Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2019	2019_605213_0034	021323-19	Complaint

Licensee/Titulaire de permis

Omni Healthcare (CT) GPCO Ltd. as General Partner of Omni Healthcare (Country Terrace) Limited Partnership
161 Bay Street, Suite 2430 TD Canada Trust Tower TORONTO ON M5J 2S1

Long-Term Care Home/Foyer de soins de longue durée

Country Terrace
10072 Oxbow Drive, R.R. #3 Komoka ON N0L 1R0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RHONDA KUKOLY (213), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 6, 7, 12, 13, 14, 2019.

This inspection was completed related to a complaint regarding resident rights.

This inspection was completed concurrently while in the home with Inspector #610 and #563 completing inspection #2019_778563_0040, and Inspection #630 completing inspection #2019_722630_0031.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, a resident, family members, friends of residents and lawyers for the resident.

The Inspectors also made observations and reviewed health records, internal investigation records, communications and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of resident and the needs and preferences of that resident.

A complaint was received by the Ministry of Long-Term Care (MOLTC) that a residents rights were being violated by the home by implementing restrictions in the plan of care.

A record review for the resident was completed and showed the resident was admitted with cognitive impairment. A capacity assessment completed just prior to admission noted the resident was mentally incompetent to manage their own finances.

A cognitive assessment completed by the home on admission showed mild cognitive impairment. A follow up cognitive assessment was completed by the home six months later and indicated a decline and moderate cognitive impairment.

A referral to the Geriatric Ambulatory Access Team was sent by the home and indicated:
- Urgent referral from cancer clinic regarding social worker and constant claims of financial abuse.
- Constantly accuses people of stealing their money. Behaviours associated with dementia.

A consultation report from an acute care facility stated, the resident asked again to help them leave the nursing home. They acknowledged that they had been well treated at the nursing home and they were receiving all the care, services and food as needed. Unfortunately, they continued to lack insight of their cognitive impairment and inability with executive function.

The resident's plan of care upon start and completion of the inspection included not to share information with anyone but their POA and various other restrictions. The resident profile in Medecare throughout the inspection included an alert that included various restrictions.

An email from the resident's POA to the Director of Care (DOC) included directions from the POA to include restrictions in the resident's plan of care. An email from the Administrator to the OMNI Director of Operations advising of the incident of alleged financial abuse and actions taken in response. They said the resident was not capable and advised that the resident's POA requested restrictions be included in the resident's plan of care until they could figure out how to protect the resident.

The Initial Assessment from the Geriatric Behavioural Response Team indicated the

resident reported to staff that they were being financially abused. The resident had been able to call and request assistance from a lawyer. It was noted by management at the home that the resident had memory impairment. The resident's POA had been cooperative since admission, all bills were paid and anything the resident requested was provided. The resident told the assessor that someone stole their phone when the phone was in the assessor's view on their bedside table. The assessor scored the resident with moderate cognitive impairment (lost points on visuospatial/executive, language, delayed recall as well as orientation).

A progress note documented by the resident's physician indicated that they had changed the resident's orders on the direction of the resident's POA.

The resident's lawyer provided the home with a letter that stated in part that they demanded that the home immediately cease any restrictions. They said the resident was mentally competent with respect to those decisions and neither the resident's POA nor the home had any legal authority to restrict the resident's activities. The lawyer had contacted the local OPP detachment and advised of the same.

The resident's lawyer provided the home with a second letter that included that they attended the home to meet with the resident and executed revocations of previous powers of attorney. The revocations were prepared upon the instructions of the resident. They reviewed the documents and in their professional opinion, the resident understood the content of each document and the impact of executing them. The home believed the resident to be incapable and refused to accept the validity of the revocations and the consent. In the home's opinion, a capacity assessment was needed before such documents could be deemed valid. Since the resident's attorney for property and personal care had come to an end, for the home to ensure that all of the resident's belongings were returned to them.

In an interview with the resident, they were not able to recall where they lived prior to long term care. The resident was aware of who their POA for personal care and finances was and that they wished for that to be revoked, but was not able to elaborate further regarding details of their concern or reason for revocation. The resident recalled that they had contacted a lawyer for the revocation but could not recall how they obtained the contact information or name. The resident was not able to recall that they had already signed the document for revocation of POA. The resident also shared that they had given a large sum of money to a friend as a gift recently. The resident said that their POA was paying all the bills for accommodation and expenses and provided them a large sum of

money per week for spending money in the home, but that was not enough. The resident was not able to elaborate on what they would spend that amount of money on. The resident said that they required assistance to get in and out of bed, to use the toilet and to get washed and dressed and felt that they that they could manage on their own in their home.

Later that day, Inspectors interviewed the resident again after the resident had received a call from their lawyer. The resident said that someone called and said that the results of the assessment were positive and that they told them that they were free to leave. The resident then asked who that person was, was it a doctor or a psychiatrist, that they had never met that person before.

The Administrator said that on admission, the resident was in a bad situation. They said there were times when the resident was able to have a conversation and there were times when they could not remember well. There were days that they were good and other days would have some type of hallucinations; days they did have clarity and other days they did not. The Administrator reported that there was an incident of suspected financial abuse and police were called. They said that a capacity assessment had just been completed and it was determined that the resident knew enough to change their POA. They said that they did not think the resident would manage okay on their own in the community and that POA for finances required another capacity assessment. The Administrator said that a capacity assessment from the time of admission that the resident incapable for finances. They said that there were restrictions in the resident's plan of care for the resident's safety that had recently been removed, because the resident's POA had been revoked and there was no POA in place at the that time.

A progress note documented in Medecare by the Administrator noted a discussion with the resident regarding the restrictions in the care plan being removed and cautioned the resident to be safe. Another progress note stated the resident was found kneeling on the floor beside bed by a Personal Support Worker (PSW) who had responded to bed alarm. The resident was very confused and speaking nonsensically.

The Director of Care (DOC) said that once a resident was incapable, even if they might have good days when they could make decisions, then they were incapable of making all decisions. They said that the decision to have someone acting as POA was based on a pattern of bad decision making; if there were things that were done that did not follow logical lines and as that pattern became more obvious to the people around them, then the person taking over could make all decisions for that person. When asked about the

resident's current plan of the DOC said that previously there restrictions in the plan of care and now they were all removed. The DOC said that they felt that the resident needed to be protected due to cognitive impairment. They said the resident had good days and bad days, days when they made sense, was lucid and could hold conversations and other days when they were not orientated. The DOC said that it was the resident's POA who decided the restrictions in the resident's plan of care needed to be in place.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of resident and the needs and preferences of that resident. [s. 6. (2)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that financial abuse of a resident by anyone that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and information upon which it was based to the Director.

On November 5, 2019, the Ministry of Long-Term Care (MOLTC) received complaint IL-71826-LO in which the complainant expressed concerns regarding a resident's rights. The Administrator said that the resident's Power of Attorney (POA) had contacted them about a concern regarding the resident's safety and potential financial abuse. The Administrator said they called the police regarding the allegations but did not report the alleged financial abuse to the MOLTC.

The Administrator also provided the inspectors with documentation related to the allegations of resident financial abuse and the home's response to those allegations. These documents included an email by the Administrator to the OMNI Director of Operations advising of the incident of alleged financial abuse and actions taken in response. The OMNI Director of Operations responded to the Administrator in an email and asked if the administrator had called the police as this was an elder abuse case for sure.

An Ontario Provincial Police (OPP) Officer said they had responded to an allegation of financial abuse that the administrator of the home had reported to the police. The Officer said they were contacted by Administrator #101 based on communication they had with the resident's POA advising of suspicious activity in the resident's bank account.

A review of LTChomes.net during the inspection identified that there were no Critical Incident System (CIS) reports related to allegations of financial abuse for this resident.

The licensee has failed to ensure that the Director was immediately notified of the allegations of financial abuse. [s. 24. (1)]

Issued on this 12th day of December, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.