For the immediate attention of Aileen Wong,

Please see the below and a request for an immediate meeting to discuss the outstanding matter of unlawful isolation in February and other matters relating to a lack of candor from senior staff relating to [redacted]'s ability to transfer.

Summary

February 13th, 2024 – [redacted] isolated without consent for 24 hours under false pretenses for a health incident caused by CCD staff failing to follow [redacted]'s care plan. This incident was not reported to the family and was actively covered up by multiple staff members.

April 2nd, 2024 – Physiotherapist ([redacted]) initiated steps to change [redacted]'s care from a two person assist to a Hoyer lift. This was done in a deceitful manner. [redacted] made false statements to either Karen and/or David to justify his actions.

April 3rd, 2024 – Unnecessary assessment of [redacted]'s transfer capability with inappropriate staff (one wearing a cock-up splint) and interference from the assessor ([redacted]). [redacted] passed the assessment with no issues and even the staff were confused why this was happening. Agreement from [redacted] and [redacted] that this would not happen again.

April 4th, 2024 – Another underhanded and improper assessment planned without the knowledge of the family. Karen was on site and prevented this but again only after another confrontation (after which [redacted] (CPL) apologized and promised all Capital Care Dickinsfield staff would be notified so this never happened again). [redacted] also apologized for not informing the family of this planned assessment, contrary to [redacted]'s agreed care plan, as noted on the sign on [redacted]'s door.

April 5th, 2024 – A short power outage resets [redacted]'s mattress so it is completely deflated. Staff do not notice and leave [redacted] for almost 2 ½ hours lying directly on a hard bed with no support. During that time, the staff come in and give [redacted] breakfast without noticing. Then they try and assist [redacted] out of bed with the mattress deflated putting [redacted] in a crouching position that not even an able bodied person could rise from (with or without assistance). All was corrected by [redacted]'s family (not the staff). Staff did not initially assist [redacted] off the toilet but instead stood and watched, apparently unaware of their requirement to provide a two person assist to [redacted].

April 5th, 2024 – Afternoon. Physio completed without incident, including step exercise (videoed).

Contemporaneous notes.

[redacted] is 80 years old. She has always transferred with no issues whatsoever with a maximum of two staff to assist. More often than not, it is with one member of staff due to staffing shortages. She transfers with our family at home with one person to assist. Every week, she transfers to and from our unmodified vehicle and has never had any issues.

On Tuesday April 2nd, 2024 at approximately 2:35 pm, I received a call from the new Physiotherapist ([redacted]) at Capital Care Dickinsfield. [redacted] called to inform me that he was modifying [redacted]'s care plan from a two person assist (in place for 12 years) to a mechanical lift (Hoyer lift). This was not posed as a discussion, but as a fait accompli. [redacted] stated he had received complaints from staff that they could not transfer her safely. I said we would need more than complaints from some new nurses to change her care plan. I informed [redacted] that we had been with [redacted] the night before and took her for supper where [redacted] was transferred by myself and Karen individually (to an unmodified private vehicle) and that [redacted] had also recently been transferred by her 82-year-old partner (when no staff were available to assist in her peri care). I explained that if some staff were suddenly unable to transfer [redacted], considering they are supposed to be fully trained with two people assisting,

then this was clearly a staffing problem, not a [redacted] problem. [redacted] continued to tell me he had decided this change was happening but not to worry as it was only temporary, and it could change in the future. I informed him that such a radical change would not be temporary and would negatively impact [redacted]'s physical and mental wellbeing by taking away her mobility permanently. As a trained physiotherapist, [redacted] should already know the impact of such a change to a geriatric resident with complex medical needs such as [redacted]. I stated that if [redacted] had deteriorated so significantly since last night, then the doctor should have been called. [redacted] had not called the doctor and what he described did not indicate any significant change whatsoever in [redacted]'s health. [redacted] was clearly not listening and I told him that Karen would call him back to discuss this, but nothing was to change in [redacted]'s care in the meantime.

Karen called CCD and spoke initially to the Covering Unit Manager for 3D, [redacted]. Karen explained she had grave concerns about the impact of a transfer change to the Hoyer lift. She reiterated everything I had discussed with [redacted] above. Karen suggested that we attend the next day to demonstrate that [redacted] had no issue with her ability to transfer even with one untrained family member, let alone two trained staff. [redacted] stated that she would have the staff demonstrate the issue to us. That meeting was arranged for the 1:30pm on Wednesday 3rd April, 2024.

Karen called [redacted] and was now told by him that he had instigated this change as he noticed [redacted] needed his help to lift her paralyzed leg onto a step. Note that this exercise is **not** part of any assessment process for [redacted] but something the family had asked to be part of her Physical Therapy as we have stairs for her to negotiate when bringing her to our home. [redacted], a new member of the CCD physiotherapy staff, is clearly unfamiliar with [redacted] or her baseline. However, he decided to canvas the staff to ask if [redacted]'s mobility had changed recently with a clear intent to implement an unnecessary and dangerous change to her care plan. He told Karen that two male members of staff had informed him that [redacted] was bearing all her weight on them both during her transfer. This does not align with any conversations we have had with staff or the experience during this chaotic week. [redacted] did not, however, check if anything else had changed for [redacted] recently. He was unaware [redacted] was on a short course of Lasix for some edema in her paralyzed lower leg/foot. This short-term course of Lasix is known to cause some temporary side effects such as pain in movement due to bone pain and dehydration. At best, [redacted] might have been moving slightly slower as a result, but not in any way that would impact her overall mobility and certainly nothing that would necessitate such a drastic and irreversible change to her care.

At 10 am on the morning of Wednesday 3rd April 2024, we received a call from [redacted] who wanted to change the parameters of the meeting (now an assessment) to be 11:30 am. She stated this would be when [redacted] would be at her weakest as she would be getting out of bed at this time. Although this gave us little time to respond, we agreed and headed to the center.

We arrived about 11:15 am and [redacted] was sitting up in bed waiting to get up. She had already had breakfast at this time.

Soon after [redacted] and [redacted] arrived with a number of healthcare workers. One of the staff chosen for this assessment by [redacted] was wearing a mask. Karen asked her to remove her mask if she was going to interact with [redacted] as is required under AHS and Capital Care guidelines for working with residents who have cognitive or communication challenges (and as agreed by Aileen Wong). This was even more important for an assessment that could irreversibly impact [redacted]'s care. As the staff member took off her mask, I noticed she was wearing a cock-up splint on her wrist/hand. I told [redacted] and [redacted] that due to an apparent injury and the fact that this medical wrist restraint was designed to limit movement of the wrist and hand, this staff member could not be used for this assessment. For the next 30 minutes, [redacted] argued this staff member was signed fit for work and should participate. The staff member confirmed she was wearing the device due to recently returning to work after a WCB injury. [redacted] refused to question the use of this staff member who had a clear restriction in movement that would directly impact the assessment. Despite [redacted] being knowledgeable on the dangerous restrictions

in movement the device would create in even a healthy person for such an assessment, he refused to intervene. During this discussion, Karen asked multiple times if they could just find another staff member without such a clear impairment caused by the wearing of this restrictive medical device.

Eventually, after half an hour of talking (in front of [redacted] which was in itself distressing for the family and [redacted]), [redacted] decided to get another staff member. This created a further 10-minute delay. Interestingly, [redacted] then returned with two new staff members having replaced both health care workers. This seemed strange as only one was wearing a restrictive medical device. The new staff members then proceeded to talk through the process of assisting [redacted] out of bed without any issues whatsoever. One of the staff members was concerned that this was even happening. She told us that she assists [redacted] on a regular basis as part of her normal duties and had never had any issues with [redacted]'s transfers. Again, this confirmed that if any staff were having issues, it was a staffing issue, not a [redacted] issue.

Note that during this 'assessment' [redacted], whose role was to observe, grabbed [redacted]'s transfer belt and put it on [redacted]. I objected to his interference in an assessment in which he was supposed to be an observer. He agreed he should not have done this.

[redacted] then continued her normal morning routine including going to the bathroom without any issues.

After this Karen, and I had a meeting in [redacted]'s office with [redacted] and [redacted]. During the conversation, [redacted] stated the assessment was to help see if they needed to add more support to [redacted]'s care such as a transfer belt, staff training or other items that did not include a Hoyer lift. I told [redacted] again that none of this had been presented by [redacted] at any time. He had just stated from the start that [redacted] would be moved to a mechanical transfer on his say so from her normal two person assist. [redacted] agreed he had done this and not provided any other options. Both continued to state that any change would have been temporary showing that neither understood (or were being deceitful) about the impact of such a change to a geriatric resident with complex care needs.

It was agreed at the end of the meeting that there would be no further assessments or changes to [redacted]'s care without prior notice to the family as is required as part of [redacted]'s care plan (and the law related to consent based on the fact that we hold [redacted]'s PoA and Medical Proxy).

During this conversation, we explained that most times we had observed that only one member of staff provided the assist for [redacted]. We did not have an issue with this as we can do this also. However, [redacted] insisted that if this happened it must be reported as they always have to have two people. As Karen pointed out, this would be difficult as there have been many times when they have been down to a single member of staff on the unit, especially on holidays, the evening and the weekend. This has been raised with management ([redacted]) before.

[redacted] agreed there would be no more assessments or change, *"unless he received more complaints"*. I again reiterated that there would be no more demonstrations, assessments or even considerations of changes without prior consent of the family and again that this was even written on [redacted]'s door. [redacted] and [redacted] agreed that [redacted] would not be subjected to this humiliating and distressing fiasco again, especially after [redacted] had clearly demonstrated this was not a concern related to her abilities.

During this time, we were also informed that contrary to her care plan, [redacted] was regularly left in bed later than the other residents and as a result was the last to come for her lunch, in many cases arriving after the other residents had finished. This is despite a prior incident in February where this delay in getting [redacted] up had resulted in the improper/illegal confinement of [redacted] in her room for 24 hours. This related to the improper application of COVID isolation protocols that were hidden from the family. This is part of another matter that has already been brought to the attention of management (including Aileen Wong) without any response to date.

That evening, we spoke with [redacted]'s physician, Dr. [redacted]. He was incensed about what had happened, in particular the fact that the center had not contacted him to discuss such a radical and life impacting change to her care plan. He stated that this should never have happened and that if [redacted] had been placed into a mechanical lift, then she would permanently lose her mobility within a week. He agreed that such a change would have put [redacted] on a path leading to a rapid end of life situation. He stated he would call the center to ensure this did not happen again and would be arranging an urgent meeting with [redacted] on her return on April 15th, 2024.

This should have been the end of the matter until [redacted]'s return.

[redacted] was scheduled for her weekly paid massage the following afternoon, Thursday April 4th, 2024. Karen went back to the center to check that [redacted] was OK after the traumatic events of the previous day and to assist with her massage therapy.

When Karen arrived, she spoke to a member of staff on the elevator who told Karen our family had been the subject of a major meeting as a result of the events the day before. This now appeared to be common knowledge in the center (another serious concern in addition to there being a meeting about us without our knowledge).

Another staff member informed Karen that there was a flurry of activity in [redacted]'s room that morning and [redacted] was up and out of bed on time for her lunch for the first time in a long while. This appeared encouraging as it seemed that management had taken the previous day's events seriously. Sadly, this could have not been further from the truth.

In the middle of [redacted]'s massage, Karen was surprised by the arrival of a large contingent of staff including the new cover for [redacted]'s position, CPL [redacted], [redacted], and a number of staff including two male healthcare workers. Karen was told by [redacted] that they were there to perform another assessment on [redacted]. [redacted] told Karen that this was not his idea and he was just told to attend. The CPL fully expected to interrupt [redacted]'s paid massage session to perform another unauthorized assessment contrary to the agreement with the family. Karen asked them to leave but they stated they would return to do the assessment. Karen said they would have to speak to me before doing anything. Karen then phoned me to explain what had just happened. I asked her to find [redacted] and the CPL so I could speak to them and make it clear this was not going to happen. I was also going to explain that for them to have arranged this behind the back of the family was an unforgivable breach of trust and failure of their respective colleges' code of conduct.

[redacted] came back to the room and refused to speak to me on the phone. [redacted], the CPL arrived, and I spoke with her on the phone. I asked who had authorized this. She stated that [redacted] had sent her an email late on Wednesday (after our meeting with [redacted] and [redacted]) to ask [redacted] to arrange an afternoon assessment to see if [redacted] was worse than the morning. This contradicted the initial request to change the assessment to the morning, when she considered [redacted] would be at her weakest. [redacted] stated that [redacted] did not provide any information on what had happened and had been agreed to with the family the day before. It was pointed out to [redacted] that regardless; this could not happen without prior contact and agreement with the family as per the care plan which was outlined on [redacted]'s door. [redacted] checked the sign on the door, agreed and started to apologize.

I explained this this incident breached the professional standards required of their respective colleges ([redacted], [redacted] and [redacted] herself) and that I now considered this harassment. We also explained how this all started. Again, [redacted] apologized and appeared very concerned that she had been misled into this confrontation. She stated she would be putting out a communication across Capital Care Dickinsfield to ensure nothing like this ever happened again.

Later in the day, Karen spoke to a number of staff involved. They had no idea what was happening or why they had

been called to be part of these assessments as they had seen no issues with [redacted]'s ability to transfer. They were all very concerned that anyone would consider changing [redacted] to a mechanical lift, even temporarily, at this time and what the impact would be to [redacted].

Now having lost complete trust in management and [redacted] (not the staff) Karen and I agreed we should be on site the following day when [redacted] would be receiving her regular physio session. We came back to Dickinsfield in the morning to be there for [redacted] getting out of bed.

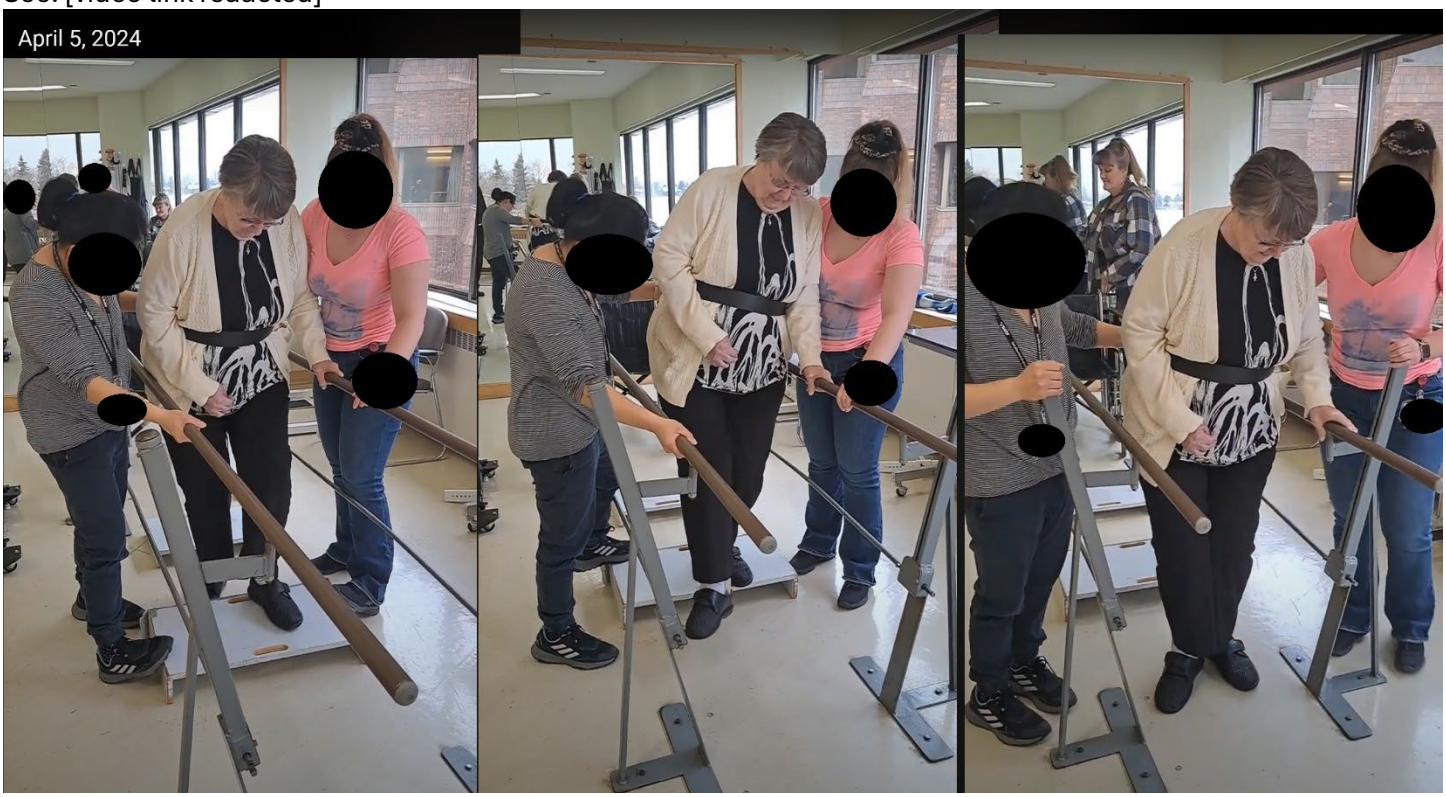
Friday April 5th, 2024.
When we arrived at [redacted]'s room there were two new staff members attempting to get [redacted] out of bed. However, Karen noticed that [redacted]'s bed was at its lowest setting and that her Hill-Rom Synergy Elite Air Mattress was completely deflated. The staff appeared completely oblivious to this despite this putting [redacted] in a forced crouched position with her disabled leg to one side. Trying to force [redacted] out of bed in this situation would have been disastrous and no doubt would have resulted in staff reporting that this was [redacted]'s issue in her ability to transfer. Karen told the staff they needed to raise the bed and correct [redacted]'s leg position. At this point, Karen noticed that the mattress was fully deflated. The staff stated they didn't know the mattress was deflated or how to get the mattress to inflate again. This was strange to state that they didn't know the mattress was deflated but also, they had tried and didn't know how to inflate the mattress. These are mutually exclusive statements. Karen told them that I would come in and inflate the mattress and demonstrate how it worked. Karen then stated they would at least have to raise the bed to compensate for the 8 inches lost with the deflated mattress. This was done and [redacted] was able to resume her morning routine with minimal assistance. There was a further challenge when Karen observed the staff watching [redacted] transfer herself to the toilet. They counted with [redacted] then stood back watching. Karen asked why they were not assisting [redacted] to stand at the toilet. They stated they thought she could do it herself. Karen asked what part of a two person assist they were missing. Considering the fiasco of the previous days, this was becoming frustrating in its contradictions.

I then came into the room to look at the mattress to see why it was deflated. The healthcare worker told me that they had a short power cut earlier. I asked how long ago that had occurred. She said it must have been after 10am as she had brought breakfast to [redacted] at around 10am. I watched as she tried to switch on the mattress. It was clear she was not familiar with this even though it is a common system in use in the center. I then had to explain to her how to switch it on (from the default standby) and also how to switch from "Static" pressure (which would create pressure points for [redacted]) to "Alternate" with a five-minute (default) interval on pressure changes.
I then checked on the power outage with the electrician who was on the unit changing light fixtures. He informed me the power outage at Capital Care Dickinsfield was at about 9am as he had checked with Epcor at the time.

I then spoke to the healthcare worker who had given [redacted] breakfast at 10am (an hour after the power outage). She could not explain how she didn't notice the mattress was completely deflated at that time. By the time Karen had assisted the staff in getting [redacted] out of bed, [redacted] had been lying on a completely deflated mattress for almost 2 ½ hours. This is a serious concern with competency of staff and care of residents. If this was an isolated incident it would be significant, but it is not.

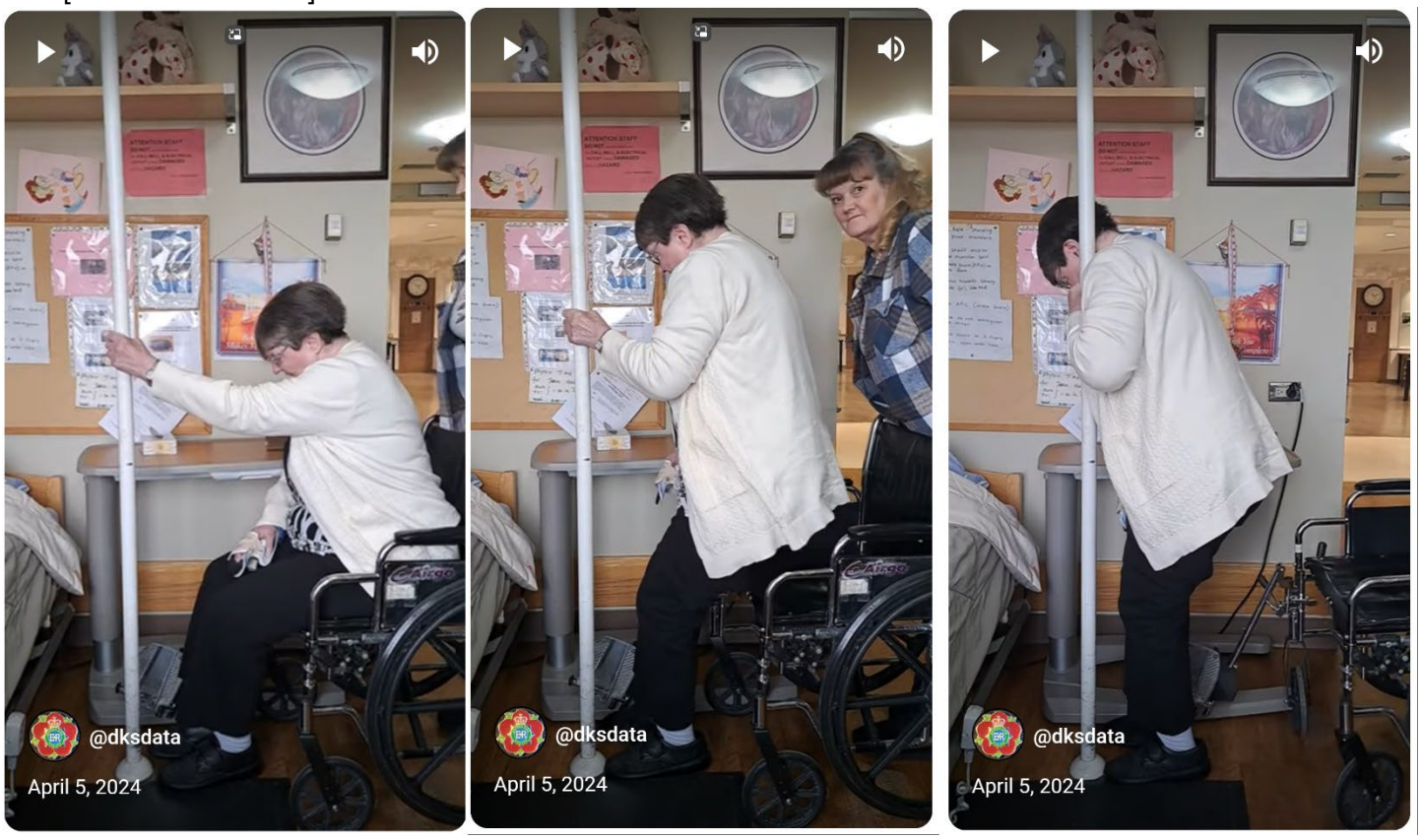
Later that day, we attended [redacted]'s physiotherapy ([redacted] was not present). All the staff were wonderful, and [redacted] had no issues. The staff were happy to have us video [redacted] doing her step exercise which again clearly shows the issue is not with [redacted].

See: [video link redacted]



[redacted] then returned to her room where she transferred from her travel chair back to her regular chair, standing on her own without assistance.

See: [video link redacted]



Note that these videos are private and the links should not be shared without prior written permission from myself or Karen.

- What was the real impetus for [redacted] to unilaterally the original decision to change [redacted]s care plan to a mechanical Lift?
- Who made the alleged complaints about being unable to transfer [redacted] safely? We found no staff who had this issue with [redacted]. All of the staff we spoke to were vocally concerned that someone would make such a false statement about [redacted]. It is also strange that this would have been brought to the attention of the second floor physio, not the RN or manager on duty.
- Why was a second distressing and unnecessary assessment planned deceitfully, without notification to the family and against the agreement made with the staff member ([redacted]) who requested the second assessment.
- Why was [redacted] allowed to lie on a deflated mattress for so long (which may have caused damage to the mattress and harm to [redacted]).
- Why are the staff so unfamiliar with the operation of this mattress system which is widely used in Capital Care?
- Why did a number of staff make so many provably false statements during this whole process?
- How much of this (and prior documented incidents) were known by senior management ([redacted] et al)?
- Were any of the above process instigated or assisted by senior management such as [redacted]?

All these items are clearly something that should normally be brought to the attention of the respective colleges. They are also now at a level that we consider to be harassment of a vulnerable resident. Each incident has caused unnecessary stress not only to [redacted] but also to her family and partner.

This cannot continue.

We are requesting an urgent meeting with you Aileen.

Thanks,

David & Karen for [redacted].

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