the items
01:41:59 related to an incident or resident care.
01:42:00 Q. Okay. And if we can talk now
01:42:05 about Elizabeth Wettlaufer, so I understand
01:42:08 that she was first assigned by Lifeguard to
01:42:12 Telfer Place sometime in February 2015; is
01:42:16 that right?
01:42:17 A. As per the schedule, yes.
01:42:19 Q. And so by "schedule", you are
01:42:23 referring to tab "F", which is document
01:42:25 26297; is that right?
01:42:27 A. Yes.
01:42:42 Q. And so when we look at this
01:42:43 document, are we able to tell whether or not
01:42:48 Elizabeth Wettlaufer received orientation at
01:42:50 Telfer Place?
01:42:51 A. Yes. So if you look under
01:42:53 the February 15th on the Sunday.
01:42:55 Q. Yes.
01:42:56 A. To the left is Bethe's name,

and it says "2-10" with a little "o", and that was -- the little "o" was what we put on for orientation.

Q. And so if the "o" is next to the "2-10", does that mean that the 2:00 to 10:00 shift was orientation?

A. Yes.

Q. Would that have been the entirety of her orientation?

A. I believe so.

Q. And who provided that orientation? Are we able to tell that by looking at the schedule?

A. Yes, so if you go up to Susan Farley, she is also scheduled the 2:00 to 10:00, and we only have one RN on at all times, so Susan would have been orientating Bethe.

Q. And Susan Farley was a Registered Nurse?

A. Yes.

Q. Do you know how long she would have been at Telfer Place at the time she orientated Bethe?

A. No. Years. She was there longer than me, and I started there in 2008, so a number of years.

Q. So is it fair to say that she was familiar with her role in orientating agency staff to the home?

A. Yes.

Q. Would she have received any

01:44:04 training specifically related to
01:44:06 orientation?
01:44:09 A. Training, no.
01:44:21 Q. If we can turn to Exhibit
01:44:21 "G", please, Commissioner, and Exhibit "G"
01:44:21 is doc ID 24849. This is the Agency Staff
01:44:26 Orientation Checklist. Sherri, are you able
01:44:38 to explain to us exactly what this document
01:44:39 is?
01:44:39 A. Yes, so this is the checklist
01:44:40 that would have been given to Susan of items
01:44:42 she needed to review with Bethe.
01:44:43 Q. And so when we look at the
01:44:45 contents of this document, it lists
01:44:49 reporting, team responsibilities, location
01:44:50 of things, including manuals and telephone
01:44:54 numbers, medication, keys, charting and
01:45:00 safety.
01:45:05 When Susan oriented Bethe, I take
01:45:08 it from the 2:00 to 10:00 that that was an
01:45:12 evening shift?
01:45:13 A. Yes.
01:45:13 Q. And so would Susan have been
01:45:14 expected to complete the orientation on all
01:45:16 of these matters while also performing her
01:45:20 own nursing duties that night?
01:45:22 A. Yes.
01:45:23 Q. And in 2015, from what I
01:45:24 understand, she would have been responsible
01:45:26 for approximately 45 residents in the home?
01:45:29 A. Yes.
01:45:30 Q. And how busy is the evening

shift?

A. It is busy.

Q. Can you elaborate?

A. So they would have had their med pass. They would have had supper, and then they have another med pass, any treatments that needed to be done at the time, any family members that come in, follow-up for doctors' orders, if there were any.

Q. Do most family members come in in the evenings?

A. I would say the majority.

Q. Is the evening shift busier than the day shift or just different?

A. I think it is just different.

Q. So we have heard from Tracy Raney that as of 2015 she worked evenings; is that your recollection as well?

A. Yes.

Q. And she indicated that she was so busy that she would have to routinely stay after her shift sometimes for longer periods of time to complete her charting. Is that your understanding as well? Is that what you recall?

A. Of Tracy staying late?

Q. Or other staff members as well.

A. Yes.

Q. And that would be because they weren't able to complete the charting

during their scheduled shift?

A. Yes.

Q. So how is it possible that Susan Farley would have been able to complete all the tasks of orienting Ms. Wettlaufer in addition to carrying out her regular duties on the floor?

A. It was just the process that we had in place at that time.

Q. And by orientating Ms. Wettlaufer, for example, would that have detracted from her nursing duties at all?

A. I think it would have taken longer because she would have to show Bethe what she was doing and complete it.

Q. And similarly, if she was tied up with a resident, then I assume that then she might not be orientating Ms. Wettlaufer at the same time then?

A. Potentially, yes.

Q. So is it realistic that as an agency nurse to absorb -- is it realistic for an agency nurse to absorb all of the information that is contained on this checklist, as well as becoming familiar with the residents of the home at the same time, the RN that is orientating her is also providing care to the residents of the home?

A. I think it is a lot of information to take in.

Q. Is it more than just a lot of information to take in? Is it really

feasible for that to happen?

A. It is what did happen. I think, yes, that they would feel that it was a lot.

Q. And is that -- in your opinion, do you think that is possibly why the Long-Term Care Homes Act requires the RN on staff to be a regular member of the nursing staff, so that they are able to provide the care to the residents and know the residents?

A. Yes.

Q. And so when we look at this document again at Exhibit "G", we note that towards the bottom there are some items that aren't checked off. Do you know what that would signify?

A. I think it would signify that they potentially weren't covered.

Q. And would this orientation sheet come back to you?

A. I believe it did.

Q. And it is our understanding from Ms. Shannon's testimony that there was no formal policy or process for evaluating the performance of agency nurses in the home; is that right?

A. That's correct.

Q. So if there were concerns expressed about an agency nurse, what was the process that would happen or that you would go through to address those concerns?

01:50:02 A. So typically, I would take
01:50:04 the concern from the staff member or whoever
01:50:07 it happened to be, and then I would address
01:50:09 it with the agency nurse and potentially
01:50:14 call Heidi from Lifeguard.
01:50:17 Q. And would you investigate the
01:50:18 incident then?
01:50:19 A. Yes.
01:50:21 Q. And did you have any training
01:50:23 in conducting any sorts of investigations
01:50:26 then in the home?
01:50:27 A. Dian did a lot of training
01:50:29 with us from her previous experience.
01:50:34 Q. And was that based on Revera
01:50:36 training or Dian's own -- her own
01:50:40 background?
01:50:40 A. I think it was probably both.
01:50:47 Q. So if we can talk about
01:50:49 Elizabeth Wettlaufer specifically right now,
01:50:51 can you describe your interactions with her?
01:50:54 What was she like?
01:50:57 A. She was friendly. She was
01:50:59 nice. She was appropriate.
01:51:03 Q. Did you see her interact with
01:51:05 residents at all?
01:51:06 A. Yes, I'm sure. I can't
01:51:09 recall a specific like instance, but I'm
01:51:12 sure I did.
01:51:13 Q. And you didn't have any
01:51:14 concerns or --
01:51:16 A. No.
01:51:18 Q. Did you have any concerns or

01:51:21 complaints reported from other families?
01:51:25 A. From families? No.
01:51:26 Q. What about other residents?
01:51:28 A. Residents, no.
01:51:31 Q. And so you indicate in your
01:51:33 affidavit at paragraph 39 that there was an
01:51:43 issue early on with her not completing some
01:51:47 documentation in relation to fall
01:51:51 assessments; do you remember that?
01:51:53 A. I do.
01:51:54 Q. Can you tell us what
01:51:54 happened?
01:51:57 A. I recall that there was a
01:51:58 fall on her shift, and when I reviewed the
01:52:01 documentation, I think it wasn't completed
01:52:06 with enough description. It was completed,
01:52:09 but there needed to be more to it.
01:52:12 Q. And what would be the
01:52:13 importance of having more than I think you
01:52:15 said a description of what had happened?
01:52:17 A. Well, just so we could look
01:52:18 at it and see exactly what happened, what to
01:52:22 look out for for the resident, the type of
01:52:26 fall, you know, if they tripped on
01:52:28 something, so we could fix whatever
01:52:30 potentially made them fall.
01:52:31 Q. And is a fall assessment, is
01:52:34 that one document that's filled out, or is
01:52:40 it more intensive than that, I guess? Are
01:52:45 there referrals made? We are not -- I don't
01:52:47 work in long-term care --
01:52:47 A. Right.

01:52:47 Q. -- so if you are able to
01:52:49 explain a little bit.
01:52:50 A. So I believe at the time that
01:52:51 the fall assessment was two pages long
01:52:57 maybe, like a piece of paper, and then
01:52:59 referrals as necessary to physio or the
01:53:01 dietitian, whatever that specific instance
01:53:07 called for.
01:53:08 Q. And what had happened with
01:53:10 Ms. Wettlaufer not completing the fall
01:53:12 assessment?
01:53:14 A. There was no negative
01:53:15 outcome. She did complete it. It just
01:53:17 wasn't very specific.
01:53:20 Q. There wasn't enough detail or
01:53:22 information contained it?
01:53:23 A. Right.
01:53:24 Q. Okay. So what was her
01:53:26 reaction when you raised this with her?
01:53:30 A. She said okay and that she
01:53:32 understood that I wanted it more detailed
01:53:33 and that she would do that.
01:53:35 Q. Okay, so she accepted
01:53:36 responsibility?
01:53:36 A. Yes.
01:53:37 Q. Did she seem angry or upset
01:53:38 at all?
01:53:39 A. No.
01:53:40 Q. Did you have any other issues
01:53:42 with her after this regarding a similar
01:53:45 situation?
01:53:46 A. No.

01:53:46 Q. Do you remember if you kept
01:53:49 any notes of that conversation with her?
01:53:51 A. No, I do not.
01:53:56 THE COMMISSIONER: Is it you
01:53:57 don't remember or you didn't take
01:53:58 notes?
01:53:59 THE WITNESS: I don't believe that
01:53:59 I took any notes.
01:54:01 THE COMMISSIONER: Thank you.
01:54:01 BY MS. MERRIFIELD:
01:54:01 Q. Do you remember if you
01:54:08 notified Heidi Wilmot-Smith of what had
01:54:12 happened with the fall assessment?
01:54:14 A. I don't specifically
01:54:15 remember, but I do recall calling Heidi with
01:54:19 things that came up, so it would have been
01:54:22 in my practice to.
01:54:24 Q. Okay. And the evidence that
01:54:30 we have heard so far indicates that you had
01:54:32 some issues with Ms. Wettlaufer not showing
01:54:37 up for a shift. We heard that she didn't
01:54:41 show up for a shift on October 24th, 2015;
01:54:44 do you remember that?
01:54:46 A. I remember that there was a
01:54:47 concern with her being a no-show. I don't
01:54:50 remember the date.
01:54:52 Q. Do you remember if it was
01:54:53 around the date of October 24th?
01:54:58 A. Without seeing the
01:54:59 documentation that is brought forward, I
01:55:01 wouldn't have been able to tell you it was
01:55:03 around that time.

01:55:04 Q. And so what would the -- you
01:55:06 indicated earlier that Telfer Place was
01:55:08 staffed by one RN. What would be the impact
01:55:11 of the RN, the one RN that is supposed to be
01:55:14 there not showing up for the shift?
01:55:16 A. It would have been a major
01:55:17 impact because the day nurse - because it
01:55:20 was an evening shift, I believe - would not
01:55:22 have been able to leave because she would
01:55:25 have been responsible for the residents.
01:55:27 Q. Okay, so in that situation,
01:55:29 would you have required the day shift to
01:55:31 stay longer then?
01:55:34 A. Yes.
01:55:35 Q. Okay.
01:55:36 A. We would try to find somebody
01:55:37 else to come in, but if there isn't -- as a
01:55:42 nurse, you need to be able to hand off your
01:55:45 keys and report to somebody else, so if
01:55:46 there is not somebody there at that time,
01:55:48 then you need to stay until your replacement
01:55:50 comes.
01:55:50 Q. And were there instances
01:55:53 where you weren't able to find someone to
01:55:56 come in? Were you able to find someone to
01:55:58 come in here on October 24th?
01:56:00 A. I don't recall. I would have
01:56:04 to look.
01:56:04 Q. Okay. And you also indicate
01:56:10 in your affidavit that you understand that
01:56:13 Heidi Wilmot-Smith testified that in
01:56:16 addition to being out of town, Elizabeth

Wettlaufer had phoned in to Lifeguard and reported to them that she could not work the shift because she had been drinking and that this wasn't reported to you.

A. That's correct.

Q. But in fact, what Ms. Wilmot-Smith testified to was that Ms. Wettlaufer had not checked her schedule and therefore didn't realize that she wasn't scheduled to come in that evening.

MS. McALEER: Sorry, where are you in her affidavit?

BY MS. MERRIFIELD:

Q. Paragraph 40. And would it be unusual for a nurse to call in and report that he or she was unable to come in for a scheduled shift because they had been drinking?

A. If they were scheduled a shift and they knew ahead of time and they called in saying I can't come in because I'm drinking, I would think that that would be unusual, yes.

Q. Would it be anything more than unusual?

A. It -- yes, it would be odd. If they were called in for a shift that they didn't know that they had, maybe I could see, well, I can't because I've had, you know, a glass of wine or whatever. But if they were scheduled, then yes, it would.

Q. Would be it concerning at

all?

A. Yes.

Q. In what way?

A. Because if the staff member knew that they were supposed to be at work, my question would be, why are you drinking?

Q. And I understand that there was another issue related to Ms. Wettlaufer not showing up for a shift on December 28th, 2015?

A. Correct.

Q. Do you remember that?

A. I do.

Q. And we have heard from Ms. Shannon that she actually went in to work then and that the only other nursing staff that could be located was an RPN to come in; do you remember that?

A. Correct, yes.

Q. And that would have been a breach of the Long-Term Care Homes Act; is that right?

A. Correct.

Q. And do you remember if the Ministry came in after that?

A. No, I don't.

Q. I think the Ministry did come in and they found that there was non-compliance with the Act, and we also heard earlier that Ms. Shannon had actually administered medication and specifically insulin to a resident, although she wasn't a

01:59:11 Registered Nurse. And do you find that
01:59:19 concerning?
01:59:19 A. Yes.
01:59:19 Q. And also in contravention of
01:59:21 the Act?
01:59:22 A. Correct.
01:59:25 Q. And did you have a
01:59:27 conversation with Ms. Wilmot-Smith in
01:59:31 January 2016 about the missed shift in
01:59:36 December 2015?
01:59:39 A. I had a conversation with
01:59:41 her, yes.
01:59:42 Q. Okay, can you tell us about
01:59:43 that?
01:59:44 A. To my recollection, the
01:59:48 conversation was about potentially, if I'm
01:59:50 recalling the correct conversation, was
01:59:53 about potentially lowering the prices of
01:59:56 Lifeguard's agency staff.
01:59:59 Q. Did she talk about -- and do
02:00:02 you remember when you spoke with her?
02:00:04 A. Specifically, no. I would
02:00:08 have to look. Are we talking about the
02:00:14 January 15th phone call?
02:00:15 Q. Yes, yes, it is at paragraph
02:00:17 43 of your affidavit.
02:00:18 A. Okay.
02:00:23 Q. So did Ms. Wilmot-Smith raise
02:00:26 any other concerns -- did she raise any
02:00:29 concerns with you during that phone call?
02:00:30 A. Not that I recall.
02:00:34 Q. So she has testified that she

also raised a comment that Elizabeth Wettlaufer had made to a PSW relating to he could leave his shoes under her bed any time.

MS. McALEER: Sorry, that was not Ms. Wilmot-Smith's evidence. Her evidence was that it was Ms. Toleff who raised that, that Ms. Toleff had raised that comment on the telephone call, not that Ms. Wilmot-Smith had raised it.

BY MS. MERRIFIELD:

Q. Thank you. Do you remember raising that with her?

A. I do not.

Q. We heard from Dianne Beauregard that Elizabeth Wettlaufer had at one point disclosed to her that she was one year sober. Were you aware of that comment?

A. No.

Q. Would it have concerned you at all that Elizabeth Wettlaufer was a recovering alcoholic and that she was one year sober?

A. No. If she was recovered and not actively drinking, no.

Q. And you never saw any signs of her being under the influence or having consumed alcohol when she was working?

A. No.

Q. Any concerns over being under the influence or consuming drugs while she

02:02:28 was working?
02:02:29 A. No.
02:02:35 Q. You never saw -- smelled
02:02:38 alcohol on her breath or saw her slur her
02:02:40 words or --
02:02:41 A. No.
02:02:43 Q. Do you recall hearing whether
02:02:44 or not anyone had any suspicions that she
02:02:46 had been drinking?
02:02:47 A. That she was drinking at
02:02:49 work?
02:02:49 Q. Yes.
02:02:49 A. No.
02:02:56 Q. And you have also indicated
02:02:57 that Tracy Raney used to -- she would raise
02:03:04 any -- that she would raise
02:03:04 concerns she had regarding Elizabeth
02:03:04 Wettlaufer to you. Ms. Raney testified that
02:03:07 she started -- she initially brought these
02:03:10 concerns to you verbally, but then
02:03:11 afterwards she would email you and put them
02:03:14 in writing. Do you have any notes of those
02:03:16 conversations?
02:03:17 A. No, I don't recall Tracy
02:03:19 coming to me.
02:03:24 Q. So if we can go to Exhibit
02:03:25 "K", at the bottom of the first page, do you
02:03:42 recognize this?
02:03:43 A. Yes.
02:03:44 Q. Okay. So the document number
02:03:46 is 72536, and so this is an email from Tracy
02:03:59 Raney to you and it says:

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

Do you recall whether or not you responded in any way to the concerns that Tracy raised in this email?

A. Well, because I have been shown the email, I do know that I emailed saying I will follow up, thanks.

Q. And do you remember following up with her?

A. With Tracy?

Q. With Ms. Wettlaufer.

A. With Bethe, not specifically, but I believe that I would have.

Q. Okay, and do you remember doing that, though?

A. No.

Q. Do you remember anything about the conversation?

A. With Bethe about leaving a door open?

Q. Yes.

A. No.

Q. And are there any notes or any documentation to identify whether or not you would have raised that with her?

02:05:05 A. No.
02:05:14 Q. And at Exhibit "L" of your
02:05:16 affidavit, that is a copy of another email,
02:05:23 and the document ID is 24212. Do you
02:05:35 recognize this email?
02:05:37 A. Because I have been shown it
02:05:39 during these proceedings, yes.
02:05:41 Q. Okay, and so Tracy writes:
02:05:46 "I have some concerns in regards to
02:05:48 Beth from the Agency. I am not
02:05:50 sure of the role they are supposed
02:05:53 to take in LTC." And I assume that
02:05:57 means long-term care. "Beth does
02:06:00 not always relay important
02:06:02 information to [doctors] and to
02:06:05 other Registered staff. I had a
02:06:07 nurse from Jenuine Care call
02:06:09 tonight to ask how [a resident's]
02:06:12 toe was after nail care because
02:06:14 there had been a bleed post care on
02:06:16 January 7th. No information had
02:06:17 been passed onto me the next shift,
02:06:19 [and] she did not chart on it nor
02:06:22 write it in the report book.
02:06:23 Therefore for 3 days it had not
02:06:25 been assessed until the foot care
02:06:27 nurse called to inquire how it was
02:06:30 doing. The other issue I have is
02:06:31 that on January 7th she addressed
02:06:33 that [she] had apnea and that she
02:06:34 called the family but did not call
02:06:34 the [doctor]. When I called the

02:06:34 1 [doctor] he came in, changed her
02:06:37 2 status to palliative and initiated
02:06:38 3 all the necessary drug changes in
02:06:40 4 [relation] to palliation status.
02:06:43 5 Yet she apparently did not feel a
02:06:44 6 need to inform the [doctor]
02:06:46 7 herself. Unsure what to think
02:06:47 8 about these issues. Thanks -
02:06:48 9 Tracy."
02:06:51 10 Can you explain to us what the
02:06:53 11 potential impact would have been of
02:06:56 12 Elizabeth Wettlaufer not passing that
02:06:57 13 information along?
02:07:00 14 A. So for the toe, it depended
02:07:04 15 upon how severe. I think that they nicked
02:07:11 16 the toe or something had happened, and so it
02:07:13 17 would just -- the resident would need to be
02:07:16 18 seen.
02:07:19 19 And for her not calling the doctor
02:07:22 20 depended upon the resident's condition. If
02:07:24 21 she was palliative, not declared palliative
02:07:27 22 by the doctor yet, but she was on, you know,
02:07:29 23 her illness trajectory, that potentially you
02:07:33 24 might not call the doctor.
02:07:35 25 Q. Okay.
02:07:38 26 A. It would just depend on the
02:07:39 27 resident and what was happening with them.
02:07:42 28 Q. Okay. And maybe you can
02:07:45 29 correct me if I'm wrong, but the way I had
02:07:49 30 read this is it sounded like the resident
02:07:54 31 had apnea and Ms. Wettlaufer called the
02:07:57 32 family but didn't call the doctor, and then

02:08:01 the doctor went ahead and changed the
02:08:04 resident's status to palliative and then
02:08:06 made all the corresponding drug changes in
02:08:09 relation to that.
02:08:11 That sounds fairly significant to
02:08:15 me. Is that -- possibly more so than the
02:08:19 foot. Am I reading that right or --
02:08:22 A. If I -- I would -- if I got
02:08:24 this information, I would look into it to
02:08:26 see what was happening, to see if it was
02:08:30 just a decline in the resident's condition,
02:08:32 or you know, if it was something absolutely
02:08:34 new, then yes, definitely follow-up needs to
02:08:39 be done.
02:08:39 Q. Okay, and so what are
02:08:40 palliative measures?
02:08:41 A. So it could be that maybe the
02:08:44 resident is not taking the same medication
02:08:47 anymore. Maybe they are not taking
02:08:49 medication by mouth, that they are not
02:08:52 getting out of bed. It just depends what is
02:08:55 happening with that particular resident.
02:08:57 Q. So are palliative measures,
02:08:59 are they changes that the resident goes
02:09:01 through or does it refer to changes that the
02:09:04 health care team initiates in relation to
02:09:07 the resident?
02:09:08 A. It could be both. So
02:09:09 typically, in long-term care when somebody
02:09:12 says that they are deemed palliative, it
02:09:14 means that they are at end of life, that
02:09:16 they are going to die soon.

02:09:18 Q. Okay. So has the doctor changed the resident's status on the basis of not receiving information about the resident's apnea?
02:09:33 A. I am not sure. I don't recall this email, and I don't know which resident it is, but he could have, based on what the resident was experiencing at that time.
02:09:45 Q. Okay.
02:09:47 MS. McALEER: Sorry, I think I didn't understand the question. So was the question did the doctor change her status based on not receiving the information? I think that is the way you put it to the witness, and that is not how I am reading this email, so I just want to be clear on this.
02:10:01 BY MS. MERRIFIELD:
02:10:01 Q. That is fine. I'm hoping that the witness can clarify. That was my question --
02:10:04 A. Okay, so I'm sorry --
02:10:04 Q. -- but I want to know if I'm right in that or not.
02:10:09 A. So can you ask me again, please?
02:10:11 Q. So the way I read this email is that the doctor changed the resident's status to palliative based on the fact that the doctor hadn't received information

relating to the resident's apnea. Am I right about that?

MS. McALEER: No, I don't think that is right, because when you read it, it says, the author, Tracy Raney, is saying, "When I called the [doctor] he came in [and] changed [...]" the information.

So he is not changing it based on not receiving information. He is changing it based on receiving information after Tracy Raney calls him.

So I just want that to be clear to the witness because I don't want her to be confused.

BY MS. MERRIFIELD:

Q. Sure. Is that right?

A. I would assume by reading the email that he came in and assessed the resident and then declared her palliative.

Q. Okay, thank you. Do you remember taking any steps in relation to this email?

A. No, I don't recall getting this email.

Q. And I understand that you resigned from Telfer Place in January 2016 to take a position elsewhere; is that right?

A. Correct, yes.

Q. And was this also a Revera home?

02:11:28 A. Yes.
02:11:30 Q. And so you are not aware of
02:11:31 the circumstances surrounding Lifeguard
02:11:34 being asked in April 2016 not to send Ms.
02:11:37 Wettlaufer back to the home; is that right?
02:11:39 A. That's correct.
02:11:47 Q. And so one last question for
02:11:48 you, and that is are you able to tell us
02:11:53 about the impact of Ms. Wettlaufer's crimes
02:11:56 on you and your work in long-term care?
02:12:01 A. So I feel like when you work
02:12:06 in long-term care, it is very much a team
02:12:09 atmosphere. It is kind of a camaraderie
02:12:12 that you have, and we are all there because
02:12:13 we like old people. We want to take care of
02:12:15 them. We want to make sure they are okay.
02:12:17 So to know that somebody was there
02:12:19 that did not have that in mind and that the
02:12:23 crimes that she confessed to is very
02:12:25 upsetting, obviously, and it was shocking.
02:12:28 So it does, you know, make you question
02:12:32 people and humanity and what is happening.
02:12:35 And working in long-term care is
02:12:37 not a glamorous job. It is very hard work.
02:12:40 It is not -- when you are in nursing school,
02:12:44 people aren't all saying, I really want to
02:12:46 go to long-term care. That is not what
02:12:48 happens. So the people who are in long-term
02:12:50 care want to be there. They are not there
02:12:53 just because it is a job. It is very hard.
02:12:55 It is very physical. It is very difficult.
02:12:57 So the people who are there are

trying to make a difference and make a home for the residents, and so it is very upsetting that there were -- she was there not with that same mindset.

MS. MERRIFIELD: Thank you. Those are all my questions, Commissioner.

THE COMMISSIONER: Thank you.

MS. HEWITT: Ms. McAleer.

MS. McALEER: I have no questions, thank you.

THE COMMISSIONER: Thank you.

MS. MERRIFIELD: And the first family group, Mr. Van Kralingen.

MR. VAN KRALINGEN: I have no questions, thank you.

MR. SCOTT: I have no questions, Commissioner.

MS. WILLIAMS: I have a few for the Ministry, thank you.

THE COMMISSIONER: Okay.

CROSS-EXAMINATION BY MS. WILLIAMS:

Q. Good afternoon. My name is Meagan Williams, and I am counsel to the Ministry of Health and Long-Term Care. I am going to ask a few questions mostly about agency staffing and a little bit about charting. I think I'll be referring to your affidavit a little bit, so I hope that is in front of you.

A. Yes.

Q. And I might also refer to

02:14:03 1 Exhibit 82.
02:14:07 2 So in your affidavit at page 5,
02:14:11 3 which is at paragraph 20, and just let me
02:14:16 4 know when you have had a chance to --
02:14:18 5 A. I am there.
02:14:18 6 Q. You state that Lifeguard was
02:14:20 7 responsible for criminal reference checks of
02:14:22 8 agency nurses when they worked at Telfer?
02:14:24 9 A. Correct.
02:14:25 10 Q. As you brought new agency
02:14:26 11 nurses into Telfer Place, did you or another
02:14:30 12 staff member confirm with Lifeguard that
02:14:31 13 this had been done?
02:14:32 14 A. No.
02:14:34 15 Q. If you go back to paragraph
02:14:36 16 16 of your affidavit, at paragraph 16 you
02:14:46 17 state that you do not recall being aware of
02:14:50 18 Revera's policy for external service
02:14:52 19 provider agencies during the time that you
02:14:53 20 were at Telfer Place?
02:14:54 21 A. That's correct.
02:14:55 22 Q. And you have got a copy of
02:14:57 23 the policy attached as Exhibit "D" to your
02:14:59 24 affidavit?
02:15:00 25 A. Correct.
02:15:01 26 Q. I would like to take a quick
02:15:03 27 look at that policy now at Exhibit "D".
02:15:04 28 A. Okay.
02:15:04 29 Q. So at the bottom of page 2 of
02:15:16 30 the policy, you have got a chart that tells
02:15:20 31 us about Revera's policy on criminal
02:15:23 32 reference checks; do you see where it says

that?

A. I do.

Q. It says that there is a process in place to make sure that criminal reference checks are performed, and do you read that as well?

A. I do.

Q. I appreciate you weren't aware of the policy at the time, but were you aware of the Revera process to make sure criminal reference checks were performed?

A. We did for our regular Telfer Place staff.

Q. But not for external or agency staff?

A. Correct.

Q. But do you agree that under the Long-Term Care Act it is ultimately Revera's responsibility to ensure that criminal reference checks have been performed on agency staff?

A. I do.

Q. I would like to go to Exhibit 82. That is document 41487, and it is the Ministry's Inspection Report after Ms. Wettlaufer's offences came to light.

A. Is it in --

THE COMMISSIONER: Is there a copy for the witness?

MS. WILLIAMS: Of Exhibit 82? I believe we passed one up earlier for an earlier examination this

morning. I hope that we still have that copy available.

THE COMMISSIONER: Thank you, Madam Clerk.

BY MS. WILLIAMS:

Q. Thank you.

So have you seen this document before?

A. I was just made aware of it recently.

Q. And at the time when the document was given to the licensee, were the findings in it discussed with you?

A. No.

Q. Were the findings in it discussed with you in the context of this proceeding?

A. Yes, I just received it.

Q. When you say "just received it", what do you mean?

A. Yesterday.

Q. Did you read it yesterday?

A. Yes.

Q. Do you take any issue or do you dispute any of the findings that you read yesterday in the report?

A. No.

Q. I would like to look at written notice number 2 for a moment. It is at the bottom of page 4, but most of the content is at the top of page 5.

So the Ministry found that the

02:17:48 1 licensee failed to ensure that criminal
02:17:52 2 reference checks had been conducted, and
02:17:55 3 further down the page it refers to an
02:17:57 4 interview with the former DOC confirming
02:17:59 5 that Telfer Place relied on agencies to
02:18:01 6 perform the checks. Do you see where it
02:18:03 7 says that?
02:18:04 8 A. Yes.
02:18:05 9 Q. Do you dispute this finding
02:18:06 10 specifically?
02:18:06 11 A. No.
02:18:11 12 Q. I want to switch gears to
02:18:13 13 talk about documentation and how it works in
02:18:14 14 nursing. You are a nurse, as we have heard
02:18:16 15 today, and you know that charting is part of
02:18:20 16 the job of being a nurse?
02:18:22 17 A. Correct.
02:18:23 18 Q. And it is an important part
02:18:24 19 of that job?
02:18:25 20 A. Correct.
02:18:26 21 Q. In order to provide good
02:18:27 22 care, it is important to understand the
02:18:28 23 needs of residents. Is that something you
02:18:31 24 would agree with as a statement?
02:18:33 25 A. Yes.
02:18:35 26 Q. In order to understand and
02:18:36 27 assess a resident's need, it is important to
02:18:38 28 keep track of incidents and changes in the
02:18:41 29 conditions of residents?
02:18:43 30 A. Correct.
02:18:43 31 Q. And it is important that that
02:18:45 32 information be gathered in a way that is

consistent?
A. Correct.
Q. And it is important that the information be stored in a way that other staff can easily gain access to it and understand it?
A. Correct.
Q. So that everyone providing care to the residents can gain access to a resident's status or their history?
A. Correct.
Q. And so they can receive consistent and high quality care?
A. Correct.
Q. So that is why it would be a concern when Ms. Wettlaufer did not chart the bleed post-care to the toe?
A. Correct.
Q. And would it be possible to provide the same high quality health care without charting?
A. No.
Q. In fact, charting is so important that the College of Nurses of Ontario has a written practice standard on documentation. Are you aware of that standard?
A. Yes.
Q. The information nurses document on each shift is important to ensuring nursing care residents receive safe, ethical and effective care?

02:19:42 A. Correct.
02:19:42 Q. And as you said earlier about falls, it is important to improving the quality of care and conditions in the home to keep track of these things through charting?
02:19:52
02:19:53 A. Correct.
02:19:54 Q. I would like to talk a little bit about the example of a fall. Would you agree that if a post-fall procedure takes two hours, it is likely because the fall resulted in some injuries or some suspected injuries?
02:19:56
02:19:59
02:20:02
02:20:05
02:20:07
02:20:10 A. It could be, yes.
02:20:11 Q. Could it take two hours if a nurse assessed a resident and did not suspect there were injuries?
02:20:14
02:20:16
02:20:18 A. There is a lot of paperwork following a fall.
02:20:20
02:20:21 Q. You mentioned a two-page report that's filled in when there is a fall?
02:20:23
02:20:26
02:20:26 A. Yes.
02:20:27 Q. Is that a document that Revera put together?
02:20:28
02:20:29 A. Yes.
02:20:30 Q. And it was to satisfy the Ministry's requirement for a fall program?
02:20:32
02:20:35 A. Yes.
02:20:36 Q. And you would also chart such a thing on Point Click Care in the form of a Progress Note?
02:20:44
02:20:47

02:20:47 A. Yes.
02:20:48 Q. And Progress Notes are a part of charting?
02:20:49 A. Yes.
02:20:50 Q. And charting is a part of nursing?
02:20:50 A. Yes.
02:20:52 MS. WILLIAMS: I believe those are all my questions. Thank you very much for your time today.
02:20:52 THE WITNESS: Thanks.
02:20:53 THE COMMISSIONER: Thank you, Ms. Williams.
02:20:54 MS. MERRIFIELD: ONA?
02:20:55 MS. BUTT: ONA has no questions.
02:20:56 MS. MERRIFIELD: College of Nurses?
02:20:58 MS. SCHWARTZENTRUBER: Uhm-hmm.
02:20:59 MS. MERRIFIELD: Ms. Schwartzentruber.
02:21:03 CROSS-EXAMINATION BY MS. SCHWARTZENTRUBER:
02:21:04 Q. Good afternoon again, Commissioner.
02:21:06 Good afternoon, Ms. Toleff. Is it okay if I continue to call you Sherri?
02:21:06 A. Yes.
02:21:08 Q. Perfect. My name is Meagan Schwartzentruber, and I am one of the lawyers here on behalf of the College of Nurses of Ontario, and so I'm going to have a few questions for you just in relation or coming from that perspective.
02:21:12
02:21:13
02:21:14
02:21:14
02:21:25
02:21:25
02:21:29
02:21:32
02:21:32
02:21:33
02:21:34
02:21:36
02:21:38
02:21:39

02:21:41 A. Sure.
02:21:42 Q. So I wanted to speak to you
02:21:44 about the information contained at paragraph
02:21:48 44 of your affidavit. Do you have that in
02:21:51 front of you?
02:21:52 A. I will.
02:21:55 Q. In relation to the
02:21:56 information about Ms. Wettlaufer's drinking
02:22:01 and some of the information you knew and
02:22:02 some of the information you didn't know.
02:22:05 Before we go into those details,
02:22:08 were you aware or what was your
02:22:11 understanding with respect to Telfer Place's
02:22:17 obligations in relation to reporting to the
02:22:18 College of Nurses? Is that something that
02:22:21 you were responsible for, or was there
02:22:23 someone else in your department that was
02:22:24 responsible for that?
02:22:26 A. It would be myself and Dian,
02:22:29 the Executive Director.
02:22:30 Q. Okay, and I take it that you
02:22:31 might take the lead in some of that, given
02:22:33 that you yourself are a Registered Nurse?
02:22:34 A. Yes.
02:22:35 Q. Okay, and I understand Ms.
02:22:36 Shannon was not a nurse.
02:22:39 A. Yes.
02:22:40 Q. Okay. So I take it then you
02:22:41 understood your obligation both as an
02:22:43 employer and also as a facility operator in
02:22:46 relation to the College of Nurses' mandatory
02:22:49 reporting requirements?

02:22:50 A. Yes.
02:22:50 Q. Okay. So I wanted to understand your understanding with respect to those obligations in relation to agency staff. So did you understand that that also applied to agency nurses that were working at Telfer Place?
02:23:07 A. Yes, it is clearer now.
02:23:09 Q. Okay.
02:23:10 A. But yes, as a nurse I understand that you would have to report.
02:23:13 Q. So if, for example, you were having any issues that you felt or you learned some information about an agency nurse that was working at Telfer Place, you understood that it was still -- or you understood you had an obligation as the facility operator to still report to the College of Nurses if the requirements were met?
02:23:30 A. Yes.
02:23:31 Q. Okay. So that is kind of the context in which I want to turn to the information at paragraph 44 of your affidavit.
02:23:39 So if I understand your evidence correctly, you don't recall information that Ms. Wilmot-Smith has testified she provided to you about Ms. Wettlaufer being a recovering alcoholic; do I have that correct? At the time, you did not -- you don't remember that?

02:24:02 MS. McALEER: Again, just to make it clear, Ms. Wilmot-Smith did not communicate to Ms. Toleff that Elizabeth Wettlaufer was a recovering alcoholic.

Ms. Wilmot-Smith testified that during the January 15th phone call, Ms. Toleff indicated to her that she had heard from within the home that Ms. Wettlaufer had indicated to someone that she was a recovering alcoholic or a recovered alcoholic.

That was Ms. Wilmot-Smith's evidence.

Ms. Toleff's evidence, which is in the affidavit, is that she actually has no recollection of that phone call.

BY MS. SCHWARTZENTRUBER:

Q. Okay, so perhaps my question was -- thank you for that clarification.

So I just want to understand what your -- the information that you knew at the time that you can tell us about with respect to your recollection.

So based on the information that I understand -- or why don't you tell us what information you had at the time in relation to Ms. Wettlaufer and any information about drinking or her being a recovering alcoholic, anything that you knew at the

time?

A. So I don't recall this conversation with Heidi. I don't recall by who or when I was made aware that she was a recovered alcoholic.

Q. I think you had testified earlier, and correct me if I'm wrong, that if you had known that information, that wouldn't necessarily have been of concern to you if she was in recovery and not currently drinking; do I have that correct?

A. Correct.

Q. Okay, and I believe -- so further on in your affidavit, the second paragraph of 44(b) of your affidavit, that is where you said:

"That information alone would not have necessarily caused me any concern."

And then you state further on:

"Further, I did not know at the time that Elizabeth Wettlaufer had told Lifeguard that she was drinking again."

So I understand, and correct me, that you had no knowledge of that information?

A. At the time that I worked at Telfer Place, correct.

Q. Okay, and you go on to say:

"If that information had been conveyed to me, I would have asked

that she not return to Telfer Place, because I would have seen that as a risk to resident care."

A. Correct.

Q. So I take it that the concern would have been that she could have placed residents at risk by not providing proper care?

A. If she was actively drinking as an alcoholic, yes.

Q. And am I correct in saying that if that was known either by Ms. Wilmot-Smith or by others, other nurses who were working with Ms. Wettlaufer, you would have expected that information to be conveyed to you?

A. If she was actively drinking as an alcoholic and they knew it?

Q. Yes.

A. Yes, I would expect that they would tell me that.

Q. Okay. And is that something, if that were the case that you came across that information, is that something that you would have considered reporting to the College in relation to their fitness to practice regime in relation to Ms. Wettlaufer?

A. If she was actively drinking as an alcoholic and working as a nurse?

Q. Yes.

A. Yes.

02:27:11 Q. Okay, so because I think -- am I correct in saying that based on some of the other evidence you have provided, if you had received that information from say one of your own nurses, is that something you would have also relayed to Ms. Wilmot-Smith as Ms. Wettlaufer's employer?

A. That she was drinking?

Q. Yes.

A. Yes.

Q. Okay. And if I understand your evidence correctly, there was nothing that came to your mind that arose, no suspicions or no concerns that came to your attention in relation to Ms. Wettlaufer having -- currently drinking or anything like that?

A. That's correct.

MS. SCHWARTZENTRUBER: Okay, those are all my questions.

THE COMMISSIONER: Thank you, Ms. Schwartzentruber.

MS. MERRIFIELD: OARC?

MS. MEADUS: We have no questions.

THE COMMISSIONER: Thank you.

MS. MERRIFIELD: RNAO? Oh, sorry, AdvantAge, Mr. Schwartz.

CROSS-EXAMINATION BY MR. SCHWARTZ:

Q. Good afternoon. Good afternoon, Sherri. My name is Jared Schwartz, and I am here asking questions on behalf of AdvantAge Ontario. I have just a

few short questions for you.

Are you able to tell us what the policy was when it came to hiring full-time registered staff at Telfer or through Revera for how current the vulnerable sector screening tests or checks or the criminal record checks had to be?

A. Within six months.

Q. And you mention at paragraph 20 of your affidavit, and Ms. Williams took you there and we don't need to go back unless you would like to review it again, which would be fine, but you mentioned that Lifeguard is responsible for ensuring that nurses submitted criminal record checks, including vulnerable sector screening.

Do you know what the expectation was of Telfer Place or of Revera with respect to how current those checks would be?

A. The expectation of what we expected Lifeguard --

Q. That's right.

A. -- to get? I would assume six months, but I don't know.

Q. You don't know for sure?

A. No.

MR. SCHWARTZ: I have no further questions, thank you.

THE COMMISSIONER: Thank you, Mr. Schwartz.

MS. MERRIFIELD: The RNAO.

02:29:44 CROSS-EXAMINATION BY MS. BINHAMMER:
02:29:44 Q. Good afternoon, Commissioner.
02:29:58 Good afternoon, Sherri. My name is Laurion Binhammer. I am a lawyer acting for the Registered Nurses Association of Ontario. I also just have a few questions for you.
02:30:08 A. Okay.
02:30:08 Q. The first one relates to training provided to Registered Nurse employees at Telfer Place as opposed to agency staff, and we have heard that the Personal Support Workers reported to Registered Nurses at Telfer Place; is that right?
02:30:23 A. Correct, yes.
02:30:23 Q. Okay. And you were the staff educator beginning in 2011; is that correct?
02:30:28 A. Correct.
02:30:30 Q. Did any of the orientation provided to Registered Nurse employees cover leadership issues like conflict management, being strong team leaders?
02:30:41 A. No.
02:30:43 Q. Would they have received any subsequent training, either annual training or on occasion on these kinds of issues?
02:30:50 A. Specifically about those issues --
02:30:51 Q. Those kinds of issues, leadership-related issues?
02:30:53 A. Not specifically, no.
02:30:55

02:30:56 Q. Okay. And how about
02:30:57 yourself, did you get any kind of training
02:30:59 along those lines from Telfer Place or
02:31:01 Revera?
02:31:05 A. I can't recall specifically,
02:31:06 but I would say yes, that Revera has
02:31:10 training for us, yes.
02:31:11 Q. Okay, on these kinds of
02:31:14 issues?
02:31:14 A. On leadership, yeah.
02:31:15 Q. Okay. And we have heard that
02:31:19 working as registered staff in a long-term
02:31:21 care home can be stressful for staff; is
02:31:24 that fair?
02:31:25 A. That is correct.
02:31:26 Q. I want to know what kinds of
02:31:27 access to mental health supports there were
02:31:29 for registered staff at Revera. Was there
02:31:33 access, do you know, to any kind of
02:31:35 confidential counselling service through
02:31:37 maybe an Employee Assistance Program?
02:31:39 A. Revera has an EAP program.
02:31:40 Q. Okay, and what about other
02:31:41 kinds of mental health supports like
02:31:43 education sessions? Were any of those kinds
02:31:47 of things provided?
02:31:48 A. For staff mental health?
02:31:49 Q. Yes.
02:31:50 A. Not that I can recall.
02:31:53 MS. BINHAMMER: Okay, thank you,
02:31:53 those are my questions.
02:31:55 THE COMMISSIONER: Thank you, Ms.

Binhammer.

MS. MERRIFIELD: And the RPNAO, Mr. Singh.

CROSS-EXAMINATION BY MR. SINGH:

Q. Hi, Sherri.

A. Hi.

Q. My name is Shaun Singh. I represent the Registered Practical Nurses Association of Ontario.

So I'm just going to turn you to paragraph 41, and it is not necessary for us to pull it up, but you had mentioned that in the fall of 2015 you had some concerns about the staffing complement?

A. Correct.

Q. What were those concerns?

A. That it was a 45 to 1 ratio, 1 RN to 45 residents.

Q. And what types of things did you take into consideration to address those concerns?

A. So with our Regional Manager of Clinical Services and my Associate Director of Care and my Executive Director, we reviewed possible different nursing models that would be available to us, getting a second nurse or splitting into two carts, changing the hours of the nursing team.

Q. Was there anything else that you can remember?

A. Not that I can recall.

02:33:05 Q. Okay. And then ultimately
02:33:06 you had, and presumably Cheryl as well,
02:33:12 determined that having an additional RPN
02:33:13 would help to address these concerns?
02:33:15 A. That was the request.
02:33:15 Q. Right.
02:33:16 A. Yes.
02:33:17 MR. SINGH: Those are all my
02:33:18 questions.
02:33:19 THE COMMISSIONER: Okay, thank
02:33:19 you, Mr. Singh.
02:33:24 MS. MERRIFIELD: Ms. McAleer.
02:33:25 RE-EXAMINATION BY MS. McALEER:
02:33:26 Q. Just briefly one question in
02:33:28 re-examination.
02:33:28 You'll recall, Sherri, that the
02:33:30 lawyer for the Ministry asked you some
02:33:32 questions about fall assessments and the
02:33:35 documentation that is required for fall
02:33:36 assessments?
02:33:36 A. Correct.
02:33:37 Q. And she asked you, could it
02:33:39 take two hours if there were no injuries. I
02:33:41 understand there are different protocols
02:33:43 that apply if the fall is witnessed or not
02:33:46 witnessed. Could you perhaps explain that
02:33:48 to the Commissioner?
02:33:49 A. Correct. So if a fall is
02:33:51 unwitnessed, then we put into place a Head
02:33:56 Injury Routine, so then the registered staff
02:33:59 were having to take neuro-vital signs of the
02:34:03 resident to ensure that they didn't hit

their head because it was unwitnessed or because of their dementia and they can't tell us.

So when a fall is unseen, then there is extra work for the registered staff.

Q. And is there a certain period of time over which you have to continue to evaluate that resident?

A. 72 hours.

MS. McALEER: Thank you.

THE COMMISSIONER: Thank you, Ms. McAleer.

MS. MERRIFIELD: Commission Counsel has no further questions for Ms. Toleff.

THE COMMISSIONER: All right. Thank you very much, Ms. Toleff, for coming. We know it is not easy, and we appreciate all the help that you have given, and you are now free to go. Thank you.

THE WITNESS: Okay, thanks.

THE COMMISSIONER: Madam Clerk, did you get back the exhibit? Did you get back the exhibit that we put over there?

THE COURT CLERK: Yes.

MS. MERRIFIELD: And, Commissioner, the time is 20 to 3:00. We are happy to continue on, unless this might be a good

time for a short break.
THE COMMISSIONER: Well, I know that --
MS. McALEER: Sorry, we are just bringing the witness in.
THE COMMISSIONER: All right, thank you.
I am happy to go ahead, but are counsel ready to go ahead?
MS. MERRIFIELD: Yes, we are ready to proceed.
MR. ZIGLER: We are.
THE COMMISSIONER: All right, then let's carry on, yeah.
MS. MERRIFIELD: Michelle Cornelissen.
MS. McALEER: I understand she is on her way. It seems to be taking a little bit longer than it should.
MR. ZIGLER: Maybe a five-minute break would be in order. Oh, she is here.
THE COMMISSIONER: Okay, thank you.
MICHELLE CORNELISSEN: SWORN
EXAMINATION IN-CHIEF BY MS. MERRIFIELD:
Q. Thank you. Ms. Cornelissen, my name is Lindsay Merrifield, and I'll be asking you some questions today. If at any time you can't hear me, just let me know and I will speak up.

02:37:36 A. Okay, thank you.
02:37:39 Q. And I understand that you have prepared an affidavit today in preparation for these proceedings, and a copy of that affidavit is in front of you. If you go to the last page of the affidavit part before tab "A", is that your signature on the page?
02:37:55 A. Yes.
02:37:56 Q. Do you have any other changes to make to the affidavit today?
02:37:59 A. No.
02:38:00 MS. MERRIFIELD: I would like to enter the affidavit of Michelle Cornelissen as the next exhibit, please, Commissioner.
02:38:05 THE COMMISSIONER: Yes, thank you, Ms. Merrifield. Exhibit 85, the affidavit of Michelle Cornelissen.
10:11:39 EXHIBIT NO. 85: Affidavit of Michelle Cornelissen.
02:38:10 BY MS. MERRIFIELD:
02:38:13 Q. Thank you. And, Ms. Cornelissen, I understand that your background is as a Registered Practical Nurse; is that right?
02:38:20 A. Originally, yes.
02:38:22 Q. When you say "originally", did you move from your role as a Registered Practical Nurse?
02:38:27 A. Yes.
02:38:29 Q. Can you tell us about that?

02:38:32 A. I did the bridging program
02:38:33 and graduated as an RN in 2010.
02:38:37 Q. And the bridging program is
02:38:38 when you go back to school for a period of
02:38:41 time and then --
02:38:43 A. Yeah, three years as opposed
02:38:57 to four.
02:38:57 THE COURT REPORTER: I'm sorry, I
02:38:57 am not sure I heard the witness'
02:38:57 full response.
02:38:57 BY MS. MERRIFIELD:
02:38:57 Q. I believe she said two years
02:38:57 as opposed to four.
02:38:57 A. No, three years as opposed to
02:38:57 four.
02:38:57 Q. Okay, thank you. And I
02:39:00 understand that you started at Telfer Place
02:39:04 on April 4th, 2016; is that right?
02:39:08 A. That's correct.
02:39:10 Q. Okay. And in your role at
02:39:12 Telfer Place, you were the Director of Care?
02:39:14 A. Yes.
02:39:16 Q. So you were there for just a
02:39:18 few weeks while Ms. Wettlaufer was still
02:39:22 working in the home; is that right?
02:39:24 A. Yeah, I think like maybe two
02:39:27 weeks.
02:39:28 Q. Two weeks, okay. So do you
02:39:31 remember roughly when she left?
02:39:33 A. Yes.
02:39:34 Q. Okay, and I suppose she
02:39:35 didn't exactly leave because she was placed

02:39:37 in the home as an agency nurse, so her -- do
02:39:40 you remember roughly when her last shift
02:39:42 would have been?
02:39:44 A. I know only because of
02:39:46 documents I reviewed. I believe it was
02:39:48 April 18th.
02:39:52 MS. MERRIFIELD: So, Commissioner,
02:39:53 I don't propose to take Ms.
02:39:56 Cornelissen through everything
02:39:57 that is already covered in her
02:39:58 fairly lengthy affidavit, but I
02:39:59 would like to ask her a couple of
02:40:01 questions about some incidents and
02:40:03 interactions that she had with Ms.
02:40:04 Wettlaufer today.
02:40:05 THE COMMISSIONER: Thank you.
02:40:07 BY MS. MERRIFIELD:
02:40:07 Q. And we have already had the
02:40:09 benefit of Ms. Shannon's testimony and Ms.
02:40:12 Toleff's as well who were able to speak more
02:40:15 extensively about the agency nurses and
02:40:19 other matters as well.
02:40:20 So, Ms. Cornelissen, if I can turn
02:40:23 you to paragraph 30 of your affidavit --
02:40:45 actually, forgive me, it is paragraph 26,
02:40:47 and at paragraph 26 of your affidavit you
02:40:58 say:
02:40:59 "As I noted earlier, when I arrived
02:41:01 at Telfer Place I found it to be
02:41:03 disorganized and there were stacks
02:41:04 of paper. In the stacks of paper,
02:41:06 I found handwritten medication

incidents reports which had not been [inputted] into our computer system. I initialled the one completed by Elizabeth Wettlaufer but I did not date it."

At tab "E" of your affidavit, and that is doc ID 24249, the title of the documents says "Medication Incident Report". Do you recognize this document, Ms. Cornelissen?

A. Yes.

Q. And is this the document that you are referring to at paragraph 26 of your affidavit?

A. Yes.

Q. And what exactly is this that we are looking at?

A. A Medication Incident Report.

Q. And what is a Medication Incident Report, and what was this one used for?

A. A Medication Incident Report is done if there is any error with medications with residents, whether it be wrong doses, omissions, et cetera.

Q. Okay. And is this an internal document, Telfer Place document, or does it go outside of the home?

A. This one was used at Telfer Place, but this was a Classic Care Pharmacy form.

Q. So am I right that the form

02:42:25 is provided by Classic Care Pharmacy, and
02:42:27 then the staff at Telfer Place complete the
02:42:29 form?
02:42:30 A. Correct.
02:42:32 Q. And so what did this, the
02:42:34 incident that is outlined on this document,
02:42:35 what -- are you able to explain to us what
02:42:38 happened here?
02:42:40 A. So the dose of medication was
02:42:41 not given as prescribed.
02:42:45 Q. Okay, and what is the
02:42:46 medication?
02:42:48 A. Kadian is --
02:42:50 Q. What is Kadian?
02:42:52 A. An opioid.
02:42:53 Q. It is an opioid, and is it a
02:42:55 liquid form or is it a pill form?
02:42:57 A. Pill form.
02:42:59 Q. And the date of the incident
02:43:01 is March 31st, 2016, and who completed this
02:43:08 form?
02:43:11 A. Elizabeth Wettlaufer.
02:43:14 Q. Okay. And then do you
02:43:15 recognize the signature on the bottom
02:43:16 right-hand corner? Do you know whose
02:43:18 signature that is?
02:43:20 A. That is my initial.
02:43:20 Q. Your initial, okay. And so
02:43:25 you weren't yet at the home when this
02:43:29 Incident Report was completed, so did you --
02:43:33 when did you sign this form; do you
02:43:36 remember?

02:43:37 A. I believe it was in July.
02:43:39 Q. In July, after.
02:43:41 A. Uhm-hmm.
02:43:41 Q. Okay, and then if we go over
02:43:43 to tab "F", and the document ID is 24247.
02:44:06 What exactly is this form?
02:44:09 A. That is the Revera online
02:44:12 reporting system for medication incidents,
02:44:18 the old system.
02:44:19 Q. Okay, and am I right that at
02:44:20 the time, after you started at Telfer Place,
02:44:24 I understand from your affidavit that you
02:44:26 went back and completed these forms at that
02:44:29 time?
02:44:29 A. Correct.
02:44:30 Q. So you completed the
02:44:32 computerized form at tab "F", 24247, and
02:44:37 then signed tab "E", 24249; is that right?
02:44:44 A. Correct.
02:44:45 Q. It had already been completed
02:44:46 by Elizabeth Wettlaufer at the time that you
02:44:48 signed it?
02:44:49 A. Yes.
02:44:50 Q. Thank you. And at paragraph
02:44:59 29 of your affidavit you talk about being
02:45:07 on-site at Telfer Place approximately a week
02:45:11 or two, and I will just read that paragraph:
02:45:19 "At the time [...]"
02:45:21 Well, I'm going to go back one
02:45:26 paragraph and I am going to start at
02:45:26 paragraph 28:
02:45:27 "Around April 20, 2016, a PSW, came

to me to discuss Elizabeth Wettlaufer. I believe that PSW may have been Lynn Jackson. A situation had arisen involving a resident with responsive behaviours. I believe that a staff member was injured but I can no longer recall how. I understand the PSW had been worried that the resident might [have] hurt himself or others. The PSW informed me that Elizabeth Wettlaufer had not responded to her concerns appropriately or monitored the situation appropriately when she had brought the situation to Elizabeth Wettlaufer's attention. Although the injury had been reported to Elizabeth Wettlaufer, she had not completed a Workplace Incident Report."

And paragraph 29 goes on:

"At the time the PSW came to speak with me, I had been on-site at Telfer Place approximately a week or two. In or around the time that this was brought to my attention, I was also advised that there had been a previous incident when Elizabeth Wettlaufer had made inappropriate comments of a sexual nature to a male staff member. I

understood that the issue of Elizabeth Wettlaufer making inappropriate comments had been an ongoing concern prior to my hire."

Do you remember what other concerns had been -- or what led you to believe that the issue of Elizabeth Wettlaufer making inappropriate concerns prior to your hire; can you explain to us a little bit more about what you mean by that?

A. As reported to me by a PSW.

Q. Okay, and is that referring to incidents other than the incident that you are talking about in this paragraph of your affidavit?

A. Yes, I believe like during that conversation, it was brought that, you know, this wasn't the first time that had happened.

Q. That there had been other comments before you had started working there; is that right?

A. Correct.

Q. Were you told what those comments were at any time?

A. I only recall the two, and I can't recall if it was like the historical or present.

Q. Okay, but you believed that Lindsay Astley knew about the previous inappropriate remarks, and I am just going back to paragraph 29 now:

"In or around that time, Dr. McDonald, a physician, also brought a concern to my attention. I cannot remember the specific nature of his concern. He was at Telfer Place maybe once a week. He was a physician to some of the residents. I recall that we had a conversation near the nurses' station about Elizabeth Wettlaufer but I do not remember any details of the complaint."

And then you go on to say that you called Heidi Wilmot-Smith in or around April 20th, 2016, and that you didn't call Elizabeth Wettlaufer directly. You didn't have her contact information.

So if there is an incident with an agency nurse, how are you able to address those concerns? Is the only recourse you have is to go back to the agency that brought them into the home in the first place?

A. Yes, that would be your initial source.

Q. Okay. Do you have any other way of contacting the agency nurse or -- because what I am trying to understand is that if you bring a concern to an agency regarding one of their nurses, how do you know that they have been able to follow up and address those concerns with the agency

nurse?

A. I would say sometimes you don't unless they tell you otherwise.

Q. Okay. And if I can refer you to paragraph 33 of your affidavit -- actually, before we do that, paragraph 32 at Exhibit "G", and it is document ID 24211. In the bottom -- this is an email. It is down at the bottom there, Amanda. Thank you.

Do you remember sending this email?

A. Yes.

Q. Okay, and who did you send it to?

A. To Heidi.

Q. And by "Heidi", you mean Heidi Wilmot-Smith of Lifeguard?

A. Correct.

Q. Okay. And so what -- can you explain to us exactly what prompted you to send this email to Heidi?

A. It was everything.

Q. Can you elaborate on that and explain it to us what you mean?

A. So having been there such a short time and having three separate incidents being told to me, I thought it was important to let her know.

So about the incident on nights where a PSW was injured and the appropriate paperwork wasn't filled out, and that PSW

relayed that she hadn't felt that she -- that Bethe had done what she felt necessary to monitor an agitated resident.

And then Dr. McDonald - who I now know is Dr. McDonald, at the time I couldn't recall - had made generalized comments about her as well.

And then when the PSWs told me about the vulgar comments she was making, it was just all too much to be dealing with an agency nurse.

Q. Okay, and are you able to speak to us a little bit more about what Dr. McDonald said to you, if you can recall?

A. Yeah, I can't recall specifics. I believe it was honestly a general conversation just about things he didn't generally like about her reporting or practice.

Q. And were there any other concerns? You have mentioned three. Were there any other concerns other than the three that you have just mentioned?

A. No, not that I am aware of.

Q. And so was there anything in particular that prompted you to send this email to Heidi?

A. I can't recall. Like I feel like it all happened at once kind of thing, but --

Q. And then what I understand you are saying is that at some point it was

02:52:29 just sort of too much and you wrote to her
02:52:32 asking that she not be brought back; is that
02:52:34 right?
02:52:37 A. I think it all kind of came
02:52:38 to light at the same time. Like I don't --
02:52:41 or the same week or something, so --
02:52:44 Q. Okay. And so do you know if
02:52:49 Elizabeth Wettlaufer was brought back into
02:52:51 the home after you sent this email?
02:52:53 A. She was not.
02:53:05 Q. I wanted to ask you about one
02:53:06 other area right now. At paragraph 41 of
02:53:11 your affidavit you talk about having heard
02:53:24 the testimony of Heidi Wilmot-Smith and
02:53:28 particularly what she said around a "do not
02:53:32 hire" list for agency nurses. Can you tell
02:53:38 us about your -- what you mean by a "do not
02:53:42 hire" list?
02:53:43 A. We don't have a "do not hire"
02:53:45 list for agency nurses.
02:53:47 Q. Okay, so that is contrary
02:53:48 then to the testimony that you have heard?
02:53:51 A. Correct.
02:53:58 Q. And at paragraph 44 you talk
02:53:59 about a conversation you had with a Wendy
02:54:02 Gilmour. Can you tell us about that?
02:54:07 A. I spoke to Wendy about a
02:54:10 conversation she had with Heidi Wilmot-Smith
02:54:14 after the incident became known to us about
02:54:19 her calling Heidi and just I guess letting
02:54:22 her know and questioning whether or not she
02:54:24 had had a police and vulnerable sector

screening and if she was registered with the CNO.

Q. So was that the conversation that was relayed to you by Ms. Gilmour?

A. Correct.

Q. Okay. Did Ms. Gilmour mention anything about a "do not hire" list to you?

A. No. They -- I believe that Mrs. Gilmour contacted Heidi Wilmot-Smith again, just to let her know that she had another last name, Parker, I believe, and just to give her kind of a heads-up. But I don't believe there was any conversation about a "do not hire" list.

Q. Okay. At paragraph 44 you say:

"Ms. Gilmour informs me that at no point did she indicate to Ms. Wilmot-Smith that (i) Elizabeth Wettlaufer had worked for Revera under [the] [...] name of Parker; or (ii) Elizabeth Wettlaufer (under her maiden name of Parker) had been on a 'do not hire' list [...]"

Is that right? Sorry, you have to say "yes".

A. Oh, yes.

Q. Thank you. Is there anything else that you want to tell us about your work with Elizabeth Wettlaufer?

A. No.

02:55:52 Q. Okay. Well, having said
02:55:55 that, I am going to ask you one other
02:55:57 question, and that is are you able to tell
02:56:02 us about the impact of Ms. Wettlaufer's
02:56:06 offences and crimes on your work and on
02:56:09 those you work with?
02:56:14 A. I think it has been huge.
02:56:16 Q. If you want to take a breath,
02:56:18 go ahead.
02:56:18 A. I think it has definitely
02:56:21 shaken things up. Everybody is, you know,
02:56:23 kind of shocked and appalled that this
02:56:26 happened. And it has been very reflective,
02:56:32 I think, for everybody.
02:56:34 It is a scary situation. Nobody
02:56:39 ever wants to think that that could really
02:56:40 happen or that you could be exposed to it
02:56:42 and not recognize it, that it is even
02:56:46 happening. It is sad.
02:56:47 And there is lots of revisions in
02:56:53 the way people are doing things and looking
02:56:55 at their practice and all sorts of things.
02:56:57 Q. Can you tell us a little bit
02:56:59 about those, the revisions and how people
02:57:01 are looking at their practices?
02:57:02 A. Well, I think everybody is
02:57:04 looking at how we can do things better. You
02:57:06 know, where are there gaps; what did we
02:57:08 miss; you know, how are we going to do a
02:57:10 better job at catching these things, if we
02:57:12 can.
02:57:13 Q. Have any of those discussions

involved anything to do with the management of medication and specifically insulin in the home?

A. Well, I think that there is definitely work being done on our medication administration systems, tracking of incidents and quarterly reviews and that sort of thing.

In terms of insulin, no. I'm not really sure how one would go about that.

Q. And why is that?

A. Because insulin is different. You don't exactly measure the metered dose as it goes down.

Q. Okay.

A. So I don't know how you would, you know, let's say track how many units are left or whatnot, especially when you always prime with some units as well.

Q. Would it be possible to track maybe not the units but the number of cartridges, to track --

A. Cartridges, yes, but it only takes such a small amount.

Q. Okay. So do I understand then that insulin hasn't been tracked at Telfer Place?

MS. McALEER: Sorry, this witness is no longer at Telfer Place.

MS. MERRIFIELD: Those are all my questions, thank you.

MR. ZIGLER: The witness can

02:58:39 1 answer the question about how it
02:58:39 2 was tracked when she was there or
02:58:41 3 not.
02:58:44 4 MS. McALEER: Okay, well, this is
02:58:45 5 a little unusual. Is the question
02:58:46 6 -- I can ask her in
02:58:48 7 re-examination, if it will make my
02:58:49 8 friend happy. Are you done?
02:58:55 9 MS. MERRIFIELD: Yes.
02:58:57 10 MR. ZIGLER: Ms. Merrifield asked
02:58:59 11 a question about when she was at
02:59:01 12 Telfer Place. She is no longer
02:59:03 13 there, but she was there for a
02:59:04 14 period of time. I think she can
02:59:05 15 answer the question, and then my
02:59:06 16 friend can re-examine all she
02:59:08 17 wants.
02:59:08 18 MS. McALEER: I am fine.
02:59:09 19 THE COMMISSIONER: Yes, I mean, I
02:59:12 20 think we understand that everybody
02:59:13 21 is trying to pitch in with Ms.
02:59:14 22 Hewitt not here, so let's have a
02:59:16 23 little patience.
02:59:17 24 And so just give your question
02:59:18 25 again and position it in time for when this
02:59:22 26 witness was at Telfer Place.
02:59:24 27 BY MS. MERRIFIELD:
02:59:24 28 Q. When you were at Telfer
02:59:24 29 Place, was there any tracking of insulin
02:59:28 30 done in the home in terms of counts, the
02:59:36 31 amount administered and so on?
02:59:38 32 A. No.

02:59:38 MS. MERRIFIELD: Thank you. Those
02:59:41 are all my questions.
02:59:42 Ms. McAleer.
02:59:44 THE COMMISSIONER: Thank you, Ms.
02:59:44 McAleer, and thank you, Ms.
02:59:45 Merrifield.
02:59:46 EXAMINATION IN-CHIEF BY MS. McALEER:
02:59:46 Q. Thank you.
02:59:46 Very briefly, Ms. Merrifield asked
02:59:50 you some questions about your conversation
02:59:51 with Wendy Gilmour. Keeping in mind today
02:59:54 is Tuesday, when did you have your
02:59:56 conversation with Ms. Gilmour?
02:59:57 A. On Sunday.
02:59:58 MS. McALEER: Thank you, those are
03:00:00 all my questions.
03:00:01 THE COMMISSIONER: Thank you.
03:00:04 MS. MERRIFIELD: The first family
03:00:05 group, Mr. Van Kralingen.
03:00:07 MR. VAN KRALINGEN: No questions,
03:00:07 Madam Commissioner.
03:00:08 THE COMMISSIONER: Thank you.
03:00:10 MS. MERRIFIELD: Mr. Scott?
03:00:10 MR. SCOTT: No questions, Your
03:00:11 Honour.
03:00:12 MS. MERRIFIELD: And the Ministry.
03:00:15 MS. WILLIAMS: A few questions,
03:00:15 thank you.
03:00:17 MS. MERRIFIELD: Ms. Williams.
03:00:17 CROSS-EXAMINATION BY MS. WILLIAMS:
03:00:17 Q. Good afternoon. My name is
03:00:25 Meagan Williams, and I am counsel to the

Ministry of Health and Long-Term Care.

I am going to ask a few questions that I think will mostly be based on your affidavit, so I hope you have that in front of you. I might also refer to Exhibit 82 again, so I hope there is a copy available for the witness.

So if you have Exhibit 82 in front of you, that is the Telfer Place Inspection Report at 41487.

A. Yes, I have it.

Q. And then also in your affidavit at paragraph 29, I would like to talk about that a bit. Just let me know when you have had a chance to have a look.

A. I have it.

Q. At paragraph 29 of your affidavit, you describe Dr. McDonald bringing a concern about Ms. Wettlaufer to your attention. Is that what it says at -- sorry, I think I spoke over you there. Can we have your answer again?

A. Yes.

Q. You recall now that it was Dr. McDonald who spoke with you, but you initially didn't remember which physician it was; is that true?

A. That is true.

Q. When you spoke to Ministry of Health investigator Lisa Vink [phonetic] in November, you could not recall which physician it was who brought the concern to

your attention?

A. That is true.

Q. So then when you spoke to the Ontario Provincial Police a few months later, you still couldn't recall which physician spoke to you?

A. True.

Q. You were able to recall which physician spoke to you after your meeting with the Ministry of Health and also after the interview with the OPP, so when you recalled it was Dr. McDonald, it was after those two interviews took place?

A. That's correct.

Q. So when Dr. McDonald brought the concern to your attention, you had only been at Telfer Place for a few weeks at that point?

A. Yes.

Q. So you were still getting to know names and faces of people who worked at Telfer Place?

A. Correct.

Q. Moving on to paragraph 20 of your affidavit, I have a few questions about agency staffing.

Now, at paragraph 20 you describe that it was Telfer Place's practice at the time to rely on agencies to perform criminal reference checks?

A. Correct.

Q. I appreciate you saying it

was the practice at the time, but do you agree that under the Long-Term Care Act it is ultimately the home's responsibility to ensure that the criminal reference checks have been performed?

A. Yes.

Q. As you brought new agency nurses into Telfer Place, did you or another staff member confirm with Lifeguard that it had been done?

A. I cannot for certain recall.

Q. Now, going to that Exhibit 82 at 41487, this is the Ministry's Inspection Report after Ms. Wettlaufer's offences came to light. Have you seen this document before?

A. Yes.

Q. When have you -- when did you first read this document?

A. Yesterday.

Q. Did someone discuss with you the findings in the document at the time when the report was released?

A. No.

Q. Turn to page 4, which is where written notice number 2 starts. The findings themselves start at the top of page 5, so there is only really a little heading at the bottom of page 4.

Now, this is the finding where the Ministry found the licensee failed to ensure that criminal reference checks had been

03:04:24 conducted. Do you have any reason to
03:04:27 dispute this finding?
03:04:28 A. No.
03:04:31 Q. Now, my last series of
03:04:33 questions is about Ministry regulations. At
03:04:37 the very bottom of your affidavit at
03:04:39 paragraph 48, and I'll give you a moment to
03:04:44 get there. In this paragraph you express a
03:04:51 concern that the Ministry's current
03:04:53 regulations for long-term care homes will
03:04:55 make it harder to encourage people to work
03:04:58 in long-term care?
03:05:00 A. Correct.
03:05:01 Q. One of the most important
03:05:03 goals of legislation is to safeguard the
03:05:05 health and well-being of residents in
03:05:07 long-term care homes. Would you agree with
03:05:08 that statement?
03:05:09 A. I would agree.
03:05:10 Q. And one of the ways this is
03:05:11 done is with clear and consistent standards
03:05:14 for long-term care homes? I'm sorry, can
03:05:18 you make an audible answer?
03:05:19 A. Yes.
03:05:20 Q. Thank you. And this is
03:05:23 backed by strong compliance, inspection and
03:05:25 enforcement. Would you agree with that
03:05:29 statement?
03:05:31 A. Sorry, can you repeat that?
03:05:33 Q. Sure. Well, the question I
03:05:34 had asked you immediately previously was
03:05:37 whether one of the ways we safeguard the

health and safety of residents is with clear and consistent standards for long-term care homes, which I think you agreed to?

A. Yeah, I agreed.

Q. And that those standards are backed by strong compliance, inspection and enforcement?

A. I don't necessarily know if I agree with that.

Q. Okay. If I told you that that was in the preamble to the Act where the purposes of the Act are stated, would you have any cause to disagree with that?

A. No.

THE COMMISSIONER: But I'm sorry, does that mean does she disagree with the fact --

BY MS. WILLIAMS:

Q. I apologize. As soon as I formulated the question, I understood the error. Apologies for that. I'm happy to move on from that, however, thank you.

So I noticed in paragraph 48 you used the word "penalized" to refer to the effect of some of the Ministry's regulations. I wondered do you mean when you use the word "penalized" the introduction of the Administrative Monetary Penalty?

A. And jail time, yes.

Q. And jail time. So when you say "jail time", what do you mean? What is

your understanding of jail time?

A. My understanding is that if there is something not followed in the regulation - and I mean, there is lots more to it - that people could potentially face fines and jail time.

Q. When you say "people", what do you mean? What kind of people can face jail time?

A. Anybody working in long-term care.

Q. Okay. Now, going back to Administrative Monetary Penalties, which are sometimes referred to as AMPs; are you familiar with the term "AMP"?

A. No, sorry.

Q. Okay, so if I refer to Administrative Monetary Penalties, that term makes more sense?

A. Yes.

Q. When Administrative Monetary Penalties are issued, they are issued against licensees?

A. Yes.

Q. They are not imposed against nurses?

A. Okay.

Q. Do you agree with that?

A. Yes.

Q. Do you also agree that they are not imposed against administrators

03:07:50 themselves in long-term care homes?
03:07:53 A. I --
03:07:53 Q. People like the Directors of
03:07:55 Care?
03:07:55 A. Sorry, can you just repeat
03:07:56 that last part?
03:07:57 Q. Sure thing, that
03:07:58 Administrative Monetary Penalties aren't
03:08:03 levied against administrators themselves, so
03:08:05 the individual staff members doing
03:08:07 administrative work in homes?
03:08:09 A. Are you asking if I know
03:08:10 that?
03:08:11 Q. That's right.
03:08:11 A. No, I don't know that.
03:08:13 Q. Okay. Is it your
03:08:15 understanding that an administrator could be
03:08:18 forced to personally pay an Administrative
03:08:19 Monetary Penalty?
03:08:21 A. That was my belief, correct.
03:08:28 Q. So if I told you that the
03:08:32 regulation is actually that only licensees
03:08:35 can pay Administrative Monetary Penalties,
03:08:38 does that change your understanding of
03:08:42 whether people would be disincentivized to
03:08:46 work in long-term care?
03:08:48 A. No. How does the criminal
03:08:50 charges affect people who work in long-term
03:08:54 care such as nurses, administrators,
03:08:55 directors of care?
03:08:57 Q. Right, I take your point.
03:08:58 I believe those are all the

03:09:00 questions I have for this witness.
03:09:01 Thank you very much.
03:09:03 THE COMMISSIONER: Thank you, Ms.
03:09:04 Williams.
03:09:12 MS. BUTT: ONA has no questions.
03:09:14 MS. MERRIFIELD: The College of
03:09:14 Nurses?
03:09:17 MR. ZIGLER: Madam Commissioner, I
03:09:17 am wondering if this is an
03:09:19 appropriate time to take a break,
03:09:20 because we started much earlier?
03:09:21 I don't know that we are going to
03:09:22 go much longer, but just if we can
03:09:25 take stock of how much time people
03:09:28 want to go.
03:09:29 THE COMMISSIONER: Do you want to
03:09:30 take stock, or do you want
03:09:30 to break to take stock?
03:09:31 MR. ZIGLER: I think it would be
03:09:33 helpful if we did.
03:09:34 THE COMMISSIONER: If we broke
03:09:34 and took stock.
03:09:34 MR. ZIGLER: Take a short break,
03:09:34 yes.
03:09:34 THE COMMISSIONER: All right, yes,
03:09:35 then we will take the afternoon
03:09:36 recess at this point, thank you.
03:09:37 -- RECESSED AT 3:09 P.M.
03:13:49 -- RESUMED AT 3:28 P.M.
03:28:02 MS. COONEY: Good afternoon,
03:28:02 Commissioner.
03:28:02 THE COMMISSIONER: Good afternoon.

03:28:02 CROSS-EXAMINATION BY MS. COONEY:
03:28:08 Q. May I call you Michelle?
03:28:09 A. Yes.
03:28:10 Q. Good afternoon, Michelle, my name is Denise Cooney and I'm one of the lawyers for the College of Nurses of Ontario.
03:28:17 As a starting point you're aware that Telfer Place has reporting obligations to the College of Nurses of Ontario?
03:28:22 A. Yes.
03:28:23 Q. As Director of Care what was your role in reporting to the College?
03:28:32 A. I would complete reports and send to the College.
03:28:33 Q. So that was part of your responsibilities?
03:28:36 A. Correct.
03:28:37 Q. And the facility directly employed Registered Nurses and Registered Practical Nurses?
03:28:43 A. Yes.
03:28:44 Q. As an employer of these registered staff you have reporting obligations to the College of Nurses?
03:28:49 A. Yes.
03:28:50 Q. And there were also agency nurses who were practicing at the facility who are not directly employed by the facility?
03:28:59 A. Correct.
03:28:59 Q. And you also had reporting

03:29:01 obligations to the College of Nurses in
03:29:02 relation to those agency nurses?
03:29:05 A. Yes.
03:29:05 Q. And facility operators are
03:29:10 required to report where there are
03:29:12 reasonable grounds to believe that a nurse
03:29:13 who practices at the facility has sexually
03:29:18 abused a client, and that's not at issue.
03:29:20 There's no concerns about sexual abuse in
03:29:22 this case?
03:29:23 A. No.
03:29:23 Q. But facility operator are
03:29:26 also required to report where there are
03:29:26 reasonable grounds to believe that a nurse
03:29:26 who practices at the facility is
03:29:28 incapacitated?
03:29:29 A. Yes.
03:29:31 Q. And as I'm sure you're aware
03:29:33 "incapacity" has a specific meaning in the
03:29:35 regulated health context, which is that the
03:29:38 nurse has a health condition that impairs
03:29:40 her or his ability to provide care?
03:29:43 A. Yes.
03:29:45 Q. And facility operators are
03:29:46 also required to report where there are
03:29:48 reasonable grounds to believe that a nurse
03:29:49 who practices at the facility is
03:29:51 incompetent?
03:29:53 A. Yes.
03:29:54 Q. And again "incompetence", as
03:29:55 I'm sure you're aware, has a defined meaning
03:29:58 in the regulated health context, which is

that the nurse's:

"[...]care shows such significant and repeated deficiencies in knowledge, skill or judgment that the nurse's practice must be restricted to ensure client safety."?

A. Yes.

Q. As of April 20th, 2016, you had a number of concerns about Ms. Wettlaufer's practice. I'm going to run through them with you.

The first involved an incident where a resident injured a staff member and Ms. Wettlaufer had not responded appropriately to the incident and appropriately monitored the situation thereafter? That was one of the incidents you were aware of that there had been an incident where --

A. Yes, that was what was reported to me by a PSW.

Q. And you were also aware that according to the PSW Ms. Wettlaufer had not completed a workplace incident report for that incident?

A. Correct.

Q. You were also aware that Ms. Wettlaufer had made inappropriate comments to a male PSW?

A. Correct.

Q. And potentially other vulgar

comments?

A. Sorry? Potentially?

Q. Other vulgar -- were there other vulgar comments that you had -- you had received reports that Ms. Wettlaufer had made other vulgar comments as well?

A. Yes.

Q. And Dr. McDonald had brought concerns to your attention that he did not feel confident in Ms. Wettlaufer's abilities as a nurse and had mentioned that he felt she lacked accountability as a nurse?

A. Yes.

Q. Did you make any inquiries of Dr. McDonald about what he meant when he said he didn't feel confident in her abilities?

A. I can't recall the conversation that we had.

Q. Based on all the information you had on April 20th you advised Heidi Wilmot-Smith that you no longer wanted to use Ms. Wettlaufer as an agency nurse?

A. Yes.

Q. Did you consider whether there were any potential reporting obligations to the College of Nurses?

A. We always consider that when looking at incidents.

Q. And in this case you didn't make a report to the College of Nurses with respect to Ms. Wettlaufer?

A. No.
Q. Why not?
A. Because I didn't have, like concrete specific incidents that were repetitive and serious cause for concern.
Q. You didn't have concerns about her competence?
A. I didn't know her well enough or the situations. I had a report from one PSW.
Q. Thank you, those are my questions.
THE COMMISSIONER: Thank you.
MS. MERRIFIELD: OARC.
MS. MEADUS: We have no questions, thank you.
MS. MERRIFIELD: AdvantAge.
MR. SCHWARTZ: AdvantAge Ontario has no questions, thank you.
MS. MERRIFIELD: RNAO?
Ms. Binhammer.
CROSS-EXAMINATION BY MS. BINHAMMER:
Q. Hello, Michelle. May I call you Michelle?
A. Yes.
Q. My name is Lauren Binhammer. I'm a lawyer representing the Registered Nurses Association of Ontario and I have a few questions for you, starting with some questions about your participation in the new grad initiative.
A. Yes.

03:33:02 Q. So if I understand the
03:33:04 staffing levels at Telfer Place at least for
03:33:07 some period of time it was one RN to all 45
03:33:11 residents?
03:33:12 A. Correct.
03:33:13 Q. And you said in paragraph 12
03:33:15 of your affidavit that you hired two RN
03:33:19 grads through the new grad initiative?
03:33:21 A. Yes.
03:33:22 Q. And you had to offer them a
03:33:24 full-time position at the conclusion of the
03:33:26 program?
03:33:26 A. Sorry, can you --
03:33:27 Q. You were supposed to offer
03:33:29 them a full-time position at the conclusion
03:33:31 of the program?
03:33:32 A. I think it's full- or
03:33:34 part-time.
03:33:35 Q. Full- or part-time, okay.
03:33:36 And for -- as I understand the
03:33:37 program, for at least a period the new grads
03:33:40 were not supposed to work alone, they were
03:33:42 paired with another nurse?
03:33:44 A. Correct.
03:33:44 Q. The idea was I think that
03:33:45 they would have a mentor, someone to teach
03:33:48 them about working in long-term care?
03:33:50 A. Correct.
03:33:51 Q. And the RN they were paired
03:33:52 with would have some support in their role
03:33:54 as well?
03:33:55 A. Correct.

03:33:55 Q. Do you recall how long the
03:33:58 new grads had to work alongside another
03:34:01 nurse for approximately?
03:34:03 A. I can't recall.
03:34:04 Q. Would it have been a period
03:34:05 of months or weeks? Do you have a sense?
03:34:07 A. Sorry, I can't recall.
03:34:09 Q. After the program concluded
03:34:11 and you hired and then -- and you hired the
03:34:14 new grad the new grad would then be dealing
03:34:16 with a 45 to 1 ratio on their own; is that
03:34:19 correct?
03:34:20 A. I wasn't there at the time.
03:34:22 Q. But if the staffing levels
03:34:24 were the same that would be the case?
03:34:26 A. Correct.
03:34:27 Q. And if you had hired a recent
03:34:29 grad into long-term care, without the
03:34:31 benefit of this program this recent grad
03:34:35 would also be working as one -- the only
03:34:38 nurse to 45 residents?
03:34:40 A. Correct.
03:34:41 Q. Now, you said in your
03:34:42 affidavit at paragraph 41 that
03:34:45 prospective -- or sorry, 14, prospective
03:34:48 nurses were sometimes scared off by the 45
03:34:52 to 1 ratio. Do you think this would be
03:34:53 particularly scary for a recent grad or a
03:34:56 new grad?
03:34:57 A. I think it would be scary for
03:34:59 anybody.
03:34:59 Q. For anybody, fair enough.

I'm going to move to a different area now.

We've heard throughout these proceedings that resident acuity level has been increasing. Does that sound fair to you?

A. Yes.

Q. You've had residents with complex medical conditions?

A. Yes.

Q. Residents with co-morbidities?

A. Yes.

Q. Residents with unstable or unpredictable conditions?

A. I'm sure at times.

Q. And I assume you've also had unpredictable situations arise?

A. Yes.

Q. Is it pretty common to have residents with complex conditions?

A. Yes.

Q. And now you started your career in long-term care as an RPN?

A. Yes.

Q. And then you went back to school to become an RN?

A. Yes.

Q. So you needed additional education and training to be an RN?

A. Yes.

Q. In fact it was three more

03:35:51 years of education I believe you said?
03:35:52 A. Yes.
03:35:53 Q. And so you would be aware
03:35:55 generally that RPNs get a two-year college
03:35:59 diploma while RNs complete a four-year
03:36:02 university degree?
03:36:02 A. Yes.
03:36:02 Q. And your education prepared
03:36:04 you to deal with more complex cases, for
03:36:07 example?
03:36:07 A. Yes.
03:36:08 Q. More unpredictable
03:36:10 situations?
03:36:10 A. Yes.
03:36:11 Q. And to have a more
03:36:12 independent practice as well?
03:36:15 A. Yes.
03:36:15 Q. And to take a greater
03:36:17 leadership role as an RN as opposed to an
03:36:19 RPN?
03:36:20 A. My education?
03:36:22 Q. Yes, your education, or maybe
03:36:24 your experience afterwards?
03:36:25 A. Maybe my experience, yes.
03:36:27 Q. And you would know that
03:36:32 differences in education between RNs and
03:36:34 RPNs translate into different
03:36:36 entry-to-practice competencies?
03:36:39 A. Yes.
03:36:39 Q. RNs have more --
03:36:41 A. Yes.
03:36:42 Q. -- than RPNs?

A. Yes.

Q. And if I can take you to document that's Exhibit 31, and it's document number 54989. And I'll just ask if you're familiar with this document? Have you seen this document before?

A. Yes.

Q. Okay. If we can go to page 3? And you'll see on the right-hand side under "Guiding Principles", the second bullet point down, and I'll just read it. It says:

"RNs and RPNs study from the same body of nursing knowledge. RNs study for a longer period of time allowing for greater foundational knowledge in clinical practice, decision making, critical thinking, leadership, research utilization and resource management."

Is that a fair description of your education when you moved on to become an RN?

A. Yes.

Q. And it says:

"As a result of these differences the level of autonomous practice of RNs differs from that of RPNs."

And then the next bullet point says:

"The complexity of a client's condition influences the nursing knowledge required to provide the level of care the client needs. A

more complex client situation and less stable environment create an increased need for consultation and/or the need for an RN to provide the full range of care requirements."

You said earlier that there were residents with complex conditions?

A. Yes.

Q. So there would be residents who would require the care of an RN, at least the involvement of an RN in their care?

A. I guess theoretically speaking.

Q. Okay. Thank you, those are my questions.

THE COMMISSIONER: Thank you, Ms. Binhammer.

MS. HEWITT: RPNAO, Mr. Singh.

CROSS-EXAMINATION BY MR. SINGH:

Q. Hi, Michelle. My name is Shaun Singh, I'm a lawyer with the Registered Practical Nurses Association of Ontario. So I do just have a couple of quick questions.

As part of your schooling to become an RPN you're required to complete a rotation in the long-term care sector, correct?

A. Yes.

Q. How long is that rotation?

A. Oh, I can't recall.

03:39:39 Q. Would you be able to -- would it be a number of weeks or a number of months or --
03:39:44 A. I would think a few weeks.
03:39:47 Q. What's involved in that rotation?
03:39:49 A. From my recollection it's basically performing the duties of a personal support worker.
03:39:56 Q. And did you feel that this rotation was beneficial in terms of your exposure to the long-term care sector?
03:40:04 A. No, I don't think it shows RPNs what they truly do in long-term care.
03:40:09 Q. Now, as part of the bridging program to become an RN you're not required to complete a rotation in the long-term care sector?
03:40:17 A. Correct.
03:40:18 Q. And do you feel that you received adequate exposure to the long-term care sector as part of your training to become an RN?
03:40:26 A. No.
03:40:28 Q. Do you believe that requiring a rotation or something similar in the long-term care sector as part of your schooling to become an RN would be beneficial?
03:40:38 A. I do.
03:40:39 Q. Why is that?
03:40:40 A. Because nurses, new grads

often don't want to come to long-term care. They've never had the exposure so they don't really understand what it is to work in long-term care; so if they had a clinical rotation maybe they would be more inclined to come and work there.

Q. Thank you, those are all my questions.

THE COMMISSIONER: Thank you, Mr. Singh.

MS. HEWITT: Mrs. McAleer.

MS. MCALEER: No questions, thank you.

MS. MERRIFIELD: I believe those are all the questions for this witness today.

THE COMMISSIONER: Thank you, Ms. Cornelissen, for coming. We appreciate your help very much.

THE WITNESS: Thank you.

MS. MERRIFIELD: You are now free to go from the inquiry.

THE WITNESS: Thank you.

MS. MERRIFIELD: If we could request to adjourn until tomorrow morning and continue at that time with the next few witnesses. And I can tell you who the anticipated witnesses are if that would help?

THE COURT: Yes, that would be good.

MS. MERRIFIELD: The first witness

is Carol Hepting, and Ms. Hepting is the VP Operations for Caressant Care.
And the next two witnesses are from St. Elizabeth Healthcare. The first is Patricia Malone, who is the Corporate Integrity Officer from St. Elizabeth healthcare; and the second is Tamara Condy, who I believe is an RN and was Ms. Wettlaufer's preceptor when she was with St. Elizabeth.
THE COMMISSIONER: All right. Would I anticipate getting their affidavit evidence today or not?
MS. MERRIFIELD: We are happy to provide you with a copy of Ms. Hepting's affidavit evidence, if that would assist the Commissioner. And for Ms. Condy and Ms. Malone if we could provide you with copies tomorrow morning?
THE COMMISSIONER: That would be fine, and you can send me an electronic version.
MS. MERRIFIELD: We're happy to do that.
THE COMMISSIONER: I have no difficulty with us adjourning now. Is the affidavit of Ms. Hepting available now or will I look for it later?

03:43:15 MS. MERRIFIELD: It is available
03:43:15 now, Commissioner.
03:43:17 THE COMMISSIONER: Thank you. So
03:43:17 I will take that.
03:43:18 Do we have any update on how
03:43:21 Ms. Hewitt is? If I may ask?
03:43:25 MS. MERRIFIELD: I'll let
03:43:26 Mr. Zigler deal with that.
03:43:31 MR. ZIGLER: They're awaiting some
03:43:34 test results but so far everything
03:43:35 is okay.
03:43:37 THE COMMISSIONER: Well that's
03:43:37 good. I hope you will have an
03:43:37 opportunity to let her know that
03:43:37 we're all thinking of her and
03:43:37 hoping she's well. So I have no
03:43:37 difficulty with rising until 9:30
03:43:37 tomorrow morning.

-- Adjourned at 3:43 p.m.

REPORTERS' CERTIFICATE

We, DEANA SANTEDICOLA, CSR, CRR, RPR, and HELEN MARTINEAU, CSR, Certified Shorthand Reporter, 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 accurate transcript of our shorthand notes so taken. Dated this 26th day of June, 2018.

NEESONS COURT REPORTING INC.
PER: DEANA SANTEDICOLA, CSR, CRR, RPR
& HELEN MARTINEAU, CSR

E