



**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**

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2014	2014_369153_0009	T-628-14	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

SIMCOE MANOR HOME FOR THE AGED
5988 – 8th Line, Beeton, ON, L0G-1A0

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

LYNN PARSONS (153)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): July 2, 22, 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, residents and substitute decision maker (SDM).

During the course of the inspection, the inspector(s) reviewed purchase 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 has failed to protect residents from financial abuse.

On April 11, 2014, an inquiry was received from a resident's family in another of the licensee's LTC Homes in relation to the length of time it took for deposits to be posted to the residents' 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 forty-six residents had funds misappropriated from their trust accounts in amounts ranging from \$0.50 to \$420.00.

The identified residents' 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 Administrator confirmed financial abuse had occurred at the corporate finance 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 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 :



1. The licensee has failed to ensure that the residents' substitute decision makers (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.

The SDMs for all the identified residents were notified of the misappropriation of funds commencing May 26, 2014.

The misappropriated funds were deposited by the licensee into the identified residents' trust accounts on April 29, 2014.

An interview with the Administrator confirmed the SDMs for the identified residents were not notified of the results of the alleged abuse investigation immediately upon completion of the investigation. [s. 97. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (8) A resident, or a person acting on behalf of a resident, who wishes to pay a licensee for charges under section 91 of the Act with money from a trust account shall provide the licensee with a written authorization that specifies what the charge is for, including a description of the goods or services provided, the frequency and timing of the withdrawal and the amount of the charge. O. Reg. 79/10, s. 241 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written authorization from the resident, or a person on behalf of the resident, who wishes to pay a licensee for charges under section 91 of the Act with money from the trust account, that specifies what the charge is for.

A review of the transaction history for resident #3 from April 1 to June 30, 2014, revealed a monthly withdrawal charge of \$72.86 for Rogers Cable.

A review of the purchased services agreement for resident #3 failed to reveal authorization to withdraw the monthly cable fee from the trust account.

An interview with the Administrator confirmed neither the resident nor the SDM had authorized the withdrawal for the monthly cable fee from the resident's trust account.

[s. 241. (8)]



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Issued on this 9th day of September, 2014

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