



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de
Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 3, 2014	2014_369153_0004	T-627-14	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

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

TRILLIUM MANOR HOME FOR THE AGED
12 GRACE AVENUE, ORILLIA, ON, L3V-2K2

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

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 23, 24, July 2, 2014.

During the course of the inspection, the inspector(s) spoke with director of human resources, general manager of health and emergency services, treasurer, controller, accounting supervisor, administrator, administrative assistant and residents.

During the course of the inspection, the inspector(s) reviewed purchased service agreements, trust transaction lists, trust statements, auditor reports and financial policies and procedures.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Trust Accounts**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :



1. The licensee failed to protect residents from financial abuse.

On April 11, 2014, an inquiry was received in relation to the length of time it took for deposits to be posted to resident trust accounts.

An internal investigation was completed identifying irregularities in some residents' trust accounts at the corporate finance department.

Through interviews and record reviews it was identified that resident #02 and #03 had \$300.00 each misappropriated from their trust accounts in March and April, 2014.

The identified residents' trust accounts were reimbursed by the licensee on April 29, 2014.

New measures were implemented by the licensee to reduce the risk of a similar incident occurring in the future.

An interview with the General Manager of Health and Emergency Services confirmed financial abuse had occurred at the corporate financial department. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure all residents are protected from financial abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :



**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 sous la
Loi de 2007 sur les foyers de
soins de longue durée**

1. The licensee failed to ensure the resident and a resident's substitute decision maker (SDM) were notified of the results of the alleged abuse investigation immediately upon completion.

The investigation was completed on May 5, 2014, involving financial abuse. On May 21, 2014, resident #3 and the SDM for resident #2 were informed of the misappropriation of funds in the identified residents' trust accounts by the Administrator.

The misappropriated funds were deposited into both residents' trust accounts on April 29, 2014.

An interview with the Administrator confirmed that resident #3 and the SDM for resident #2 were not notified of the results of the alleged abuse investigation immediately upon completion of the investigation. [s. 97. (2)]

Issued on this 3rd day of September, 2014

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